

Oklahoma State Board of Health Retreat

Oklahoma State University
179 Student Union, Council Room 412
301 S. Hester St.
Stillwater, OK 74078
August 11-12, 2017

Retreat Objectives:

- Gain a better understanding of the role of communication in public health.
- Engage in board action planning and next steps.

Friday, August 11th

1:30 PM	Call to Order & Welcome	Martha Burger
	Retreat Mission and Objectives	Martha Burger
	Generational Translation	Dr. Rita Murray
	Break	
	Protecting the Public's Health in a Time of Change	John Auerbach
	Proposed Executive Session	
	<i>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.</i>	Martha Burger
	<i>Possible action taken as a result of Executive Session</i>	
	Adjournment	Martha Burger

Saturday, August 12th

7:30 AM	Continental Breakfast	
8:30 AM	Call to Order & Welcome	Martha Burger
	Approval of July 11, 2017 Meeting Minutes <i>Discussion and possible action</i>	
	Public Health for Future Generations <i>Implications for Workforce and Outreach</i>	Dean Gary Raskob
	Board Member Perspectives <i>Discussion of health issues from Board members' perspective</i>	Dr. Jenny Alexopoulos Dr. R. Murali Krishna Cris Hart-Wolfe
	Break	
	High Level Strategic Plan Update <i>Discussion and possible action</i>	Julie Cox-Kain Brian Downs
	Board Member Perspectives <i>Discussion of health issues from Board members' perspective</i>	Dr. Robert Stewart Tim Starkey Dr. Charles Grim
	Working Lunch <i>Payne County Health Department Presentation</i>	Kelli Rader
	Board Member Perspectives <i>Discussion of health issues from Board members' perspective</i>	Dr. Terry Gerard Dr. Edward Legako

Break

Current Health Issues

Role of the Disease Intervention Specialists in protecting the public's health.

Dr. Kristy Bradley
Disease Intervention Specialists

Summary, Wrap-Up

*(Breakout discussion on objectives & take-home message;
Collective report out and individual member report out with Board
member next steps and action plan)*

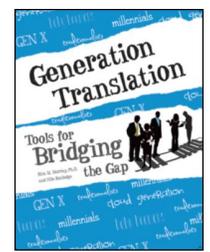
Martha Burger

Adjournment

Martha Burger

Generational Translation

GENERATIONS AT A GLANCE



These thumbnails of each generation are not boxes to put ourselves or others into. Rather, they are frameworks for understanding how the events of our formative years shaped so many of our work dispositions.

TRADITIONALISTS 1920 – 1945



The stabilizing Traditionalists grew up in the shadow of two World Wars and the biggest economic depression in U.S. history. As they stepped into adulthood, they witnessed authority (government, the military, and society) save the world from fascism and ruin. This trust of authority and hierarchy became the core of the Traditionalists' approach to work and family. Most Traditionalists were into late adulthood before computers, or certainly the internet, were realities, which has made this group slower to adopt and trust the technical solution to problems, and change is embraced more slowly. Hierarchy works, experience matters, and patriotism and good citizenship as well as stability and security are prized by Traditionalists, who tend to be both surprised and irritated when these core societal and workplace values are not shared.

BABY BOOMERS 1946 – 1964



The transformational Baby Boomers who once pronounced, "Don't trust anyone over 30" were the first workaholics, not because it was fun but because it was essential in light of the swelling volume of competing Baby Boomers. Being "high profile" and "standing out from the crowd" were keys to survival. They paid their dues under the old hierarchical rules, got ahead by making their bosses look good, and are now redefining themselves in light of global initiatives and business restructuring. The first generation to be graded in school for "getting along well with others," Baby Boomers tend to be—through a lifetime of practice—oriented toward politics, social skills, and meetings. Now widely in positions of leadership and power, Boomers quest for and talk about work/life balance, which eludes many within this hard-charging generation.

GENERATION X 1965 - 1980



The entrepreneurial, skeptical, and often misunderstood, Generation X-ers stepped into adulthood in a world of fracturing families, latch-key kids, ineffective and mistrusted government, and deep economic uncertainty. The trust and loyalty past generations gave and expected from their organizations came sharply into contrast and into question with this group who witnessed long-held commitments and the idea of job security become more of a fantasy. This group responded with a focus on their own career development, the arc of which takes them to and through many different professional affiliations which draw upon their technological acuity and business savvy. Resourceful and independent, X-ers want to get in, get the work done, and move on to the next thing. Among core values are freedom and variety in the workplace; they have taught the other generations to "dress down and lighten up."

MILLENNIALS 1981-2000



The "always on" Millennials came of age in an era of instantaneous global communication, media saturation, and material excess. They also grew up in the "decade of the child" with an extraordinary focus on children's issues. Most Millennials cannot remember a world that was not internet-enabled and when they did not have a personal digital device to connect them to any content, person or virtual activity that they wished to engage. They are high-speed, multitasking, stimulus junkies who pay constant partial attention (to you and everything). These digital natives are oriented to group-work, 24/7 instant access to power and information and fast-paced work. So why should their expectation of feedback (usually positive) leading to quick advancement, be any different? They presume it will be fast, frequent and friendly. Millennials tend away from reading traditional books, relying more on video and sound bites to learn.



GENERATION ACTION PLAN

My generation is: *(circle one)*



The focus of this action plan is greater self-awareness and self-management—helping you derive generational insights that you can use immediately to better manage your own reactions and interactions.

What are 3 to 5 descriptions or details of your generation with which you identify most strongly?

- 1.
- 2.
- 3.
- 4.
- 5.

Identify ways in which your generational outlook and style have benefited your career and served you well.

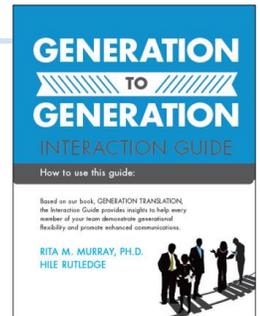
- 1.
- 2.
- 3.

Identify ways your generational outlook and style may prove challenging to others and may have limited your career.

- 1.
- 2.
- 3.

What two actions will you take to put any of these generational insights to work in the next week?

- 1.
- 2.



Protecting the Public's Health in a Time of Change

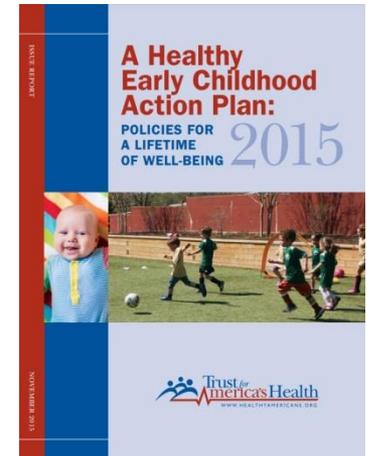
Protecting the Public's Health in a Time of Change

John Auerbach
President and CEO



About TFAH: Who We Are

- Translate existing data & research
- Build support for strong public system
- Produce strategic policy reports
- Conduct targeted communications & educate policymakers
- Support non-partisan



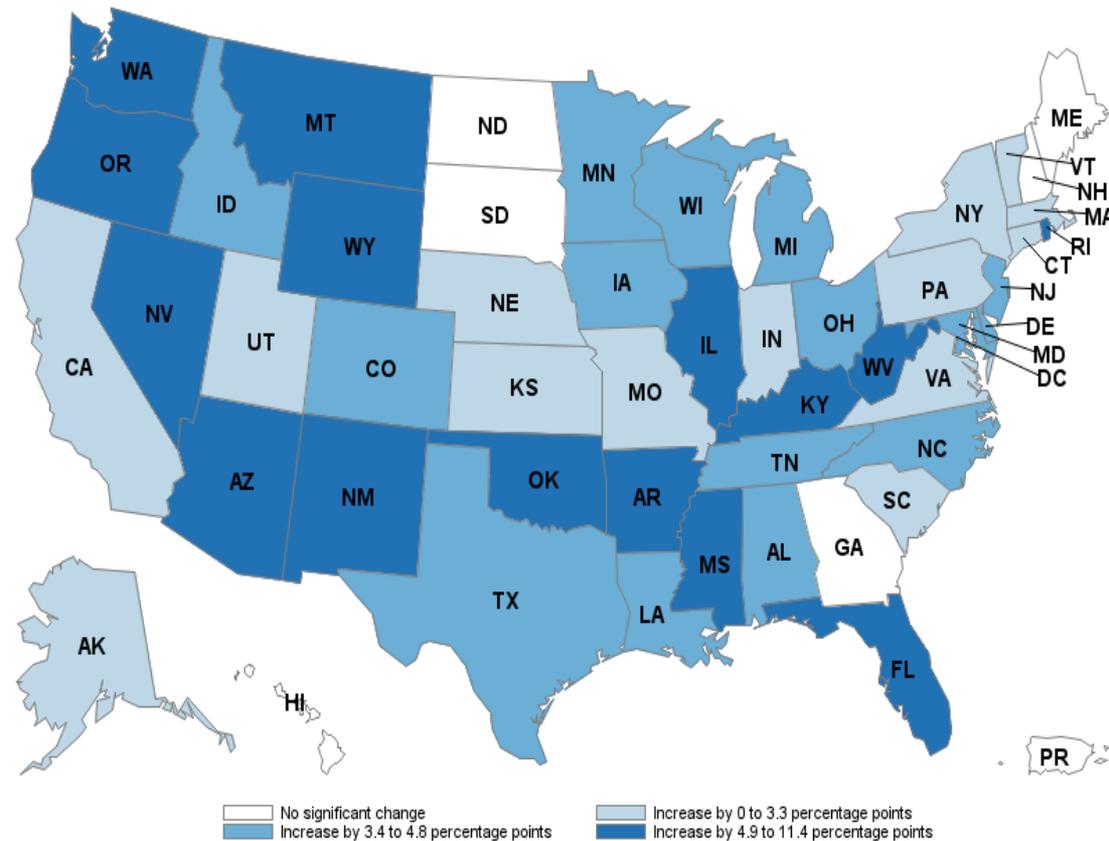
Who Am I?



