

# Oklahoma State Board of Health Retreat

Chickasaw Retreat and Conference Center

Great Room

4205 Goddard Youth Camp Road

Sulphur, OK 73086

August 12-13, 2016

## Retreat Objectives:

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

## Friday, August 12<sup>th</sup>

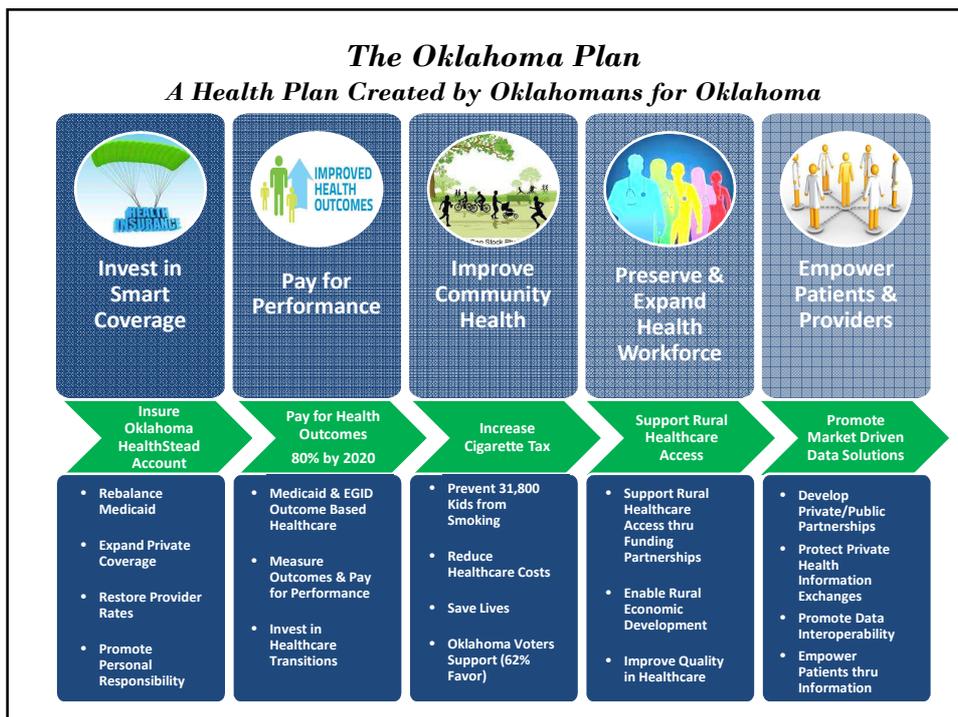
12:00 PM	Board Tutorial (Board of Health Members)	VaLauna Grissom
	Break	
1:00 PM	Meet and Greet	
2:00 PM	Call to Order	Martha Burger
	Welcome	Governor Anoatubby
	Retreat Mission and Objectives	
	1. <i>Strategic changes based on environment</i>	Martha Burger
	2. <i>Deeper understanding of other influences on health</i>	
	Panel Discussion	
	<i>Moderator: Terry Cline</i>	
	<i>Panelists: Julie Cox-Kain, Nico Gomez, Ted Haynes</i>	Dr. Cline
	<i>(3) 15 minute presentations: Oklahoma Plan; Background on Medicaid Rebalancing Act; Payment Reform- Value Based</i>	
	Break	
	Panel Discussion	Dr. Cline
	<i>Moderator: Terry Cline</i>	
	<i>Panelists: Julie Cox-Kain, Nico Gomez, Ted Haynes</i>	
	<i>Open discussion with the Board</i>	
	Proposed Executive Session	Martha Burger
	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.	
	<ul style="list-style-type: none"><li>• OAS 2016-029</li></ul>	
	Possible action taken as a result of Executive Session	
	Adjournment	Martha Burger

## Saturday, August 13<sup>th</sup>

### **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	Martha Burger
	Approval of June 14, 2016 Meeting Minutes <i>Discussion and possible action</i>	
	Retreat Objectives	Neil Hann
	State Innovation Model (SIM) Presentation	Julie Cox-Kain
	Break	
	High Level Strategic Plan Metrics <i>Discussion and possible action</i>	Neil Hann Julie Cox-Kain
	Budget Cuts / Impact of Budget on Strategic Plan Breakout <i>Board discussion and possible readjustments</i>	Neil Hann Deborah Nichols
12:00 PM	Working Lunch	
	Innovation Breakout <i>Discussion and possible action</i>	Neil Hann
	Health Impact Assessments (HIA) + Health in All Policies (HiAP) <i>Deeper dive into the HiAP (Choctaw Nation)</i>	Julie Cox-Kain
	Break	
3:00 PM	Summary, Wrap up, Closing, Adjournment	Martha Burger



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 410<sup>th</sup> 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 Alexopoulos, 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; VaLauna 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 Explain that immediately following 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: Alexopoulos, 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: Alexopoulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson**

**ABSENT: Burger, Grim**

Dr. Alexopoulos 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

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

**Accountability, Ethics, & Audit Committee**

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

**Public Health Policy Committee**

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

**PRESIDENT’S REPORT**

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

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

**ELECTION OF OFFICERS 2016-2017**

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

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

34 **AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson**

35 **ABSENT: Burger, Grim**

**COMMISSIONER’S REPORT**

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

**NO NEW BUSINESS**

**ADJOURNMENT**

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

51 **AYE: Alexopulos, Gerard, Krishna, Stewart, Starkey, Wolfe, Woodson**

52 **ABSENT: Burger, Grim**

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The meeting adjourned at 11:48 a.m.

Approved

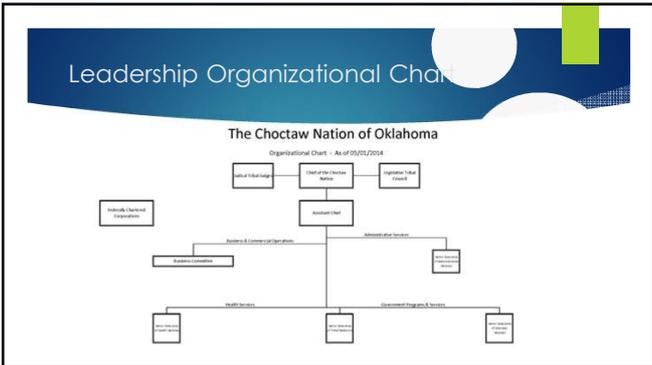
\_\_\_\_\_  
Martha A. Burger, M.B.A.  
President, Oklahoma State Board of Health  
August 13, 2016

Welcome on behalf of the Choctaw Nation of Oklahoma and the Choctaw Nation Health Care



### Overview

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



### Chief Gary Batton



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 at the Choctaw Nation Housing Authority.

In 1997, he accepted the position of Executive Director of Health. His first undertaking was constructing 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 system 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 opening 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 soon after being honorably discharged from the 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.

Attending the Lighthouse Cathedral Church for the past 30 years, Austin has served as a board member there the past ten years and enjoys work as a youth pastor, 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
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## Tribal Council



District 7 Jack Austin, Sr. District 8 Perry Thompson District 9 Ted Dosh District 10 Anthony Dillard District 11 Bob Fate District 12 James Frazer

## Tribal Judges

- ▶ Constitutional Court
  - ▶ Chief Justice David Burrage, Judge Mitch Mullin, Judge Frederick Bobb
- ▶ Appellate Division
  - ▶ Chief Judge P.L. Pat Phelps
  - ▶ Judge Bob Rabon
  - ▶ Judge Warran Gotcher
- ▶ Tribal District Courts
  - ▶ Chief Judge Rick Branam
  - ▶ Judge Steven Parker
  - ▶ Judge Rebecca Cryer

## Senior Executive Officers

- ▶ MEMBER SERVICES: Stacy Shepherd
  - ▶ Cultural Services, Summer Camps, Ivshka homma, Historic Preservation, Wheelock, 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, WIOA, College and Career Retention, Career Development, STARS program
  - ▶ Housing, Rental Assistance, Homeowners Services, Rental Services
  - ▶ Outreach, Youth Outreach, Injury Prevention, Connecting Choctaw Kids to Coverage, EMPOWER, Project HOUSE, Victim Assistance, Elder Advocacy, Community Based Social Work, Vocational Rehabilitation, Pregnant and Parenting Teen Project, Community Health
  - ▶ Special Services, Job of the Day, Veterans Advocacy, Child & Family Services, Tribal Services, Membership, CDIB, Genealogy, Emergency Services, Next Step

## Senior Executive Officers

- ▶ HEALTH SERVICES – Teresa Jackson
  - ▶ Tallhina campus includes hospital and clinic
    - ▶ Diabetic Wellness Center, two residential substance abuse centers, Behavioral Health program, Youth Center, Hospitality House, Tallhina Community Clinic.
  - ▶ Eight Clinics-Poteau, Stigler, McAlester, Atoka, Durant, Hugo, Idabel, & Broken Bow.
  - ▶ Employee Health locations in Durant and Poteau
  - ▶ Pharmacy Refill Center located in Poteau
  - ▶ Wellness Centers located in-Talihina, Poteau, Wilburton, McAlester, Crowder, Coalgate, Atoka, Durant, Hugo, Idabel, Broken Bow, and 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 Aids (EDH) Program

## Senior Executive Officers

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

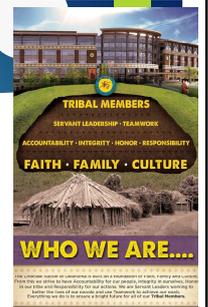
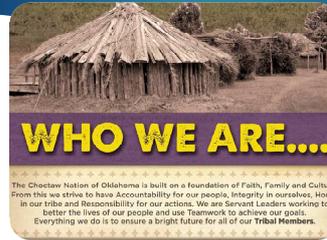
## Senior Executive Officers

- ▶ 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

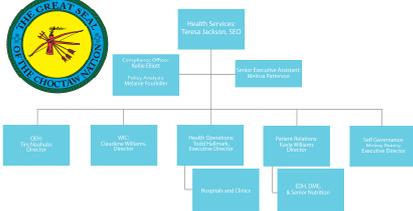
- ▶ COMMERCE – Thomas (TR) Kanuch
  - ▶ Gaming
  - ▶ Travel Plazas
  - ▶ Franchises
  - ▶ Grocery
  - ▶ Agriculture
  - ▶ Leasing
  - ▶ Business Development
  - ▶ Tourism
  - ▶ Project Management
  - ▶ Construction
  - ▶ Facilities Management

