

**Agenda for the 11:00 a.m., Tuesday, December 8, 2015
Regular Meeting of the Oklahoma State Board of Health**

Posted at www.health.ok.gov

Oklahoma State Department of Health
1000 N.E. 10th Street – Room 1102
Oklahoma City, OK 73117-1299

- I. CALL TO ORDER AND OPENING REMARKS
- II. REVIEW OF MINUTES
 - a) **Approval of Minutes for October 6, 2015, Tri-Board Meeting**
- III. APPOINTMENTS
 - b) **Home Care, Hospice and palliative Care Advisory Council Appointment (Presented by Henry F. Hartsell, Jr.)**

Appointments: One Member
Authority: 63 O.S., § 1-103a.1(G)
Members: The Advisory Council shall consist of seven (9) nine members. Membership is defined in statute. Two members shall be appointed by the Governor, three members shall be appointed by the President Pro Tempore of the Senate, three members shall be appointed by the Speaker of the House, and one member shall be appointed by the State Board of Health.
- IV. PROPOSED RULEMAKING ACTIONS

Discussion and possible action on the following:

PROTECTIVE HEALTH SERVICE

 - c) **CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL [PERMANENT] [EMERGENCY]** Presented by Donald D. Maisch
PROPOSED RULES:
 - Subchapter 1. Purpose and Definitions [NEW]
 - 310:15-1-1. Purpose [NEW]
 - 310:15-1-2. Definitions [NEW]
 - Subchapter 3. Physician Application and Reporting [NEW]
 - 310:15-3-1. Physician application [NEW]
 - 310:15-3-2. Physician reporting [NEW]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 2-801 – 2-805.
SUMMARY: These proposed regulations, if adopted, will implement the agency's requirements from House Bill Number 2154, from the 1st Session of the 55th Oklahoma Legislature (2015) known as "Katie and Cayman's Law" and codified at 63 O.S. §§ 2-801 through 2-805. The proposed regulations set forth the Department's requirements for the necessary approvals of clinical trials on subjects under the age of 18 for the use of Cannabidiol in treating certain types of seizures as required by the House Bill. *Cannabidiol* means a nonpsychoactive cannabinoid found in the plant *Cannabis sativa L.* or any other preparation thereof, that has a tetrahydrocannabinol concentration of not more than three-tenths of one percent (0.3%) and that is delivered to the patient in the form of a liquid [63 O.S. § 2-801]
 - d) **CHAPTER 265. HEARING AID DEALERS AND FITTERS [PERMANENT]** Presented by Lynnette Jordan
PROPOSED RULES:
 - Subchapter 1. General Provisions
 - 310:265-1-3 [AMENDED]
 - Subchapter 3. Examinations
 - 310:265-3-1 [AMENDED]
 - 310:265-3-2 [AMENDED]

310:265-3-3 [AMENDED]
Subchapter 5. License Requirements
310:265-5-1 [AMENDED]
310:265-5-2 [AMENDED]
310:265-5-3 [AMENDED]
310:265-5-4 [AMENDED]
310:265-5-6 [AMENDED]
310:265-5-7 [AMENDED]
310:265-5-8 [AMENDED]
Subchapter 7. Regulatory Enforcement
310:265-7-2 [AMENDED]
310:265-7-3 [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-1750 et seq.

SUMMARY: The current rule applies to individuals licensed for the purpose of fitting and dealing hearing aids pursuant to authority in Title 63 § 1-1750 et seq. The proposed changes clarify the exam requirements to agree with changes in law at Title 63, O.S., Section 1-1751, established in Senate Bill 46 (2015) and effective November 1, 2015. The change in law makes the applicant responsible for the examination fee. With this change, the Department amends the rule to allow the applicant greater discretion in choosing an examination provider. Other changes give consideration to industry feedback and update the rule to best practices for the entire Chapter. A summary of these changes include updates and clarification for: supervision of those with temporary permits, reciprocity license application process, business regulatory authority, authorization of mobile or temporary clinics, notification of customer protections to suspend tolling the thirty day contract cancellation clause where hearing aids are returned for repair, authorizes online continuing education, updates requirements for a hearing aid waiver related to ambient background noise at the time of testing, and updates references to the applicable advisory council based on changes in law. These changes are needed to allow the hearing aid fitting and dealing profession to stay current with national standards and ensure customers are protected and aware of their rights under this Rule. The effect of this Rule change will allow applicants the option to choose the most applicable exam for hearing aid fitter and dealer licensure and update the rule with current practices in the profession.

e) **CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**

[PERMANENT] Presented Mike Cook

PROPOSED RULES:

Subchapter 9. Resident Care Services
310:675-9-9.1 [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-1950.

SUMMARY: This proposal amends OAC 310:675-9-9.1(i) which deals with bulk non-prescription drugs. This rule change removes a limitation on dispensing over the counter medications from bulk supplies of drugs maintained in nursing facilities. This change inserts verbatim language from the law concerning the ordering or authorizing of medications by a physician. This change deletes language which restricts the use of bulk over the counter medications to only as needed or unscheduled dosage regimens and only upon written order of a physician. This change will allow nursing facilities to dispense scheduled regimens of over the counter medications with an order or other authorization. This change brings the rule into conformity with the authorizing statute [Title 63 O.S. Section 63.1-1950(B)] which is permissive, rather than restrictive, regarding the dispensing of bulk over the counter medications based on a nonscheduled regimen.

f) **CHAPTER 680. RESIDENTIAL CARE HOMES**

[PERMANENT] Presented Mike Cook

PROPOSED RULES:

Subchapter 13. Medication Storage and Administration
310:680-13-2. [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-1950.

SUMMARY: This proposal amends OAC 310:680-13-2 which deals with bulk nonprescription drugs. This rule change removes a limitation on dispensing over the counter medications from bulk supplies of drugs maintained in residential care homes. This change inserts verbatim language from the law concerning the ordering or authorizing of medications by a physician. This change deletes language which restricts the use of bulk over the counter medications to only as needed or unscheduled dosage regimens and only upon written order of a physician. This change will allow residential care homes to dispense scheduled regimens of over the counter medications with an order or other authorization. This change brings the rule into conformity with the authorizing statute [Title 63 O.S. Section 1-1950(B)] which is permissive, rather than restrictive, regarding the dispensing of bulk over the counter medications based on a nonscheduled regimen.

V. OKLAHOMA HEALTH IN ALL POLICIES PRESENTATION

Julie Cox-Kain, M.P.A., Deputy Secretary for Health & Human Services and Senior Deputy Commissioner; Joseph Fairbanks, M.P.P., Director for Health Innovations and Effectiveness

VI. 2016 LEGISLATIVE PRIORITIES

Carter Kimble, M.P.H., Senior Policy Analyst, Office of State and Federal Policy

VII. CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee – Dr. Woodson, Chair

Discussion and possible action on the following:

g) Update

Finance Committee – Ms. Burger, Chair

Discussion and possible action on the following:

h) Update

Accountability, Ethics, & Audit Committee – Ms. Wolfe, Chair

Discussion and possible action on the following:

i) Update

Public Health Policy Committee – Dr. Stewart, Chair

Discussion and possible action on the following:

j) Update

VIII. PRESIDENT'S REPORT

Related discussion and possible action on the following:

Discussion and possible action

IX. COMMISSIONER'S REPORT

Discussion and possible action

X. NEW BUSINESS

Not reasonably anticipated 24 hours in advance of meeting.

XI. PROPOSED EXECUTIVE SESSION

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 Complaint number is 2015-042
- Annual performance evaluation for the Office of Accountability Systems Director & Internal Audit Unit Director, and Board of Health Secretary

Possible action taken as a result of Executive Session.

XII. ADJOURNMENT

Oklahoma State Board of Health (OSBH)
Oklahoma City-County Board of Health (OCCBH)
Tulsa City-County Board of Health (TCCBH)

Tuesday, October 6, 2015, 1:00 p.m.
Presbyterian Health Foundation Research Park
655 Research Parkway, Suite 100, Colloquium Room
Oklahoma City, Ok 73104

Tuesday, October 6, 2015 1:00 p.m.

CALL TO ORDER

Dr. Woodson, President of the Oklahoma State Board of Health and Dr. Stephen Cagle, Oklahoma City-County Board of Health, Chair called the Tri-Board meeting to order on Tuesday, October 6, 2014 at 1:09 p.m. The final agenda was posted on October 5, 2014 on respective Board websites as well the building entrance on October 5, 2015 at 1:00 p.m.

OSBH Members in Attendance: Ronald Woodson, M.D., President; Cris Hart-Wolfe, Secretary-Treasurer; Charles W. Grim, D.D.S.; Timothy E. Starkey, M.B.A.; Jenny Alexopoulos, D.O.; Robert S. Stewart, M.D.
Absent: Martha Burger, M.B.A., Vice-President; Terry Gerard, D.O.; R. Murali Krishna, M.D.

OSDH Staff in Attendance: Terry Cline, Commissioner; Henry F. Hartsell, Deputy Commissioner Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Director of Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director of Internal Audit and Office of Accountability Systems; Tony Sellars, Office of Communications; Deborah Nichols, Chief Operating Officer; VaLauna Grissom, Secretary to the State Board of Health.

OCCBH Members in Attendance: Dr. Stephen Cagle, Dr. Courtney Gray, Dr. Timothy Hill, Mary Mélon, Dr. William Mills, Scott Mitchell and Dr. Lois Salmeron. Dr. Gary Raskob arrived at 1:13 p.m. and Dr. J. Don Harris arrived at 1:17 p.m.

OCCHD Staff in Attendance: Gary Cox, Bob Jamison, Myron Coleman, Tony Miller, Alicia Meadows, Jackie Shawnee, Shannon Welch, Laura Holmes, Phil Maytubby, Dave Cox, and Patrick McGough.

TCCBH Staff in Attendance: Dr. Bruce Dart, Karla Benford

Visitors in attendance: (see sign in sheet)

OPENING REMARKS, INTRODUCTIONS

Dr. Woodson welcomed all to the annual Tri-Board meeting thanking special guests for their attendance. Dr. Cagle thanked the Oklahoma State Health Department, on behalf of himself, the OCCHD Board, and Executive Director Gary Cox, for hosting the Tri-Board board meeting.

Dr. Bruce Dart, Director for the Tulsa Health Department thanked the Oklahoma State Department of Health for hosting and passed along the regrets of the Tulsa Board of Health as they were unable to be in attendance.

REVIEW OF MINUTES – OSBH

Dr. Woodson asks for motion/discussion for approval of Minutes for July 14, 2015 and August 14-16, 2015. Dr. Alexopoulos moved Board approval of the July 14, 2015 meeting minutes as presented. Second Dr. Grim.

1 Motion Carried.
2 AYE: Alexopulos, Grim, Starkey, Stewart, Wolfe, Woodson
3 ABSENT: Burger, Gerard, Krishna

4
5 Dr. Alexopulos moved Board approval of the July 14, 2015 meeting minutes as presented. Second Dr. Grim.
6 Motion Carried.
7 AYE: Alexopulos, Grim, Starkey, Stewart, Wolfe, Woodson
8 ABSENT: Burger, Gerard, Krishna

9
10 **REVIEW OF MINUTES – OCCBH**

11 Dr. Stephen Cagle entertained a motion to approve the September 1, 2015 meeting minutes. Mary Mélon made
12 a motion to approve the September 1, 2015 meeting minutes. Dr. William Mills seconded this motion. Vote
13 taken: Dr. Stephen Cagle, Dr. Courtney Gray, Dr. Timothy Hill, Mary Mélon, Dr. William Mills, Scott
14 Mitchell, Dr. Lois Salmeron Motion Carried.

15
16 **HEALTH DEPARTMENT UPDATES**

17 Terry Cline, Ph.D. (OSDH), Gary Cox, J.D. (OCCHD), Bruce Dart, Ph.D. (THD)
18 Dr. Cline provided an overview of organizations updates for 2015, emphasizing key initiatives and
19 events: the launch of the Oklahoma Health Improvement Plan 2020; the new 2015 Strategic Map for the
20 Oklahoma State Department of Health; the continuation of the Collaborative Improvement and Innovation
21 Networks (COIN); update on the 24/7 Tobacco Free Schools and Adult Smoking Prevalence; Obesity
22 initiative including Fitness Gram and Health in All Policies (HiAP); Health Transformation, NGA
23 Workforce Policy Academy and SIM Model Design Grant; and updates regarding monitoring of Ebola in
24 2015.

25 Gary Cox presented OCCHD updates on Innovation in Action. He spoke about OCCHD’s efforts to
26 regionalize and develop new evidence-base programs such as My Heart –CVD Prevention and
27 Community Health Workers hospital pilot reducing inappropriate utilization of emergency rooms. He also
28 discussed the use of systematic evaluations to increase effectiveness of proven programs, investing in
29 public health information infrastructure, developing systematic methods for completing community health
30 needs assessment, and sharing data that demonstrates linkages between health, education and our
31 economy.

32 Bruce Dart presented on the Development of a new strategic map (2016-2020) for the Tulsa Health
33 Department.

34 *See Attachments A, B, and C.*

35
36 **STATE INNOVATION MODEL / NATIONAL GOVERNOR’S ASSOCIATION PRESENTATION**

37 Julie Cox-Kain, M.P.A., Senior Deputy Commissioner, Oklahoma State Department of Health
38 For more information on this see the attached document.
39 *See Attachment D for presentation of the State Innovation Model / National Governor’s Association*
40 *Presentation.*

41
42 **LEGISLATIVE PRIORITIES PRESENTATION**

43 Mark Newman, Ph.D., Director, Office of State and Local Policy, Oklahoma State Department of Health
44 *See Attachment E for presentation of Legislative Priorities.*

45
46 Dr. Grim moved Board approval to adopt the policy agenda priorities as presented. Second Dr. Alexopulos.
47 Motion Carried.
48 AYE: Alexopulos, Grim, Starkey, Stewart, Wolfe, Woodson
49 ABSENT: Burger, Gerard, Krishna

1
2 Dr. Stephen Cagle asked for a motion from the Oklahoma City County Board of Health to adopt the policy
3 agenda priorities as presented. Dr. Timothy Hill made the first motion and Mary Mélon seconded this
4 motions. Roll call: Dr. Stephen Cagle, Dr. Courtney Gray, Dr. Timothy Hill, Mary Mélon, Dr. William
5 Mills, Dr. Gary Raskob. Scott Mitchell nay, Dr. Lois Salmeron and Dr. J. Don Harris were absent for
6 vote. Motion Carried.

7
8 Dr. Bruce Dart indicated the Tulsa Board of Health would consider the adoption of the policy agenda
9 priorities as presented at the next Board meeting.

10
11 **CHAIRMAN’S REPORT – OCCBH**

12 Dr. Stephen Cagle stated that it is his pleasure to be there and represent the Board and thanked all who came.
13 He invited everyone to visit the NE Regional Health and Wellness Campus and utilize the sports fields and
14 walking trails. He informed every one of the future South campus similar to the model at the NE Regional
15 Campus. OCCHD will add a proposed date and time of October 4, 2016 1:00 p.m., to the December Board
16 of Health Agenda.

17
18 **PRESIDENT’S REPORT – OSBH**

19 Dr. Woodson provided a brief update of the State Board of Health retreat. The retreat was productive and the
20 product was a new 5 year strategic map to be implemented in January 2016. He thanked all who participated
21 and partnered in this process. Dr. Woodson reminded Board members to complete the post-retreat survey.
22 Dr. Woodson proposed a 2016 Board of Health Meeting schedule for review and approval by the Board.

23
24 Dr. Alexopulos moved Board approval to adopt the 2016 Board schedule as presented. Second Ms. Wolfe.
25 Motion Carried.

26 AYE: Alexopulos, Grim, Starkey, Stewart, Wolfe, Woodson

27 ABSENT: Burger, Gerard, Krishna

28 *See Attachment F for 2016 Board of Health Meeting Schedule.*

29
30 **NEW BUSINESS**

31 No new business.

32
33 **ADJOURNMENT**

34 Dr. Stewart moved board approval to adjourn. Second Dr. Grim. Motion Carried

35 AYE: Alexopulos, Grim, Starkey, Stewart, Wolfe, Woodson

36 ABSENT: Burger, Gerard, Krishna

37
38 Dr. Stephen Cagle asked for a motion to adjourn. Mary Mélon made the first motion to adjourn, Dr.
39 William Mills seconded this motion. Vote taken: Dr. Stephen Cagle, Dr. Courtney Gray, Dr. Timothy Hill,
40 Mary Mélon, Dr. William Mills, Scott Mitchell. Motion Carried.

41
42 The meeting adjourned by unanimous consent at 3:02 p.m.

43
44 Approved

45
46 _____
47 Ronald Woodson,
48 President, Oklahoma State Board of Health
49 December 8, 2015



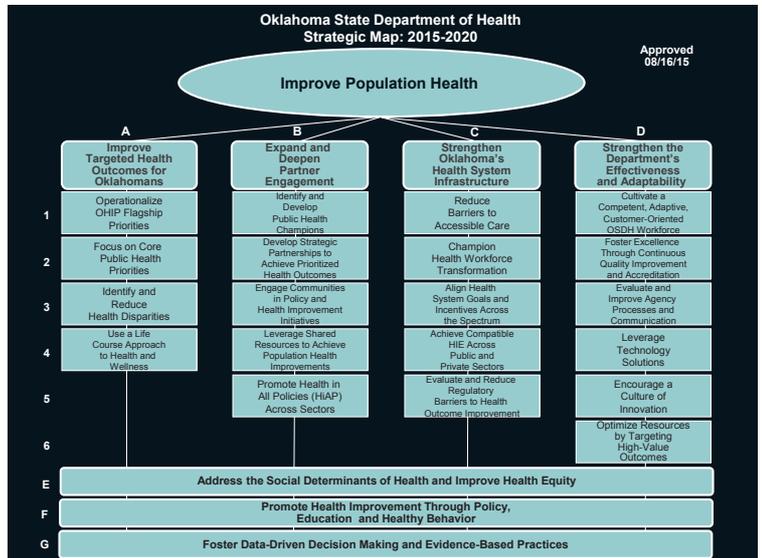
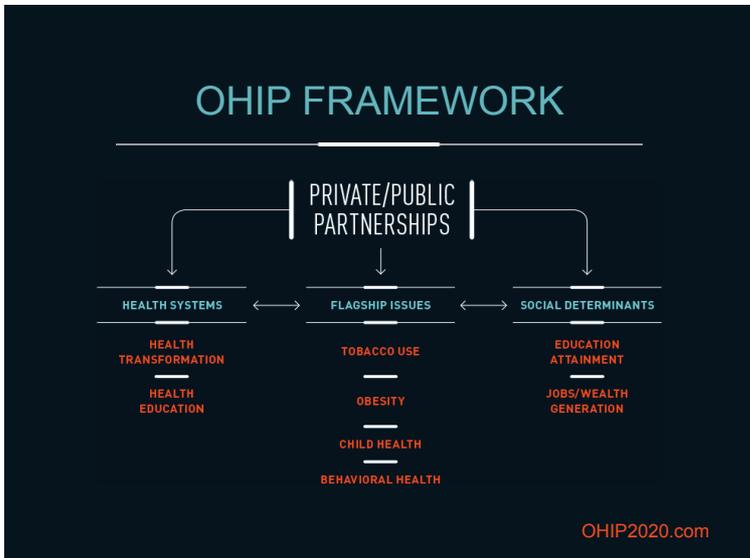
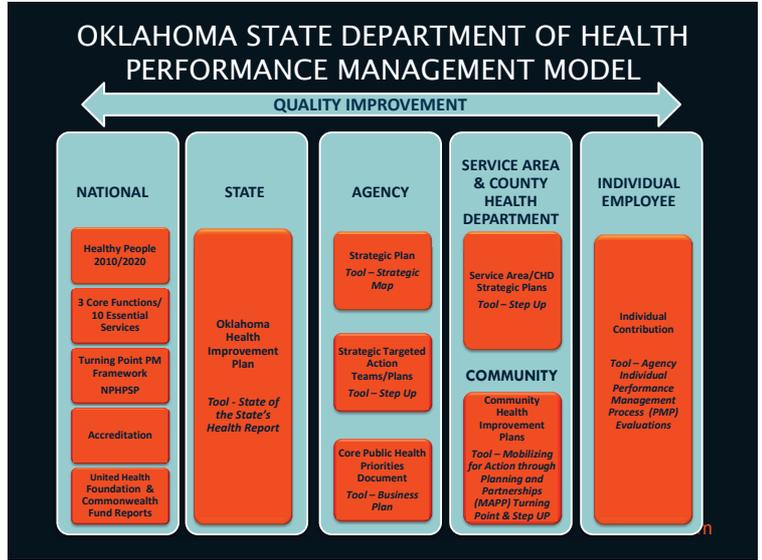
ORGANIZATIONAL UPDATE

- Launched Oklahoma Health Improvement Plan (OHIP) 2020 (March 2015)
- Finalized OSDH agency strategic plan (August 2015)
- Continue with the Collaborative Improvement and Innovation Networks (COIN) to reduce infant mortality
- Tobacco
 - 24/7 tobacco free schools
 - Adult smoking prevalence
- Obesity
 - Fitness Gram
 - Health In All Policies (HiAP)
- Health Transformation
 - NGA Workforce Policy Academy (October 2015)
 - Awarded and implementing SIM Model Design grant
- Ebola

OHIP2020.com

OHIP & STRATEGIC PLAN

OHIP2020.com



PREPARING FOR A LIFETIME & EVERY WEEK COUNTS

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PREPARING FOR A LIFETIME

Infant Mortality Collaborative Improvement and Innovation Networks (CollINs)