National Trend #1: Increased Access

146,000 OK residents enrolled via Exchange in 2017

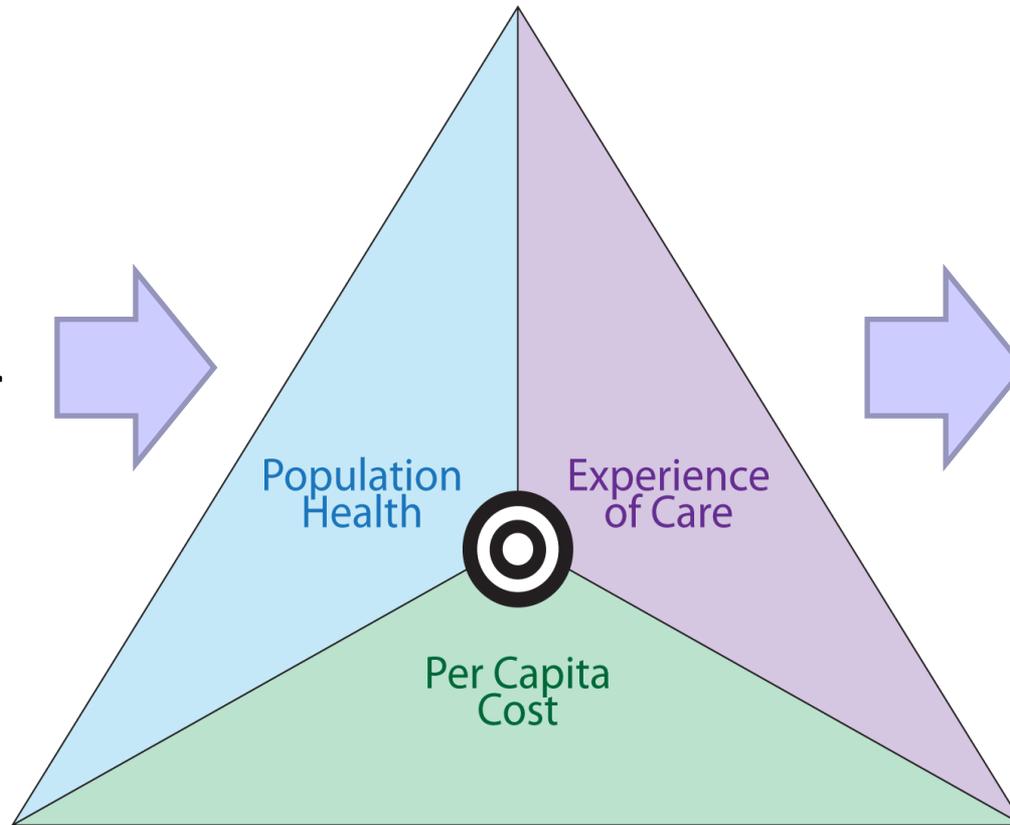
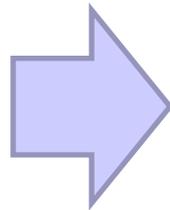
- Nearly 20 million more Americans are insured
- Rate of uninsured Americans is down 21% to 13%
- Access to coverage has increased in every state, but is still uneven



National Trend #2: Payment Reform is Widespread

Oklahoma's 1332 waiver would strengthen this

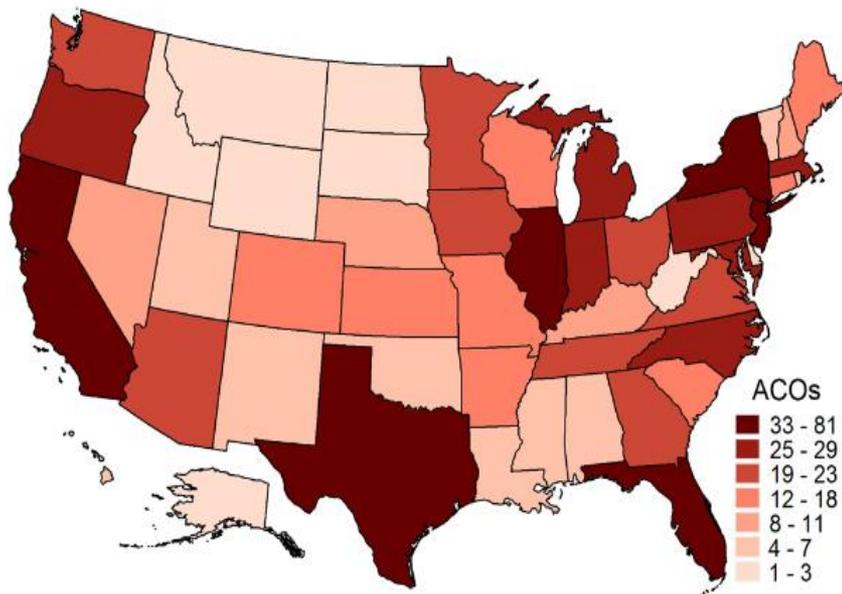
Fee-for-Service or "Volume-Based" Payment Model



Value-Based Payment Model

National Trend #3: Emerging Clinical Care Models

Figure 3. Number of ACOs by State, January 2015



Source: Leavitt Partners Center for Accountable Care Intelligence

Federally Qualified Health Centers (FQHCs)



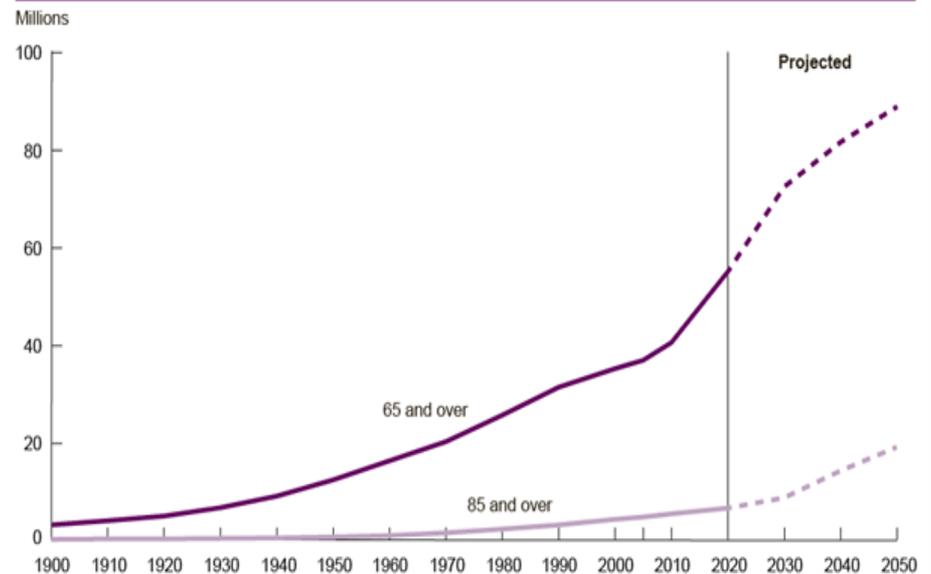
Source: Centers for Medicare and Medicaid Services; U.S. Department of Health and Human Services; October 2015.