## Choctaw Nation of Oklahoma



## Health Organizational Chart

Health System Total Employees - 1402



## Choctaw Nation Health Care

- ▶ 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 Refill Center located in Poteau
- ▶ Wellness Centers located in-Talihina, Poteau, Wilburton, McAlester, Crowder, Coalgate, Atoka, Durant, Hugo, Idabel, Broken Bow, and 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 Aids (EDH) Program



## Geographic Structure and Services

- ▶ 10.5 Counties/12 council districts
- ▶ Area size comparison-State of Vermont
- ▶ Over 200,000 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, Obstetrics & Gynecology, General Surgery, Emergency & Urgent Care, Podiatry, Optometry, Behavioral Health, Physical Therapy, Hearing Clinic, Speech Pathology, Dental, Pharmacy, Radiology, Laboratory, Nutrition, Respiratory Therapy.
- ▶ SPECIALTIES- Orthopedics, Ophthalmology, Cardiology, Pediatric Dentistry, Diabetic Retinal Eye Surgery, Memory Loss Clinic, Pediatric Endocrinology, Pathology, ENT, 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



## Certifications, Partnerships and Successes

- ▶ Joint Commission Accredited
- ▶ Medical contracts with Oklahoma, Arkansas, and Texas
- ▶ Contracts with private insurance carriers
- ▶ Medicare A and B contracts
- ▶ Staff certified to enroll members for insurance through the Affordable Care Act
- ▶ One of two Tribes in the country to have a fully accredited Family Practice Residency Program partnering with Oklahoma State University
- ▶ First Tribe in Oklahoma to sign a contract with Logisticare for billing for medical transportation
- ▶ 1999 we were the first tribe to construct our own hospital, which was completely debt free when we moved in.
- ▶ With the opening of the new facility in Durant, we will be the first tribe to have an out-patient 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 in Oklahoma 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. Adapting 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 thru 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

- ▶ Priority was both tribal & non tribal school age children, parents, school staff and visitors.
- ▶ Extended to businesses, community centers, & community events
- ▶ Shortened paperwork to reduce burden of documentation for individuals
- ▶ As a result of this collaboration and proactive strategies, the OSDH was able to administered **23,987** doses of flu vaccines to community residents within the 11 counties between Sept 2015 to Feb 2016, compared to only 9,537 doses during the same time period in 2014-2015



## Certifications, Partnerships, & Successes

- ▶ Oklahoma Department of Health-Medical Emergency Response Program
- ▶ Choctaw Nation is designated as a Push Partner Site with Region 5 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/prophylaxis events.
- ▶ Choctaw Nation participates in all trainings and exercises associated with the program.



## Certifications, Partnerships, & Successes

- ▶ Oklahoma Department of Health-Healthcare Workforce Subcommittee of the Governor's Council for Workforce and Economic Development
- ▶ A newly developed subcommittee in compliance with a recently passed State Law.
- ▶ David Wharton, Choctaw Nation Health Care employee, has been nominated to represent Tribal Nations. (One of two serve as tribal representation on the committee)



## Certifications, Partnerships, & Successes

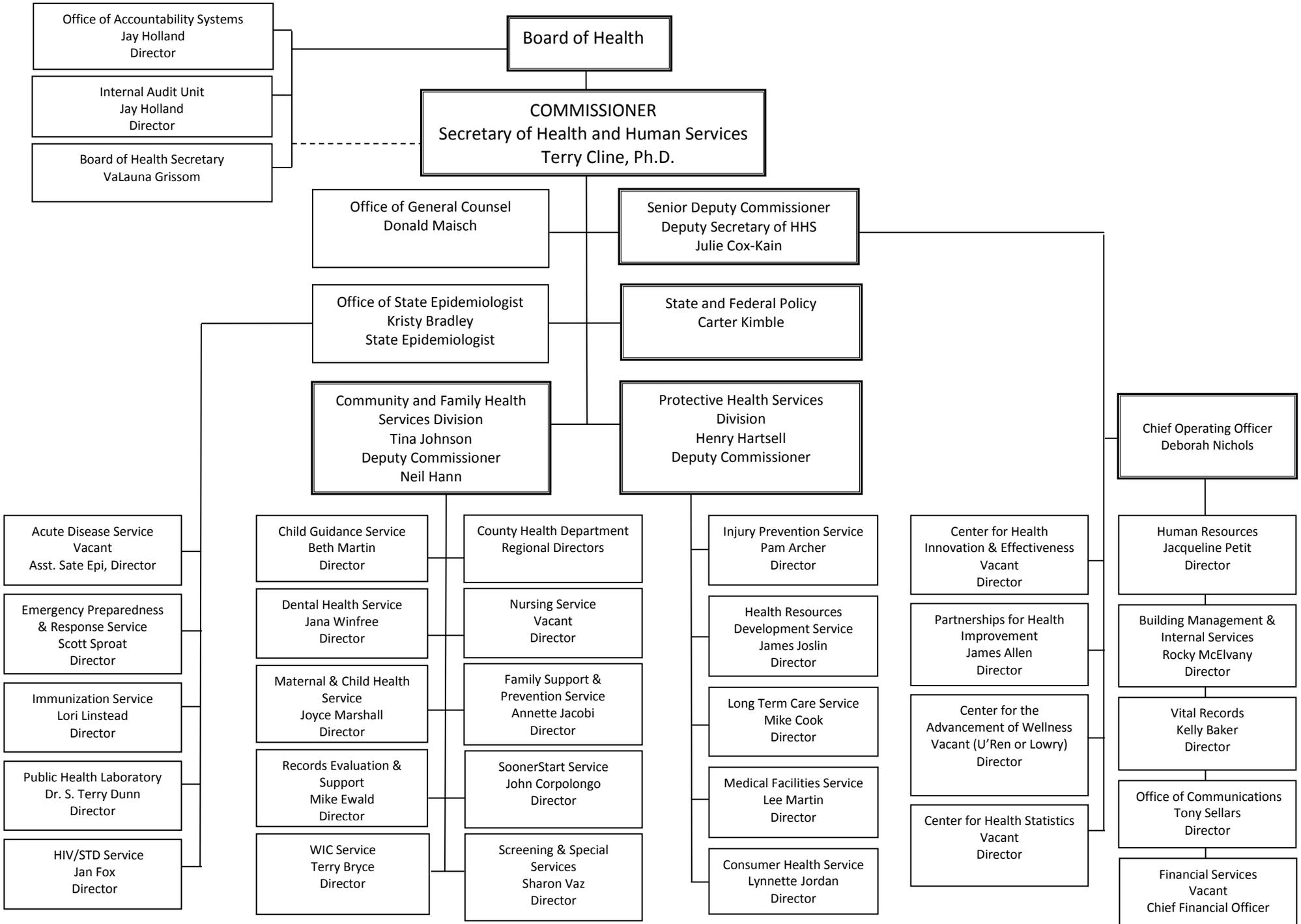
- ▶ Oklahoma Department of Health- Boswell tornado relief efforts
- ▶ May 9, 2016 the communities of Hugo and Boswell were effected by a tornado that hit the area
- ▶ Oklahoma Department of Health and the Choctaw Nation public health nursing department collaborated and provided staffing in both areas to administer tetanus shots to residents and volunteer workers in the area.



## Yakoke (Thank You)

- ▶ Questions?

**ATTACHMENT B**



# Oklahoma State Department of Health



## Oklahoma State Innovation Model

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



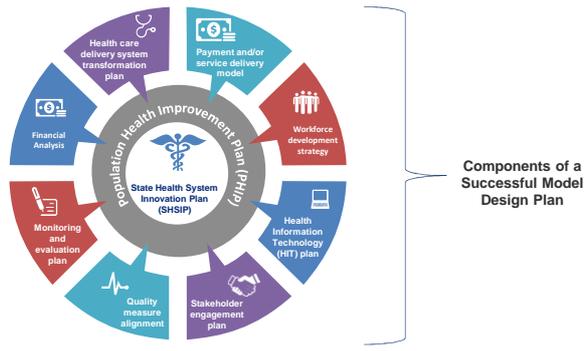
### Oklahoma State Innovation Model Design Grant - What is it?

- 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



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### OSIM State Health System Innovation Plan



**Components of a Successful Model Design Plan**

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### Report on Stakeholder Engagement

This section details stakeholder engagement activities and analysis and interpretation of key findings on collected data.

#### Forums and Communication Channels

- Advisory Committees
- Workgroups/Affinity Groups
- Statewide Webinars
- Conference Presentations
- One-on-One Meetings
- Website and Public Comment Box
- Stakeholder Surveys

#### Executive Steering Committee & Workgroup Meetings

Committee/Workgroup	No. Meetings
Executive Committee	4
All Workgroup	3
HEE Workgroup	7
HWF Workgroup	10
HF Workgroup	7
HET Workgroup	6

#### Stakeholder Organizations Engaged (Total=100)

Organization Type	Percentage
Advisory	3%
Academic/Research	15%
Business	2%
Business Association	2%
Community Organization	6%
Healthcare Association	8%
Payer	15%
Provider	11%
Public Health Coalition	11%
State Local Agency	6%
Tribal Nation/Association	3%
Vendor/Consultancy/Other	15%

#### External Stakeholder Meetings

Stakeholder Organization Type	No. Meetings
Statewide Webinar (All Agency)	2
Advisory	1
Academic	5
Business	2
Business Assoc	5
Community	7
Healthcare Assoc	21
Payer	19
Provider	6
Public Health	14
State/Local	6
Tribal Nation	3
Vendor/Other	3

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### Goals of OSIM

**Create 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

**Achieve the Triple Aim**

Cost  
Quality  
Population 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

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

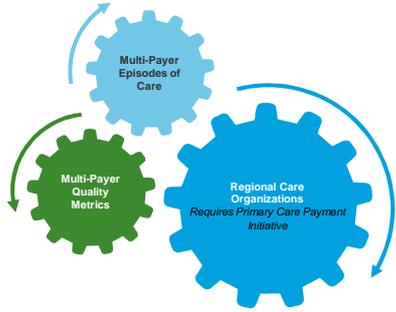
- Multiple models of care coordination
- Provider directed teams
- Community support structure

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# SIM Model Proposal

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 & Value Based Payment Alignment