- Preconception/Interconception
- Prematurity
- Safe Sleep
- Social Determinants

ASTHO Multi-State Learning Community

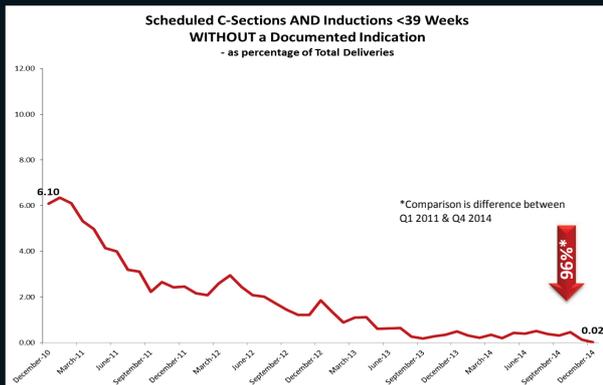
- Breastfeeding
- Long Acting Reversible Contraceptives (LARC)

AMCHP/RWJF Improving Infant Outcomes

- Racial and Ethnic Disparities

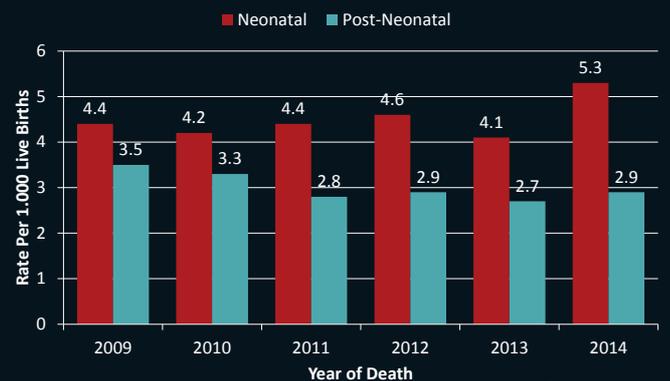
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SUCCESSES



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ONGOING CHALLENGES

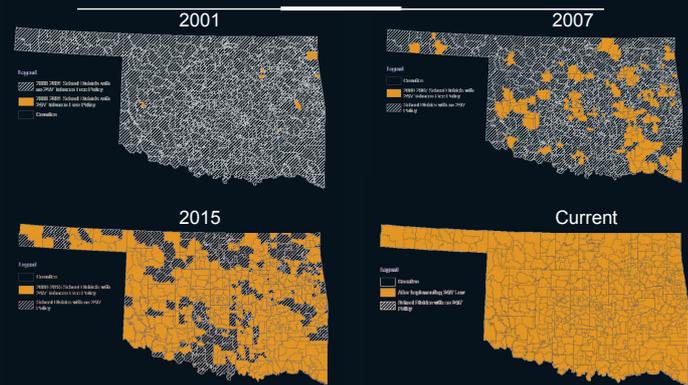


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TOBACCO

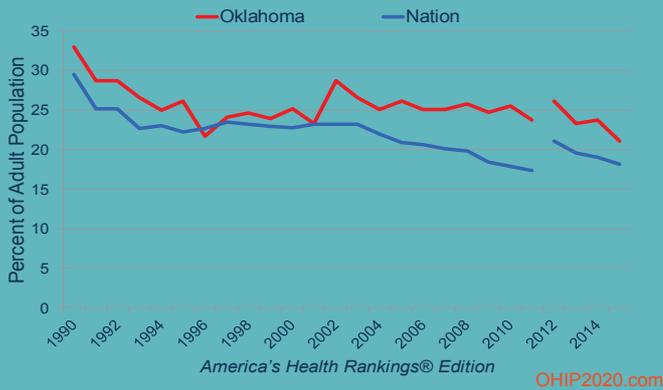
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OKLAHOMA PUBLIC SCHOOL DISTRICT ADOPTION 24/7 TOBACCO-FREE POLICIES



OKLAHOMA STATE DEPARTMENT OF HEALTH · CREATING A STATE OF HEALTH · WWW.HEALTH.OK.GOV

UHF SMOKING MEASURE OKLAHOMA AND THE NATION



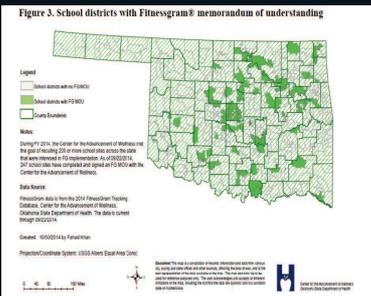
OBESITY

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FITNESS GRAM

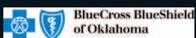
Locations

Results



- Completed First Year of Program
- 247 School Site MOUs
- 192 Schools Trained
- 9,879 Individual students assessed
- Approx. 50% of students in BMI Healthy Fitness Zone *

*Not a representative sample



OHIP2020.com

HEALTH IN ALL POLICIES

- Aspen Institute TeamWork Award
- Intersectoral, multi-disciplinary team
- Applying Health Impact or Health Lens Assessment
- Integrated with Oklahoma Works
 - Workforce
 - Education
 - Health

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HEALTH TRANSFORMATION

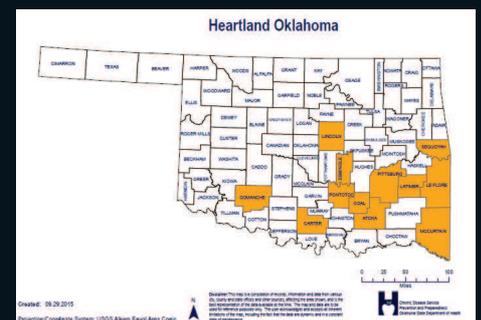
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HEARTLAND OKLAHOMA

Pilot Success

Heartland OK Expanded to 12 Counties

- Standardized BP protocol
- Community determined pay for performance
- Multi-disciplinary, organization team
- Use of Medicaid predictive analytics tools for provider notification
- Multi-payer participation



NGA POLICY WORKFORCE ACADEMY



- NGA Health Workforce Policy Academy
- Governor supported multi-disciplinary team
- Integrated into and governed through OHIP Health Workforce Team
- Key partnerships include economic development and workforce, academic and health technology

OKLAHOMA STATE INNOVATION MODEL (OSIM)

- Statewide collaborative grant process
- Multi-payer payment & delivery system reform initiative
- February 1, 2015 – January 31, 2016
- \$2 Million
- Links clinical population goals and community health goals
- Achieving the Triple Aim



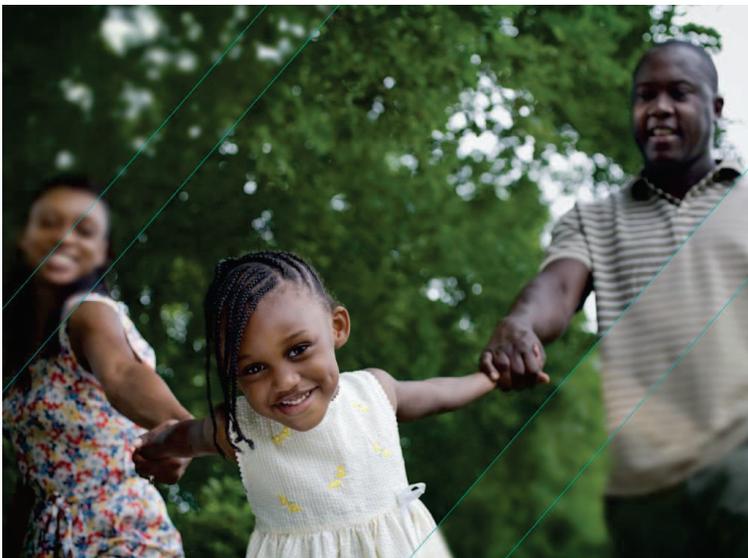
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EBOLA

- Traveler monitoring
 - Total of 90 travelers monitored statewide
- Public Health Emergency Preparedness Funding (\$1,874,584)
 - State and local health departments for on-going activities
- Hospital Preparedness Funding (\$1,170,175)
 - OU, EMSA, Assessment Hospitals
- OSDH Emerging Infectious Disease Response ICS is scheduled for demobilization effective October 6, 2015
 - Active traveler monitoring, laboratory biosafety and medical readiness will continue in accordance with protocols and guidance

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ATTACHMENT B

OCCHD UPDATE TRI-BOARD 2015

Gary Cox, J.D.
Executive Director
Oklahoma City-County Health Department

occhd.org

LIVING FORWARD >>>



INNOVATION IN ACTION

- Regionalization
 - Bring preventive, primary and mental health services to the communities with most disparate health outcomes
- Developing a new evidence-base
 - My Heart – CVD Prevention project that connects under and uninsured clients with regular clinical visits and healthy lifestyle coaching
 - CHW Hospital Pilot – Integrating CHWs in local Emergency Departments to reduce inappropriate utilization of services

occhd.org

LIVING FORWARD >>>



occhd.org

LIVING FORWARD >>>



INNOVATION IN ACTION

- Using systematic evaluation to increase effectiveness of proven programs
 - Total Wellness – modified length and curricula in response to evaluation findings
 - Internal integration of clinical and community health services – Community Health Workers (CHWs) in all clinical locations
 - Health at School - team-based approach to provide the WCWSWC model in targeted under-served and at risk communities

occhd.org

LIVING FORWARD >>>



EXECUTIVE SUMMARY TOTAL WELLNESS

- The effectiveness of the 8-week course is equivalent to the 12-week course on the 5% body weight loss goal, after controlling for demographic information, food diary completion, and physical activity. The data collected demonstrates that the 8-week curriculum was as effective as the 12-week course when addressing change in graduate biometrics and development of healthy habits.
- The majority of graduates realized significant decreases in triglyceride levels, fasting blood sugar levels, total cholesterol levels and systolic blood pressure.
- 14.9% of graduates achieved the primary goal of at least 5% body weight loss. Logistic regression was conducted to determine the effectiveness of course length on the 5% body weight loss goal.

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LIVING FORWARD >>>



INNOVATION IN ACTION

- Investing in public health information technology infrastructure
- Developing systematic methods for completing Community Health Needs Assessment
- Disseminating data to non-traditional partners

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LIVING FORWARD >>>



Home Admissions and Cashier Scheduling Family Planning Immunization My Heart Sexual Health FMR Consumer Protection Water Testing Reporting MyHealth

Susan Sarah Smith 2/21/2015 Schedule West James St. Clair - OCCHD Nurse

New Client

Does patient have limitations that make it difficult to plan or prepare meals? Yes No

Does patient have a working stove, oven, and refrigerator? Yes No

Food pantry assistance needed? Yes No

Concerned about weight? Yes No

Regular exercise? Yes No

Exercise frequency: ---

Has client been tested for tuberculosis? ---

Are all vaccinations current? ---

If client is over 65, have they received a Shingles vaccine? ---

Has client had a flu shot this year? ---

Safety

Is domestic violence currently an issue for the client? Yes No

Physical or sexual abuse? Yes No

Do you feel safe at home? Yes No

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LIVING FORWARD>>>



Home Admissions and Cashier Scheduling Family Planning Immunization My Heart Sexual Health FMR Consumer Protection Water Testing Reporting MyHealth

Susan Sarah Smith 2/21/2015 Schedule West James St. Clair - OCCHD Nurse

Home New Early Start Supply Problem Annual Emergency Contraceptive Pregnancy Test

Program Forms - All Forms -

Family Planning New Client History

Test Form	Name	VisitType	Start Time
Clinical Services BCD		FPIH	10:30:00

Completed Forms

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LIVING FORWARD>>>



Home Admissions and Cashier Scheduling Family Planning Immunization My Heart Sexual Health FMR Consumer Protection Water Testing Reporting MyHealth

Susan Sarah Smith 2/21/2015 Schedule West James St. Clair - OCCHD Nurse

SSN: 111223333 Edit

Household Size: 4

Address: 1234 S Columbia Ave Tulsa 36 74112

Phone: 9185555555

E-mail: susan.smith@demo.net

Special Needs: No

Language: English

Employment: ---

Race: Hispanic or Latino

Ethnicity: ---

Income: 24000

Education: ---

Last Modified By: Jason Roberts

Completed Forms

- Pregnancy Case Management
- Encounter Details
- Pregnancy Case Management
- Encounter Details
- Test Form
- Test Form
- Test Form

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LIVING FORWARD>>>



Home Admissions and Cashier Scheduling Family Planning Immunization My Heart Sexual Health FMR Consumer Protection Water Testing Reporting MyHealth

Susan Sarah Smith 2/21/2015 Schedule West James St. Clair - OCCHD Nurse

Home New Early Start Supply Problem Annual Emergency Contraceptive Pregnancy Test

Program Forms - All Forms -

Scheduled Appointments

First Name	Last Name	VisitType	Start Time
Susan	Smith	FPIA	11:00:00

Completed Forms

- Pregnancy Case Management
- Encounter Details
- Pregnancy Case Management
- Encounter Details
- Test Form
- Test Form
- Test Form
- Family Planning New Client History
- Family Planning New Client History
- Family Planning New Client History
- Early Start History & Assessment
- Family Planning New Client History

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LIVING FORWARD>>>



WELLNESS NOW

CREATING SYSTEMS OF CARE

- Integration of Health Services
 - Public Health
 - Mental Health
 - Pharmacy
 - Clinical Care
 - Dental
- CHW Hospital Pilot

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LIVING FORWARD>>>

INTEGRATED HEALTH SERVICES MODEL



ENGAGING NON-TRADITIONAL PARTNERSHIPS

Examples of Engagement

- CEO Forum
- Open Streets
- Family Fun Nights
- Community Gardening
- School Partnership
- Law Enforcement
- Faith Based Community



CEO FORUM



OPEN STREETS



CREATING A CULTURE OF QUALITY

- Using PHAB Standards to Drive Organizational Culture of Improvement and Transparency
 - Reducing staff through attrition, re-allocating duties and funds more effectively
 - Strategic Planning Process which is tracked and disseminated at all levels for input and feedback
 - Purposeful engagement of staff in developing and implementing Quality Improvement projects and initiatives
 - Ongoing efforts to develop and implement a staff-driven performance management system

CREATING RELATIONSHIPS

- Engage federal delegation
 - Invitations to all federal legislators to visit and tour regional campuses
 - Work with federal partners to develop mechanisms to support direct funding to locals as well as states
- Engage with National Association of County and City Health Officials and/or State Association of Health Officials to develop collective agendas
- Build relationships with appropriate federal agencies: CDC, HRSA, CMS, and others



WHEN IS CHANGE NECESSARY?

“Change across our nation’s diverse health departments **will occur at different times and at different paces, but beginning the process is necessary for departments of all sizes whether or not they have lost resources.** The demands of the future are unavoidable. Governmental public health must be ready to meet them.”

occhd.org

LIVING FORWARD>>>



CHIEF HEALTH STRATEGIST

The Local Health Department as Chief Health Strategist:

- Investing in innovation and best practices
- Collaborating with traditional and non-traditional partners
- Emphasizing use of multi-level, upstream approaches to improving population health

occhd.org

LIVING FORWARD>>>



THOUGHT PROVOKERS

- How should public health departments reorganize themselves internally - no matter what size - to take advantage of opportunities, partnerships, networks, big data, and the Affordable Care Act?
- How can public health departments pay for this? What kind of flexible financing structures are needed?
- Who are, or could be, critical partners in advocating with public health and for health priorities?
- How can this become a priority of public health departments?

occhd.org

LIVING FORWARD>>>

Tulsa Health Department Strategic Map Development

October 6, 2015
Tri-Board Meeting, Oklahoma City
Bruce Dart, Ph.D., Executive Director



THD's Plan

- Need: Develop a Strategic Map for 2016-2020
- How: In-house facilitation
- Who: Policy & Health Analytics and QI/Service Excellence managers
- Why: Assurance that our goals align with our Mission/Vision & Core Values
- What: Present draft Strategic Map goals to BOH



AIM Statement

What is an AIM statement?:

This is a QI tool that is used to restrict the problem statement or task to a discrete issue. It directs team attention to the goal and specified parameters. The AIM statement focuses on a specific target that is time-bound, measurable, and outcome based.

Our AIM Statement Today

"To create the updated 2016-2020 THD Strategic Map to benefit the department and the community that it serves. This process will begin on August 1, 2015 and conclude by December 31, 2015, with an overall goal of creating consensus, communication and understanding of the steps used in the creation of the 2016 THD Strategic Map."



Buzzword: ROI

- BOH strongly encouraged developing a process to measure program effectiveness in alignment with traditional business practices of:
 - **Cost benefit analysis**
 - **Return on Investment**

Buzzword: ROI

- Evaluate effectiveness of programs
- Evaluate current investment & capacity vs. needed capacity
- Recommend where to invest/divest



Divisions of THD

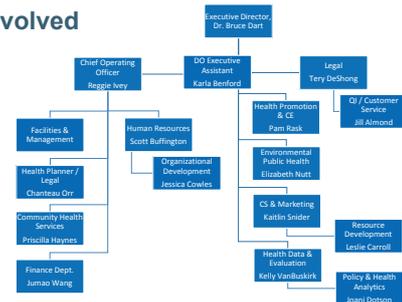
Four THD divisions that support core public services (Foundational Areas):

- Community Health Services
- Health Promotion & Community Engagement
- Environmental Public Health
- Health Data & Evaluation

Four THD divisions that support THD:

- Creative Services and Marketing
- Finance
- Human Resources
- Legal

Who's Involved



Strategic Map Retreat

- Historical success
- Upcoming opportunities and challenges
- Agency and division specific goals
- Activities & skills THD must maintain or grow
- How finances will be used to measure



Mission & Vision Principles

- Healthy Environment
- Healthy People
- Community Empowerment & Respect
- Health Equity

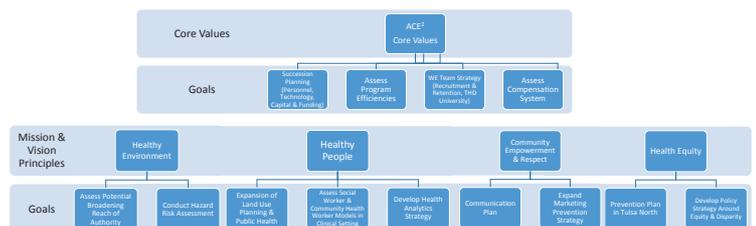
Core Values

We carry out our mission by upholding our core values:

- Accountability
- Collaboration
- Effective
- Empower

ACE²

Strategic Map: the New (working draft)



Next Steps

Working with Division Chiefs on Prioritization and Control/Influence (QI tools)

- Not forgetting the AIM Statement!

Communicating and ensuring understanding with Managers

Program development of prioritized objectives

Connect it all into financial measurement tool

Present the final map to BOH in December

Implement January 2016

Questions/comments?

THANK YOU!

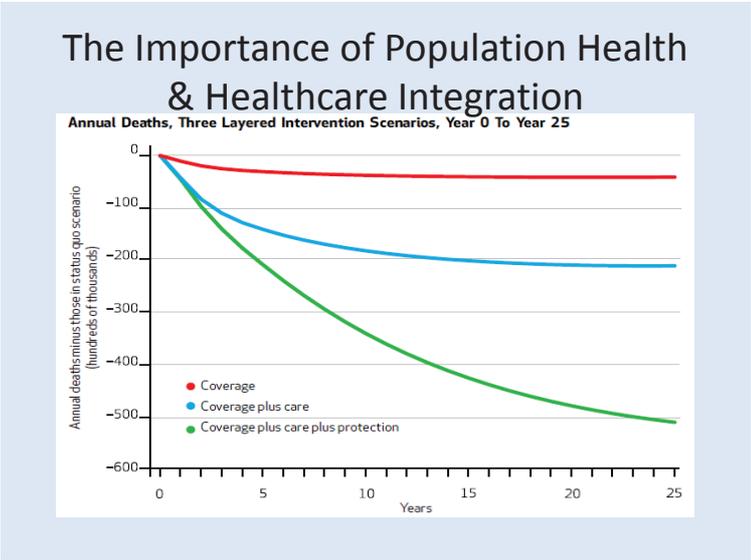
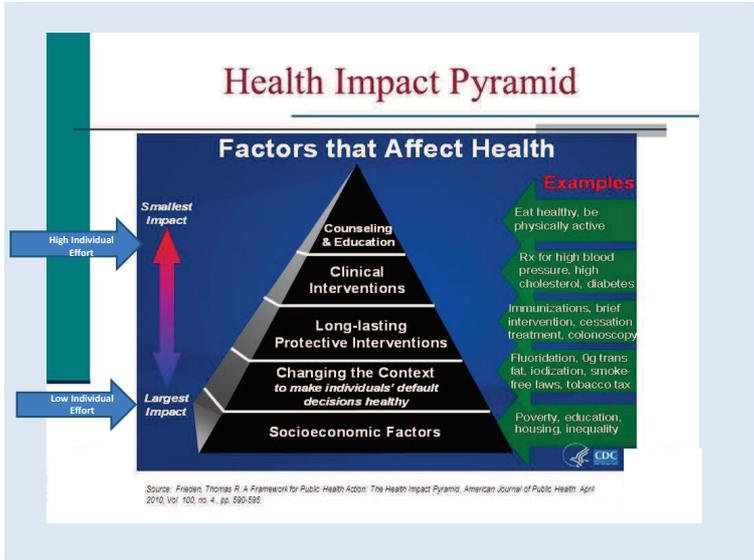
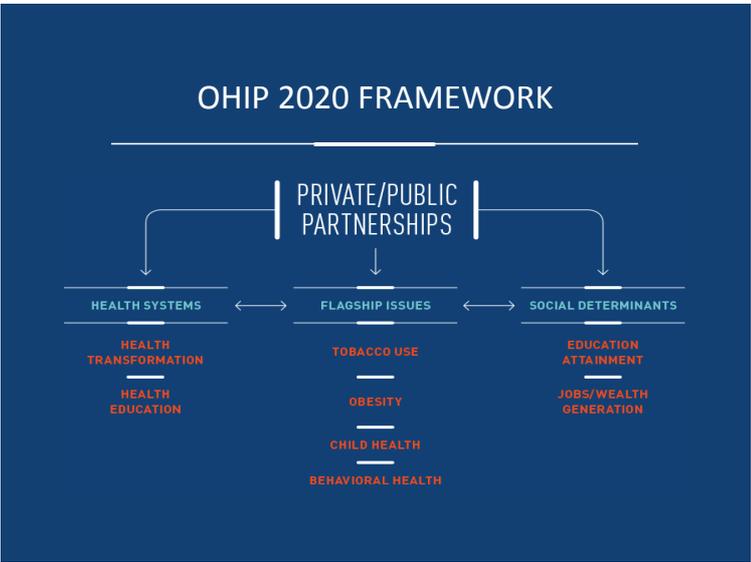
ATTACHMENT D

Oklahoma State Department of Health

Oklahoma State Innovation Model (OSIM) Update

Tri-Board Meeting
October 6, 2015





OVERVIEW OF THE STATE INNOVATION MODEL PROJECT

The Oklahoma State Innovation Model (OSIM) is a multi-payer initiative aligned to the Triple Aim Strategy to improve care, population health, and costs.