Note: Alaska and Hawaii not shown to scale

National Trend #4 – Changing Demographics and Health Needs

- Changing demographics of the country
- Changing health care needs
- Evolving information & data revolution
- Growing awareness of non-health sector roles

Population age 65 and over and age 85 and over, selected years 1900–2010 and projected 2020–2050

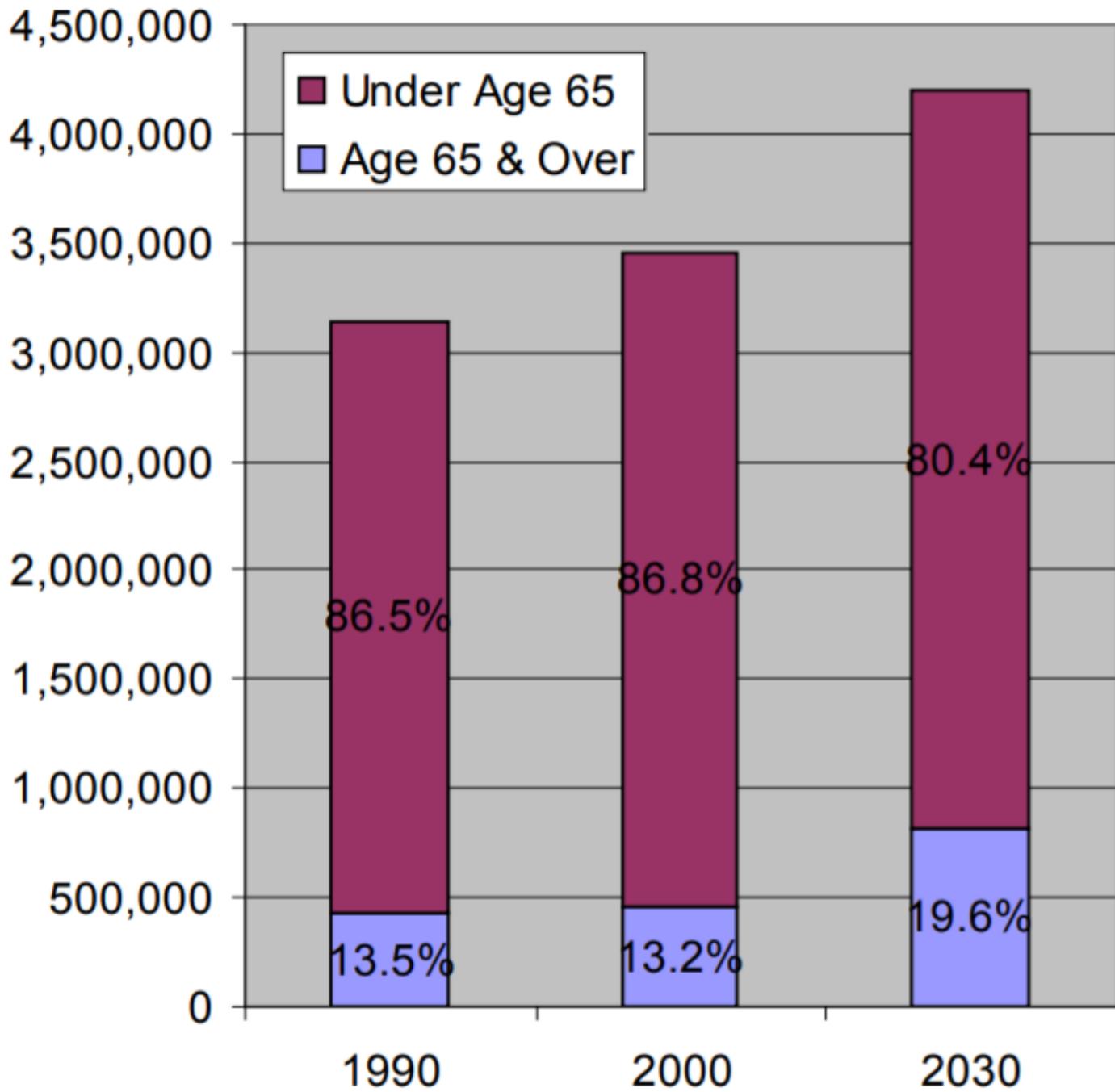


NOTE: These projections are based on Census 2000 and are not consistent with the 2010 Census results. Projections based on the 2010 Census will be released in late 2012.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, Census 2000 Summary File 1; U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S.: April 1, 2000 to July 1, 2010 (US-EST00INT-01); U.S. Census Bureau, 2011, 2010 Census Summary File 1; U.S. Census Bureau, Table 2: Projections of the population by selected age groups and sex for the United States: 2010–2050 (NP2008-12).

Population

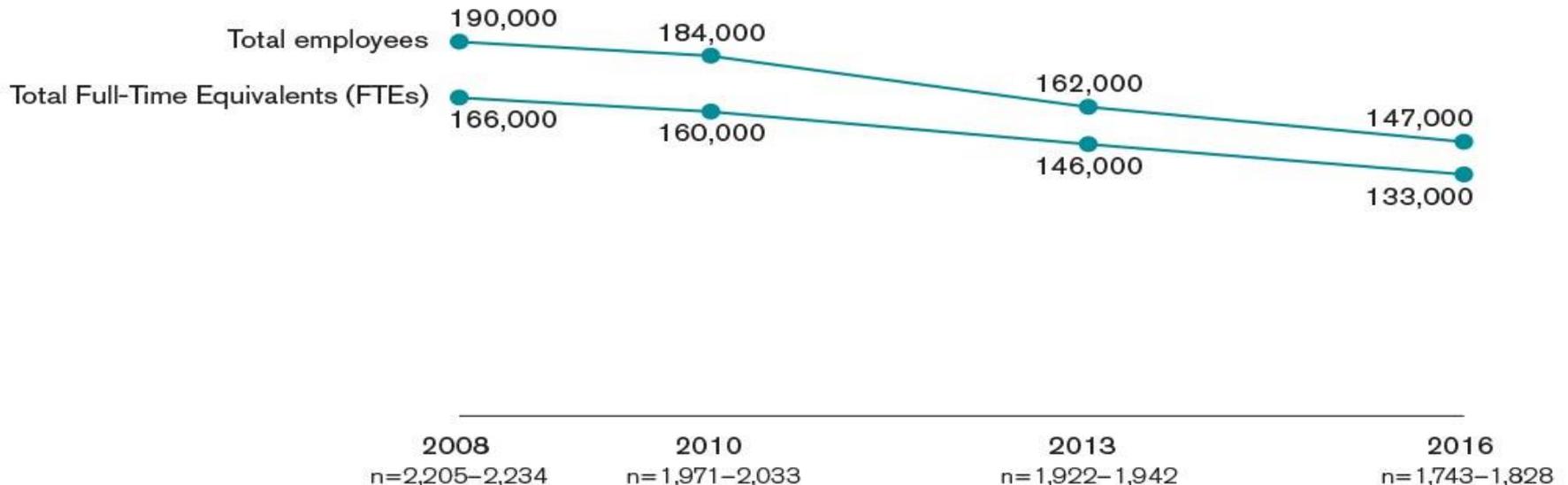


The workforce is shrinking –due to funding

Recession cuts remain/50,000 fewer jobs (source: NACCHO)

- 24 states decreased PH budgets in 2015-16
- CDC budget down \$500 M since 2010

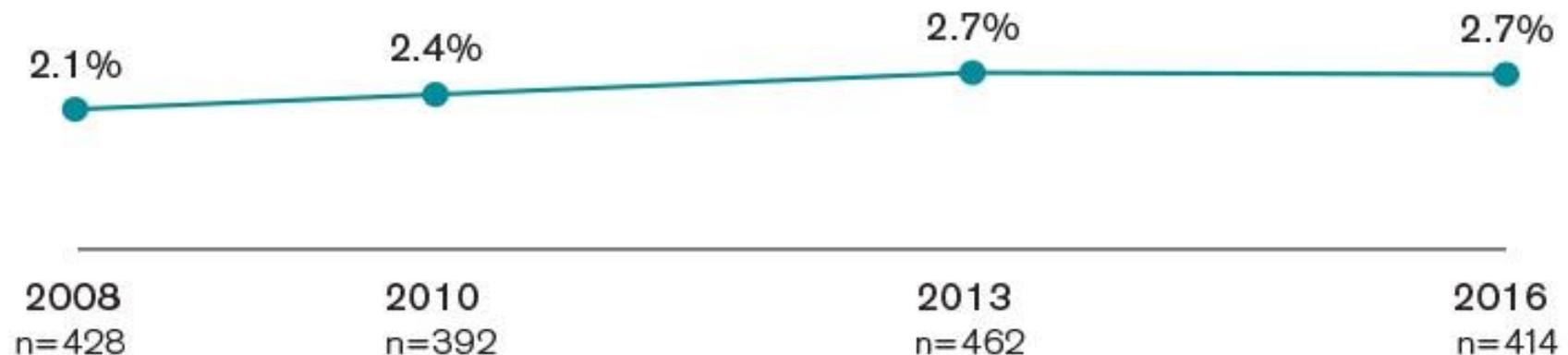
Estimated size of LHD workforce over time



The workforce is aging

- The average PH worker is 47 years old—7 years older than US workforce.
- PH WINS Results Point to Imminent Public Health Workforce Exit —38% plan to leave the public health workforce by 2020, either to retire or to pursue positions in other sectors.
- Of those planning to leave, 25 percent plan to retire

Percentage of total workforce retired over time

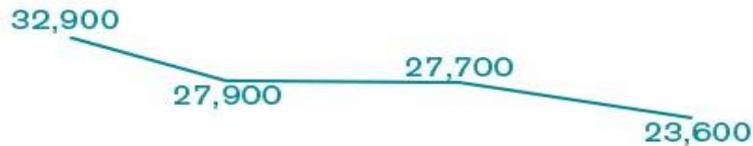


Composition of the workforce is changing

Estimated size of select occupations over time

Number of Full-Time Equivalents (FTEs)

Registered nurses



Year	n
2008	n=1,992
2010	n=1,855
2013	n=1,704
2016	n=1,611

Environmental health workers



Year	n
2008	n=1,925
2010	n=1,802
2013	n=1,573
2016	n=1,645

Behavioral health staff



Year	n
2008	n=1,831
2010	n=1,766
2013	n=1,388
2016	n=1,804

Health educators



Year	n
2008	n=1,899
2010	n=1,754
2013	n=1,441
2016	n=1,652

Meet Fran Edwards:

- ❑ Newly insured
- ❑ At MD for first physical years
- ❑ 55 years old, married, smokes, overweight, exercise
- ❑ Asthmatic, pre-diabetic
- ❑ Stopped taking medications in past due to cost



Insurance and Quality Care Help... But they Aren't Enough

- ❑ **Income** - Poor, family of 5
- ❑ **Barriers to Fitness** – Rising crime, few parks, no nearby supermarket
- ❑ **Under stress** - Son with behavioral health concerns, worried about money
- ❑ **Sub-par Housing** – Mold and ventilation problems



What would help Ms. Edwards?