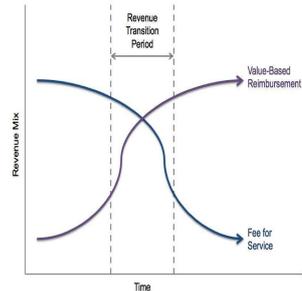
Quality Metric Alignment	State of Oklahoma High-Cost Condition Relative Cost	
	% Increase	Average Annual Cost
1. Maximize health impact		
2. Attack primary cost drivers & causes of death		
3. Reduce burden for providers		
4. Add "P"opulation health component		
	<b>Entire Population</b>	100% \$4,993
	<b>Diabetes</b>	349% \$17,426
	<b>Obesity</b>	343% \$17,126
	<b>Tobacco Usage</b>	345% \$17,226
	<b>Behavioral Health</b>	313% \$15,628
	<b>Hypertension</b>	283% \$14,130

Quality Metric & Value Based Payment Alignment

80% Value Based by 2020

1. Transition the state insurance programs with other carriers
2. Minimize provider loss through planned transition
3. Invest in provider infrastructure

Minimize Loss During Transition



Quality Measure Alignment

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

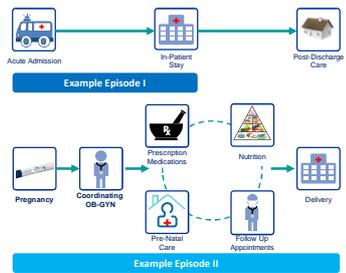
Two key things came from this finding:

1. Recommendations to establish a Quality Metrics Committee to compile a list of recommended measures for state purchased healthcare and private payers
2. Take a deeper dive into what quality metrics would be most effective to use based on our population health priorities (obesity, tobacco use, hypertension, diabetes, behavioral health)

SIM also proposed a list of quality metrics to align payers and hold the RCO model accountable that can be found in the SHSIP. The 11 multi-payer measures are below:

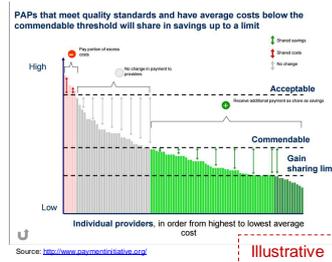
NQF 0028: Tobacco Screening	NQF 0099: Diabetes management poor control	NQF 1932: Diabetes screening of schizophrenia or bipolar
USPTF: Blood Glucose screening for overweight or obese 40-70 yrs	NQF 0018: Controlling high blood pressure	NQF 0421: BMI screening and follow up
NQF 0024: Weight assessment for children/adolescents	NQF 0105: Anti-depressant medication management	NQF 048: Depression Screening
NQF 004: Initiation and engagement of alcohol and other drug dependence treatment	NQF 0576: Follow up after hospitalization (within 30 day) (BH primary diagnosis)	

Episodes of Care – Payment Model Design



- Episodes begin with a triggering event
  - E.g. Acute admission to a hospital
  - E.g. Confirmation of pregnancy
- Episode lasts until a pre-determined duration elapses
  - E.g. 60-day postpartum upon completion or termination of pregnancy
- Episodes define which related services and patients will be considered within the episode's performance year
  - E.g. Certain patients with complex conditions may be excluded and non-related services would also be excluded for episode
- PAPs are initially paid on a fee for service basis and then retroactively evaluated against a set benchmark for the average cost of the care delivered per episode

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 come in under the cost benchmarks receive a percentage of the savings as a bonus, provided they also meet quality benchmarks
- PAPs that exceed the acceptable level of costs may have to pay a portion of the overrun as a penalty
  - Penalties are capped to ensure provider viability

### 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

Governed by a partnership of health care providers, community members, and other stakeholders in the health systems 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

Utilize global, capitated payments with strict quality measure accountability to ensure cost and quality targets are being met statewide

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, et al

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

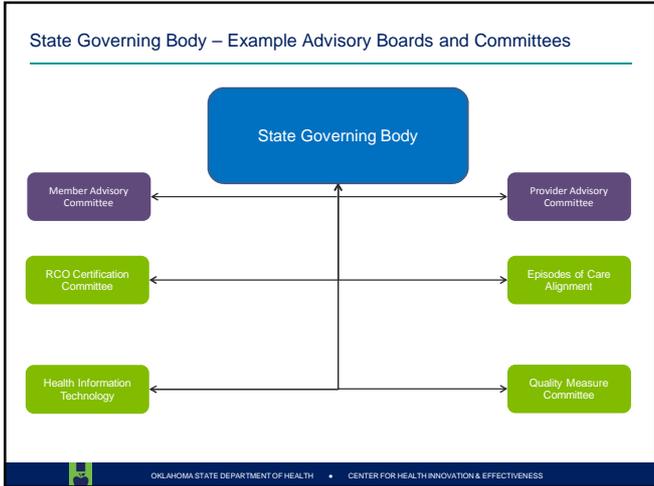
**Regional Care Organizations**

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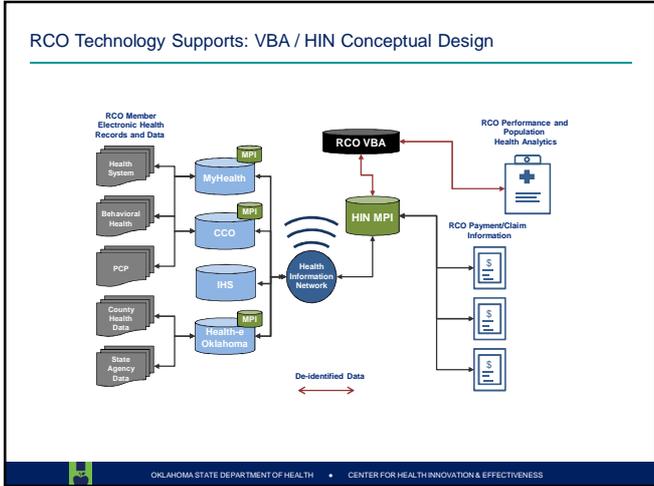
### Regional Care Organization

- Risk adjusted PMPM, globally capitated rate to RCO
- 80% of payments made by RCO to providers will be in a selected APA by 2020
- Community Quality Incentive Pool pays for meeting quality benchmarks set by SGB
- Integrate the social determinants of health through CAB, flexible spending, human needs survey, quality measures, and resource guide
- RCO will articulate best delivery system for region to meet a high bar of quality care based on standards set by SGB
- RCOs will organize a governance structure that incorporates the providers and community they serve
- RCOs will connect to an interoperable HIE to ensure the data to best manage patient care and analyze performance is available to all participating

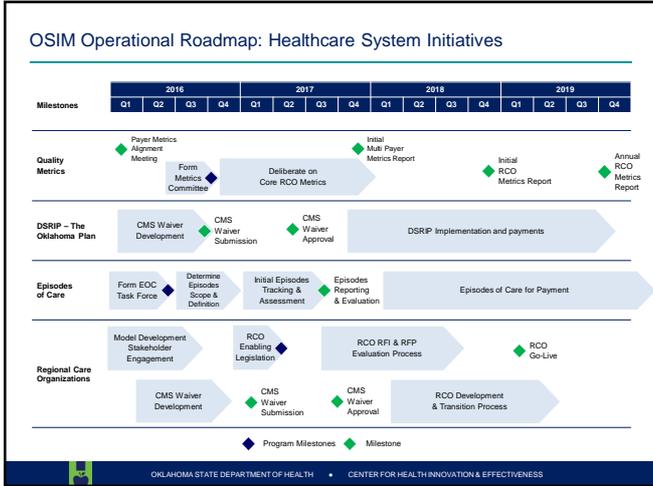
OKLAHOMA STATE DEPARTMENT OF HEALTH • CENTER FOR HEALTH INNOVATION & EFFECTIVENESS 14



# OSIM Health Information Technology Plan



# Next Steps & Timeline



# Impacts to Market/Health Services

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

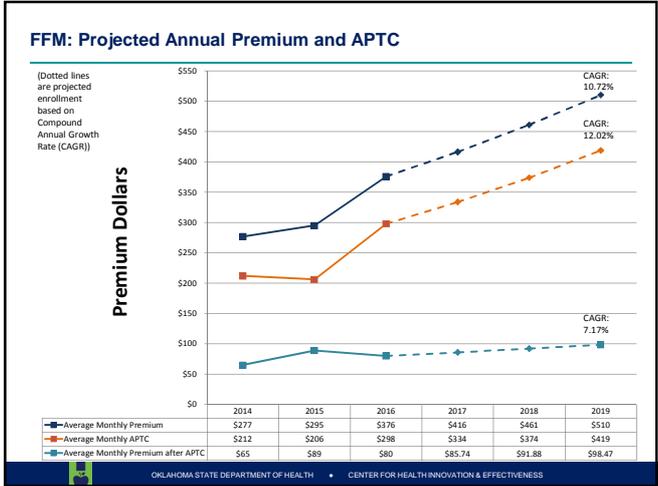
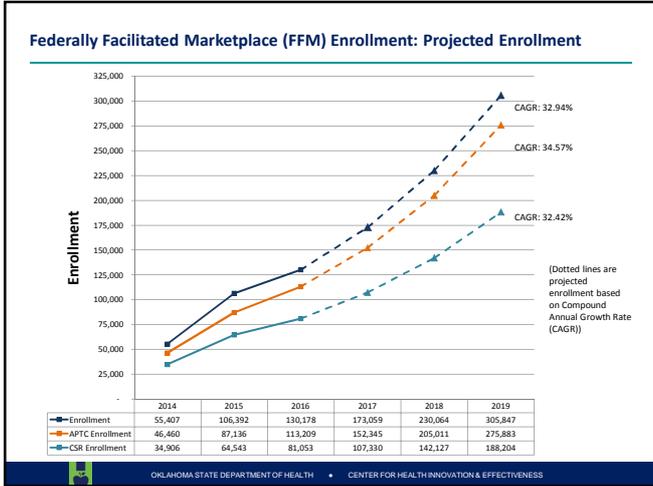
	2014		2015		2016		Compound Annual Growth Rate (Effectuated Only)
	Pre-effectuated	Effectuated	Pre-effectuated	Effectuated	Pre-effectuated	Effectuated	
<b>Enrollment</b>	69,221	55,407	126,115	106,392	145,329	130,178	32.94%
<b>APTC Enrollment</b>	46,460		87,136		113,209		34.57%
<b>CSR Enrollment</b>	34,906		64,543		81,053		32.42%