Current System	Future System
<ul style="list-style-type: none"> • Fee-for-service/encounter based • Poor coordination and management for chronic diseases • Lack of focus on the overall health of the population • Unsustainable costs • Fragmented delivery system with variable quality 	<ul style="list-style-type: none"> • Patient-centered (mental, emotional, and physical well-being) • Focused on care management and chronic disease prevention • New focus on population-based outcomes • Reduces costs by eliminating unnecessary or duplicative services • Incentivizes quality performance on defined measures

Source: CMS SIM Round Two Funding Opportunity Announcement Webinar

OSIM DELIVERABLES

The SHSIP is the primary deliverable from the OSIM initiative



Population Health Improvement Plan (PHIP)
State Health System Innovation Plan (SHSIP)

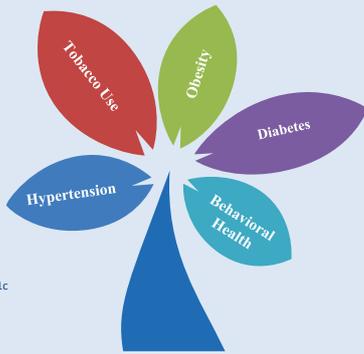
- Healthcare Delivery System Transformation Plan
- Payment and/or Service Delivery Model
- Workforce Development Strategy
- Health Information Technology (IT) Plan
- Stakeholder Engagement Plan
- Quality Measure Alignment
- Monitoring & Evaluation Plan
- Financial Analysis

OSIM MEASURE ALIGNMENT

OSIM Population Health Goals

OSIM Clinical Population Health Goals

- Tobacco Use**
 - Four level smoking status
 - Percent with a quit attempt in the last year
- Obesity**
 - Adult BMI
 - Youth BMI
 - Physical Activity Guidelines
 - Adult Fruit and Vegetable Consumption
 - Food Desert/Food Availability
- Adult Hypertension**
 - Taking medicine for high blood pressure control among adults age ≥ 18 years
- Adult Diabetes**
 - Percentage of Adults with Diabetes having two or more A1c tests in the last year
- Behavioral Health**
 - TBD



OSIM WORKGROUP UPDATE: HEALTH EFFICIENCY & EFFECTIVENESS

Health Efficiency & Effectiveness



Deliverable / Milestone	Status	Date
Population Health Needs Assessment	Completed	8/17
Initiatives Inventory	Completed	7/20
Care Delivery Models	Reviewed. Undergoing revisions for final version	8/17
High Cost Services	Reviewed. Undergoing revisions for final version	8/24

Key Findings

Population Health Needs Assessment

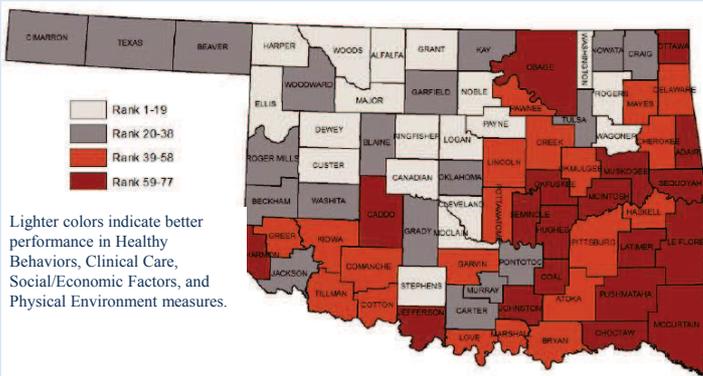
- Chronic disease affects all populations within the state, albeit at somewhat varying degrees
- 37.5% of adults in Oklahoma have hypertension, the 9th highest rate nationally
- Oklahoma is the 6th most obese state in the nation
- Diabetes, hypertension, obesity, physical activity and nutrition, and tobacco use are risk factors associated with heart disease and cancer—the leading causes of death in Oklahoma

Initiative Inventory

- The most common initiatives found in Oklahoma are concentrated on improving behavioral health
- 90% of initiatives have a project length of that is less than 5 years, 45% of the those initiatives are 1 year

POPULATION HEALTH NEEDS ASSESSMENT

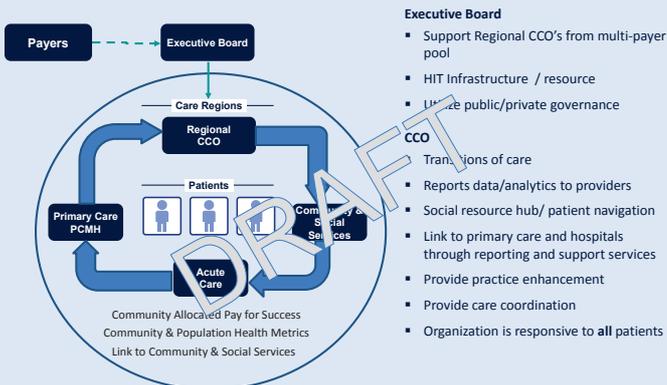
County Health Factors by Quartile Ranking, Oklahoma, 2015



COMMUNITY COORDINATION ORGANIZATION (CCO MODEL)

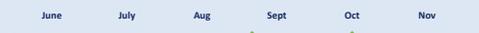
Function	Issues Addressed	Supporting Infrastructure	Flexibility
<ul style="list-style-type: none"> For Patients: <ul style="list-style-type: none"> Social/Environmental Care Coordination Support Transitions of Care Patient Navigator For Providers: <ul style="list-style-type: none"> Surrounding/Supporting the Practice Practice Facilitation Health IT Resource Care Coordination Co-op Quality Measure Reporting Co-op 	<ul style="list-style-type: none"> Social Determinants of Health Care Coordination Supports Provider and Reduces Provider Burden Responds to barriers to compliance 	<ul style="list-style-type: none"> Community health and social services providers Community health coalitions Public Health 	<ul style="list-style-type: none"> Scalable allowing for different providers to perform different functions based on community Able to wrap around existing models Able to include other delivery system & payment tools (e.g., PCMH)

CARE COORDINATION ORGANIZATION



OSIM WORKGROUP UPDATE: HEALTH WORKFORCE

Health Workforce



Deliverable / Milestone	Status	Date
Provider Organizations	Completed	8/05
Gap Analysis	Completed	8/05
Emerging Trends	Reviewed. Undergoing revisions for final version	9/01
Policy Prospectus	Awaiting deliverable completion	10/01

Key Findings

Provider Organizations and Provider Landscapes

- Major landscape overview inventoried the number various provider types in Oklahoma
 - Physicians: 7,839, Nurses: 47,167, Physician Assistants: 1,193, Dentists: 1,756, Psychologists: 571
- Significant urban vs rural disparities in provider to population ratios for dentists and psychologists
 - Urban: 57% Dentists, Psychologists: 56%

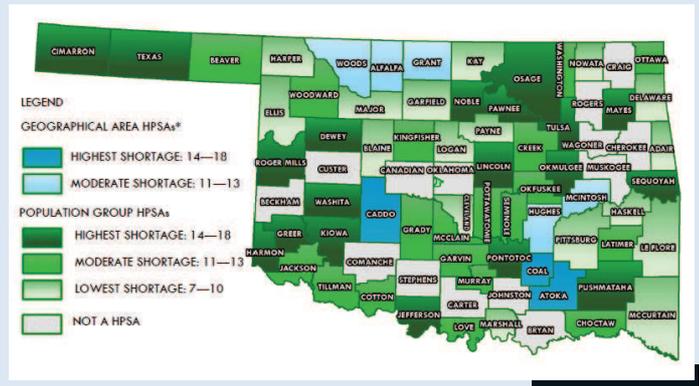
Workforce Gap Analysis

- Although precision of measurement is lacking, it is evident that there is a severe shortage of primary care providers
- Workforce data must be improved to accurately depict the shortage and need

NATIONAL GOVERNOR'S ASSOCIATION: A PLAN FOR HEALTH WORKFORCE TRANSFORMATION

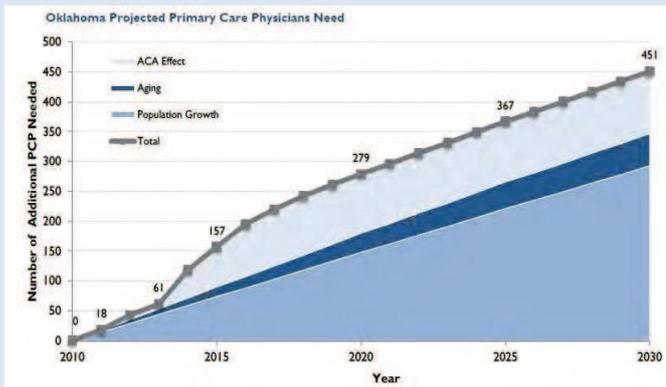
High Quality Data	<ul style="list-style-type: none"> •Determined minimum data set, integrating into licensure renewal •Centralizing and aggregating data – OSDH •Expanded health workforce surveys - OSDH •NEXT STEP – Linking to education (including GME) •NEXT STEP – Linking to economic data •NEXT STEP – Rational care delivery areas
Coordination of Efforts	<ul style="list-style-type: none"> •Determined sustainable and inclusive mechanism for coordinating health workforce efforts •Integrated health workforce coordination into economic development work and established health workforce subcommittee in statute •NEXT STEP – Building comprehensive plan and recommendations for consideration of health workforce subcommittee and approval of the Governor's Council on Workforce and Economic Development •NEXT STEP – Inclusion of health workforce planning locally in Oklahoma Works
Workforce Redesign to Meet Transformed Health System	<ul style="list-style-type: none"> •Determined 25 most needed health professions in the next 5 – 10 years based on economic analysis •Determined to 5 – 6 emerging professions based on assessment of evidence and stakeholder feedback •NEXT STEP – Develop recommendations for training, retraining, academic detailing, and practice facilitation •NEXT STEP – Linking to other existing efforts H2O
Pipeline, Recruitment and Retention	<ul style="list-style-type: none"> •GME Subcommittee working on statewide data aggregation – graduates, residents, GME funding, availability and type •NEXT STEP – Building a longitudinal data system for better evaluation and analysis •NEXT STEP – Integration and coordination of recruitment and retention programs PMTC, NMSC, J-1 Visa Waivers, etc.

PRIMARY CARE SHORTAGE AREAS



HEALTH WORKFORCE GAP ANALYSIS

Oklahoma Project Primary Care Physicians Need



HEALTHCARE PROFESSIONS NEEDED BY 2025

Economic Projections

- Magnetic Resonance Imaging Technologists
- Nurse Anesthetists
- Pediatricians, General
- Psychiatrists
- Anesthesiologists
- Internists, General
- Surgeons
- Respiratory Therapists
- Diagnostic Medical Sonographers
- Optometrists
- Phlebotomists
- Nurse Practitioners
- Radiologic Technologists
- Medical and Clinical Laboratory Technologists
- Mental Health Counselors
- Medical and Clinical Laboratory Technicians
- Dentists, General
- Physical Therapists
- Family and General Practitioners
- Medical Records and Health Information Technicians
- Pharmacists
- Physicians and Surgeons, All Other
- Medical and Health Services Managers
- Licensed Practical and Licensed Vocational Nurses
- Registered Nurses

Emerging Professions

- Community Health Workers
- Community Paramedics
- Informaticians
- Patient Navigator
- Medical Scribes

OSIM WORKGROUP UPDATE: HEALTH FINANCE

Health Finance Timeline: June, July, Aug (08/29), Sept, Oct (10/28), Nov

Deliverable / Milestone	Status	Date
Insurance Market Analysis	Completed	8/13
High Cost Delivery Services	Reviewed. Undergoing revisions for final version	8/24
Care Delivery Models	Reviewed. Undergoing revisions for final version	8/17
Financial Forecast of New Delivery Models	Awaiting deliverable completion	10/26

Key Findings

Oklahoma Insurance Market Analysis

- Reduction in the number of uninsured Oklahomans in 2014
- Rise in premium amounts expected for 2016, could impact uptake
- OSDH can engage 80% of the insured market by including the top six carriers
 - Medicaid, Medicare, EGID, and public programs
 - With 25% of the covered lives insured through other self-funded employer sponsored health plans, it will also be imperative to engage these businesses to achieve the goal of engaging 80% of the insured market

Enrollment by Insurance Source

Figure III-1
State of Oklahoma
Estimated Enrollment by Insurance Source
Calendar Years 2013 through 2015

Insurance Source	2013	2014	2015
Uninsured	657,200	607,100	543,800
Individual	122,100	171,800	223,500
Small Group	189,000	182,800	177,300
Large Group	488,800	491,300	493,200
Self-Funded	840,400	849,400	854,500
EGID ¹⁰	169,800	175,200	184,500
Medicaid/CHIP (with Duals)	792,500	805,800	826,700
Medicare (without Duals)	499,300	501,900	504,200
Other Public Programs	91,400	91,900	92,500
Total	3,850,500	3,877,200	3,900,200

Notes:

1. Individual includes both FFM and non-FFM enrollment for 2014 and 2015.
2. Values have been rounded.

State of Oklahoma: Federally Facilitated Marketplace (FFM) Average Premium and Cost Sharing by Metal Level

Metal Level	Average Premium 2014	Average Premium 2015	Average Deductible (Single/Family) 2015	Average OOP Max (Single/ Family) 2015
Bronze	\$163.28	\$173.64	\$5,200/ \$11,400	\$6,400/ \$12,900
Silver	\$212.58	\$222.56	\$4,200/ \$9,300	\$6,000/ \$12,200
Gold	\$259.16	\$280.07	\$1,600/ \$4,400	\$3,800/ \$9,600
Platinum	\$343.75	\$396.95	Not Available	Not Available
Catastrophic	\$134.30	\$135.38	Not Available	Not Available

Source: Oklahoma State Innovation Model Insurance Market Analysis prepared by Milliman

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RELATIVE COSTS FOR CHRONIC DISEASE FOR OKLAHOMA COMMERCIAL CARRIERS

State of Oklahoma High-Cost Condition Relative Cost	
	Commercial
Obesity	3.42
Diabetes	3.80
Hypertension	2.91
Tobacco Usage	3.60
Entire Population	1.00

OSIM WORKGROUP UPDATE: HEALTH INFORMATION TECHNOLOGY



Key Findings

Electronic Health Record / Health Information Exchange Surveys

- Electronic health record (EHR) penetration is fairly strong in urban Oklahoma, but weaker in rural areas
- Financial limitation is still the number one reason for not adopting HIT technology
- Two predominant health information exchanges (HIE) have similar coverage and structures
- 3 different paths to interoperability within the state are suggested
 - Network of exchanges, select an existing HIE, state sponsored HIE

VBA CONCEPTUAL DESIGN PROPOSAL DISCUSSION

Value-Based Analytic Roadmap

- Three process phases:



Design that Supports the Following:

- Develops trust among providers through proper governance
- Supportive of current competitive HIE environment
- Capable of complementing existing data streams and systems
- Capable of allowing participation from entities not otherwise participating with private HIEs

OSIM: Stakeholder Engagement

	March/April	May	June	July	August	September	Total
# of Stakeholder Meetings	10	13	13	16	13	9 (as of 9/18)	74

Business	Insurance & Health Systems	Advocacy Groups
State Chamber of Commerce	Global Health HMO	Oklahoma Hospital Association
Tulsa Chamber of Commerce	Blue Cross/Blue Shield	Oklahoma Primary Care Association
Oklahoma City Chamber of Commerce	St. John Health System	The Rural Health Conference of Oklahoma
Yukon Chamber of Commerce	St. Anthony ACO	Oklahoma Healthy Aging Initiative
Oklahoma Restaurant Association	Variety Care LLC	Oklahoma City Health Underwriters Association

QUESTIONS

ATTACHMENT E

2016 LEGISLATIVE PRIORITY

Oklahoma Tri-Boards of Health

OCTOBER 2015



Tammie Kilpatrick - OCCHD
 Scott Adkins - THD
 Mark Newman - OSDH

PROPOSED LEGISLATIVE PRIORITY

Economic Research Confirms That Cigarette Tax Increases Reduce Smoking

- Cigarette tax or price increases reduce both adult and underage smoking.
- A cigarette tax increase that raises prices by ten percent will reduce smoking among pregnant women by seven percent, preventing thousands of spontaneous abortions and still-born births, and saving tens of thousands of newborns from suffering from smoking-affected births and related health consequences.

Source: Campaign for Tobacco-Free Kids

Economic Research Confirms That Cigarette Tax Increases Reduce Smoking Continued

- Cigarette price and tax increases work even more effectively to reduce smoking among males, Blacks, Hispanics, and lower-income smokers.
- By reducing smoking levels, cigarette tax increases reduce secondhand smoke exposure among nonsmokers, especially children and pregnant women.
- Cigarette smoking is the number one cause of preventable disease and death worldwide.

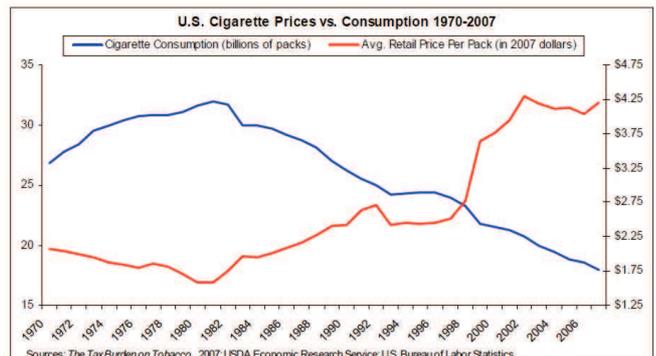
Source: Campaign for Tobacco-Free Kids

Recent State Experiences

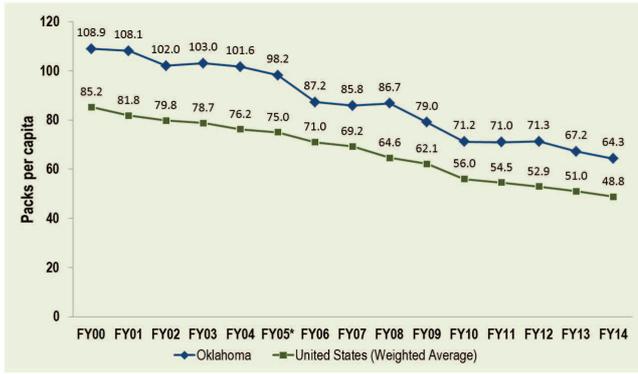
- In every single state that has significantly raised its cigarette tax rate, pack sales have gone down sharply.
- Some of the decline in pack sales comes from interstate smuggling and from smokers going to other lower-tax states to buy their cigarettes.
- However, reduced consumption from smokers quitting and cutting back plays a more powerful role.

Source: Campaign for Tobacco-Free Kids

Increasing U.S. Cigarette Prices and Declining Consumption



Per Capita Cigarette Sales Oklahoma and United States



* A voter-approved increase in Oklahoma's cigarette tax took effect on January 1, 2005, midway through fiscal year 2005

Source: Orzechowski and Walker, 2014. *The Tax Burden of Tobacco - Historical Compilation, Volume 49.*

Total Oklahoma Cigarette Sales Tribal & Non-Tribal Combined



Tax stamp sales provided by Oklahoma Tax Commission

Projected New Annual Revenue from Increasing the Cigarette Tax Rate:

Rate	Projected New Annual Revenue
\$1.50	\$181.99 million
\$1.00	\$140.84 million

New Annual Revenue is the amount of additional new revenue over the first full year after the effective date. The state will collect less new revenue if it fails to apply the rate increase to all cigarettes and other tobacco products held in wholesaler and retailer inventories on the effect date.

Source: Campaign for Tobacco-Free Kids and Cancer Action Network

Projected Public Health Benefits for Oklahoma from the Cigarette Tax Rate Increase

	\$1.50	\$1.00
Percent decrease in youth smoking:	18.2%	12.1%
Youth under age 18 kept from becoming adult smokers:	35,300	23,500
5-Year health care cost savings from fewer smoking-affected pregnancies & births:	\$15.60 million	\$10.39 million
5-Year health care cost savings from fewer smoking-caused heart attacks & strokes:	\$13.02 million	\$8.68 million
5-Year Medicaid program savings for the state:	\$3.33 million	\$2.22 million
Long-term health care cost savings from adult & youth smoking declines:	\$1.40 billion	\$938.67 million

Source: Campaign for Tobacco-Free Kids and Cancer Action Network

For More Information

Mark Newman, Ph.D., Director, Office of State and Federal Policy
(405) 271-4200

MarkSN@health.ok.gov

QUESTIONS

OKLAHOMA STATE BOARD OF HEALTH MEETINGS
1000 N.E. 10th Street, Room 1102
Oklahoma City, OK 73117
(405) 271-8097

PROPOSED DATES

First Quarter

January 12, 2016 (11:00 a.m.)
February 9, 2016 (11:00 a.m.)
March 8, 2016 (11:00 a.m.) Pottawatomie CHD

Second Quarter

April 12, 2016 (11:00 a.m.)
May 10, 2016 (11:00 a.m.)
June 14, 2016 (11:00 a.m.) Choctaw CHD

Third Quarter

July 12, 2016 (11:00 a.m.)
August 12-13, 2016 (Chickasaw Retreat & Conference Center)

Fourth Quarter

October 4, 2016 (1:00 p.m. Oklahoma County)
December 13, 2016 (11:00 a.m.)