- ❑ Primary care & meds- no cost
- ❑ Asthma home visits
- ❑ Diabetes Prevention Program
- ❑ Behavioral services for son
- ❑ Neighborhood safety
- ❑ Affordable, healthy foods
- ❑ Mold removal in apartment



The 3 Buckets of Prevention

Traditional Clinical Prevention



Health Care

Innovative Clinical Prevention



Community-Wide Prevention



Public Health

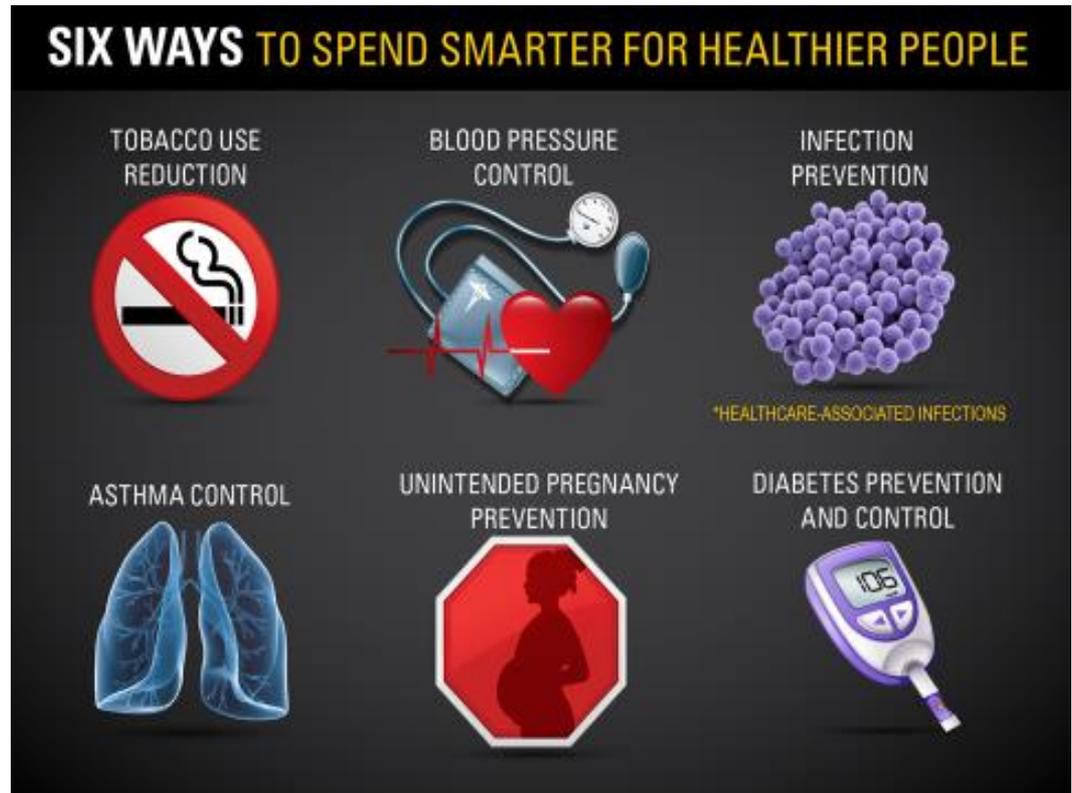
Bucket 1: Traditional Clinical Approaches

Focus on Preventive Care



Development of 6 | 18 Initiative

- ❑ Focus on 6 high-cost, high-prevalence conditions
- ❑ Review of CIO evidence-based clinical interventions
- ❑ 18 interventions identified



Provide all tobacco cessation meds without cost



Bucket 2: Innovative Patient-Centered Care

Focus on Preventive Care



To Address Asthma: Healthy Home Risk Reduction

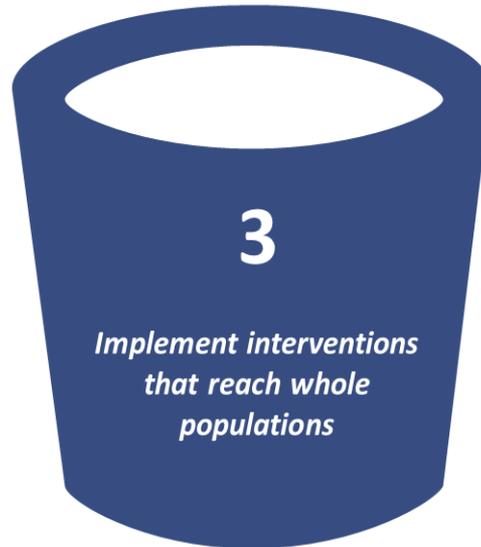


Home visit by CHWs to

- Provide additional education/ encouragement
 - Assess risk factors in the home
 - Assist in removing risk factors

Bucket 3: Community-Wide Health

Focus on Preventive Care



- School-Based Programs to Increase Physical Activity
- School-Based Violence Prevention
- Safe Routes to School
- Motorcycle Injury Prevention
- Tobacco Control Interventions
- Access to Clean Syringes
- Pricing Strategies for Alcohol Products
- Multi-Component Worksite Obesity Prevention



Changing the Context

Making the healthy choice the easy choice

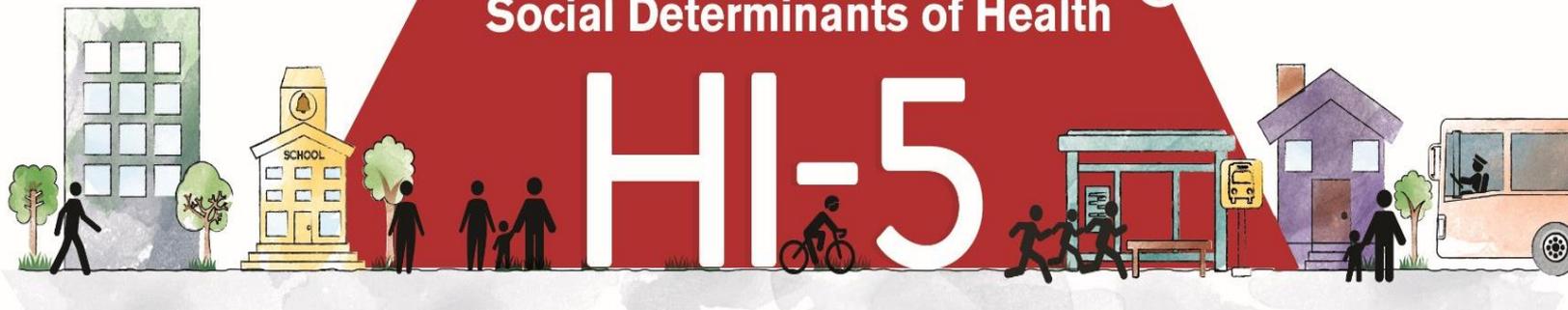
-
- Counseling and Education
 - Clinical Interventions
 - Long Lasting Protective Interventions

- Early Childhood Education
- Clean Diesel Bus Fleets
- Public Transportation System
- Home Improvement Loans and Grants
- Earned Income Tax Credits
- Water Fluoridation



Social Determinants of Health

HI-5



HEALTH **IMPACT** IN 5 YEARS

Was This Approach Useful?