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

	2014	2015	2016	Compound Annual Growth Rate (Effectuated)
<b>Enrollment</b>	55,407	106,392	130,178	32.94%
<b>Average Monthly Premium (Total)</b>	\$277	\$295	\$376	10.72%
<b>Average Monthly APTC</b>	\$212	\$206	\$298	12.02%
<b>Average Monthly Premium After APTC</b>	\$65	\$89	\$80	7.17%
<b>Estimated Annual Total of APTC</b>	\$140,955,408	\$263,001,024	\$465,516,528	48.92%
<b>Estimated Annual Amount Spent on Premium</b>	\$184,172,868	\$376,627,680	\$590,487,408	47.46%

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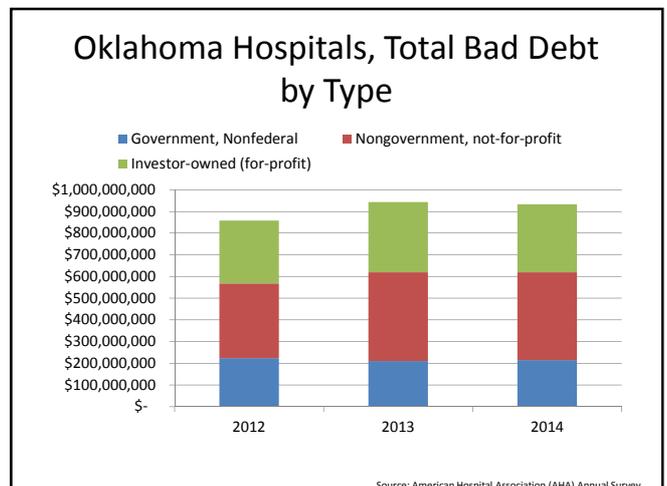
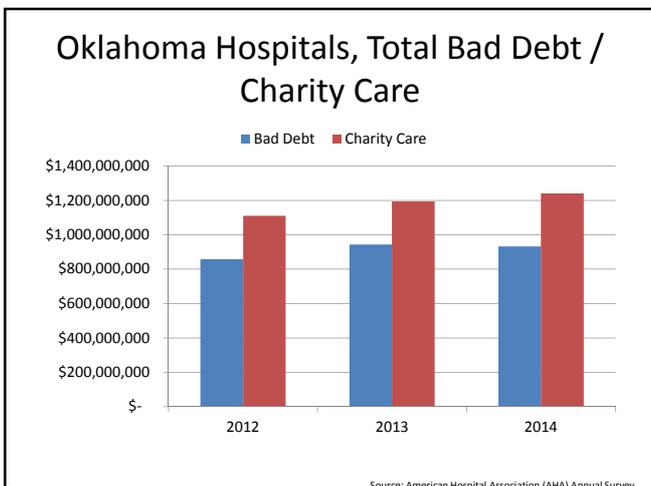
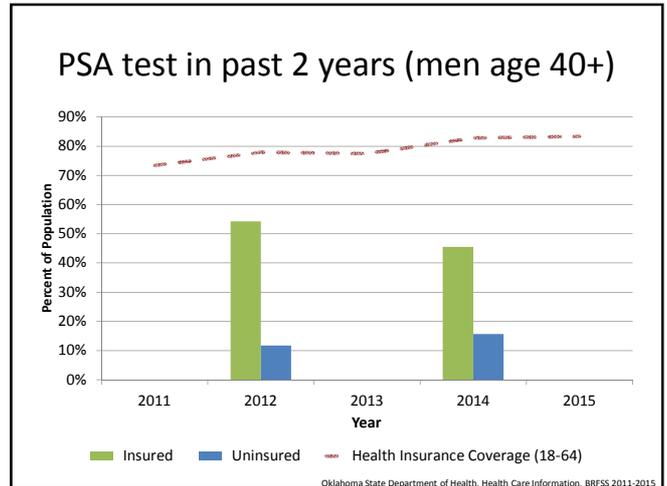
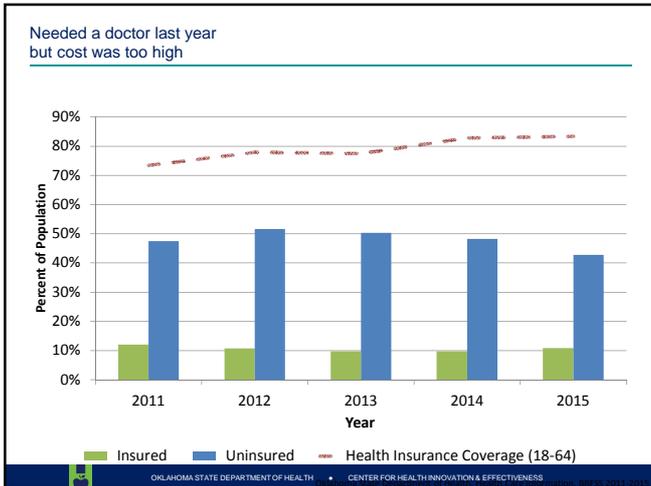


### 2016 FFM Enrollment by FPL

Total Number of Individuals Who Selected a Plan (not effectuated)	Number of Plans with FPL Status	<100% of FPL	≥100% - ≤150% of FPL	>150% - ≤200% of FPL	>200% - ≤250% of FPL	>250% - ≤300% of FPL	>300% - ≤400% of FPL	>400% of FPL
145,329	134,266	4%	38%	23%	16%	9%	8%	2%

### 2016 FFM Enrollment by

Total Number of Individuals Who Selected a Plan (not effectuated)	Number of Plans with Rural Status	In Zip Codes Designated as Rural	In Zip Codes Designated as Urban
145,329	145,329	37%	63%

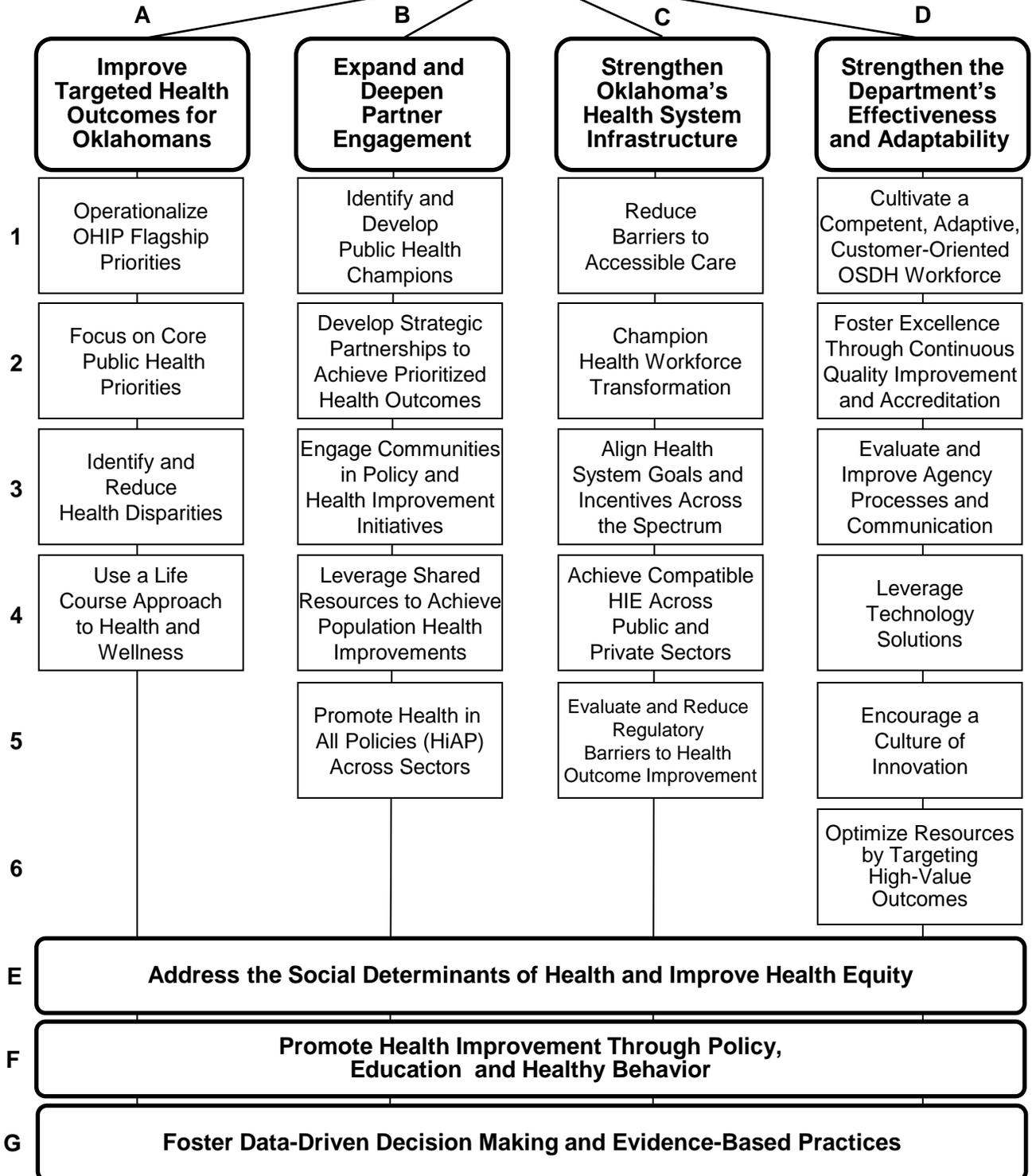


# Questions

# Oklahoma State Department of Health Strategic Map: 2016-2020

Approved  
08/16/15

## Improve Population Health



## Oklahoma State Department of Health (OSDH)

### 2015 - 2020 Core Measure Performance Scorecard for SFY 2016

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:

-  Target Met or Exceeded
-  Within 5% or Less of Target
-  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.