- - -

State Of Oklahoma
Department of Health

Memorandum

November 10, 2015

TO: State Board of Health Members

FROM: Terry Cline, Ph.D. *T. Cline*
Commissioner of Health
Secretary of Health and Human Services

SUBJECT: Home Care, Hospice and Palliative Care Advisory Council Appointment

This requests appointment of one new member to the Home Care, Hospice and Palliative Care Advisory Council by the State Board of Health. The proposed appointee is as follows:

One member representing an association which advocates on behalf of home care or hospice issues

- Ms. Karen Vahlberg, R.N., B.S.N.

The State Health Department's staff conducted a check of the history of the proposed appointee using public information, including the Oklahoma Department of Corrections Offender Lookup, the Oklahoma State Court Networks Court Dockets, and Oklahoma State Department of Health licensure records. The staff identified no offenses or adverse actions that would impair the ability of this individual to perform the responsibilities of the advisory council.

This nominee meets the qualifications of the position for which she is nominated. Ms. LaTrina Frazier, Ph.D., MA, RN, Administrative Programs Manager of the Home Services Division has personally contacted the nominee and confirmed her willingness to serve and attend public meetings of the advisory council.

Additional information for the advisory council is as follows:

Statutory Citation

The Home Care, Hospice and Palliative Care Advisory Council is authorized in Title 63 O.S. Section 1-103a.1(G).

Appointing Authority

The Commissioner of Health with the advice and consent of the Board of Health.

Membership

The Advisory Council has nine members, consisting of:

- Two members shall be appointed by the Governor:
 - 1) One member who is the owner or administrator of an entity licensed in accordance with the Oklahoma Hospice Licensing Act, and
 - 2) One member who is an owner or administrator of an entity licensed in accordance with the Oklahoma Home Care Act.

- Three members shall be appointed by the President ProTempore of the Senate:
 - 1) One member who is an owner or administrator of an entity licensed in accordance with the Oklahoma Hospice Licensing Act,
 - 2) One member who is an owner or administrator of an entity licensed in accordance with the Oklahoma Home Care Act, and
 - 3) One member who is a member of the palliative care patient advocacy community
- Three members shall be appointed by the Speaker of the House:
 - 1) One member representing the public who is or was a legal guardian of a recipient of hospice services,
 - 2) One member representing the public who is a recipient or legal guardian of a recipient of services from a home health agency, and
 - 3) One member who is an allopathic or osteopathic physician or nurse certified in palliative care delivery in this state, and
- The State Board of Health shall appoint one member representing an association which advocates on behalf of home care or hospice issued.

The one new member will join the current Home Care, Hospice and Palliative Care Advisory Council Members, who are:

President Pro Tempore of the Senate Appointees:

- Mr. Greg McCormick, Owner/Administrator, Current Term Expires 08/31/2016
- Ms. Rayetta Dominguez, Owner/Administrator, Current Term Expires 08/31/2016

Speaker of the House Appointees:

- Mr. David Gibson, Public member, Current Term Expires 10/31/2016
- Ms. Michelle Fox, Public member, Current Term Expires 10/31/2016

Advisory Council Duties/Responsibilities

The jurisdictional areas of the Home Care, Hospice and Palliative Care Advisory Council shall include all issues that arise in the areas of home care, hospice services, and palliative care, including, but not limited to:

- a. Identifying methods that improve the quality and delivery of home care, hospice and palliative care,
- b. Reviewing best practices from home care, hospice and palliative care programs in the state,
- c. Developing information on home care, hospice and palliative care issues for the general public, and
- d. Such other areas as designated by the State Board of Health

H. In addition to other powers and duties assigned to each Advisory Council pursuant to this section, each Advisory Council, within its jurisdictional area, shall:

1. Have authority to recommend to the State Board of Health rules on behalf of the State Department of Health. The State Department of Health shall not have standing to recommend to the State Board of Health permanent rules or changes to such rules within the jurisdiction of an Advisory Council which have not been submitted previously to the appropriate Advisory Council for action;

2. Before recommending any permanent rules to the State Board of Health, give public notice, offer an opportunity for public comment and conduct a public rulemaking hearing when required by the Administrative Procedures Act;

3. Have the authority to make nonbinding written recommendations to the State Board of Health and/or to the State Department of Health which have been concurred upon by at least a majority of the membership of the Advisory Council;

4. Have the authority to provide a public forum for the discussion of issues it considers relevant to its area of jurisdiction, and to:

- a. pass nonbinding resolutions expressing the sense of the Advisory Council, and
- b. make recommendations to the State Board of Health or the State Department of Health concerning the need and the desirability of conducting meetings, workshops and seminars; and

5. Cooperate with each other Advisory Council, the public, the State Board of Health and the Commissioner of Health in order to coordinate the rules within their respective jurisdictional areas and to achieve maximum efficiency and effectiveness in furthering the objectives of the State Department of Health.

I: The Advisory Councils shall not recommend rules for promulgation by the State Board of Health unless all applicable requirements of the Administrative Procedures Act have been followed, including but not limited to notice, rule-impact statement and rulemaking hearings.

Advisory Council Meeting Frequency

Each Advisory Council shall meet at least twice a year, but no more than four times a year.

Appointment Process

Two members shall be appointed by the Governor, three members shall be appointed by the Speaker of the House of Representatives, three members shall be appointed by the President Pro Tempore of the Senate and one member shall be appointed by the State Board of Health. Five members shall constitute quorum.

Attachments

- Ms. Karen Vahlberg, R.N., B.S.N., Curriculum Vitae



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T. Cline 11-24-2015*
Commissioner

Through: James Joslin
Agency Rule Liaison E-mail approval 11/19/15

From: Don Maisch
General Counsel E-mail approval 11/19/15

Date: November 18, 2015

Subject: CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL

The attached rule and supporting documents are submitted for **EMERGENCY** and **PERMANENT** adoption of the rule at the Board of Health's December 2015 meeting.

We received no public comment. There were no revisions to the previously reviewed rule.

Attachments:

- Rule Impact Statement
- Rule Text
- Rule Comment Summary

RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL [NEW]

1. **DESCRIPTION:** *(a brief description of the purpose of the proposed rule [75 O.S. §303.D.2(a)])*
These proposed regulations, if adopted, will implement the agency's requirements from House Bill Number 2154, from the 1st Session of the 55th Oklahoma Legislature (2015) known as "Katie and Cayman's Law" and codified at 63 O.S. §§ 2-801 through 2-805. The proposed regulations set forth the Department's requirements for the necessary approvals of clinical trials on subjects under the age of 18 for the use of Cannabidiol in treating certain types of seizures as required by the House Bill. *Cannabidiol* means a nonpsychoactive cannabinoid found in the plant *Cannabis sativa L.* or any other preparation thereof, that has a tetrahydrocannabinol concentration of not more than three-tenths of one percent (0.3%) and that is delivered to the patient in the form of a liquid [63 O.S. § 2-201]
2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:** *(a description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the agency from any private or public entities [75 O.S. §303.D.2(b)])* Those classes of persons potentially affected are physicians and patients that will be wanting to develop clinical trials for the use of Cannabidiol, as well as the educational facilities where the trials will occur. The costs of compliance of these rules will be to the physicians and the hospitals where the trials will occur. Since there is no fee associated with the filing for the approval, the only cost to the physician and the hospital will be the time needed to fill out and collect the appropriate paperwork.
3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:** *(a description of the classes of persons who will benefit from the proposed rule [75 O.S. §303.D.2(c)])* The potential benefit will be to the patients who receive the Cannabidiol treatment in the lessening or ceasing of certain seizure events. Additional benefit will be to the physicians and hospitals in determining whether Cannabidiol treatment is effective concerning such seizure events. The Department will track and determine potential benefits through the receipt of reports from any of the approved trials.
4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:** *(a description of the probable economic impact of the proposed rule upon affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change [75 O.S. §303.D.2(d)])*

While the cost to the physicians or hospitals is unknown at the present time, it is assumed that there will be minimal costs to the physician or hospital if the proposed rules are adopted. Necessary time and equipment will need to be obtained to fill out the forms necessary to obtain approval and to conduct the needed clinical trial.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:** *(the probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency [75 O.S. §303.D.2(e)])*

The cost to implement the rule for the Oklahoma State Department of Health is unknown at the present time. If adopted the proposed rules would establish new requirements for physicians and hospitals wanting to conduct clinical trials on the use of Cannabidiol as a treatment for certain type of seizures in individuals under the age of 18. These new requirements would increase the cost to the Oklahoma State Department of Health in receiving applications, reviewing applications and issuing approvals for the use of Cannabidiol in clinical trials.

The cost to the Department to implement the amendments will be approximately \$[4,419.63] to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. **IMPACT ON POLITICAL SUBDIVISIONS:** *(a determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule [75 O.S. §303.D.2(f)])*

There will be no economic impact on any political subdivisions.

7. **ADVERSE EFFECT ON SMALL BUSINESS:** *(a determination of whether implementation of the proposed rule may have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act [75 O.S. §303.D.2(g)])¹²*

Since all trials must occur at a research hospital, there will be no impact on small business.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:** *(an explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule [75 O.S. §303.D.2(h)])*

There have been no effort to minimize compliance costs, as all the requirements contained in the proposed regulations are required by the implementing statutory requirements.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:** *(a determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk [75 O.S. §303.D.2(i)])*

If adopted the proposed rules would establish new requirements for physicians and hospitals wanting to conduct clinical trials on the use of Cannabidiol as a treatment for certain type of seizures in individuals under the age of 18.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:** *(a determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented [75 O.S. §303.D.2(j)])*

¹ 75 O.S. § 502. As used in the Oklahoma Small Business Regulatory Flexibility Act:

4. "Small business" means a for-profit enterprise consisting of fifty or fewer full-time or part-time employees.

² 75 O.S. § 504(B). If the proposed rules may have an adverse economic effect upon small business, the agency shall submit a copy of the proposed rules and a rule impact statement to the Small Business Regulatory Review Committee for its review and comment pursuant to the review and comment provisions of paragraph 2 of subsection A and paragraph 6 of subsection B of [Section 303](#) of this title.

It is unknown if there are any detrimental effects on public health and safety if these proposed rules are not adopted.

11. This rule impact statement was prepared on August 3, 2015. Modifications made subsequent to the publication of the *Notice of Rulemaking Intent* were made on: none. (*the date the rule impact statement was prepared and if modified, the date modified* [75 O.S. §303.D.2(k)])

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL**

SUBCHAPTER 1. PURPOSE AND DEFINITIONS

310:15-1-1. Purpose

The rules in this Chapter implement the Commissioner of Health's authorities established in Enrolled House Bill Number 2154, from the 1st Session of the 55th Oklahoma Legislature (2015) known as "Katie and Cayman's Law" and codified at 63 O.S. §§ 2-801 through 2-805.

310:15-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Clinical Trial" means a trial at an academic medical center of the use of cannabidiol at an academic medical center on patients eighteen (18) years of age or younger pursuant to the requirements of Katie and Cayman's Law, codified at 63 O.S. §§ 2-801 through 2-805.

"O.S." means Oklahoma Statute.

"Severe forms of epilepsy" means refractory epilepsy that is not adequately treated by traditional medical therapies, including Lennox-Gastaut Syndrome and Dravet Syndrome, also known as Severe Myoclonic Epilepsy of Infancy.

SUBCHAPTER 3. PHYSICIAN APPLICATION AND REPORTING

310:15-3-1. Physician application

Any physician, who has been designated a principal investigator of a clinical trial concerning *Lennox-Gastaut Syndrome*, also known as *Severe Myoclonic Epilepsy of Infancy*; any other severe form of epilepsy not adequately treated by traditional medical therapies (63 O.S. § 2-101 (23)), or any other form of refractory epilepsy that is not adequately treated by traditional medical therapies (63 O.S. § 2-801 (5)) on individuals eighteen (18) years of age or younger, and who requests approval from the Commissioner of Health, or designee shall:

- (1) Submit an application on a form provided by the Commissioner of Health, which shall include the name, address and other contact information for the principal investigator;
- (2) Submit a statement from either the Oklahoma State Board of Medical Licensure or the Oklahoma State Board of Osteopathic Examiners that the physician is licensed and in good standing with said licensure board;
- (3) Submit a copy of the documents from the United States Food and Drug Administration naming the physician as the principal investigator;
- (4) Submit a copy of the license obtained by the United States Drug Enforcement Administration;
- (5) Submit and maintain a current Oklahoma State Bureau of Narcotics and Dangerous Drugs Control registration;
- (6) Demonstrate registration with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control;
- (7) Submit the names, addresses and other contact information of any subinvestigators who will be assisting the principal investigator and include with the submission:

- (A) A copy of the license obtained by the United States Drug Enforcement Administration; and
- (B) Information demonstrating registration of the subinvestigator with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control;
- (8) Submit the following information concerning the clinical trial to be performed:
 - (A) Name, address and contact information of the academic medical center where the clinical trial will occur;
 - (B) Statement from Institutional Review Board (IRB) of the academic medical center where the clinical trial will occur, concurring with the requirements for said clinical trial;
 - (C) Statement from the United States Food and Drug Administration allowing cannabidiol to be used as a investigation new drug on qualified patients with severe forms of epilepsy;
 - (D) Name, address and other contact information of the source of the cannabidiol to be used for the study. The submission of the information of the source of the cannabidiol shall include:
 - (i) Information that the cannabidiol was manufactured at a facility in the United States or in a foreign country that was approved by the United States Food and Drug Administration; and
 - (ii) Information that the cannabidiol has been tested on animals to:
 - (I) demonstrate preliminary effectiveness; and
 - (II) ensure the cannabidiol is safe to administer to humans;
 - (E) Submit a statement that the clinical trial will be performed at the highest standards of clinical research; and
 - (F) Submit a statement that the clinical trial will conclude no later than December 31, 2017;
- (9) Submit a statement that the principal investigator and all subinvestigators shall adhere to the rules and regulations established by the relevant Institutional Review Board for the clinical trial; and
- (10) Submit an attestation by the principal investigator as to the accuracy and completeness of the information provided in the application.

310:15-3-2. Physician reporting

- (a) Any physician approved by the Commissioner of Health or designee to perform a clinical trial, pursuant to this Chapter shall submit annual reports, and a final report, to the Commissioner of Health. The report shall include:
 - (1) Data from the clinical trial; and
 - (2) Summary of findings from the clinical trial.
- (b) Any physician, approved by the Commissioner of Health or designee to perform a clinical trial pursuant to this Chapter shall immediately report to the Commissioner of Health and to the Director of the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control any adverse outcomes or injuries to any subjects participating in the clinical trial.

RULE COMMENT SUMMARY AND RESPONSE

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) *A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules;* (10) *A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.*[75:303.1(E)(9)&(10)]

No Comments Received.

Agency Rule Contact:

Donald D. Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th St, Oklahoma City, OK 73117, (405) 271-6017, donm@health.ok.gov .



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T. Cline 11-24-2015*
Commissioner

Through: James Joslin Approved via email 11/19/15
Agency Rule Liaison

Through: Don Maisch Approved via email 11/19/15
General Counsel

Through: Henry F. Hartsell Pending
Deputy Commissioner, Protective Health Services

From: Lynnette Jordan Approved via email 11/18/15
Administrative Programs Manager, Occ. & Consumer Protection Licensing

Date: November 18, 2015

Subject: Chapter 265. Hearing Aid Dealers and Fitters Regulation

The attached rule and supporting documents are submitted for **PERMANENT** adoption of the rule at the Board of Health's December 2015 meeting.

Public comment resulted in a revision to the previously reviewed rule. The Consumer Protection Licensing Advisory Council meeting held November 6, 2015 reviewed the comments and proposed response of the Department and concurred with the proposed response. As noted in the Rule Comment Summary, the revisions include adding clarifications and removing proposed revisions for further review.

Additional Recommended Amendments for Board Consideration:

Rule Impact Statement: Section 1 Description, second sentence, refers to proposed changes to the law. "Proposed Changes" should be revised to "November 1, 2015 changes."

Rule Text: Page 1, section 310:265-1-2, the definition for "Personal sound amplification product" should be removed at the recommendation of the consumer protection licensing advisory council as this term is not used elsewhere in law or rule.

Attachments:

- Rule Impact Statement
- Rule Text
- Rule Comment Summary

RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 265. HEARING AID DEALERS AND FITTERS

1. **DESCRIPTION:** *(a brief description of the purpose of the proposed rule [75 O.S. §303.D.2(a)])*

The current rule applies to individuals licensed for the purpose of fitting and dealing hearing aids as set for in Title 63 § 1-1750 et seq. The **proposed changes** clarify the exam requirements to agree with proposed changes to the law but also have given consideration to the review and update of best practices for the entire chapter. A summary of these changes include updates and clarification to temporary permits, reciprocity, business regulatory authority, customer notification, continuing education requirements, clarification of waivers and update of advisory council. These changes are needed to allow the hearing aid fitting and dealing profession to stay current with national standards and ensure customers are protected and aware of their rights under this Rule. The effect of this Rule change will allow applicants the option to choose the most applicable exam for hearing aid fitters and dealers licensure and update the rule with current practices in the profession.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:** *(a description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the agency from any private or public entities [75 O.S. §303.D.2(b)])*

Those classes of persons affected are persons applying for licensure to engage in the practice of fitting and dealing in hearing aids through the Oklahoma State Department of Health.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:** *(a description of the classes of persons who will benefit from the proposed rule [75 O.S. §303.D.2(c)])*

Persons benefiting will be all applicants of the hearing aid licensure program as they will be given options to choose the exam that best meets their professional requirements and offer more testing sites and availabilities. In addition, review and update of the entire rule will benefit all Oklahomans utilizing hearing aid devices or whom have family members who use such devices to ensure practices are up to date and in line with best practices.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:** *(a description of the probable economic impact of the proposed rule upon affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change [75 O.S. §303.D.2(d)])*

By modifying this language, the Department would be able to identify multiple third party exam vendors that would allow the applicant to choose the best fit for their profession. Of these exam vendors, the Department is aware of two that range in pricing from \$50 (strictly for proctoring) to \$225 (exam recognized at an international level for the profession and currently utilized in 49 other states). Roughly 20 written exams are taken each year in Oklahoma; based on the applicants decision, they may elect to pay the higher price exam but all fees will be paid directly to the third party exam vendor.

The Department will identify all applicable third party exam vendors who meet minimum requirements for testing and will provide all options for testing to the applicants.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:** *(the probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency [75 O.S. §303.D.2(e)])*

The cost to the Department to implement the amendments will be approximately \$5,586.93 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. **IMPACT ON POLITICAL SUBDIVISIONS:** *(a determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule [75 O.S. §303.D.2(f)])*

There is no anticipated impact on political subdivisions.

7. **ADVERSE EFFECT ON SMALL BUSINESS:** *(a determination of whether implementation of the proposed rule may have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act [75 O.S. §303.D.2(g)])¹²*

There is no anticipated adverse effect on small business.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:** *(an explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule [75 O.S. §303.D.2(h)])*

This proposed regulation would ensure the agency could identify an adequate exam at no anticipated exam fee increase to the applicant.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:** *(a determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk [75 O.S. §303.D.2(i)])*

There is no anticipated effect on public health and safety.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:** *(a determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented [75 O.S. §303.D.2(j)])*

¹ 75 O.S. § 502. As used in the Oklahoma Small Business Regulatory Flexibility Act:

4. "Small business" means a for-profit enterprise consisting of fifty or fewer full-time or part-time employees.

² 75 O.S. § 504(B). If the proposed rules may have an adverse economic effect upon small business, the agency shall submit a copy of the proposed rules and a rule impact statement to the Small Business Regulatory Review Committee for its review and comment pursuant to the review and comment provisions of paragraph 2 of subsection A and paragraph 6 of subsection B of [Section 303](#) of this title.

Without adoption of this proposed change, the Oklahoma State Department of Health would not be able to offer testing as required in the regulation within six months of an application being received.

11. This rule impact statement was prepared on August 12, 2014. Modifications made subsequent to the publication of the *Notice of Rulemaking Intent* were made on: November 6, 2015. (*the date the rule impact statement was prepared and if modified, the date modified* [75 O.S. §303.D.2(k)])

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 265. HEARING AID DEALERS AND FITTERS**

SUBCHAPTER 1. GENERAL PROVISIONS

310:265-1-1. Purpose [AMENDED]

310:265-1-2. Definitions [AMENDED]

310:265-1-1. Purpose

The rules in this Chapter implement the Hearing Aid Dealers and Fitters Act, 63 O.S. ~~Supp. 1990~~, Section 1-1750 et seq.

310:265-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Act" means those statutes relating to Hearing Aid Dealers and Fitters codified at 63 O.S., Sections 1-1750 to 1-1754, as amended.

"Board" means the State Board of Health.

"Commissioner" means the State Commissioner of Health or his/her authorized representative.

"Department" means the Oklahoma State Department of Health.

"Direct on-site supervision" means a licensed hearing aid dealer and fitter shall accompany a temporary permit holder anytime the permit holder is performing the practice of fitting and dealing in hearing aids.

"Established procedures and instrumentation in fitting of hearing aids" means a minimum requirement all hearing tests shall include both air-conduction and bone conduction threshold measurements except in the case of a re-test when there is less than a fifteen (15) dB loss between the current air-conduction threshold and the previous air-conduction threshold and the previous tests showed the loss to be sensorineural.