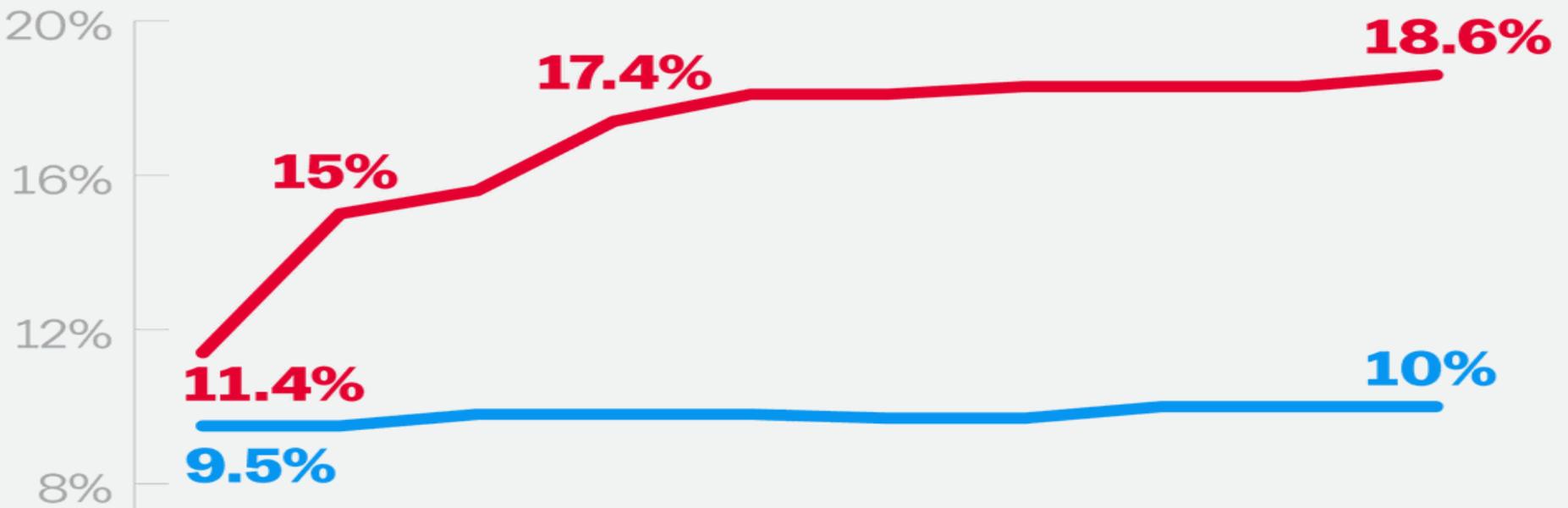
Is It Still Relevant?

The ACA is still law...

...but the future is uncertain

Uninsured rates under GOP plan vs. Obamacare

■ GOP replacement ■ Obamacare



Proposed Federal Cuts in Many Agencies That Affect Health



↓ 31.4%



↓ 16.2%



↓ 28.7%



↓ 15.7%



↓ 12.7%



↓ 20.7%



↓ 13.5%



↓ 11.7%



↓ 20.7%



↓ 13.2%

What TFAH Does at a Time Like This

The Prevention and Public Health Fund

- ❑ *12 % of CDC budget/\$1 billion – most goes to states*
- ❑ State packets for each governor/health official
- ❑ Educational sessions with Congress



Access to Clinical Preventive Services

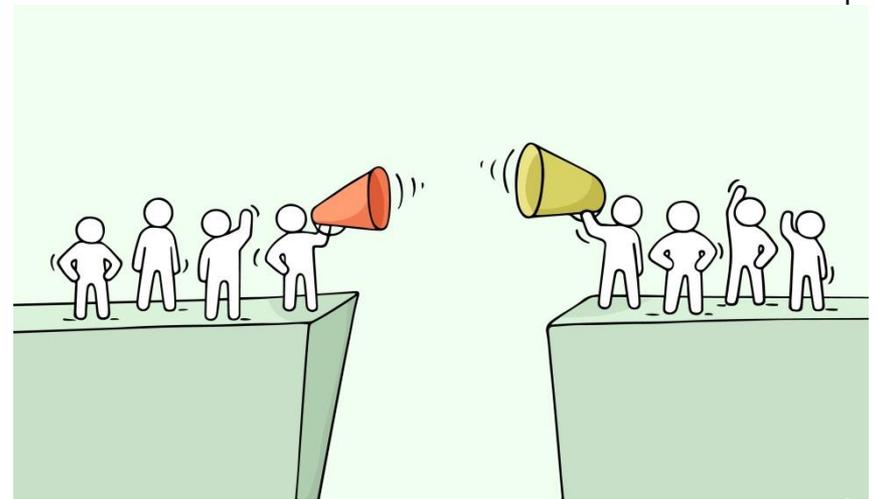
- ❑ *Mandated public/private insurance provide cost-free preventive services.*
- ❑ Educational analysis of Essential Benefits/Medicaid expansion requirements
- ❑ Analysis of impact on health and cost thus far



Clinical Services

Non-Partisan Convenings

- ❑ *Need for collaboration among those with different beliefs*
- ❑ Creation of non-partisan forum
- ❑ Attendees from red & blue states
- ❑ Focus on overlooked states - Mississippi



The CDC's Budget

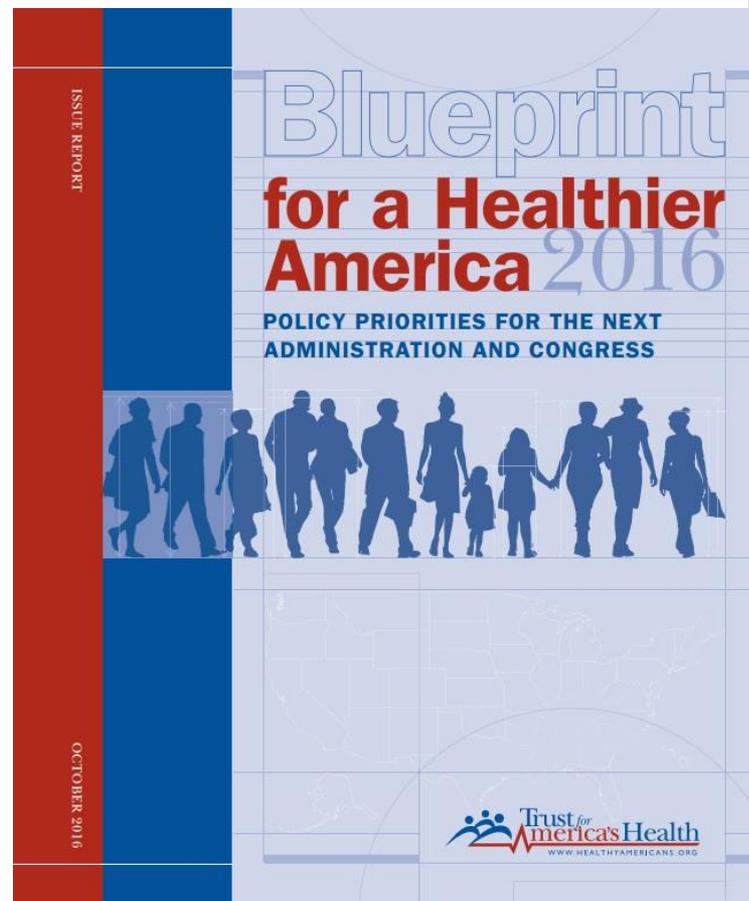
- *CDC could lose up to 1/3 of its budget*
- Packets re: direct impact of loss to each state
- Hill briefings on key programs
- Congressional district health profiles



Saving Lives.
Protecting People.
Saving Money
Through Prevention.

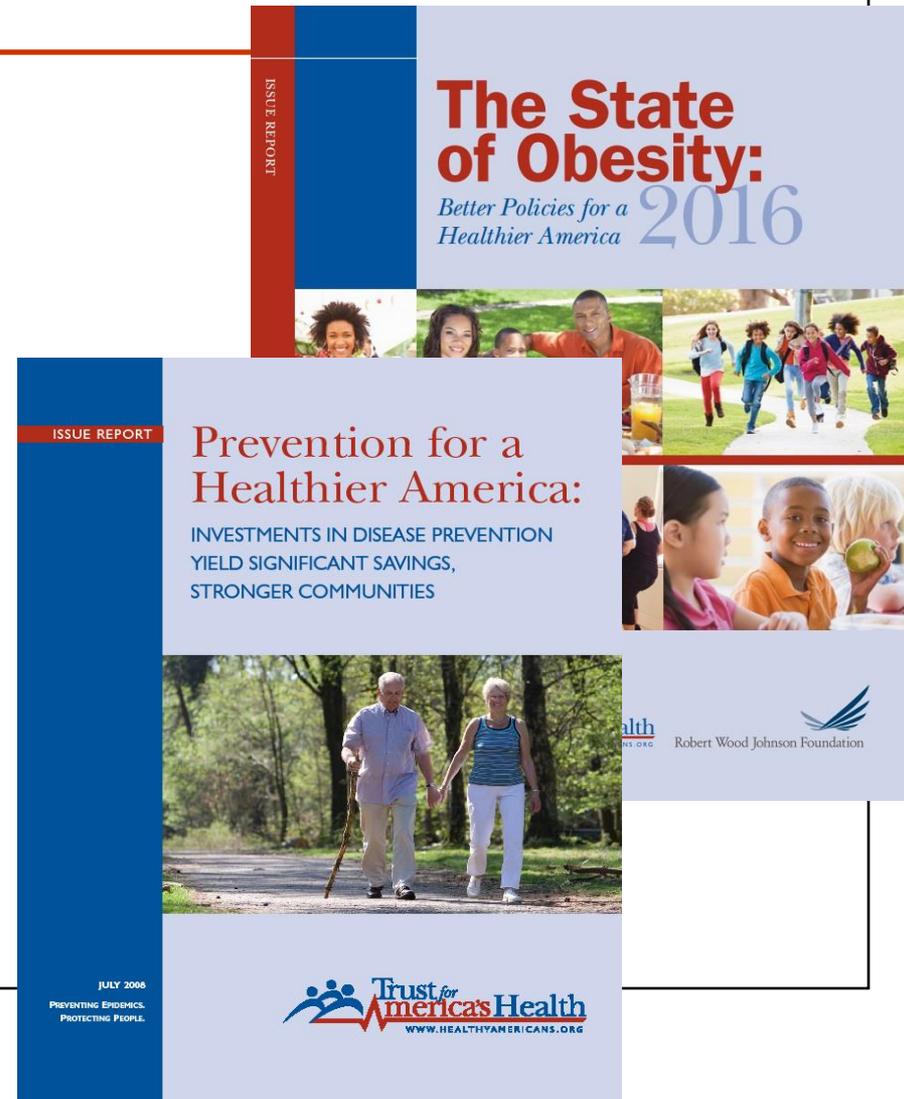
The Functioning Of The Public Health System