# 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.

Strategic Map Reference	Measure	Baseline Data	Year 1 Target	Year 1 Actual	Trend	5 Year Target
A2	<b>Inspection</b> - Percent of state mandated inspection frequency and complaint investigations are achieved annually.	100%	100%	100%	→	100%
A2	<b>Infectious Disease</b> - % of immediately notifiable reports received by phone consultation or PHIDDO submission in which investigation is initiated within 15 minutes.	95%	96%	95%	→	98%
A2	<b>Infectious Disease</b> - Average number of reported Tuberculosis, Pertussis and Salmonella cases per 100,00 population.	27.2	New Measure	27.2	→	20.25
A2	<b>Preparedness</b> - Improve State Score on National Health Security Preparedness Index by 0.5%*	6.5	New Measure	6.5	→	9
A1	<b>Children</b> - Infant deaths per 1,000 live births	7.5	7.4	7.4*	↓	7
A1	<b>Children</b> - Maternal deaths per 100,000	28.4	24.7	25*	↓	23.1
A1	<b>Children</b> - Birth rate to adolescents age 15-17	20.5	20.2	16.2*	↓	19.2
A1	<b>Injury</b> - Reduction in the age-adjusted motor vehicle crash hospitalization rate per 100,000 population	70.6	69.2	60	↓	63.5
A2	<b>Injury</b> - Prevent any increase in the rate per 100,000 of fall-related hospitalizations among persons age 65 and older.	1289.7	1289.7	1175.9	↓	1289.7
A2	<b>Prevention</b> - Reduce the rate, per 100,000, of potentially preventable hospitalizations.	1836.2	1762.8	1702.9	↓	1468.96
A2	<b>Immunization</b> - 4:3:1:3:3:1:4 immunization coverage rates of children 19-35 months of age	73.30%	71.96%	73.3%	→	80%
A2	<b>Immunization</b> - Percent of adolescents age 13 - 17 receiving meningococcal vaccine	70.80%	70.94%	70.8%	→	71.50%
A2	<b>Immunization</b> - Percent of adults age 65 and over receiving influenza vaccine	67%	69.60%	68.9%	↑	80%
A1	<b>Obesity</b> - Percent of adults who are obese	33.0%	32.30%	34%	↑	29.5%
A1	<b>Obesity</b> - Percent of adolescents who are obese	11.8%	11.56%	17.3%	↑	10.6%
A1	<b>Obesity</b> - Percentage of the population that has participated in any physical activity in the last 30 days	67.0%	69.44%	66.8%	↓	79.2%
A1	<b>Tobacco</b> - Percent of adults who smoke	21.1%	20.48%	22.2%	↑	18%
A1	<b>Tobacco</b> - Percent of high-school adolescents who smoke	15.1%	14.08%	14.6%	↓	10%
A1	<b>Tobacco</b> - Percent of middle-school adolescents who smoke	4.8%	4.24%	4.1%	↓	2%
A2	<b>Cardiovascular</b> - Cardiovascular disease deaths per 100,000	289.8	284.8	288.5	↓	265
A1	<b>Behavioral Health</b> - Suicide deaths per 100,000	24.7	23.64	26.9*	↑	19.4
A1	<b>Behavioral Health</b> - Unintentional poisoning deaths per 100,000	19.66	19.26	18.88	↓	17.69
B1/B2	<b>Policy</b> - # of community organizations supporting OHIP legislation	13	18	60	↑	40
B3	<b>Public Health Partnerships</b> - # of certified healthy community	77	80	78	↑	94
B3	<b>Public Health Partnerships</b> - # of certified healthy schools	595	640	683	↑	820
C4	<b>Immunization Interoperability</b> - # of interoperable immunization systems	0	0	0	→	1
D1	<b>Workforce</b> - % of turnover agency wide	12.9%	12.32%	12.18%**	↓	10%
D2	<b>Accreditation</b> - # of PHAB accredited OSDH Health Departments in OK	2	4	2	→	10

■ Target met or exceeded  
■ Within 5% of target  
■ Greater than 5% from target

## Scorecard Explanation for Unmet Performance Measures 2015 - 2020

**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 OSIS. 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 29-30<sup>th</sup>, 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.

## Oklahoma State Department of Health (OSDH)

### 2015 - 2020 Proxy / Provisional Dashboard

**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 [OK2SHARE@health.ok.gov](mailto:OK2SHARE@health.ok.gov).

Data last updated July 21, 2016

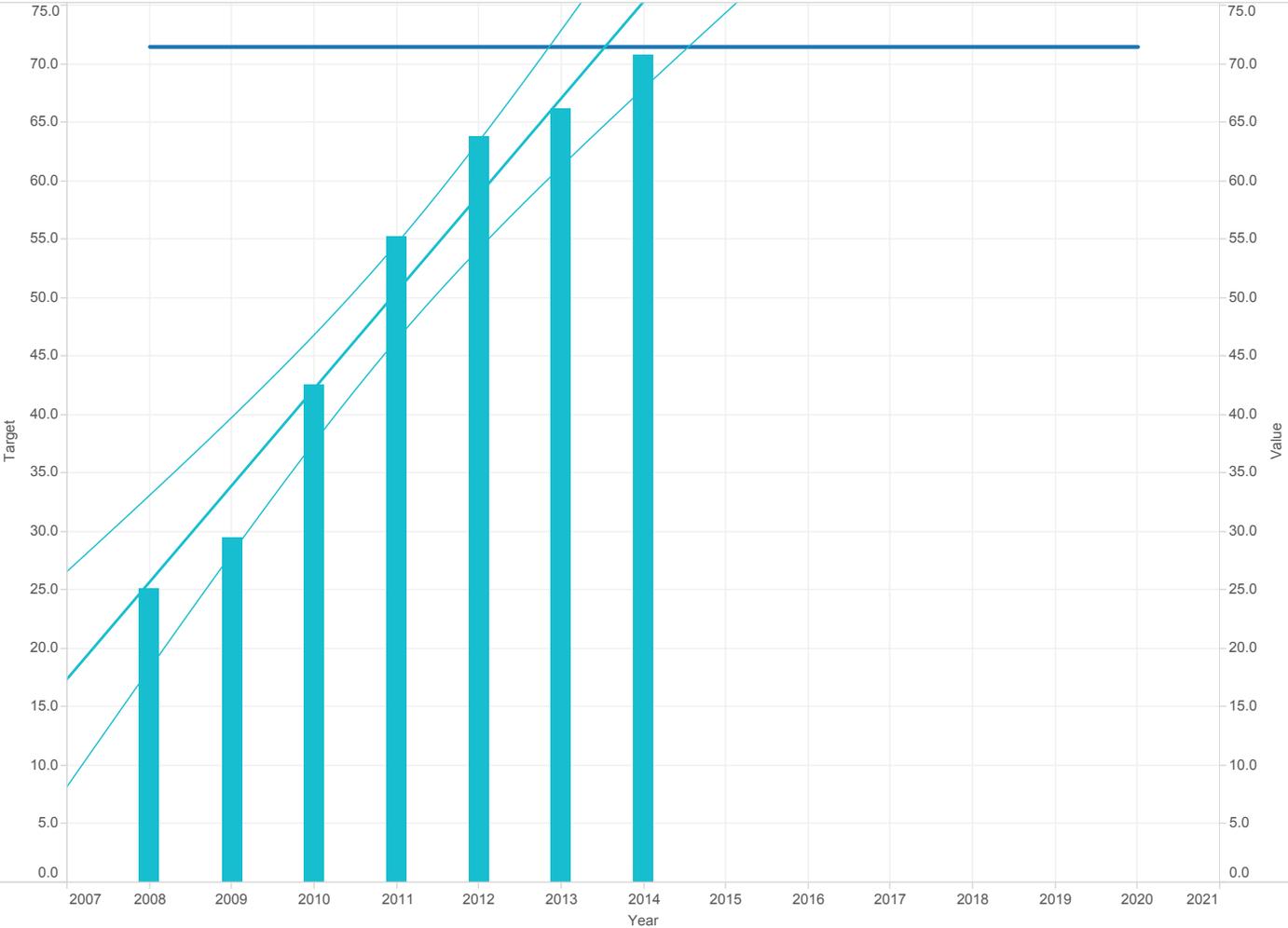
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Measure  
Adolescent Meningococcal Vaccination

■ Target ■ Value

Percent of adolescents age 13 - 17 receiving meningococcal vaccine

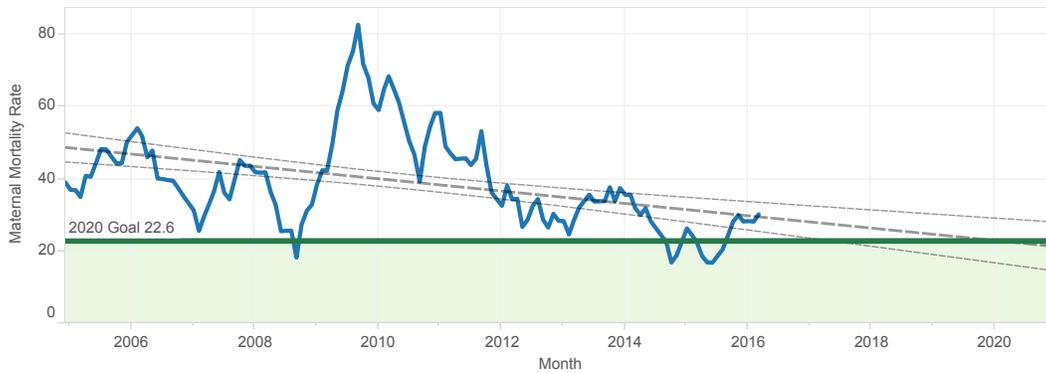


## PROXY/PROVISIONAL - A1 OHIP Children's Health Measures

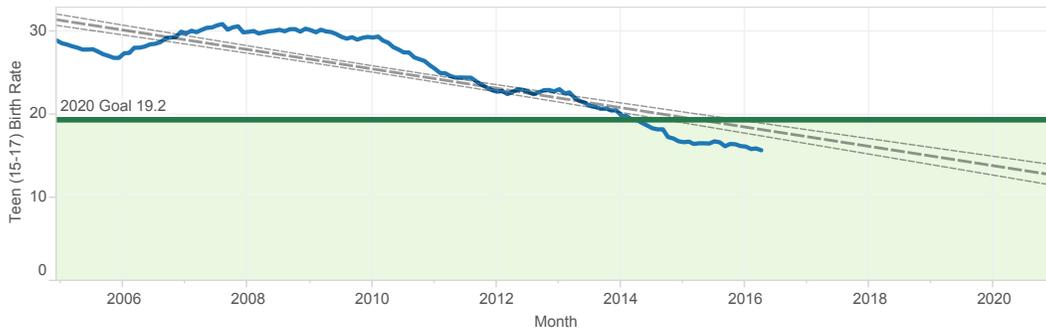
### Infant Mortality Rate (per 1,000 Live Births)