"Hearing aid" means any wearable instrument or device designed for or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments or accessories, but excluding earmolds, batteries, and cords; provided that this definition shall not include lenses or spectacle frame fronts for eyeglass-type hearing aids; except in the case of spectacle frame fronts which include electrical wiring as part of the hearing aid.

"Hearing Screening" means a binary pure tone screening at a preset intensity level for the purpose of determining if an individual screened needs further testing prior to the selection or sale of a hearing aid.

"License" means a license issued by the Commissioner to hearing aid dealers and fitters.

"Personal Sound Amplification Product" or "PSAP" means a wearable electronic product not intended to compensate for impaired hearing.

"Practice of fitting and dealing in hearing aids" means those practices used for the purpose of selection, adaptation and sale of

hearing aids including direct observation of the ear together with the counseling and instruction pertaining thereto, the testing of human hearing for these purposes and the making of impressions for earmolds.

"Qualified waiver" means a written acknowledgment endorsed by the person supplied with a hearing aid, or his lawfully appointed guardian, that indicates ~~that~~ the person supplied with a hearing aid was advised ~~that~~ the ambient noise level of the testing environment used to fit a hearing aid exceeded 45 dB on a slow weighted dB (a) scale and ~~that~~ the hearing test conducted could result in an inappropriately fitted hearing aid.

"Sell" or "sale" means any transfer of title or of the right to use by lease, bailment, or any other contract, excluding wholesale transactions with distributors or dealers.

"Seller" means any person who dispenses a hearing aid to any member of the consuming public.

"Temporary permit" means a permit issued while the applicant is training to become a licensed hearing aid dealer or fitter.

SUBCHAPTER 3. EXAMINATIONS

310:265-3-1. Qualifications [AMENDED]

310:265-3-2. Contents of examination [AMENDED]

310:265-3-3. Fees for ~~licenses~~ license applications and examinations [AMENDED]

310:265-3-1. Qualifications

(a) Applicants may obtain a hearing aid dealer or fitter license by successfully passing qualifying examinations, provided the applicant:

(1) Is at least eighteen (18) years of age;

(2) Is of good moral character. A criminal record shall not in itself bar an applicant from licensing, but evidence of such record may be considered along with other information in determining whether or not the applicant is of good moral character.

(3) Has an education equivalent to a four-year course in an accredited high school; and

(4) Has filed with the Commissioner an application for registration and examination and paid the examination fee of Ninety-five Dollars (\$95.00), or paid the examination fee to a national examination provider whose exam meets the requirements of this Chapter and who has entered into an agreement with the Department to provide the exam.

(b) An applicant for license by examination shall appear ~~at a time, place and~~ before such persons as the Commissioner may designate to be examined to demonstrate that he/she is qualified to practice the fitting and sale of hearing aids. Nothing in this examination shall

imply that the applicant shall possess the degree of medical competence normally expected of physicians.

(c) The Commissioner shall give examination as required to permit applicants to be examined within six (6) months following the submission of the official application form.

(d) Successfully passing the examination means passing each of the sections ~~based on the following criteria~~. When a passing score is obtained for any section, that section will not have to be taken again. A passing score for each section below will be approved by the Department based on the submitted and approved examination.

(1) Written Examination meeting the requirements of this Chapter ~~Passing score for the written examination is established by the examination provider.~~

(2) ~~Passing score for the Oklahoma Audiometric Practical examination is 70% or above.~~

(3) ~~Passing score for the Oklahoma Hearing Aid Rules examination is 70% or above.~~

(4) ~~Passing score for the Oklahoma Ear Impression Practical practical examination is 70% or above.~~

(5) ~~Passing score for the Hearing Aid Trouble Shooting Practical Examination is 70% or above.~~

(e) No person may take any portion of the ~~state~~ examination more than three (3) times and must wait at least seven days before retaking a portion of any examination. Any person failing any section of the ~~state licensing~~ examination three times shall not be allowed to apply for an Oklahoma Hearing Aid Dealers and Fitters License for ~~five (5) years~~ one (1) year from their application last testing date. If a person fails any portion of the ~~state licensing~~ examination three (3) times, the Department shall summarily suspend and seek permanent revocation of the person's current temporary hearing aid dealers and fitters permit.

310:265-3-2. Contents of examination

The hearing aid dealer or fitter examination shall consist of an examination ~~as compiled~~ at the discretion of the Commissioner, taking into consideration the guidelines if available for a national examination and guidelines if available for similar examinations given by surrounding states. The tests under this section shall not require a higher education in the fields of medicine, audiology or communication disorders. The examination shall consist of tests of knowledge as it pertains to the sale and fitting of hearing aids as follows:

(1) Function of a hearing aid;

(2) Pure tone audiometry, including air conduction testing and bone conduction testing (continuous-pulsing ~~audiometer~~ audiometer setting not accepted);

(3) Recorded voice speech audiometry;

(4) Masking when indicated;

(5) Recording and evaluation of audiograms and speech audiometry to determine proper selection and adaptation of a hearing aid;

- (6) Taking earmold impressions;
- (7) Rules and regulations pertaining to the sale and fitting of hearing aids; and
- (8) Trouble Shooting pertaining to the identification of ~~visable~~ visible physical defects or damage to hearing aids.

310:265-3-3. Fees for licenses and examinations

(a) Fees for ~~licenses~~ license applications, permits and examinations shall be as follows:

- (1) Initial License Application Fee - \$50.00;
 - (2) Examination Fee - \$95.00, or receipt for payment of an examination fee for an examination from a national provider that meets the requirements of this Chapter and who has entered into an agreement with the Department to provide the exam;
 - (3) Temporary Permit Application Fee - \$15.00;
 - (4) ~~Renewal of~~ License Fee (on or before January 30) - \$50.00;
 - (5) Reexamination Fee - \$95.00;
 - (6) ~~Renewal of~~ Temporary Permit Extension Fee - \$15.00;
 - (7) Renewal of License (within thirty-day grace period) - \$75.00; and
 - (8) Renewal of License (after thirty-day grace period) - \$100.00.
- (b) Licensure by equivalency fees, grounds for renewal and procedures for the suspension and revocation shall be the same as for initial licensing, renewal, suspension and revocation of a license.

(c) Application fees are non-refundable.

SUBCHAPTER 5. LICENSE REQUIREMENTS

Section

- 310:265-5-1. License required [AMENDED]
- 310:265-5-2. Applicant requirements for reciprocity [AMENDED]
- 310:265-5-3. Address of place of business [AMENDED]
- 310:265-5-4. Receipts [AMENDED]
- 310:265-5-6. Continuing education requirements [AMENDED]
- 310:265-5-7. Temporary permits [AMENDED]
- 310:265-5-8. Procedures and instrumentation in fitting of hearing aids [AMENDED]

310:265-5-1. License required

(a) No person shall engage in the sale of or practice of fitting hearing aids or display a sign or in any other way advertise or represent himself as a person who practices the fitting and sale of hearing aids without first obtaining a license or permit in accordance with these rules from the ~~commissioner~~ Commissioner or his designated representative. The license shall be conspicuously posted in his/her office or place of business. Duplicate licenses shall be issued by the Commissioner to valid license holders operating more than one office, without additional payment.

(b) Nothing in these regulations shall prohibit a corporation, partnership, trust, association or other like organization maintaining an established business address from engaging in the business of selling or offering for sale hearing aids at retail without a license, provided ~~that~~ it employs only properly licensed persons in the direct sale and fitting of such products. Such corporations, partnerships, trust, associations or other like organizations shall ~~file annually with the Commissioner~~ make a list of all licensed hearing aid dealers and fitters directly or indirectly employed by them available to the Department upon request.

(c) Nothing in these regulations shall permit a licensed hearing aid dealer or fitter to take facial measurements for eyeglasses or to fit, adjust, duplicate or adapt lenses or spectacle frames, except that a licensed hearing aid dealer or fitter may adapt or replace the temple or temples incorporating hearing aid components in eyeglass-type hearing aids.

310:265-5-2. Applicant requirements for reciprocity

(a) Whenever the Commissioner determines ~~that~~ another state or jurisdiction has requirements equivalent to or higher than those in effect pursuant to these regulations excluding trouble-shooting and Oklahoma regulations, and that such state or jurisdiction has a program equivalent to or stricter than the program for determining whether applicants pursuant to these regulations are qualified to dispense and fit hearing aids, the Commissioner may issue a license to applicants who hold current, unsuspended and unrevoked certificates or licenses to fit and sell hearing aids in such other state or jurisdiction. ~~No such applicants shall be required to submit to or under go a qualifying examination other than the payment of fees, pursuant to these regulations, and shall be registered in the same manner as licensees. The fee shall be the same as the fee for an initial license.~~

(b) Applicants must submit an application for reciprocity on forms as designated by the Department.

(c) Applicants must submit an Out-of-State Licensure Verification form filled out by the other licensing state.

(d) Applicants must register with the Department and pass the Oklahoma Hearing Aid Rules examination and Hearing Aid Trouble Shooting Practical Examination.

310:265-5-3. Address of place of business

(a) A person who holds a license shall notify the Commissioner in writing of each address of the business(es) where he/she engages or intends to engage in the fitting or the sale of hearing aids. A post office box number by itself does not fulfill this requirement.

(b) The Commissioner shall keep a record of the place of business of licensees.

(c) Any notice required to be given by the Commissioner to a person who holds a license shall be mailed to him/her by certified mail at

the address of the last place of business of which he/she has notified the Commissioner.

(d) Where more than one (1) office is operated by the licensee, duplicate licenses shall be issued by the Commissioner for posting in each location, without additional payment. The licensee must send a written request for a duplicate license indicating the address of the place of business where the duplicate license will be posted.

310:265-5-4. Receipts

(a) Any person who practices the fitting and sale of hearing aids shall deliver to each person supplied with a hearing aid a receipt which shall contain the licensee's signature and show his business address, (a post office box number by itself does not meet the requirement of a business address), and number of his State license, together with specifications as to the make and model of the hearing aid furnished, with full terms of the sale clearly stated. If an aid which is not new is sold, the receipt shall be clearly marked as "used" or "reconditioned", whichever is applicable, with terms of guarantee, if any.

(b) Such receipt shall bear in no smaller type than the largest used in the body copy portion the following: "Any examination or representation made by a licensed hearing aid dealer and fitter in connection with the fitting and selling of this hearing aid is not an examination, diagnosis, or prescription by a person licensed to practice medicine in this state and therefore must not be regarded as medical opinion or advice. Further, it is recommended that medical advice from a licensed physician should be obtained."

(c) No receipt for a hearing aid shall be valid without the original signature of a licensed hearing aid dealer and fitter. Said receipt shall constitute a contract of sale between the hearing aid dealer and fitter and the purchaser. The holder of a temporary license may not issue a receipt unless the original signature of the direct supervisor also appears on the receipt. Said receipt shall have the state license number of both the licensed hearing aid dealer and fitter and the temporary licensed person.

(d) The hearing aid dealer and fitter may retain a cancellation fee of 10% or \$150 per aid, whichever is less, of the purchase price of the hearing aid(s). The guarantee must entitle the purchaser, upon cancellation for any reason within the 30-day period after taking possession of the hearing aid(s), to receive the full refund less the cancellation fee. Said refund shall be provided to the purchaser within 30 days after the return of the hearing aid(s). If the hearing aid must be repaired, remade or adjusted during the 30-day refund period, the running of the 30-day period is tolled for any period during which the hearing aid provider takes possession or control of a hearing aid after its original delivery.

(e) ~~The hearing aid provider shall provide a written receipt or contract to the purchaser that includes, in immediate proximity to~~

~~the space reserved for the signature of the purchaser, the following specific statement in all bold-faced type capital letters no smaller than the largest print used in the written receipt or contract:~~ The hearing aid provider shall provide a written receipt or contract to the purchaser that includes, in immediate proximity to the space reserved for the signature of the purchaser, the following specific statements in all bold-faced type capital letters no smaller than the largest print used in the written receipt or contract:

(1) Statement One

OKLAHOMA STATE LAW GIVES THE PURCHASER THE RIGHT TO CANCEL THIS PURCHASE FOR ANY REASON BY RETURNING THE HEARING AID TO THE HEARING AID PROVIDER AT ANY TIME PRIOR TO MIDNIGHT OF THE THIRTIETH CALENDAR DAY AFTER RECEIPT OF THE HEARING AID.

BY LAW, THE HEARING AID PROVIDER MAY BE ENTITLED TO A CANCELLATION FEE NOT TO EXCEED TEN PER CENT (10%) OF THE TOTAL PURCHASE PRICE FOR THE HEARING AID OR ONE HUNDRED FIFTY DOLLARS (\$150.00) PER HEARING AID, WHICHEVER IS LESS, TO COVER THE COSTS INCURRED BY THE HEARING AID PROVIDER.

IF THE PURCHASER RETURNS THE HEARING AID WITHIN THE THIRTY-DAY PERIOD, THE PURCHASER WILL RECEIVE A REFUND OF \$.00. (HEARING AID PROVIDER MUST INSERT THE DOLLAR AMOUNT OF THE REFUND). IF THE HEARING AID PROVIDER FAILS TO COMPLY WITH THIS PROVISION, COMPLAINTS SHOULD BE FORWARDED TO:

OKLAHOMA STATE DEPARTMENT OF HEALTH

OCCUPATIONAL LICENSING DIVISION

TH
1000 N.E. 10 STREET

OKLAHOMA CITY, OKLAHOMA 73117 [15:764.1(A)(3)]

(2) Statement two

DURING THE THIRTY-DAY PERIOD, IF THE HEARING AID IS RETURNED FOR REPAIRS OR ADJUSTMENTS THE THIRTY-DAY PERIOD SHALL BE TOLLED UNTIL RETURN OF THE AID(S) TO THE PURCHASER.

(f) The following information and measurements shall be included in each customer/patient file or permanent record, and be documented for the client:

- (1) A description, including location of any visible, congenital or deformity of the ear.
- (2) Whether the client has active, or a history of, drainage from the ear within the last 90 days.
- (3) Whether the client has acute or chronic dizziness.
- (4) Whether the client has unilateral hearing loss of a sudden or recent onset within the previous 90 days.
- (5) Whether the client has a history of sudden or rapidly progressive hearing loss within the previous 90 days.
- (6) Whether the client has an Audiometric Air Bone Gap equal to or greater than 15 decibels at 500 Hertz, 1000 Hertz and 2000 Hertz.
- (7) Whether the client has visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
- (8) Whether the client has pain or discomfort in the ear.

310:265-5-6. Continuing education requirements

(a) Each applicant for renewal of a hearing aid dealer or fitter license must submit written evidence showing he/she has completed ten (10) clock hours of continuing education, completed during the previous year and pertaining to the hearing sciences, ~~as approved by the National Institute of Hearing Instruments Studies or an equivalent; or have had the curriculum approved by the Department.~~

(1) No more than four (4) online continuing education clock hours may be submitted for the required ten (10) annual hours.

(2) The continuing education hours must be approved by the International Institute of Hearing Instruments or have had the curriculum approved by the Department.

(b) **Continuing education course approval by the Department.** An entity which desires to sponsor education to licensees in compliance with the continuing education requirements of subsection (a) of this Section shall file an application for approval on the form prescribed by the Department. An application shall include a list of the course instructors and their qualifications, an agenda detailing the material to be presented, the location of the training, the program objectives, and the number of clock hours of classroom and supervised instruction. After completion of the course, the entity shall submit sign-in sheets for all sessions which require a signature and social security number or state license number of each person in attendance. The program shall verify the total number of continuing education hours completed by each attendee. All programs shall be presented as submitted unless changes have been approved prior to presentation. Changes which occur during the presentation shall be submitted to the Department within ten (10) days of the training session for review by the Department. Failure to obtain approval of changes may result in loss of certification.

(c) **Approval requirements for continuing education**

(1) All material and information presented shall pertain to the hearing aid dealers and fitters profession.

~~(2) The training location must be outside the regular work place or after regular work hours.~~

~~(3) All training should utilize materials that are to be generic and non-proprietary in nature.~~

310:265-5-7. Temporary permits

(a) An applicant who fulfills the requirements regarding age, character and education as set forth in these regulations shall be entitled to a temporary hearing aid dealer or fitter permit upon application to the Commissioner. Previous experience or a waiting period shall not be required to obtain a temporary permit.

(b) Upon receiving an application as provided under this section and accompanied by a temporary permit application fee of Fifteen Dollars (\$15.00), the Commissioner shall issue a temporary permit which shall entitle the applicant to engage in the fitting and sale

of hearing aids for a period not to exceed six (6) months or until the holder has successfully passed the examination required for a license, whichever period is less. A person holding a valid Oklahoma Hearing Aid Dealers' and Fitters' License shall be responsible for the direct on-site supervision and training of such applicant ~~and maintain adequate personal contact.~~

(c) A temporary permit may be extended for an additional period by the Commissioner upon payment of a fee of Fifteen Dollars (\$15.00). The Commissioner shall not extend a temporary permit more than one (1) time.

(d) A maximum of two (2) people with temporary permits may work under the direct on-site supervision of a person holding a valid Oklahoma Hearing Aid Dealers' and Fitters' License.

310:265-5-8. Procedures and instrumentation in fitting of hearing aids.

(a) Testing

(1) All instruments used to measure thresholds shall be annually certified to meet American National Standard Specifications for Audiometer, S3.6-1969 or a standard which supersedes it. In addition, some form of live voice or recorded voice testing must be made to obtain at least a subjective evaluation of the individual's ability to discriminate. In the case of live voice testing, the tests should be run without visual cue. A hearing aid of similar characteristics can be refitted to an individual without a hearing test if this is done within six (6) months of the original fitting and original hearing test.

(2) Hearing testing for the purpose of fitting hearing aids shall not be conducted where ambient noise levels exceed 45 dB measured on a slow weighted dB (a) scale. If the testing environment exceeds 45 dB, the testing shall be considered a "Hearing Screening" and shall not be utilized to determine the auditory thresholds in the selection of a hearing aid unless a qualified waiver is executed by the person supplied with a hearing aid and is accompanied by written documentation from a competent medical authority as outlined in 310:265-5-8(c).

(b) **Screening.** A licensee may conduct a hearing screening at a health fair, state fair, public location or similar facility, but due to excessive background noise commonly found in these environments, measurement of auditory thresholds are not acceptable. A licensee should present to the person receiving the "Hearing Screening" a written statement at the time of the screening containing the following provisions: Results of a "Hearing Screening" are not a medical or audiological evaluation of your ear nor a diagnosis of a hearing disorder. You passed/failed (circle one) the hearing screening. Failing a screening is an indication you need further testing prior to the selection of a hearing aid.

(c) **Qualified waiver.** The waiver must be accompanied by written documentation from a competent medical authority that the person

supplied with a hearing aid is not ambulatory and any transport of that person would create a serious risk of harm or cause an imminent threat to their health and ~~well-being~~ wellbeing. A qualified waiver may not be utilized at a hearing screening conducted at a health fair, state fair, public location or similar facility that exceeds 45 dB on a slow weighted dB (a) scale.

SUBCHAPTER 7. REGULATORY ENFORCEMENT

Section

310:265-7-2. Prohibited acts [AMENDED]

310:265-7-3. Complaint procedure [AMENDED]

310:265-7-2. Prohibited acts

(a) No person shall:

(1) Sell, barter, or offer to sell or barter a license;

(2) Purchase or procure by barter a license with intent to use it as evidence of the holder's qualification to practice the fitting and sale of hearing aids;

(3) Alter a license with fraudulent intent;

(4) Use or attempt to use as a valid license which has been purchased, fraudulently obtained, counterfeited or materially altered;

(5) Willfully make a false statement in an application for a license or application for renewal of a license;

(6) Engage in the practice of fitting and dealing in hearing aids with a temporary permit unless under the direct on-site supervision of an Oklahoma Licensed Hearing Aid Dealer and Fitter; ~~or~~

(7) Allow a temporary permit holder to engage in the practice of fitting and dealing in hearing aids unless under the direct supervision of an Oklahoma Licensed Hearing Aid Dealer and Fitter;

(8) Sell a hearing instrument to a person under eighteen (18) years of age unless the prospective user, parent or guardian has presented to the licensee a medical evaluation signed by a ~~board eligible or board certified otolaryngologist~~ physician who specializes in diseases of the ear, that states the client may be considered a candidate for a hearing instrument. This requirement may be waived if a ~~otolaryngologist~~ physician who specializes in diseases of the ear is not available within 100 miles of the person's residence and a licensed physician provides the medical evaluation. This evaluation must have taken place within the preceding six (6) months of the testing and fitting. A licensed audiologist should perform the evaluation and rehabilitation; ~~or~~

(9) ~~An Oklahoma licensed hearing aid dealer and fitter shall not infer~~ Infer directly or indirectly in advertisement or written material that the hearing aid dealer and fitter is licensed as a

physician or audiologist or performs diagnostic procedures to determine the cause of a hearing impairment.

(b) Violations of this Section may be brought pursuant to Title 63 O.S. Section 1-1701.1A (Administrative penalty), as amended.

310:265-7-3. Complaint procedure

(a) **Purpose.** The purpose of this section is to specify the administration and investigation of complaints and the filing of disciplinary actions against hearing aid dealers and fitters who hold a license or temporary permit in Oklahoma, or against persons who sell hearing aids in Oklahoma without a license or temporary permit and who are not otherwise exempt from the license requirements.

(b) Complaints

(1) Any person may file a complaint against a licensed hearing aid dealer and fitter or temporary licensed dealer and fitter or a person selling or fitting hearing aids. A person desiring to report a complaint or violation by a licensee or seller shall notify the Department in writing. The Department will determine whether the complaint alleges a possible violation of the Act or this chapter. The Department may present the complaint to the ~~Hearing Aid Advisory Council~~ Consumer Protection Licensing Advisory Council for consultation.