- *System needs vision & resources*
- Support PH 3.0/Chief Health Strategist Approach
 - Upstream
 - Evidence-based
 - Cross sector
 - Data driven

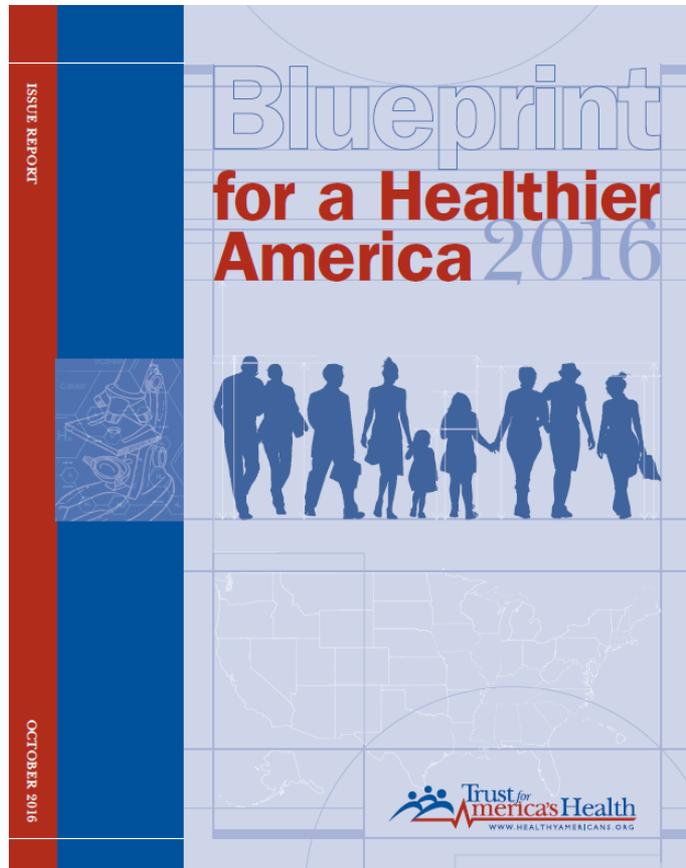


Key Health Issues To Prioritize

- *Key health issues at this time*
- Publish in-depth reports/media work
 - Behavioral Health
 - Emergency Preparedness
 - Obesity



We Have Tools to Assist *Blueprint for a Healthier America 2016*



*Access the Full Report at
<http://healthyamericans.org/report/129>*

***Priorities for the Next Administration
and Congress***

*Please visit TFAH's website at:
<http://healthyamericans.org/>*

She Needs Our Help



July 11, 2017 Meeting Minutes

STATE BOARD OF HEALTH

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

July 11, 2017

CALL TO ORDER

Ms. Burger, President of the Oklahoma State Board of Health, called the 419th meeting of the Oklahoma State Board of Health to order on Tuesday, July 11, 2017, at 11:07 a.m. The final agenda was posted at 11:00 a.m. on the OSDH website on July 10, 2017; and at 11:00 a.m. on the Oklahoma State Department of Health building entrance on July 10, 2017.

ROLL CALL

Members in Attendance: Martha A. Burger, M.B.A, President; Cris Hart-Wolfe, Vice-President; Robert S. Stewart, M.D., Secretary-Treasurer; Charles W. Grim, D.D.S.; R. Edward A. Legako, M.D.; Murali Krishna, M.D., Timothy E. Starkey, M.B.A.

Absent: Jenny Alexopoulos, D.O.; Terry R. Gerard, D.O.

Staff present were: Terry Cline, Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Tina Johnson, Deputy Commissioner, Community & Family Health Services; Deborah Nichols, Chief Operating Officer; Brian Downs, Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director, Office of Accountability; VaLauna Grissom, Secretary to the State Board of Health.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Ms. Burger called the meeting to order and thanked all guests in attendance. She asked Dr. Krishna to share some exciting news with the Board. Dr. Krishna updated the Board on the status of a world class mental health and addiction recovery center planned for Oklahoma City. Significant strides have been made in commitments to fund and resource the facility. This will be a tremendous asset to Oklahoma. Ms. Burger introduced the newest member to the Board of Health, Dr. Edward Legako. Dr. Legako is a pediatrician in Lawton and replaces Dr. Woodson. He serves on the Board of the Oklahoma Chapter of the Academy of Pediatrics as well as on the Board of Trustees for the Comanche Memorial Hospital in Lawton. Dr. Legako thanked the Board members for the welcome and briefly introduced himself. He is excited to serve on the Board and looks forward to working with this group.

REVIEW OF MINUTES

Ms. Burger directed attention toward approval of the Minutes for June 13, 2017, regular meeting. **Ms. Wolfe moved Board approval of the June 13, 2017 meeting minutes as presented. Second Dr. Krishna. Motion Carried.**

AYE: Burger, Grim, Krishna, Legako, Stewart, Wolfe

ABSENT: Alexopoulos, Gerard,

ABSTAIN: Starkey

STRATEGIC MAP PRESENTATION

Julie Cox-Kain, M.P.A., Senior Deputy Commissioner and Deputy Secretary of Health and Human Services;
Adrienne Rollins, M.P.A., Interim Director, Center for Health Innovation and Effectiveness
See attachment A.

CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION**Executive Committee**

Ms. Burger thanked Cris Hart-Wolfe and Dr. Krishna for their efforts on the retreat planning committee. She asked the Board to be looking for a communication regarding the retreat and respond accordingly. She briefly updated members on the decision to discontinue use of the BoardMax software and utilize an OSDH SharePoint site (in development) in order to continue in a paperless environment. More details on that are forthcoming.

Finance Committee

Ms. Wolfe directed attention to the Financial Brief provided to each Board member and presented the following SFY 2017 Finance Report and Board Brief as of June 22, 2017:

- The agency is in "Green Light" status overall.
- June's performance rating was 99.70%, July's performance rating is 99.84%. A net increase in performance of .14%
- Although the State Fiscal year 2017 is over, OSDH will continue to process invoices over the next 90 days.

The Finance Brief focused on WIC (Women Infant Children) Service. The committee learned of continued successes in the implementation of the program including Oklahoma's progressive implementation of e-WIC well ahead of the Federal mandate for all states to comply with e-WIC provisions by October 2020.

Accountability, Ethics, & Audit Committee

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

Public Health Policy Committee

The Policy Committee met on Tuesday, July 11, 2016. The Committee update focused on updates regarding the Smoking Cessation and Prevention Act of 2017, the Public Health Lab Bond, and updates to rules promulgated by the Board in the last session.

- A lawsuit was filed last month challenging the constitutionality of SB 845. The law was challenged by several individuals, tobacco wholesalers and tobacco companies. Oral arguments are scheduled for August 8 with the Oklahoma Supreme Court.
- The Oklahoma Capital Improvement Authority met yesterday and approved awards for the four RFPs that were issued last month to assemble our project finance team which includes bond counsel, underwriting and registrar services.
- A Public Health Lab project management committee has been created and began meeting last week to discuss project timelines and the process of working with OMES Construction and Properties.
- The OSDH proposed permanent rules were approved by the Governor's Declaration on June 13, 2017.
- Office of State and Federal Policy is currently working with agency service areas on policy development for the 2018 legislative session.