### Maternal Mortality Rate (per 100,000 Births)

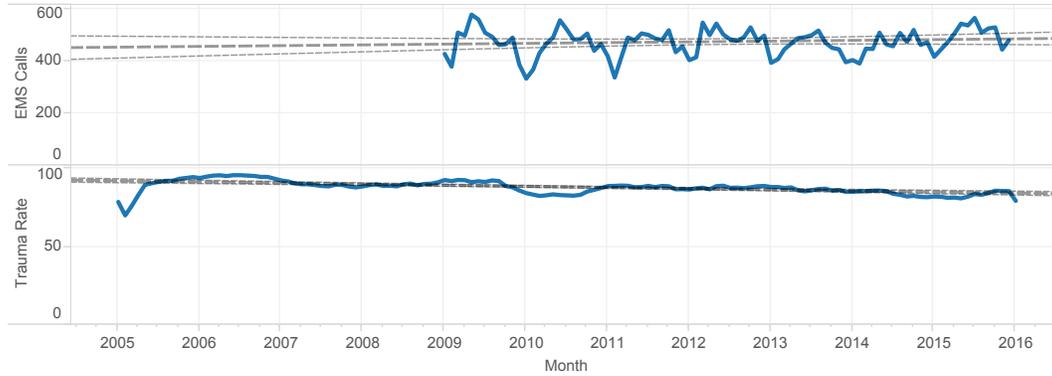


### Teen (15-17 yrs) Birth Rate (per 1,000 Females)



## 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)

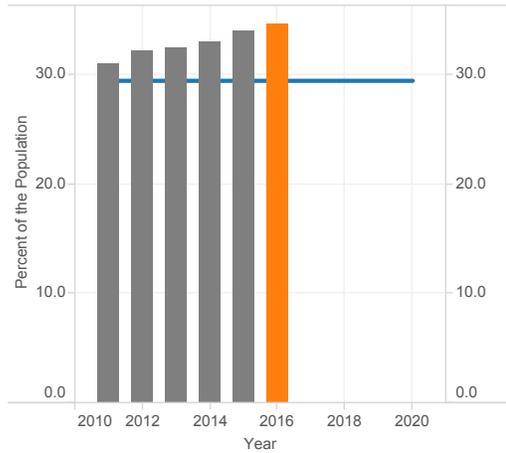


Suicide (25+ yrs) Rate (per 100,000 Population)

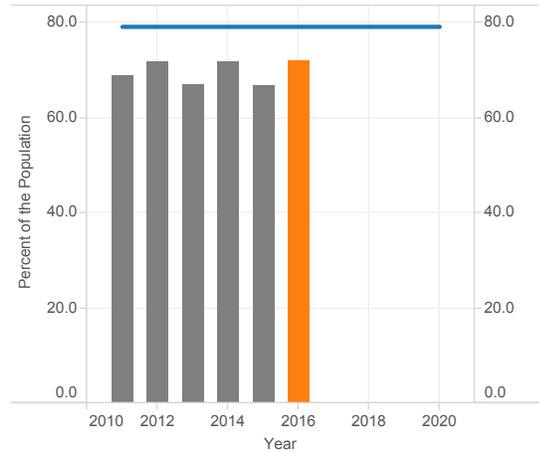


## PROXY/PROVISIONAL - A1 OHIP Obesity & Physical Activity Measures

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

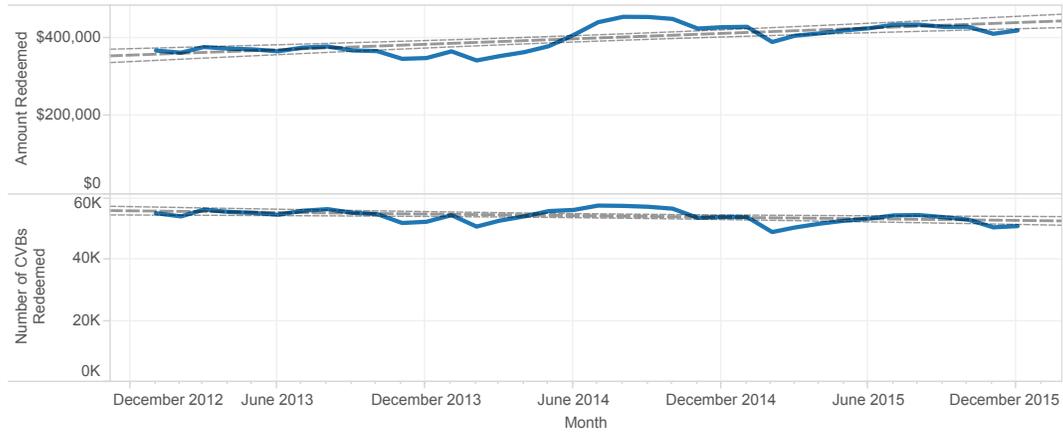


Percent of the Adult Population that Participated in Any Leisure Time Physical Activity (past 30 days)



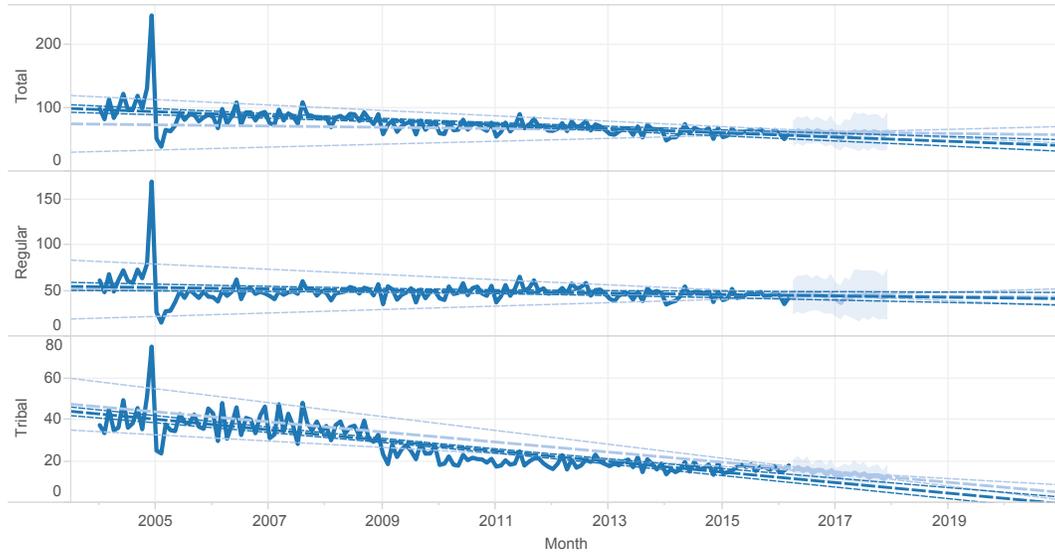
Final  
 Provisional (5 months)  
 Target

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

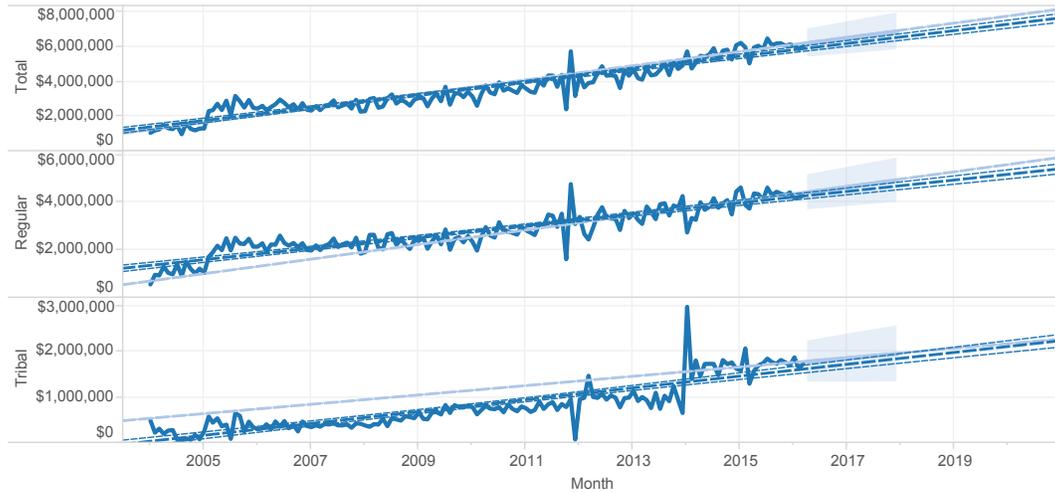


## PROXY/PROVISIONAL - A1 OHIP Tobacco Measures

Cigarette packs per capita (Total, Regular & Tribal)

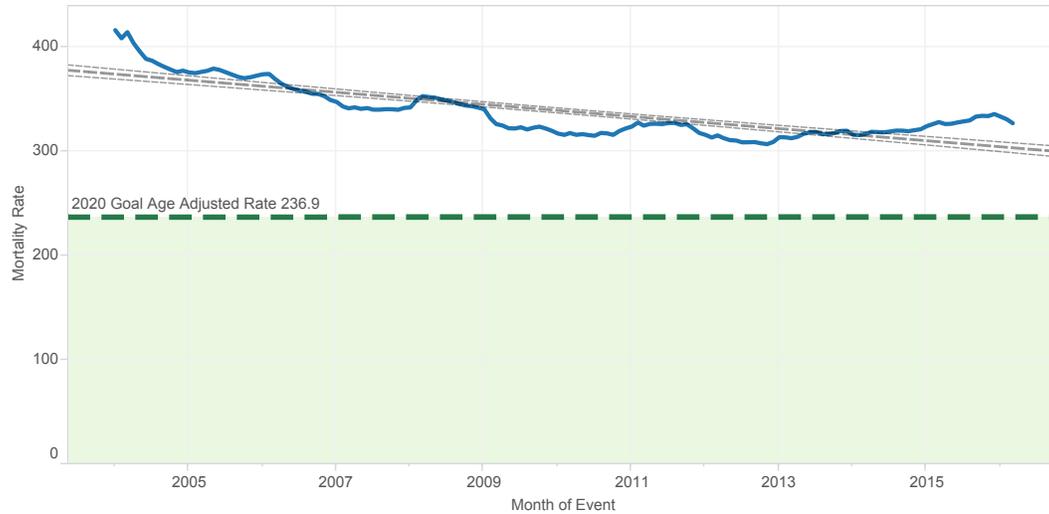


Other tobacco product tax collected (Total, Regular, & Tribal)