(2) The Department may request a written response to the complaint from the licensee to determine if the complainant has exhausted their remedy under the sales agreement.

(3) Except as provided in Paragraph (2) of this subsection, the complaint and the identity of the complainant may be confidential and unavailable for public inspection or disclosure unless otherwise required by law. The Department shall confirm whether or not a complaint has been received.

(c) **Investigation.** If the Department determines ~~that~~ a possible violation of the Act or this Chapter has occurred, the Department may commence an investigation of the complaint.

(d) **Filing of an action.** The Department may begin a disciplinary action against a person who holds a license or temporary permit as a hearing aid dealer and fitter or a person selling hearing aids who is not exempt from licensure. The Department shall specifically state the violation(s) and shall request the appropriate remedy. Remedies include revocation of a license, suspension of a license, probation of a licensee, an administrative penalty, injunctive relief, or a combination of the foregoing remedies.

(e) **Referral of investigation.** Notwithstanding subsection (d) of this section, the Commissioner of Health may refer the results of an investigation, or complaint, received by the Department to the appropriate official(s) in consideration for criminal prosecution.

RULE COMMENT SUMMARY AND RESPONSE

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 265. HEARING AID DEALERS AND FITTERS**

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) *A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules;* (10) *A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.*[75:303.1(E)(9)&(10)]

Name & Organization: Michael Grimm, PhD, CCC/A, Staff Audiologist for the VA Center – OKC and Secretary of the Consumer Protection Licensing Advisory Council

Rule Subchapter and Section: 310:265-3-1(d)

Comment: The commenter noted that this section proposed changes that would eliminate any reference to an actual passing score for all four different exams that must be passed. Questions raised included: if the references to the passing score for these exams are eliminated, exactly who or what group will then determine a passing score; will the passing score change depending upon who oversees or administers the exam; and whether eliminating a reference to a passing score potentially open up the state to any legal challenges related to who or why a particular passing score was set or changed if someone fails to pass one of the exams?

Response: The current rule proposal will allow the Department to approve multiple exams thereby giving the applicant the option to determine which exam best suits their need for the profession. With the benefit of multiple exam options for the hearing aid dealer and fitter applicants, it is expected a different passing score may be identified for each test as they are validated by the exam entity. However, based on comments, the Department does recognize the need to clarify that passing scores will be approved by the Department.

Therefore, a clarification is being added to 310:265-3-1(d) that follows the Department’s process, that passing scores are approved by the Department.

These comments were discussed during the Consumer Protection Licensing Advisory Council meeting held November 6, 2015 at the Oklahoma State Department of Health. The council agreed and approved the added language that would clarify all passing scores would be approved by the Department.

310:265-3-1. Qualifications

.....
(d) Successfully passing the examination means passing each of the sections ~~based on the following criteria~~. When a passing score is obtained for any section, that section will not have to be taken again. A passing score for each section below will be approved by the Department based on the submitted and approved examination.

(1) Written Examination meeting the requirements of this Chapter ~~Passing score for the written examination is established by the examination provider, International Institute for Hearing Instrument Studies.~~

- (2) ~~Passing score for the Oklahoma Audiometric Practical examination is 70% or above.~~
- (3) ~~Passing score for the Oklahoma Hearing Aid Rules examination is 70% or above.~~
- (4) ~~Passing score for the Oklahoma Ear Impression Practical ~~practical~~ examination is 70% or above.~~
- (5) ~~Passing score for the Hearing Aid Trouble Shooting Practical Examination is 70% or above.~~

Rule Subchapter and Section: 310:265-5-3(e) & (f)

Comment: The commenter noted they were concerned about the lack of definitions for mobile clinic or off-site clinic and what makes a mobile clinic a mobile clinic or an off-site clinic an off-site clinic.

Questions raised included: would a license holder be able to find an appropriately quiet room in any nursing facility and simply designate that room as an off-site clinic; besides providing written information about where the "main clinic" is and what hours it operates, what would preclude a license holder from Altus setting up multiple temporary off-site clinics in multiple nursing facilities throughout the Tulsa area; what would ensure that individuals purchasing hearing aids in the off-site clinic would then have appropriate access to follow-up services if the license holder decided after a few months to no longer maintain the off-site clinics; other than providing an address other than a PO Box as a main clinic, what would preclude a license holder from working primarily from multiple off-site or mobile clinics without really having an actual main clinic?

The commenter noted there was no reference to indicate whether a license holder would be required to state if they plan on maintaining an off-site clinic or if it is simply a one or two-time event – once to test for a hearing aid and the second time to fit a hearing aid, and noted they saw potential for abuse if this section is not more clearly defined in greater detail.

Response: The current rule does not disallow the practice of a mobile or off-site operation for hearing testing; however, based on the comments, the Department feels additional research is necessary to identify best practices for off-site services or mobile services to ensure the protection of vulnerable populations.

Therefore, the Department is removing the proposed language.

These comments were discussed during the Consumer Protection Licensing Advisory Council meeting held November 6, 2015 at the Oklahoma State Department of Health. The council agreed and approved in removing the language and recommended getting together a workgroup to address this issue further.

310:265-5-3. Address of place of business

- (a) A person who holds a license shall notify the Commissioner in writing of each address of the business(es) where he/she engages or intends to engage in the fitting or the sale of hearing aids. A post office box number by itself does not fulfill this requirement.
- (b) The Commissioner shall keep a record of the place of business of licensees.
- (c) Any notice required to be given by the Commissioner to a person who holds a license shall be mailed to him/her by certified mail at the address of the last place of business of which he/she has notified the Commissioner.
- (d) Where more than one (1) office is operated by the licensee, duplicate licenses shall be issued by the Commissioner for posting in each location, without additional payment. The licensee must send a written request for a duplicate license indicating the address of the place of business where the duplicate license will be posted.

[Proposed language at (e) and (f) are now removed.]

Rule Subchapter and Section: 310:265-5-8(a)(3)

Comment: The commenter noted that this section contains the only reference they could find that provides any guidance related to the conditions of an off-site or mobile clinic and expressed concern about the lack of a better definition or explanation for the purpose is of a mobile clinic. Questions included: is it primarily for the evaluation and sale of hearing aids to individuals that are unable to travel; if these individuals are unable to travel and a mobile clinic is only set-up primarily for the purpose of the sale of hearing instruments, how will these individuals successfully receive follow-up care for their hearing instruments if the mobile clinic is not available on a re-occurring basis? The commenter observed that use of the term "clinic" to refer to what may be simply a room with a portable audiometer and a limited number of tools used to obtain an earmold impression (s) may be miss-leading and offered "temporary testing location" as a more descriptive term.

Response: The current rule does not disallow the practice of a mobile or off-site operation for hearing testing; however, based on the comments, the Department feels additional research is necessary to identify best practices for off-site services or mobile services to ensure the protection of vulnerable populations. Therefore, the Department is removing the proposed language.

These comments were discussed during the Consumer Protection Licensing Advisory Council meeting held November 6, 2015 at the Oklahoma State Department of Health. The council agreed and approved removing the language and recommended convening a workgroup to address this issue further.

310:265-5-8. Procedures and instrumentation in fitting of hearing aids.

(a) Testing

(1) All instruments used to measure thresholds shall be annually certified to meet American National Standard Specifications for Audiometer, S3.6-1969 or a standard which supersedes it. In addition, some form of live voice or recorded voice testing must be made to obtain at least a subjective evaluation of the individual's ability to discriminate. In the case of live voice testing, the tests should be run without visual cue. A hearing aid of similar characteristics can be refitted to an individual without a hearing test if this is done within six (6) months of the original fitting and original hearing test.

(2) Hearing testing for the purpose of fitting hearing aids shall not be conducted where ambient noise levels exceed 45 dB measured on a slow weighted dB (a) scale. If the testing environment exceeds 45 dB, the testing shall be considered a "Hearing Screening" and shall not be utilized to determine the auditory thresholds in the selection of a hearing aid unless a qualified waiver is executed by the person supplied with a hearing aid and is accompanied by written documentation from a competent medical authority as outlined in 310:265-5-8(c).

[Proposed language at (3) is now removed.]

Rule Subchapter and Section: 310:265-5-8(c)(3)

Comment: Relative to the final sentence in subsection (c) below the commenter noted that it appeared that the sentence could be read to imply that a waiver could be utilized at the referenced locations as long as they did not exceed 45 dB on a slow weighted scale.

310:265-5-8. Procedures and instrumentation in fitting of hearing aids.

.....

(c) **Qualified waiver.** The waiver must be accompanied by written documentation from a competent medical authority that the person supplied with a hearing aid is not ambulatory and any transport of that person would create a serious risk of harm or cause an imminent threat to their health and ~~well-being~~ wellbeing. A qualified waiver may not be utilized at a hearing screening conducted at a health fair, state fair, public location or similar facility that exceeds 45 dB on a slow weighted dB (a) scale.

The commenter proposed breaking the sentence into two sentences to be clearer:

A qualified waiver may not be utilized at a hearing screening conducted at a health fair, state fair, public location or similar facility. Additionally, a qualified waiver may not be utilized for screening conducted at any location at which the sound levels exceed 45 dB on a slow weighted dB (a) scale.

Response: The Department reviewed this comment and presented the concerns to the Consumer Protection Licensing Advisory Council meeting held November 6, 2015 at the Oklahoma State Department of Health. In the opinion of the Council, the proposed change would disallow any type of operation, regardless if a board certified otolaryngologist approved such testing due to the immobility or overall health of a patient. The Council voted to maintain the proposed language and the Department concurs. However, a recommendation was made to organize a workgroup to focus solely on mobile or off-site operations to ensure adequate safeguards are present to protect the public’s health, especially vulnerable populations. The Department will convene the workgroup in the coming year.

Name & Organization: Consumer Protection Licensing Advisory Council

Rule Subchapter and Section: 310:265-7-2(a)(8)

Comment: In reviewing comments and the final proposal of Chapter 310:265, during the open meeting of the Consumer Protection Licensing Advisory Council, council members identified a potential issue with the use of “ear specialist.” The term was too broad and could be interpreted to mean board certified audiologist while the intent is to be a board certified physician who had a specialty in the ear. Recommendations were made and voted on by the Council during the open meeting to modify the language to be more specific yet not restrictive to a single type of physician. The proposed change was, “by a physician who specializes in diseases of the ear, for example an otologist, . . .” and, “by a physician who specializes in disease of the ear. . .”

Response: The intent of the original proposal was to not be prescriptive to one type of physician, otolaryngologist. Upon comments from the council, staff realized the original proposal was not clear on the intent.

Therefore, a revision was made to 310:265-7-2(a)(8) to replace board certified ear specialist with language that requires a physician.

310:265-7-2. Prohibited acts

(a) No person shall:

.....

(8) Sell a hearing instrument to a person under eighteen (18) years of age unless the prospective user, parent or guardian has presented to the licensee a medical evaluation signed by a board eligible or board certified otolaryngologist physician who specializes in diseases of the ear, that states the client may be considered a candidate for a hearing instrument. This requirement may be waived if a otolaryngologist physician who specializes in diseases of the ear is not available

within 100 miles of the person's residence and a licensed physician provides the medical evaluation. This evaluation must have taken place within the preceding six (6) months of the testing and fitting. A licensed audiologist should perform the evaluation and rehabilitation; or.

Final Response: Based on the overall comments and agreement of the Consumer Protection Licensing Advisory Council, proposed language relating to mobile clinics or off-site clinics is being removed and clarification has been added for a board certified ear specialist to be a physician who specializes in disease of the ear.

Agency Rule Contact:

Lynnette Jordan, Interim Director, Consumer Health Service, Oklahoma State Department of Health, 1000 N.E. 10th St, Oklahoma City, OK 73117, (405) 271-5779, Lynnette@health.ok.gov.



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T. Cline 11-24-2015*
Commissioner

Through: James Joslin Approved via email 11/19/15
Agency Rule Liaison

Through: Don Maisch Approved via email 11/19/15
General Counsel

Through: Henry F. Hartsell Approved via email 11/19/15
Deputy Commissioner, Protective Health Services

From: Mike Cook Approved via email 11/19/15
Service Director, Long Term Care Service

Date: November 18, 2015

Subject: **CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**

The attached rule and supporting documents are submitted for **PERMANENT** adoption of the rule at the Board of Health's December 2015 meeting.

We received no public comment. There were no revisions to the previously reviewed rule. The Long Term Care Facility Advisory Board voted to recommend adoption of this rule change on July 8, 2015.

Attachments:

- Rule Impact Statement
- Rule Text
- Rule Comment Summary

INITIAL RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 675. NURSING AND SPECIALIZED FACILITIES

1. DESCRIPTION:

This proposal amends OAC 310:675-9-9.1(i) which deals with bulk non-prescription drugs. This rule change removes a limitation on dispensing over the counter medications from bulk supplies of drugs maintained in nursing facilities. This change inserts verbatim language from the law concerning the ordering or authorizing of medications by a physician. This change deletes language which restricts the use of bulk over the counter medications to only as needed or unscheduled dosage regimens and only upon written order of a physician. This change will allow nursing facilities to dispense scheduled regimens of over the counter medications with an order or other authorization. This change brings the rule into conformity with the authorizing statute [Title 63 O.S. Section 1-1950(B)] which is permissive, rather than restrictive, regarding the dispensing of bulk over the counter medications based on a nonscheduled regimen.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:

Affected persons will be residents and their families as well as owners, operators, and staff of Nursing and Specialized Facilities. These parties will benefit from greater access to bulk nonprescription drugs that nursing facilities may maintain for residents and the attendant reduction in expenses available through bulk purchasing.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:

Affected persons will be residents and their families as well as owners, operators, and staff of Nursing and Specialized Facilities. These parties will benefit from greater access to bulk nonprescription drugs that nursing facilities may maintain for residents and the attendant reduction in expenses availability through bulk purchasing. The Department received comments to the effect that failing to delete language on as-needed and nonscheduled dosage regimens limited the effectiveness the 2014 rule changes which expanded the types of drugs available for dispensing from bulk supplies.

4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:

These rules involve no additional fees. Elimination of the “as-needed” and “nonscheduled dosage regimen” restrictions on bulk medications has the potential to reduce medication costs for residents and facilities.

5. COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:

The cost to the Department to implement the amendments will be approximately \$4,000 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. IMPACT ON POLITICAL SUBDIVISIONS:

There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.

7. ADVERSE EFFECT ON SMALL BUSINESS:

There is no known adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

8. EFFORTS TO MINIMIZE COSTS OF RULE:

No less costly or nonregulatory methods have been identified.

9. EFFECT ON PUBLIC HEALTH AND SAFETY:

No public comment was received on the effects on public health and safety.

10. DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:

No public comment was received on any detrimental effects on public health and safety.

11. This rule impact statement was prepared on June 17, 2015 and revised on November 18, 2015.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**

SUBCHAPTER 9. RESIDENT CARE SERVICES

310:675-9-9.1. Medication services

(a) Storage.

- (1) Medications shall be stored in a medication room, a locked cabinet, or a locked medication cart, used exclusively for medication storage.
- (2) The medication storage area temperature shall be maintained between 60° F. (15.5° C.) to 80° F.(26.6° C.)
- (3) The medication room, the medication storage cabinet, and medication cart shall be locked when not in use.
- (4) The key to the medication storage areas shall be in the possession of the person responsible for administering medications.
- (5) Scheduled medications shall be in a locked box within the locked medication area or cart.
- (6) Medications for external use shall be stored separately from medications for internal use.
- (7) Medications requiring refrigeration shall be kept within a temperature range of 36° F. (2.2° C.) to 48° F. (8.8° C.) and separated from food and other items. There shall be a method for locking these medications.
- (8) The medication areas shall be well lighted, clean and organized.
- (9) Running water shall be in close proximity to the medication area.
- (10) Powdered over-the-counter medication for topical use may be kept in the resident's room for administration by a nurse aide if:
 - (A) The facility develops and implements policies and procedures for safe storage and application of the powder; and
 - (B) Each aide who applies the over-the-counter topical medication is trained in accordance with the established policies and procedures of the facility.

(b) Emergency medications. Emergency medication, policies and equipment shall include but not be limited to:

- (1) An electric suction machine with necessary aseptic aspirator tips.
- (2) An emergency tray or cart with the following items labeled and accessible to licensed personnel only: resuscitation bag; tongue depressors; and assorted airways; sterile hypodermic syringes in 2 cc, 5 cc, and 20 cc or larger sizes and appropriate needles. The content shall be limited to emergency medications and contain no scheduled medications. Only two single dose vials of the following medications may be on the tray or cart: 50% Dextrose, respiratory stimulant, a cardiac stimulant, injectable lasix, injectable dilantin and injectable benadryl.
- (3) A certified medication aide shall not administer injectable medications from any emergency tray or cart, but shall have access to resuscitation bags, tongue depressors, and assorted sizes of airways.

(c) Medication accountability.

- (1) Medications shall be administered only on a physician's order.

(2) The person responsible for administering medications shall personally prepare the dose, observe the swallowing of oral medication, and record the medication. Medications shall be prepared within one hour of administration.

(3) An accurate written record of medications administered shall be maintained. The medication record shall include:

(A) The identity and signature of the person administering the medication.

(B) The medication administered within one hour of the scheduled time.

(C) Medications administered as the resident's condition may require (p.r.n.) are recorded immediately, including the date, time, dose, medication, and administration method.

(D) Adverse reactions or results.

(E) Injection sites.

(F) An individual inventory record shall be maintained for each Schedule II medication prescribed for a resident.

(G) Medication error incident reports.

(4) A resident's adverse reactions shall be reported at once to the attending physician.

(d) Medication labels and handling.

(1) All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of medication, dosage, directions for use, date of issue and expiration, and name, address and telephone number of pharmacy or physician issuing the medication, and the quantity. If a unit dose system is used, medications shall indicate, at least, the resident's full name, physician's name and strength of medication, and directions for use.

(2) When over-the-counter medications are prescribed and obtained in the original manufacturers container, the package directions shall be considered part of the label. The resident's name shall be on the package.

(3) Each resident's medications shall be kept or stored in the originally received containers. Paper envelopes shall not be considered containers.

(4) Medication containers having soiled, damaged, illegible or makeshift labels shall be relabeled by the issuing pharmacy or physician. Labels on containers shall be clearly legible and firmly affixed. No label shall be superimposed on another label on a medication container except for over-the-counter medication containers.

(5) No person shall change labels on medication containers. If the attending physician orders a change of directions, there shall be a procedure to mark the container indicating a label change is needed at the next prescription refill.

(6) A pharmacist shall dilute, reconstitute and label medications, whenever possible. If not possible, a registered nurse may reconstitute, dilute and label medications. A distinctive, indelible, supplementary label shall be affixed to the medication container when diluted or reconstituted for other than immediate use. A licensed practical nurse may reconstitute oral medications only. The label shall include the following: resident's name, dosage and strength per unit/volume, nurse's initials, expiration date, and date and time of dilution or reconstitution.

(7) When a resident is discharged, or is on therapeutic leave, the unused medication shall be sent with the resident, or with the resident's representative, unless there is a written physician's order to the contrary, or the medication has been discontinued, or unless the resident or the resident's representative donates unused prescription medications for dispensation to medically indigent persons in accordance with the Utilization of Unused

Prescription Medications Act. The clinical record shall document the quantity of medication sent, and returned or donated, and the signature of the person receiving or transferring the medications.

(8) All medication orders shall be automatically stopped after a given time period, unless the order indicates the number of doses to be administered, or the length of time the medication is to be administered. The automatic stop order may vary for different types of medications. The facility shall develop policies and procedures, in consultation with the medical director and pharmacist, to review automatic stop orders on medications. The policy shall be available to personnel administering medications.

(9) No resident shall be allowed to keep any medications unless the attending physician or interdisciplinary team has indicated on the resident's clinical record that the resident is mentally and physically capable of self-administering medications.

(10) A resident who has been determined by the physician or interdisciplinary team as capable of self-administering medication may retain the medications in a safe location in the resident's room. The facility shall develop policies for accountability. Scheduled medications shall not be authorized for self-administration, except when delivered by a patient controlled analgesia pump.

(11) A physician's telephone orders shall be conveyed to, recorded in the clinical record, and initialed by the licensed nurse receiving the orders.

(12) Medications shall be administered only by a physician, registered nurse, a licensed practical nurse, or a certified medication aide. The only injectables which a certified medication aide may administer are insulin and vitamin B-12 and then only when specifically trained to do so.

(13) A pharmacy, operating in connection with a facility, shall comply with the State pharmacy law and the rules of the Oklahoma State Board of Pharmacy.

(14) Powdered over-the-counter medication for topical use may be administered by a trained nurse aide when designated in writing by the attending physician and delegated by a licensed nurse. The licensed nurse shall ensure that the aide demonstrates competency in reporting skin changes, storage, application and documentation policies and procedures. The licensed nurse or the attending physician shall document in the resident's record a skin assessment at least twice each week and more often if required by the facility's approved policy.

(e) **Medication destruction.**

(1) Non-controlled medications prescribed for residents who have died and non-controlled medications which have been discontinued shall be destroyed by both the director of nursing and a licensed pharmacist or another licensed nurse. Controlled medication shall be destroyed by a licensed pharmacist and the Director of Nursing. The facility may transfer unused prescription drugs to city-county health department pharmacies or county pharmacies in compliance with the Utilization of Unused Prescription Medications Act and all rules promulgated thereunder. Prescription only medications including controlled medications shall not be returned to the family or resident representatives. The destruction and the method used shall be noted on the clinical record.

(2) Medications prescribed for one resident may not be administered to, or allowed in the possession of, another resident.

(3) There shall be policies and procedures for the destruction of discontinued or other unused medications within a reasonable time. The policy shall provide that medications pending destruction shall not be retained with the resident's current medications. The destruction of

medication shall be carried out in the facility and a signed record of destruction shall be retained in the facility.