1 **Dr. Stewart concluded the report with a recommendation and motion to inactivate all Board of Health**
2 **Current Policies (CP), CP-1 through CP-53.** The recommendation is a result of the committee's careful
3 review of current policy and position statements beginning in May of 2017. The current set of policies and
4 position statements can be summarized as directives to the Department of Health from the Board of Health.
5 Many directives have been carried out as internal policies or organizational changes within the Department;
6 implemented within the Strategic Plan/Oklahoma Health Improvement Plan (OHIP); and/or memorialized in
7 administrative rules promulgated by the Board including those that serve as governing documents for the
8 agency and Board. **Second Dr. Krishna. Motion Carried.**

9
10 **AYE:** Burger, Grim, Krishna, Legako, Starkey, Stewart, Wolfe

11 **ABSENT:** Alexopoulos, Gerard

12
13 **PRESIDENT'S REPORT**

14 Ms. Burger directed attention to the retreat agenda titled "Board Member Perspectives." With about 10
15 minutes allotted to each member, the goal is to give each member the opportunity to give their perspectives
16 on health issues, whether in their community, statewide, or in their field of practice. This would set the
17 foundation for a closing breakout discussion on objectives and take-home message through collective and
18 individual report outs to include Board member next steps and action plans for the upcoming year.

19
20 **COMMISSIONER'S REPORT**

21 Dr. Cline thanked Dr. Legako for his willingness to volunteer his time to the Board. He also expressed
22 thanks to Chris Bruehl of the Governor's for attending and his efforts given to careful selection of Board
23 members. Additionally, Dr. Cline thanked all board members for their volunteer service to the Board.
24 Dr. Cline asked Dr. Kristy Bradley to give a brief update on current disease and investigation issues. Dr.
25 Bradley gave a brief update indicating the Department had responded to multiple outbreaks including 13
26 enteric, 4 influenza or respiratory diseases, 4 vaccine-preventable diseases, 1 healthcare-associated, 1
27 botulism in federal prison system. She highlighted the ongoing mumps and syphilis outbreak response
28 activities as they have demanded the greatest resources. The report concluded.

29
30 **NO NEW BUSINESS**

31
32 **NO EXECUTIVE SESSION**

33
34 **ADJOURNMENT**

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

36
37 **AYE:** Burger, Grim, Krishna, Legako, Starkey, Stewart, Wolfe

38 **ABSENT:** Alexopoulos, Gerard

39
40 The meeting adjourned at 12:18 p.m.

41 Approved

42 _____
43 Martha Burger

44 President, Oklahoma State Board of Health

45 August 11, 2017

Attachment A

Strategic Map Update

OKLAHOMA STATE DEPARTMENT OF HEALTH



Julie Cox-Kain, M.P.A.

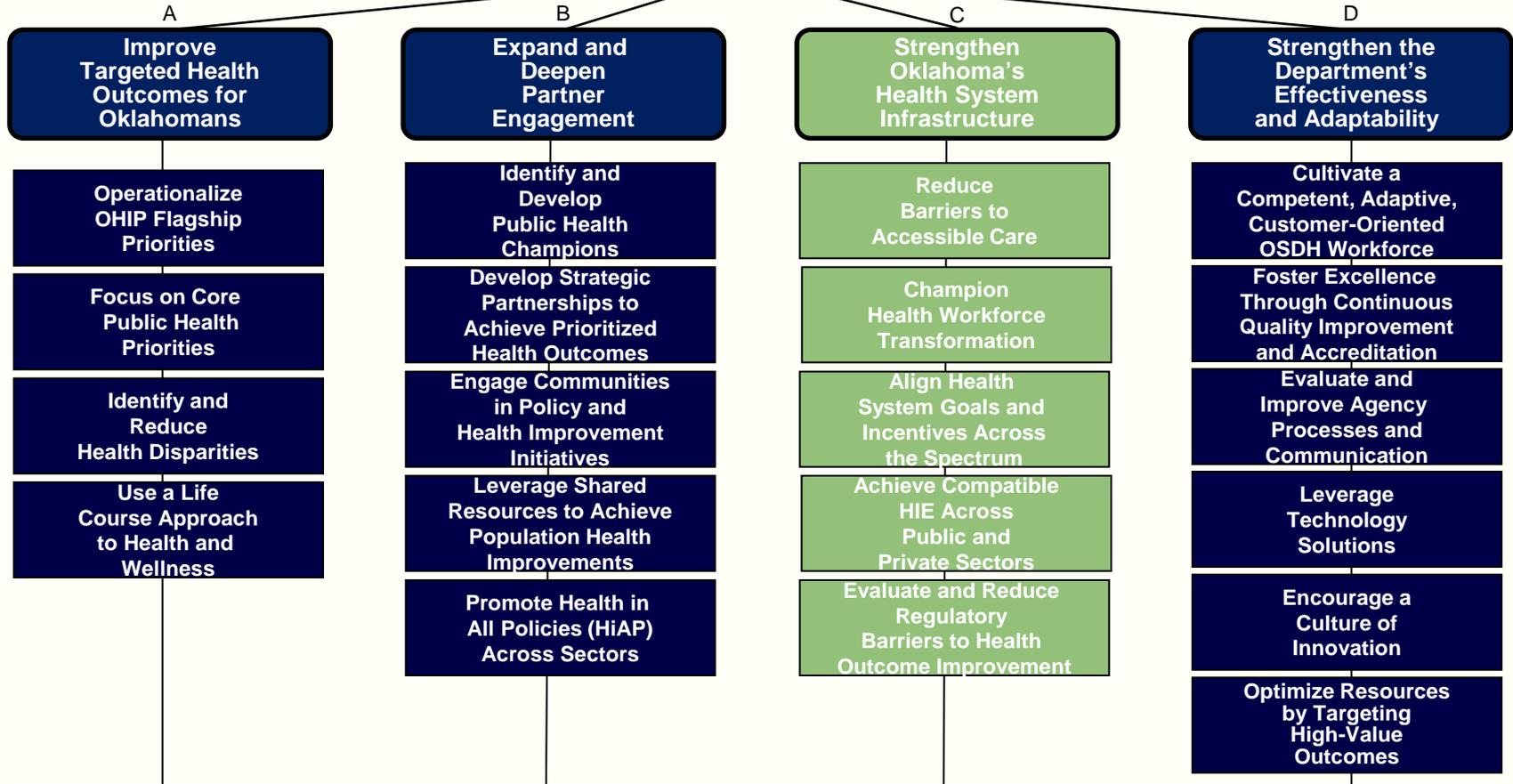
Deputy Secretary of Health and Human Services
Senior Deputy Commissioner

Adrienne Rollins, M.P.A.

Interim Director, Center for Health Innovation and Effectiveness

July 11, 2017

Improve Population Health



Address the Social Determinants of Health and Improve Health Equity

Promote Health Improvement Through Policy, Education and Healthy Behavior

Foster Data-Driven Decision Making and Evidence-Based Practices

Reduce Barriers to Accessible Care

Opportunities

- Data Sharing & Integration w/Licensure Boards
- FQHC Uniform Data Set
- Expand National Health Service Corps and FQHC sites
- Expand use of J-1 Visa Waivers
- Safety Net Directory

Barriers

- Data Standardization
- Data Quality
- Data Visualization Tools
- Data Needs – Telehealth & Local Economic Information

Measures of Success

- Improve Data for Detailed Analysis
- Increase Safety Net Sites & Workforce
- Increase Public Information