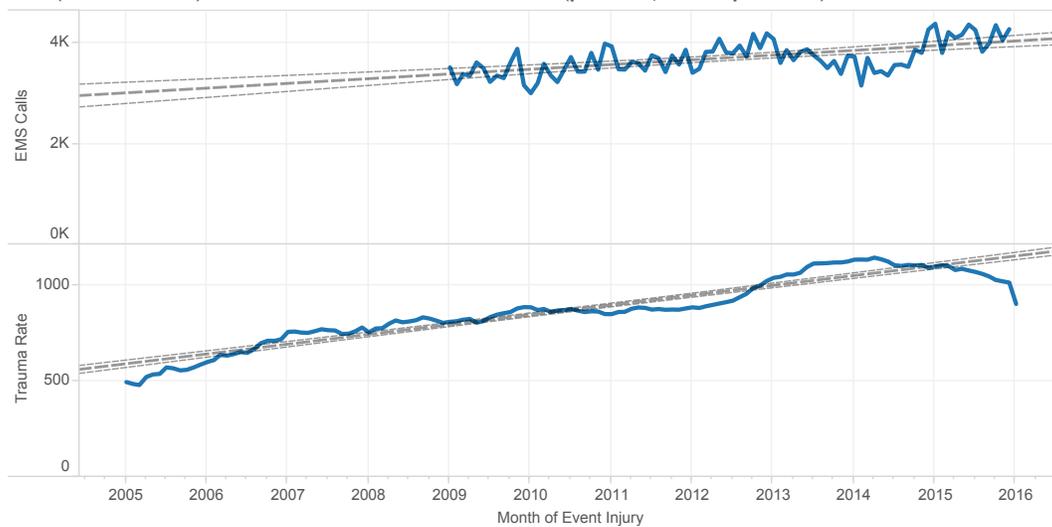


## PROXY/PROVISIONAL - A2 CORE PH Priorities (CVD & Falls)

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

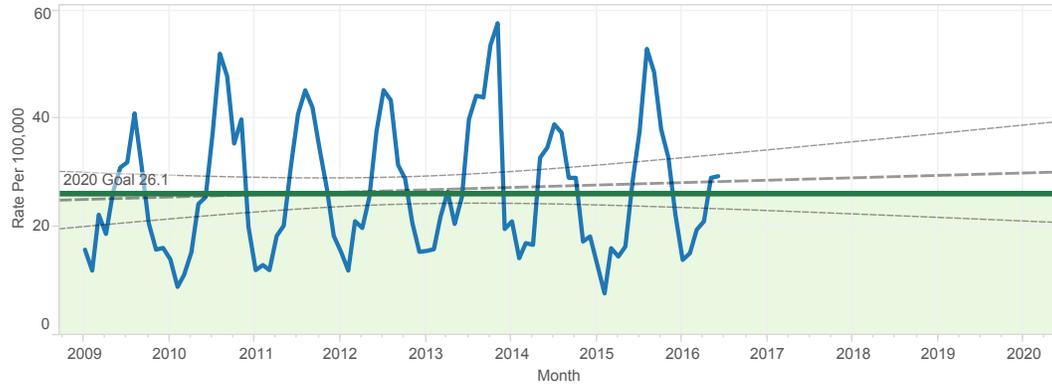


Fall (65 and older) related EMS Calls & Trauma Rate (per 100,000 Population)

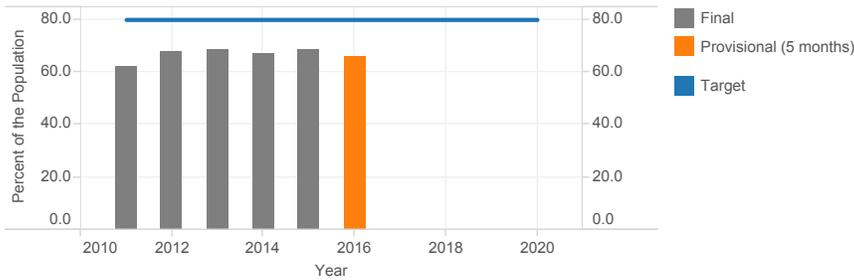


## PROXY/PROVISIONAL - A2 CORE PH Priorities (Infectious & Immunizatio..

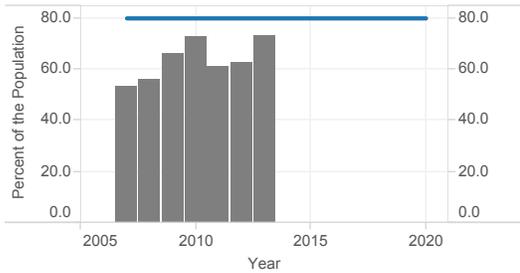
Reported Tuberculosis, Pertussis and Salmonella cases (per 100,000 population)



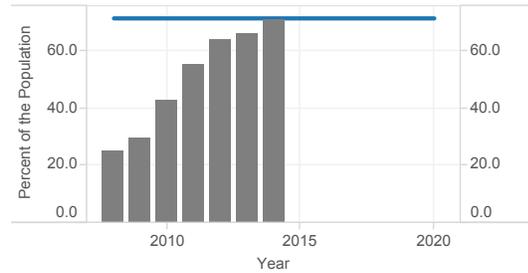
Percent of Seniors (65+) that Received an Influenza Vaccination (Past 12 Months)



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

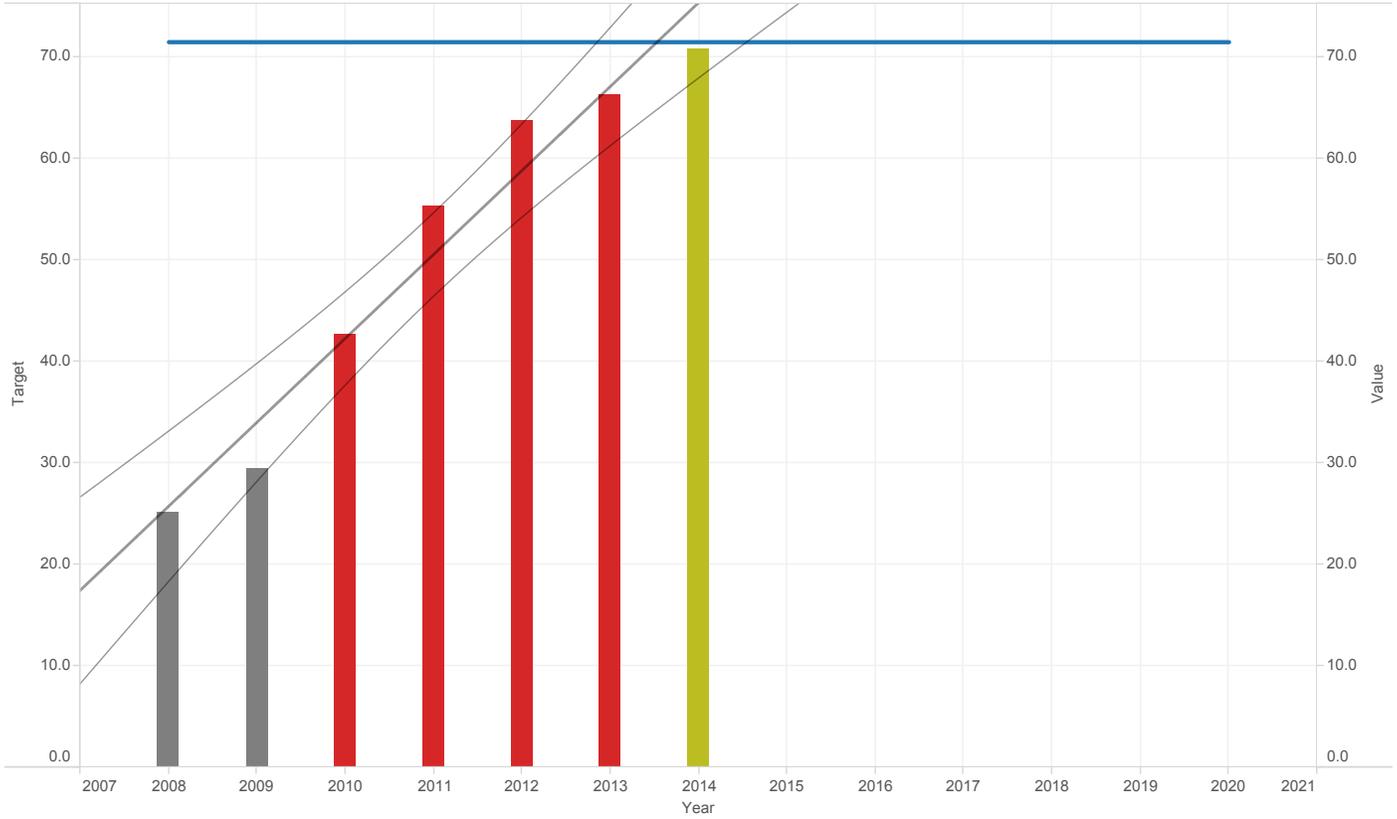


Percent of adolescents age 13 - 17 receiving meningococcal vaccine



**Measure**  
Adolescent Meningococcal Vaccination

**Percent of adolescents age 13 - 17 receiving meningococcal vaccine**



■ Target

**StopLight**

■ Historic

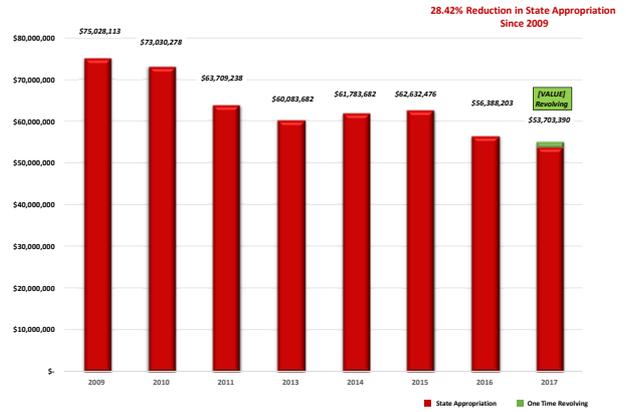
■ Greater Than 5% From Target

■ Within 5% of Target

Oklahoma State Department of Health

State Appropriation Reductions  
SFY- 16 & SFY - 17  
August 2016

OSDH Appropriations History  
SFY 2009 - SFY 2017



SFY 16 & SFY 17 State Appropriation Reductions

SFY-16 Revenue Failure - 7%		SFY-17 Revenue Failure 4.76% in General Revenue	
OSDH Infrastructure	\$ 1,242,691	OSDH Infrastructure (VOBO State Savings)	\$ 914,566
Federally Qualified Health Centers (FQHC)	\$ 319,531	Federally Qualified Health Centers (FQHC)	\$ 237,891
Start Up Funding		Uncompensated Care	
Federally Qualified Health Centers (FQHC)	\$ 741,051	Oklahoma Child Abuse Prevention Services	\$ 252,933
Uncompensated Care		County Health Department Closures (\$360,000 Local Millage)	\$
Cord Blood Bank	\$ 500,000	HIS - Reduction to Health Improvement Services due to unintended reduction to state appropriation in SB 1616.	\$ 1,275,108
Strategic Planning (STEP-UP) Software Purchase	\$ 220,000	Oklahoma Athletic Commission	\$ 4,315
Dental Health Education Services	\$ 220,000	<b>Total</b>	<b>\$ 2,684,813</b>
Colorectal Cancer Screening	\$ 200,000		
Ryan White Part B Program	\$ 786,000		
Oklahoma Athletic Commission	\$ 14,000		
<b>Total</b>	<b>\$ 4,243,273</b>		

**SB 1616 General Appropriations Bill**  
OSDH received a one time appropriation in revolving funds to be used for public health activities as outlined in SB 1616 in the amount of \$1,275,108.