(f) **Medication regimen review.** The facility shall ensure that each resident's medications are reviewed monthly, by a registered nurse or a licensed pharmacist. The reviewer shall notify the physician and director of nursing, in writing, when irregularities are evident.

(g) **Consultant pharmacist.** The facility shall have a consultant licensed pharmacist to assist with the medication regimen review and medication destruction. The consultant pharmacist shall discuss policies and procedures for the administration, storage, and destruction of medications with the administrator, director of nursing and other appropriate staff.

(h) **Emergency pharmacy.** The facility shall have a contract, or letter of agreement, with a licensed pharmacy that agrees to serve as the emergency pharmacy. The emergency pharmacy shall be available twenty-four hours a day.

(i) **Bulk nonprescription drugs.** A facility may maintain nonprescription drugs for dispensing from a common or bulk supply as ordered or otherwise authorized by a physician currently licensed to practice medicine in this state [63:1-1950(B)] if all of the following are accomplished.

(1) **Policy of facility.** The facility must have and follow a written policy and procedure to assure safety in dispensing and documentation of medications given to each resident.

(2) **Acquisition.** The facility shall maintain records which document the name of the medication acquired, the acquisition date, the amount and the strength received for all medications maintained in bulk.

(3) **Dispensing.** Only licensed nurses, physicians, pharmacists or certified medication aides (CMA) may dispense ~~for administration these medications and only upon the written order for as needed (p.r.n.) or nonscheduled dosage regimens dosing from a physician as documented in the clinical record of the resident.~~

(4) **Storage.** Bulk medications shall be stored in the medication area and not in resident rooms.

(5) **Records.** The facility shall maintain records of all bulk medications which are dispensed on an individual signed medication administration record (MAR).

(6) **Labeling.** The original labels shall be maintained on the container as it comes from the manufacturer or on the unit-of-use (blister packs) package.

(7) **Package size.** The maximum size of packaging shall be established by the facility in its policy and procedures and shall insure that each resident receives the correct dosage; provided however, that no liquid medications shall be acquired nor maintained in a package size which exceeds 16 fluid ounces.

(8) **Allowed nonprescription drugs.** Facilities may have only oral analgesics, antacids, and laxatives for bulk dispensing and/or drugs listed in a facility formulary developed or approved by the consultant pharmacist, medical director and director of nurses. Non formulary over the counter medications may be prescribed if the resident has therapeutic failure, drug allergy, drug interaction or contraindications to the formulary over the counter medication.

RULE COMMENT SUMMARY AND RESPONSE

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 675. NURSING AND SPECIALIZED FACILITIES**

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) *A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules;* (10) *A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.*[75:303.1(E)(9)&(10)]

None received.

Agency Rule Contact:

Mike Cook, Service Director, Long Term Care Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, phone 405-271-6868, or by e-mail to mikec@health.ok.gov



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T. Cline 11-24-2015*
Commissioner

Through: James Joslin Approved via email 11/19/15
Agency Rule Liaison

Through: Don Maisch Approved via email 11/19/15
General Counsel

Through: Henry F. Hartsell Approved via email 11/19/15
Deputy Commissioner, Protective Health Services

From: Mike Cook Approved via email 11/19/15
Service Director, Long Term Care Service

Date: November 18, 2015

Subject: CHAPTER 680. RESIDENTIAL CARE HOMES

The attached rule and supporting documents are submitted for **PERMANENT** adoption of the rule at the Board of Health's December 2015 meeting.

We received no public comment. There were no revisions to the previously reviewed rule. The Long Term Care Facility Advisory Board voted to recommend adoption of this rule change on July 8, 2015.

Attachments:

- Rule Impact Statement
- Rule Text
- Rule Comment Summary

RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 680. RESIDENTIAL CARE HOMES

1. DESCRIPTION:

This proposal amends OAC 310:680-13-2 which deals with bulk nonprescription drugs. This rule change removes a limitation on dispensing over the counter medications from bulk supplies of drugs maintained in residential care homes. This change inserts verbatim language from the law concerning the ordering or authorizing of medications by a physician. This change deletes language which restricts the use of bulk over the counter medications to only as needed or unscheduled dosage regimens and only upon written order of a physician. This change will allow residential care homes to dispense scheduled regimens of over the counter medications with an order or other authorization. This change brings the rule into conformity with the authorizing statute [Title 63 O.S. Section 1-1950(B)] which is permissive, rather than restrictive, regarding the dispensing of bulk over the counter medications based on a nonscheduled regimen.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:

Affected persons will be residents and their families as well as owners, operators, and staff of residential care homes. These parties will benefit from greater access to bulk nonprescription drugs that residential care homes may maintain for residents and the attendant reduction in expenses available through bulk purchasing.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:

Affected persons will be residents and their families as well as owners, operators, and staff of residential care homes. These parties will benefit from greater access to bulk nonprescription drugs that residential care homes may maintain for residents and the attendant reduction in expenses availability through bulk purchasing.

4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:

These rules involve no additional fees. Elimination of the “as-needed” and “nonscheduled dosage regimen” restrictions on bulk medications has the potential to reduce medication costs for residents and residential care homes.

5. COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:

The cost to the Department to implement the amendments will be approximately \$4,000 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. IMPACT ON POLITICAL SUBDIVISIONS:

There will be no impact on political subdivisions and it will not require their cooperation in implementing or enforcing the proposed amendment.

7. ADVERSE EFFECT ON SMALL BUSINESS:

There is no known adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act.

8. EFFORTS TO MINIMIZE COSTS OF RULE:

No less costly or nonregulatory methods have been identified.

9. EFFECT ON PUBLIC HEALTH AND SAFETY:

No public comment was received on the effects on public health and safety.

10. DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:

No public comment was received on any detrimental effects on public health and safety.

11. This rule impact statement was prepared on June 17, 2015 and revised on November 18, 2015.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 680. RESIDENTIAL CARE HOMES**

SUBCHAPTER 13. MEDICATION STORAGE AND ADMINISTRATION

310:680-13-2. Bulk nonprescription drugs

A facility may maintain nonprescription drugs for dispensing on an as needed basis from a common or bulk supply ~~only~~ *as ordered or otherwise authorized by a physician currently licensed to practice medicine in this state [63:1-1950(B)]* if all of the following are accomplished.

- (1) **Policy of facility.** The facility must have and follow a written policy and procedure to assure safety in dispensing and documentation of medications given to each resident.
- (2) **Acquisition.** The facility shall maintain records which document the name of the medication acquired, the acquisition date, the amount and the strength received for all medications maintained in bulk.
- (3) **Dispensing.** Only licensed nurses, physicians, pharmacists or medication aide technicians (MAT) may dispense ~~for administration~~ these medications ~~and only upon the written order for nonscheduled dosage regimens, as needed, dosing from a physician as documented in the record of the resident.~~
- (4) **Storage.** Bulk medications shall be stored in the medication area and not in resident rooms.
- (5) **Records.** The facility shall maintain records of all bulk medications which are dispensed on an individual signed medication administration record (MAR).
- (6) **Labeling.** The original labels shall be maintained on the container as it comes from the manufacturer or licensed repackager or on the unit-of-care (blister packs) package.
- (7) **Package size.** The maximum size of packaging shall be established by the facility in its policy and procedures and shall insure that each resident receives the correct dosage; provided however, that no liquid medication shall be acquired nor maintained in a container larger than 16 fluid ounces.
- (8) **Allowed nonprescription drugs.** Facilities may have drugs from each of the following categories for bulk dispensing. No other categories may be maintained as bulk medications.
 - (A) Oral analgesics.
 - (B) Antacids.
 - (C) Laxatives.

RULE COMMENT SUMMARY AND RESPONSE

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 680. RESIDENTIAL CARE HOMES

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) *A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules;* (10) *A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.*[75:303.1(E)(9)&(10)]

None received.

Agency Rule Contact:

Mike Cook, Service Director, Long Term Care Service, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, phone 405-271-6868, or by e-mail to mikec@health.ok.gov

Health in All Policies

Julie Cox-Kain, M.P.A.
Joseph Fairbanks, M.P.P.
December 8, 2015



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.

(APHA: Introduction to Health in All Policies, A Guide for State and Local Governments)



Aspen Institute

- **TeamWork:** Leadership for Healthy States
- **Competitive Application:** 5 States
- **Institute Period:** August 2015 – August 2016
- **TeamWork Goals:**
 - Create robust relationships among health officials, their legal counsel, and policy makers within states
 - Foster collaborations and trust across branches of state government and partisan divides
 - Encourage innovative approaches to population health policy
- **Project Focus:** Health in All Policies
- **Benefits:** Access to technical assistance & resources



Oklahoma TeamWork Team Members

- **Terry Cline**, Secretary of Health & Human Services
- **Chris Benge**, Secretary of State & Secretary of Native American Affairs
- **AJ Griffin**, State Senator
- **Teresa Jackson**, Senior Executive Officer of Choctaw Nation Health Services
- **Donald Maisch**, General Counsel, Oklahoma State Department of Health
- **Carol McFarland**, Director of Performance & Efficiency, Office of Management Enterprise Services
- **Julie Cox-Kain**, Senior Deputy Commissioner & Deputy Secretary of Health & Human Services
- **Stephanie Uren**, Director of the Center for the Advancement of Wellness, Oklahoma State Department of Health
- **Joe Fairbanks**, Director of the Center for Health Innovations, Oklahoma State Department of Health
- **James Allen**, Director of Partnerships for Health Improvement, Oklahoma State Department of Health
- **Melissa Fenrick**, Health Planning Coordinator, Oklahoma State Department of Health



TeamWork Oklahoma

- Implement Health Impact Assessment (HIA)
- HIA Defined - HIAs use a flexible, data-driven approach that identifies the health consequences of new policies and develops practical strategies to enhance their health benefits and minimize adverse effects
- Assess and measure type, likelihood, magnitude and distribution of effect



TeamWork Oklahoma Works HIA Project

- **Population:** Pre-K thru 2nd Grade
- **Potential policy areas for assessment of impact on health and educational progress:**
 - Implementing recommended physical activity in schools
 - Implementing recommended policies for proper nutrition in schools
 - Implementing trauma informed services in schools
- **Current Status:** Research evidence to narrow policy assessment
- **Next Steps:** Stakeholder engagement



TeamWork Oklahoma Choctaw Nation Promise Zone HIA Project

- **Promise Zone:** A new anti-poverty program meant to provide resources such as grants and tax incentives to help improve conditions in persistently high poverty communities
- **Focused on the following:**
 - Jobs/Economic Development
 - Education
 - Housing
 - Public Safety
- **Next Steps:** Partner with Choctaw Nation to target/narrow the scope of the project



Questions



2016 Legislative Priorities

OKLAHOMA STATE DEPARTMENT OF HEALTH · DECEMBER 2015



Carter Kimble, M.P.H.
Office of State and Federal Policy

LEGISLATIVE PRIORITIES

- Good Samaritan Law For Drug Overdose
- Emergency Health Planning Task Force
- Open Records Act
- Birth and Death Record Index
- Tobacco Tax



Save Lives By Introduction Of A Good Samaritan Provision For Drug Overdoses

- Effect on Public Health and Well-being
 - Unintentional poisoning deaths surpassed motor vehicle crashes for the leading cause of injury death in Oklahoma.¹
 - Oklahoma drug overdose death (all intents)
 - 178 deaths in 1999
 - 790 deaths in 2013¹
 - Of the more than 4,600 unintentional poisoning deaths from 2007-2013, nearly four out of five involved prescription drugs.
 - Nearly 9 out of 10 prescription drug-related overdose deaths involved an opioid analgesic.
 - More overdose deaths involved hydrocodone or oxycodone than all illegal drugs combined.²

1. CDC Web-based Injury Statistics Query and Reporting System (WISQARS)

2. OSDH Injury Prevention Service Fatal Unintentional Poisoning Surveillance System (data abstracted from medical examiner reports)



Save Lives By Introduction Of A Good Samaritan Provision For Drug Overdoses (*continued*)

- Use and effects of Naloxone (Narcan®) or other opiate antagonist
 - In some instances, Naloxone can reverse the effects of opioid overdose and restore respiratory efforts.
 - HB1782 (2013) revised administration of Naloxone criteria and allows first responders to administer without a prescription when encountering an individual exhibiting signs of an opiate overdose.
 - Majority of overdose deaths take place 1-3 hours after taking an opioid³, and most of these overdoses occur in the presence of others⁴, meaning there is time for many lives to be saved.

3. Davidson P.J., McLean R.L., Kral A.H., Gleghorn A.A., Edlin B.R., & Moss, A.R. (2003). Fatal heroin-related overdose in San Francisco, 1997-2000: A case for targeted intervention. *Journal of Urban Health*, 80, p. 261-273.

Sporer, K.A. Strategies for preventing heroin overdose. *BMJ*. 2003;326(7386):442-444

Barcelous, Donald G. *Medical Toxicology of Drug Abuse: Synthesized Chemicals and Psychoactive Plants*, John Wiley & Sons, Inc. 2012.

4. Lagu T., Anderson B.J., Stein M. Overdoses among friends: drug users are willing to administer naloxone to others. *J Subst Abuse Treat*. 2006;30:129-133.



Save Lives By Introduction Of A Good Samaritan Provision For Drug Overdoses (*continued*)

Policy Proposal

- Allows a person who, in good faith, is seeking medical assistance for a person experiencing a drug overdose from being arrested or prosecuted for the possession or use of a controlled substance or drug paraphernalia.
- Provides limited immunity, subject to the discretion of the law enforcement officer present, for persons who report the emergency drug overdose.
- Based on the Good Samaritan law for alcohol-related offenses, SB 1 signed by Governor Fallin in 2013.
- Currently 28 states including New Mexico, Colorado and Arkansas have some form of Good Samaritan law.⁵

5. Prescription Drug Abuse Policy System. Good Samaritan Overdose Prevention Laws. July 2015.

http://lawatlas.org/files/upload/20150814_Good%20Samaritan_EssentialInformation_PDAPS2.pdf.



Adjustments To The Emergency Health Planning Task Force

- Oklahoma Catastrophic Health Emergency Planning Task Force
 - 19 member task force, statutorily dictated membership
 - Charged with the development of a state plan in the event of a catastrophic health emergency, including but not limited to:
 - Communication plan
 - Coordination of resources and essential materials
 - Role of law enforcement
 - Evacuation plans
 - Treatment plan for individuals affected



Adjustments To The Emergency Health Planning Task Force (*continued*)

- Task force hasn't had a quorum in years, Emergency Preparedness unit at OSDH has continued to keep plan updated

Policy Proposal

- Establish a quorum to allow for Task Force to more regularly take action
- Allow in statute for the Fire Marshall to send a designee



Modernization Of The Oklahoma Open Records Act

Incentivize Government Transparency

- 2005 Attorney General opinion stated that a public body that places a record on the internet or world wide web does not meet the obligation of providing “prompt, reasonable access” to the record.
- Oklahoma State Department of Health receives 100-200 open record requests annually.

Policy Proposal

- Amend Title 51, Section 24A.5 by adding;
 - “Any public body making its records available on the internet or the world wide web meets the obligation of providing prompt, reasonable access to its records as required by this Act”



Birth And Death Event Index And Electronic Verification Of Existing Vital Record

- Birth and Death Index
 - OSDH will have a birth and death index available on its website that will include:
 - Name
 - Gender
 - Date of event
 - County in which event occurred
 - Ease ancestral study for genealogists
 - Index will include data for births and deaths occurring more than 25 years after the event
 - Use of index will have no cost unless entire index is requested, fee established by Board of Health



Birth And Death Event Index And Electronic Verification Of Existing Vital Record (*continued*)

- Electronic Verification Component
 - Previously, private entities with a legitimate business relationship were able to access the Social Security Administration's Death Master File. The Federal government no longer shares that index with private entities as the records were deemed protected.
 - National Association for Public Health Statistics and Information Systems will create a hub where states can provide records for comparison for a business to determine if an individual is deceased.
 - Businesses will now be able to compare records in bulk, where as they were previously required to formally request each record individually.



Tobacco Tax Continues To Be A Policy Priority

- Increasing the price point of tobacco products is a recommended strategy to achieve the following:
 - Reduces the total amount of tobacco consumed
 - Reduces the prevalence of tobacco use
 - Increases the number of tobacco users who quit
 - Reduces initiation of tobacco use among young people
 - Reduces tobacco-related morbidity and mortality
- Increasing the unit price for tobacco products by 20% would result in the following:
 - Reduce overall consumption of tobacco products by 10.4%
 - Reduce prevalence of adult tobacco use by 3.6%
 - Reduce initiation of tobacco use by young people by 8.6%

Reducing Tobacco Use and Secondhand Smoke Exposure: Interventions to Increase the Unit Price for Tobacco Products. (n.d.). Retrieved November 17, 2015, from <http://www.thecommunityguide.org/tobacco/increasingunitprice.html>



For More Information

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QUESTIONS



**OKLAHOMA STATE DEPARTMENT OF HEALTH
BOARD OF HEALTH FINANCE COMMITTEE BRIEF
DECEMBER 2015**

SFY 2016 BUDGET AND EXPENDITURE FORECAST: AS OF 11/23/2015

<u>Division</u>	<u>Current Budget</u>	<u>Expenditures</u>	<u>Obligations</u>	<u>Forecasted Expenditures</u>	<u>Not Obligated or Forecasted</u>	<u>Performance Rate</u>
Public Health Infrastructure	\$ 17,057,780	\$ 1,303,033	\$ 4,881,385	\$ 10,692,443	\$ 180,919	98.94%
Protective Health Services	\$ 61,913,383	\$ 13,099,949	\$ 11,614,412	\$ 34,453,187	\$ 2,745,835	95.57%
Prevention & Preparedness Services	\$ 62,466,416	\$ 8,480,152	\$ 30,031,081	\$ 20,533,329	\$ 3,421,854	94.52%
Health Improvement Services	\$ 25,618,444	\$ 1,726,999	\$ 6,882,110	\$ 15,236,184	\$ 1,773,151	93.08%
Community & Family Health Services	\$ 235,545,750	\$ 28,248,354	\$ 35,438,869	\$ 167,974,632	\$ 3,883,895	98.35%
Totals:	\$ 402,601,773	\$ 52,858,487	\$ 88,847,857	\$ 248,889,775	\$ 12,005,654	97.02%
< 90%	90% - 95%		95% - 102.5%		102.5% - 105%	>105%

Expenditure Forecast Assumptions

- Payroll forecasted through June 30, 2016
- Budgeted vacant positions are forecasted at 50% of budgeted cost
- Forecasted expenditures includes the unencumbered amounts budgeted for:
 - Travel reimbursements
 - WIC food instrument payments
 - Trauma fund distributions
 - FQHC reimbursements
 - Amounts budgeted for county millage
 - Budget amounts for fiscal periods other than state fiscal year not yet active

Explanation of Change

- The amounts reported as 'Not Obligated or Forecasted' are not an estimate of lapsing funds. This represents planned expenditures that OSDH is currently taking action to execute.
- Two divisions, Prevention & Preparedness Services (PPS) and Health Improvement Services (HIS), have a "yellow light" status as of November 23, 2015
- The PPS performance rate of 94.52% is a 2.12% increase from the previously reported 92.40% for October. The HIS performance rate of 93.08% is a 2.94% increase from the previously reported 90.14% for October. Both divisions have improved since last reported in October.
- The amounts not obligated and not forecasted for these two divisions are due to contracts that are budgeted and in the process of being encumbered and budgeted vacant positions that are in the process of being filled

**OKLAHOMA STATE DEPARTMENT OF HEALTH
BOARD OF HEALTH FINANCE COMMITTEE BRIEF
DECEMBER 2015**

POTENTIAL STATE GENERAL REVENUE REDUCTIONS FOR STATE FISCAL YEAR 2017

The OSDH received state general revenue appropriations of \$60,632,476 for state fiscal year 2016. With significant revenue reductions forecasted for state fiscal year 2017, the OSDH was asked to provide reduction scenarios that represent a 5%, 7.5%, and 10% state general revenue reductions.

5% (\$3,031,624) Reduction Scenario	
Amount	Description
\$10,000	Oklahoma State Athletic Commission: This would reduce the number of inspectors trained for events scheduled in SFY-17
\$500,000	Elimination of the RFP for the establishment of a Cord Blood Bank would take effect July 1, 2016 which supports positions within the Oklahoma Blood Institute.
\$2,521,624	FQHC Uncompensated Care: A reduction in funds to the OSDH would eliminate the FQHC Uncompensated Care Fund and prevent the OSDH from reimbursing FQHCs for uncompensated care costs associated with the delivery of primary, dental, and behavioral health care to uninsured patients. This will impact 15 FQHCs (representing 67 sites), which will lose partial reimbursement for 14,502 encounters with underinsured or uninsured clients.