The following Services were not restored for SFY-17:

- OSDH Infrastructure budgeted at SFY-16 ending balance
- Cord Blood
- Colorectal Cancer Screening (Restored \$50,000)
- FQHC Start Up Funding
- Dental Health Education Services
- Ryan White - Utilizing Drug Rebate Funds

SFY - 17 Impact OSDH Due to State Appropriation Reductions

- Federally Qualified Health Centers (FQHC) Uncompensated Care - \$237,891 Reduction**  
OSDH restored funding to Federally Qualified Health Centers in the amount of \$2,314,586 and is anticipated to support approximately 12,352 encounters. The SFY-17 funding amount represents an overall decrease of 9.32% from beginning SFY-16.
- OCAP - \$252,933 Reduction**  
OCAP would be impacted in all three scenarios through the elimination of contractors performing family services using the Healthy Family America (HFA) program. OCAP currently has 11 Start Right contracts to provide home visitation services statewide, reduced from 22 contracts in SFY09.
- OSDH VOBO (State Savings) - \$914,556**  
86 Positions were vacated in SFY-16  
69 of the 86 will not be filled for the next two years
- Health Improvement Services (HIS) - \$1,275,108**  
Reduction to Health Improvement Services due to reduction to state appropriation per SB 1616. Office of Management and Enterprise Services issues a one time appropriation of revolving funds.
- Performance Related Impacts:**
  - Loss of institutional knowledge (VOBO)
  - County Health Department Closures (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)
    - 25% 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 requirement 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

<p><b>Goal: 1</b></p> <p>OSDH staff are provided with information to recognize a transformational and innovative culture.</p>	<p><b>D5 Objective: 1</b></p> <p>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.</p>	<p><b>D5 Performance Measure: 1</b></p> <p>Definition of innovation</p>
	<p><b>D5 Objective: 2</b></p> <p>By 12/31/2017, 80% of OSDH staff will receive transformational and innovative thinking training.</p>	<p><b>D5 Performance Measure: 2</b></p> <p>Number of OSDH staff and public partners provided definition for feedback</p>
		<p><b>D5 Performance Measure: 3</b></p> <p>Definition approved by leadership</p>
		<p><b>D5 Performance Measure: 1</b></p> <p>Number of training provided</p>
		<p><b>D5 Performance Measure: 2</b></p> <p>Number of staff trained</p>
<p><b>D5 Goal: 2</b></p> <p>OSDH staff is encouraged to participate in an innovative culture.</p>	<p><b>D5 Objective: 1</b></p> <p>By 12/31/2016, innovation is promoted on the IRENE homepage.</p>	<p><b>D5 Performance Measure: 1</b></p> <p>Innovation web part implemented</p>
	<p><b>D5 Objective: 2</b></p> <p>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.</p>	<p><b>D5 Performance Measure: 1</b></p> <p>Number of venues</p>
		<p><b>D5 Performance Measure: 2</b></p> <p>Number of new ideas</p>
		<p><b>D5 Performance Measure: 3</b></p> <p>Number of participants of venues</p>
	<p><b>D5 Objective: 3</b></p> <p>By 6/30/2018, OSDH staff are recognized for innovative thinking (Innovation Day).</p>	<p><b>D5 Performance Measure: 1</b></p> <p>Number of staff participating</p>
<p><b>D5 Performance Measure: 2</b></p> <p>Number of staff recognized for innovative thinking</p>		



## 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.

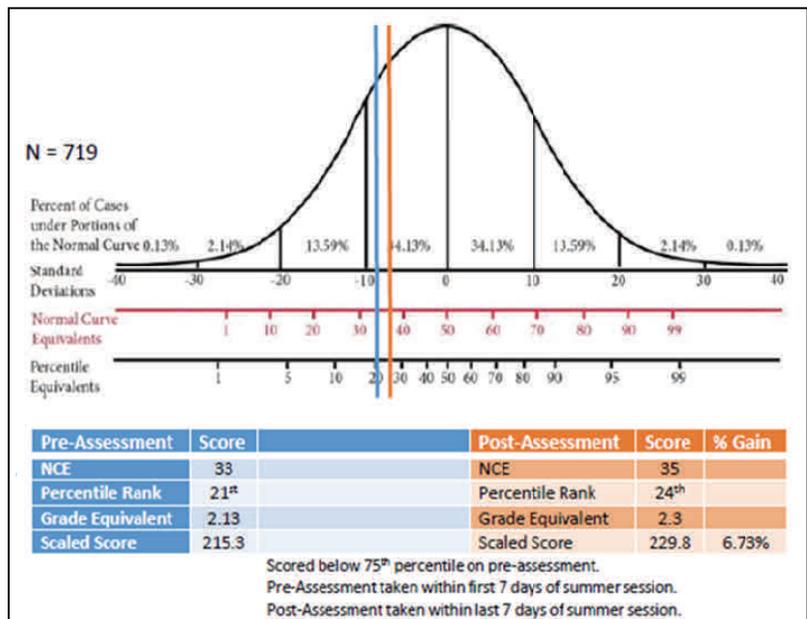
### POSSE Program

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 3<sup>rd</sup> 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.<sup>1</sup>
- ◇ 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.<sup>2</sup>
- ◇ There is some evidence of a relationship between low literacy and teenage pregnancy.<sup>3</sup>
- ◇ Though inconclusive, several studies indicate favorable effects of summer learning programs on high school completion and participation in post-secondary education.<sup>1</sup>

The HIA impact analysis is provided below.

Impact Analysis: K-3 Summer Learning Programs				
Initial Academic Outcome	Direction and Extent of Effect	Likelihood	Distribution	Quality of Evidence
Academic achievement (3 <sup>rd</sup> Grade Reading Performance)	↑↑↑↑ Significant impact on a high proportion of participants	Likely	Low-income students and students behind in reading impacted more	▲▲▲ Many studies that support a direct relationship; supporting local data
Potential Long-Term Health Outcomes	Direction and Extent of Effect	Likelihood	Distribution	Quality of Evidence
Teen pregnancy	↓↓↓ Small impact on a high proportion of participants	Possible	Hispanic and African American adolescent women may be impacted more	▲ At least one study that strongly supports an indirect relationship
High school completion	↑↑↑ Small impact on a high proportion of participants	Possible	Hispanic and African American children, as well as low-income children, are impacted more	▲ More than one study that supports a direct relationship but results are inconclusive

1. Knopf, J.A., et al. (2015). Out-of-school-time academic programs to improve school achievement: A Community Guide health equity systematic review. *Journal of Public Health Management Practice*, 21(6), pp. 594-608
2. Partnership of Summer School Education. (2016). Program data.
3. Bennett, I.M., Frasso, R., Bellamy, S., Wortham, S. & Gross, K. (2013). Pre-teen literacy and subsequent teenage childbearing in a US population. *Contraception* 87(4): pp. 459-464.

## 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*<sup>1</sup> – 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.<sup>1</sup>

### Focus on children who are at risk for academic failure.

Summer learning programs are shown to be effective for children who are at-risk,<sup>1</sup> 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.<sup>1</sup> 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.<sup>4</sup>

### 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.

*An extensive body of evidence links educational achievement and attainment to lifelong health outcomes through 3 interrelated pathways: (1) development of psychological and interpersonal strength, such as a sense of control and social support, which, in turn, contribute to healthy social interactions; (2) problem-solving abilities and the ability to pursue and maintain productive work and adequate income, and the health benefits they provide; and (3) adoption of healthy behaviors.<sup>1</sup>*

4. Cooper, H., Charlton, K., Valentine, J.C., Muhlenbruck, L. & Borman, G.D. (2000). Making the most of summer school: A meta-analytic and narrative review. *Monographs of the Society for Research in Child Development*, 65(1), pp. i-vi+1-127

## 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.



# Oklahoma Health 360

**Healthy Citizens and Strong Families**  
Julie Cox-Kain Deputy Secretary of Health and Human Services

Life expectancy



Healthy Life Expectancy



Years of Potential Life Loss

## Process for Evaluation of Health Priority Areas

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

Recommendations

*What is the best investment to improve health?*

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

# HEALTH IMPACT ASSESSMENT FACT SHEET

February 2013

## 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.

## HOW DOES HIA START?

An HIA can be initiated by public health practitioners, community groups, advocacy organizations, affected stakeholders, responsible public agencies, or policy-makers who are interested in the consideration of health in a decision-making process. HIA can also be required by project-specific legislation or to comply with environmental regulations.

## 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.*



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## 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.



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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:**

## HEALTHY COMMUNITY FRAMEWORK

### **Meets basic needs of all**

- Safe, sustainable, accessible, and affordable transportation options
- Affordable, accessible and nutritious foods, and safe drinkable water
- Affordable, high quality, socially integrated, and location-efficient housing
- Affordable, accessible and high quality health care
- Complete and livable communities including quality schools, parks and recreational facilities, child care, libraries, financial services and other daily needs
- Access to affordable and safe opportunities for physical activity
- Able to adapt to changing environments, resilient, and prepared for emergencies
- Opportunities for engagement with arts, music and culture

### **Quality and sustainability of environment**

- Clean air, soil and water, and environments free of excessive noise
- Tobacco- and smoke-free
- Green and open spaces, including healthy tree canopy and agricultural lands
- Minimized toxics, greenhouse gas emissions, and waste
- Affordable and sustainable energy use
- Aesthetically pleasing

### **Adequate levels of economic and social development**

- Living wage, safe and healthy job opportunities for all, and a thriving economy
- Support for healthy development of children and adolescents
- Opportunities for high quality and accessible education

### **Health and social equity**

### **Social relationships that are supportive and respectful**

- Robust social and civic engagement
- Socially cohesive and supportive relationships, families, homes and neighborhoods
- Safe communities, free of crime and violence

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## 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](mailto:hiap@phi.org).