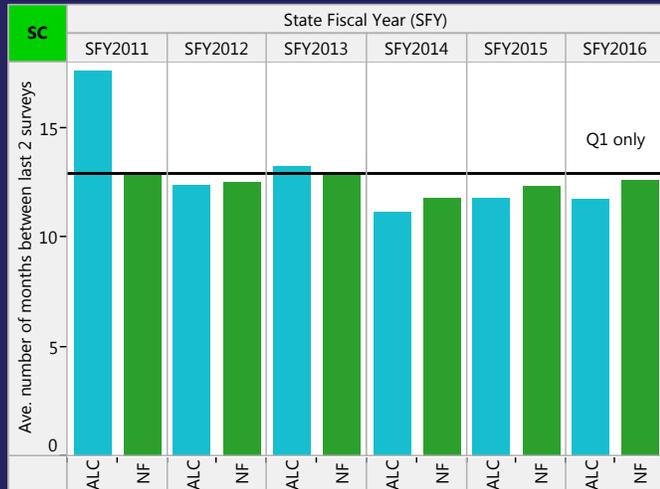
7.5% (\$4,547,436) Reduction Scenario	
Amount	Description
\$15,000	Oklahoma State Athletic Commission: This would reduce the number of inspectors trained for events scheduled in SFY-17 and impact attendance by Board Commissioners to national conferences.
\$500,000	Elimination of the RFP for the establishment of a Cord Blood Bank would take effect July 1, 2016 which supports positions within the Oklahoma Blood Institute.
\$1,479,959	Community Based Child Abuse Prevention: A 50% cut would impact 369 families that would not be served and approximately 26 positions within the community non-profits would no longer be funded. In order to determine which programs would be eliminated, contractors will be rated and ranked by the number of home visits made and number of families served.
\$2,552,477	FQHC Uncompensated Care: A reduction in funds to the OSDH would eliminate the FQHC Uncompensated Care Fund and prevent the OSDH from reimbursing FQHCs for uncompensated care costs associated with the delivery of primary, dental, and behavioral health care to uninsured patients. This will impact 15 FQHCs (representing 67 sites), which will lose partial reimbursement for 14,502 encounters with underinsured or uninsured clients.

10% (\$6,063,248) Reduction Scenario	
Amount	Description
\$20,000	Oklahoma State Athletic Commission: This would reduce the number of inspectors trained for events scheduled in SFY-17; impact attendance by Board Commissioners to national conferences and reduce the number of inspectors employed to ensure compliance with Athletic Commission regulated events.
\$500,000	Elimination of the RFP for the establishment of a Cord Blood Bank would take effect July 1, 2016 which supports positions within the Oklahoma Blood Institute.
\$2,896,014	Community Based Child Abuse Prevention: This would impact approximately 749 families that would not be served and approximately 52 positions within the community non-profits that would no longer be funded. This would impact all 13 regional contractors.
\$2,552,477	FQHC Uncompensated Care: A reduction in funds to the OSDH would eliminate the FQHC Uncompensated Care Fund and prevent the OSDH from reimbursing FQHCs for uncompensated care costs associated with the delivery of primary, dental, and behavioral health care to uninsured patients. This will impact 15 FQHCs (representing 67 sites), which will lose partial reimbursement for 14,502 encounters with underinsured or uninsured clients.
\$94,757	OSDH Infrastructure will be impacted with the elimination of one management level vacant position which requires the permanent redistribution of responsibilities to existing FTE. The reduction is based on actual salary and estimate benefit cost to refill the position.

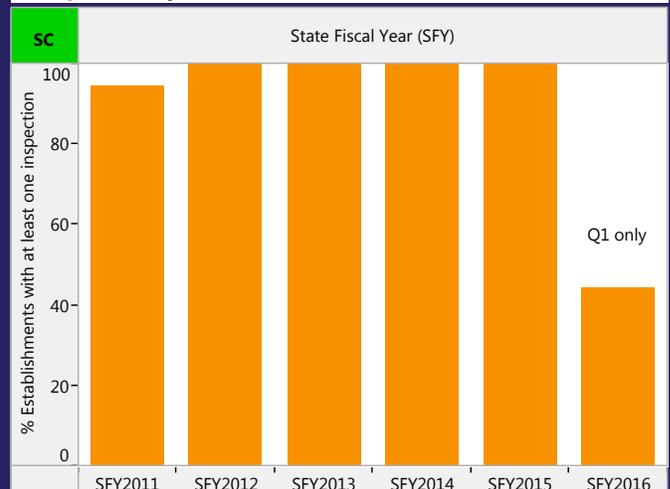
Oklahoma State Board of Health Dashboard

Public Health Imperative: Regulatory Measures

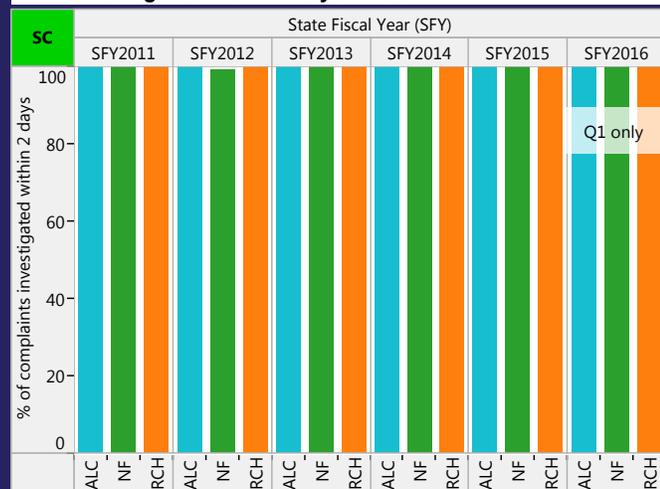
A. Average interval between inspections for ALCs and NFs is less than or equal to 12.9 months. N (ALCs)=165, N (NFs)=301



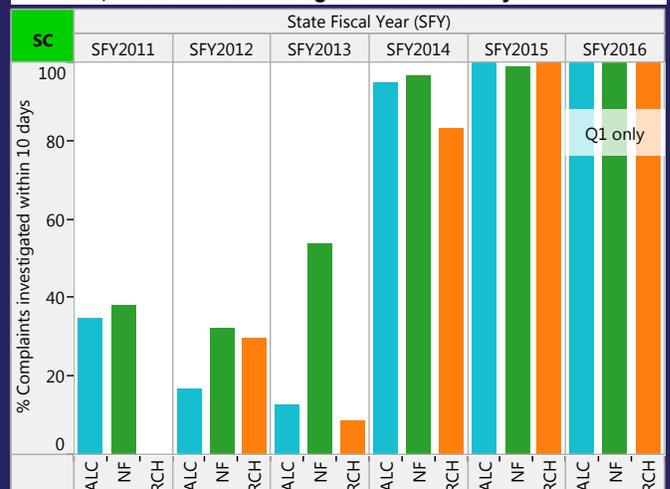
B. Percentage of food service establishments inspected at least once per fiscal year



C. Percent of immediate jeopardy complaints for ALCs, NFs & RCHs investigated within 2 Days. N=38



D. Percent of non immediate jeopardy-high priority complaints for ALCs, NFs & RCHs investigated within 10 Days. N=112



Explanation of Dashboard

State Fiscal Year (SFY) begins July 1st and ends June 30th. SFY 2016 is from July 1, 2015 to June 30, 2016.

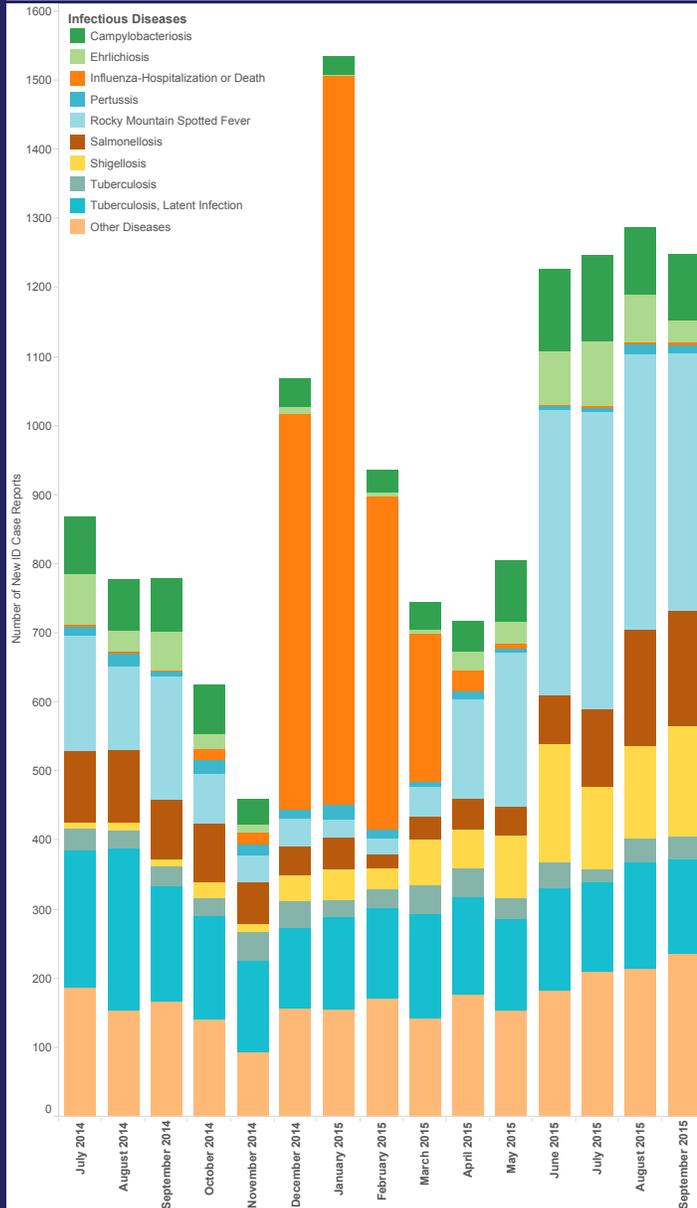
Protective Health Services has a "green light" for all four of the performance measures by meeting the benchmarks for (A) average interval between inspections for ALCs and NFs; (B) food service establishment inspections; (C) immediate jeopardy complaints for ALCs, NFs, and RCHs; and (D) non-immediate jeopardy high-priority complaints for ALCs, NFs and RCHs.

Assisted Living Centers (ALCs), Nursing Facilities (NFs), Residential Care Homes (RCHs)
SC = Score card: Green = Measure is Satisfactory; Yellow = Two Quarters Not Met in Last Year;
 Red = Shortfall Has Occurred Three Consecutive Quarters

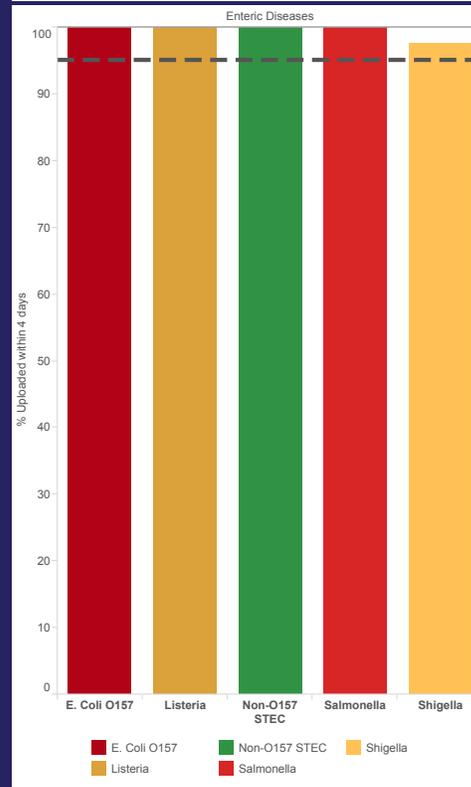
Oklahoma State Board of Health Dashboard

Public Health Imperative: Infectious Disease Measures

Number of New Infectious Disease (ID) Case Reports



Percentage of PH Lab Enteric Diseases Uploaded to PulseNet within 4 Days, July 2014 - June 2015
Benchmark = 95%



Number of New Infectious Disease Case Reports and Estimated Investigation Time (Hrs):
July 2014 - June 2015

Month of Month	# of Rep	Est. Hrs	# Specimens
October 2014	625	1,137	15,976
November 2014	459	1,144	12,196
December 2014	1,069	1,542	14,039
January 2015	1,534	979	14,211
February 2015	935	964	13,022
March 2015	744	1,062	14,759
April 2015	717	1,137	15,220
May 2015	802	1,144	13,271
June 2015	1,227	1,542	15,795
July 2015	1,247	1,523	15,795
August 2015	1,286	1,808	15,952
September 2015	1,248	1,874	15,728

Explanation of Dashboard

'Number of New Infectious Disease (ID) Case Reports' shows the new cases of infectious disease received by the Acute Disease Service by month. The 'Number of New Infectious Disease Case Reports' reflect significant seasonal trends. Most notable is the increase of flu cases in the winter months of December, January and February. The Acute Disease Service (ADS) received increased reports of enteric (Campylobacteriosis, Salmonellosis and Shigellosis) and tickborne (Ehrlichiosis and Rocky Mountain Spotted Fever) diseases. This increase was expected as part of the seasonality of these diseases. The increase of the infectious disease reports resulted in an increase in investigation time of ADS epidemiologists and county health department Communicable Disease and Tuberculosis nurses.

"Other Diseases" includes other non-HIV, non-STD, non-hep B and non-hep C diseases such as enterohemorrhagic E. coli, Haemophilus influenzae, hepatitis A, listeriosis, mumps, tularemia, and animal rabies.

'Percentage of PH Lab Disease Uploaded to PulseNet within 4 Days' indicates that the benchmark of 95% has been met and exceeded for all factored enteric diseases. The overall rate is 99.7% for the uploading of PulseNet within 4 days for the first quarter of SFY 2016.

'Total Number of Lab Specimens' shows the volume of specimens received. The number of lab specimens depicts the work performed by PHL quarterly and gives a clear account of the interaction between divisions collaborating effectively to create a state of health. 'Number of New Infectious Disease Case Reports and Estimated Investigation Time (Hrs.)' shows the number of hours spent in disease investigation by month and includes both County Health Department Communicable Disease Nurse and Acute Disease Service Epidemiologist person-time.

Oklahoma State Board of Health Dashboard

Public Health Infrastructure: County Health Department Visits

Figure 1: Total Visits for OSDH + OCCHD + THD Clinics by Quarter
Does not include Immunization Visits

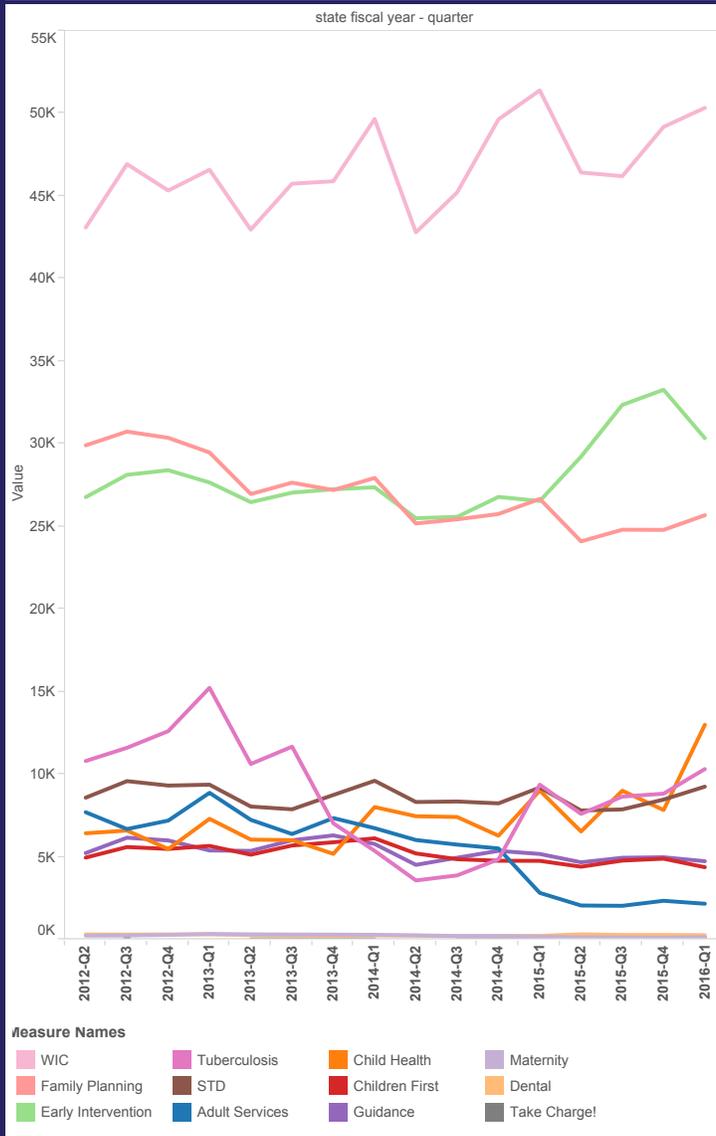


Figure 2: Total Immunization Visits by Quarter
Recorded in Oklahoma State Immunization Information System

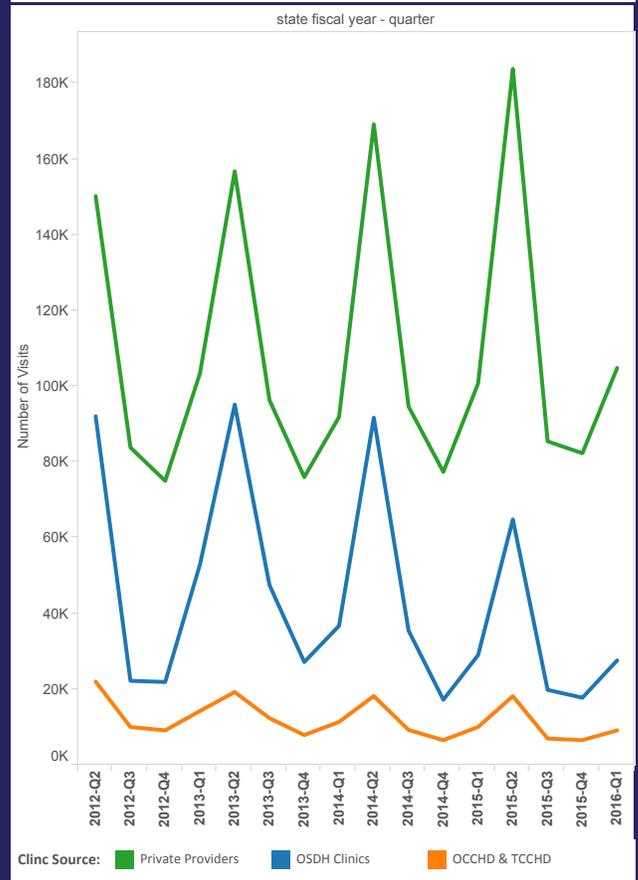


Table 1: OSDH + OCCHD + THD Clinic Services by Quarter

Quarter	2013	2014	2014-2013 %Change	2015	2015-2014 %Change	2016
Q1	622,066	582,616	-6.34	580,474	-0.37	540,329
Q2	562,372	550,747	-2.07	617,166	12.06	
Q3	567,752	514,731	-9.34	525,860	2.16	
Q4	582,616	520,059	-10.74	530,189	1.95	
Total	2,334,806	2,168,153		2,253,689		540,329

Explanation of Dashboard

Figure 1. Total Visits for OSDH + OCCHD + THD Clinics by Quarter. Notably, there has been an increase in number of client visits for the Early Intervention program when compared to the first quarter of SFY2015. Referrals have increased and some key vacancies have been filled across the state, which likely contributed to the increase in encounters being reported.

Figure 2. Total Immunization Visits by Quarter. The current data shows a decrease in immunizations for OSDH. However, immunizations at private provider clinics has increased, perhaps reflecting increased availability of flu shots at private clinics and drug stores. Large retail pharmacies receive vaccine shipments several weeks earlier than health departments. The strong cyclic data trend continues as it has in the previous three years, with a decline in immunization services in the 3rd and 4th quarter. This is followed by an increase in the 1st quarter and peaking in the 2nd quarter as children return to school and individuals receive flu shots before the winter flu season.

Table 1. OSDH + OCCHD + THD Clinic Services by Quarter. Services in county health department clinics appear to have decreased in the 1st quarter of SFY2016. The numbers are projected to increase when final data from several programs have been fully entered by the 2nd quarter of SFY 2016.

OKLAHOMA STATE BOARD OF HEALTH

COMMISSIONER'S REPORT

Terry Cline, Ph.D., Commissioner

December 8, 2015

PUBLIC RELATIONS/COMMUNICATIONS

Champions of Health (Blue Cross and Blue Shields of Oklahoma) – video presentation

FOCUS Physician Associate Program Lecture

Oklahoma Perinatal Quality Improvement Collaborative Summit – speaker

OU First Year Medical Students Lecture

Jaclyn Cosgrove, Oklahoman – interview

GANSU Province MOU Signing

Global Health Forum in Taiwan- panelist

STATE/FEDERAL AGENCIES/OFFICIAL

Governor's Executive Council Meeting on Developmental Disabilities

General Myles Deering, Executive Director, Oklahoma Department of Veterans Affairs

Tobacco Settlement Endowment Trust (TSET) Board Meeting and Retreat

Governor's Health Policy & Health Initiatives Cabinet Meeting

Nico Gomez, CEO, Oklahoma Health Care Authority

Robert Patton, Director, Oklahoma Department of Corrections

John Foust, Executive Director, Board of Pharmacy

Governor's Office – Legislative Agenda

SITE VISITS

Washington County Health Department

Osage County Health Department

Texas County Health Department

Beaver County Health Department

Harper County Health Department

Woods County Health Department

Woodward County Health Department

OTHERS:

Tri-Board Health Department Meeting

OHIP Executive Committee

OHIP Full Team Meeting

Oklahoma Academy for State Goals Town Hall Forum

Susan Rogers, Board Administrator/Executive Director, Oklahoma Board of Dentistry

ASTHO Board Meeting, Policy Meeting, & Annual Meeting – speaker

Kize Concepts

NORC (National Opinion Research Center) at the University of Chicago Site Visit

Stan Hupfeld, Senior Consultant, INTEGRIS Health

Pam Cross, Executive Director, Health Alliance for the Uninsured

Reforming States Group Executive Steering Committee – speaker

National Academy for State Health Policy Conference – speaker

Teresa Jackson, Senior Executive Officer, Choctaw Nation of Oklahoma Health Services

Dr. Mary Anne McCaffree, Pediatrician and Specialist in Neonatal-Perinatal Medicine

Chris Taylor, Executive Commissioner, Texas Health and Human Services

“Back the Blue” Law Enforcement Rally