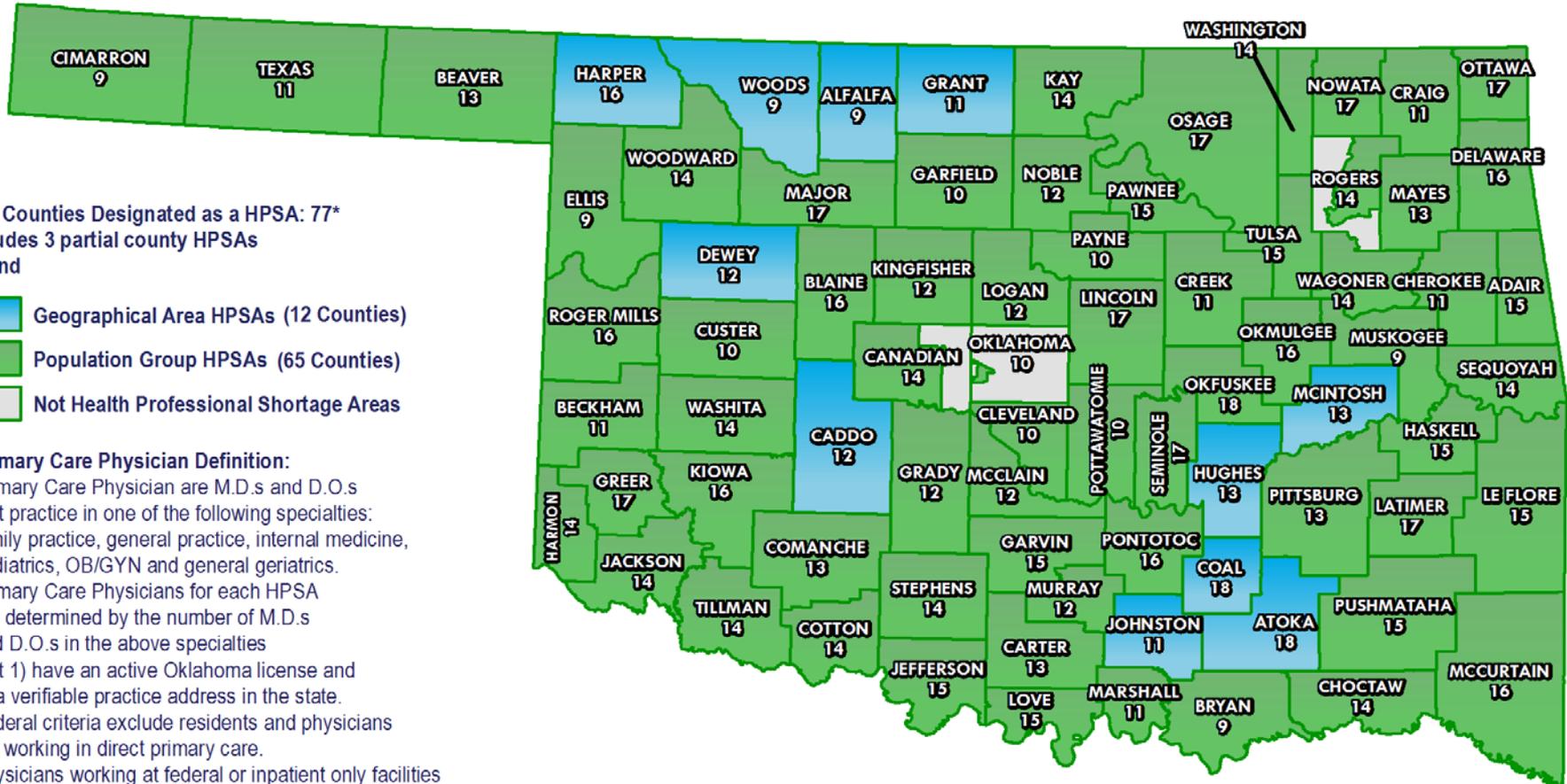


Accomplishments

- New Access Point Sites Identified
- More NHSC Awards than Any State in Region
- 13 High Priority Critical Access Hospitals Identified for NHSC
- J-1 Foreign Physician Waivers Increased by 47%
- Safety Net Directory Outreach



Primary Care Health Professional Shortage Areas (HPSAs)



Total Counties Designated as a HPSA: 77*

*Includes 3 partial county HPSAs

Legend

- Geographical Area HPSAs (12 Counties)
- Population Group HPSAs (65 Counties)
- Not Health Professional Shortage Areas

Primary Care Physician Definition:

Primary Care Physicians are M.D.s and D.O.s that practice in one of the following specialties: family practice, general practice, internal medicine, pediatrics, OB/GYN and general geriatrics. Primary Care Physicians for each HPSA are determined by the number of M.D.s and D.O.s in the above specialties that 1) have an active Oklahoma license and 2) a verifiable practice address in the state. Federal criteria exclude residents and physicians not working in direct primary care. Physicians working at federal or inpatient only facilities are also excluded from HPSA calculations.

Notes on Health Professional Shortage Areas:

HPSAs demonstrate a critical shortage of primary care physicians, in accordance with the federal Health Resources & Services Administration (HRSA) Shortage Designation Branch guidelines. Each type of HPSA is further classified into one of the following categories: geographic, population group, facility, or automatic. Each HPSA is given a score by the Shortage Designation Branch based on certain specific criteria for each type of HPSA. This score indicates the degree of shortage. HPSA designations are updated every 3-4 years.*

Data Source: HRSA Datawarehouse, SDMS, Office of Primary Care & Rural Health Development

Projection/Coordinate System: USGS Albers Equal Area Conic

Created: 5.5.2017

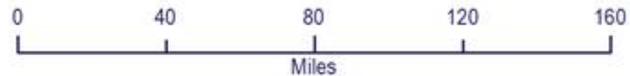
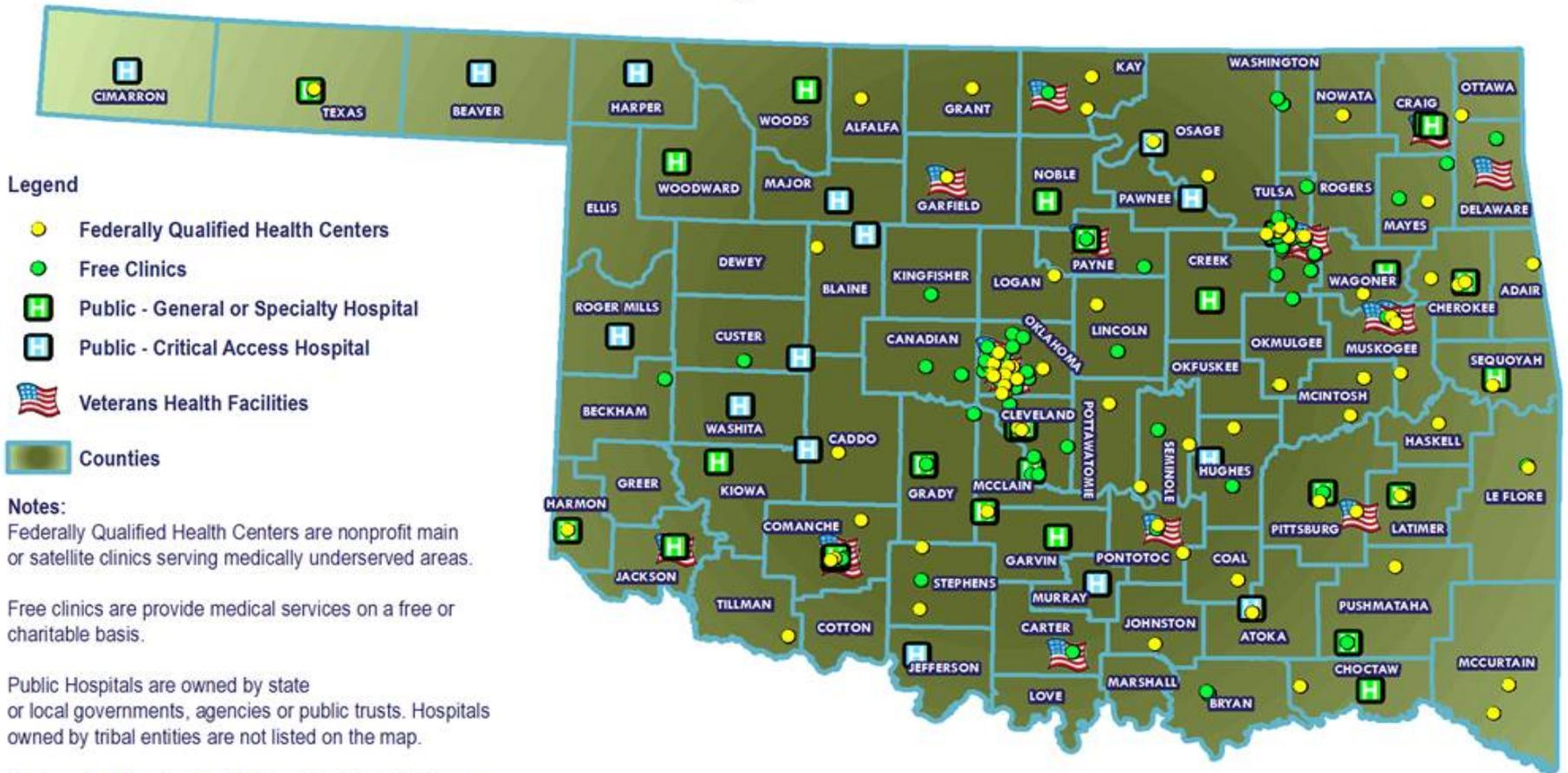


Office of Primary Care & Rural Health Development
Center for Health Innovation & Effectiveness
Oklahoma State Department of Health



Disclaimer: This map is a compilation of records, information and data from various city, county and state offices and other sources, affecting the area shown, and is the best representation of the data available at the time. The map and data are to be used for reference purposes only. The user acknowledges and accepts all inherent limitations of the map, including the fact that the data are dynamic and in a constant state of maintenance.

Safety Net Facilities



Disclaimer: This map is a compilation of records, information and data from various city, county and state offices and other sources, affecting the area shown, and is the best representation of the data available at the time. The map and data are to be used for reference purposes only. The user acknowledges and accepts all inherent limitations of the map, including the fact that the data are dynamic and in a constant state of maintenance.



Office of Primary Care & Rural Health Development
Center for Health Innovation and Effectiveness
Oklahoma State Department of Health

Champion Health Workforce Transformation

Opportunities

- Health Workforce Subcommittee
- MACRA/MIPS/H2O Technical Assistance Assets
- HHS Cabinet Governance
- Medicaid Waiver for Transformation (DSRIP)
- Health-e Oklahoma

Barriers

- Funding
- Emerging Profession Infrastructure

Measures of Success

- Health Workforce Development & Distribution
- TA & Training for Transformation



Accomplishments

- NGA TA Grant Improved Medicaid 1115 Waiver for Supplemental Payment to Support Recruitment and Retention
- White Papers: Community Health Worker & Community Paramedic



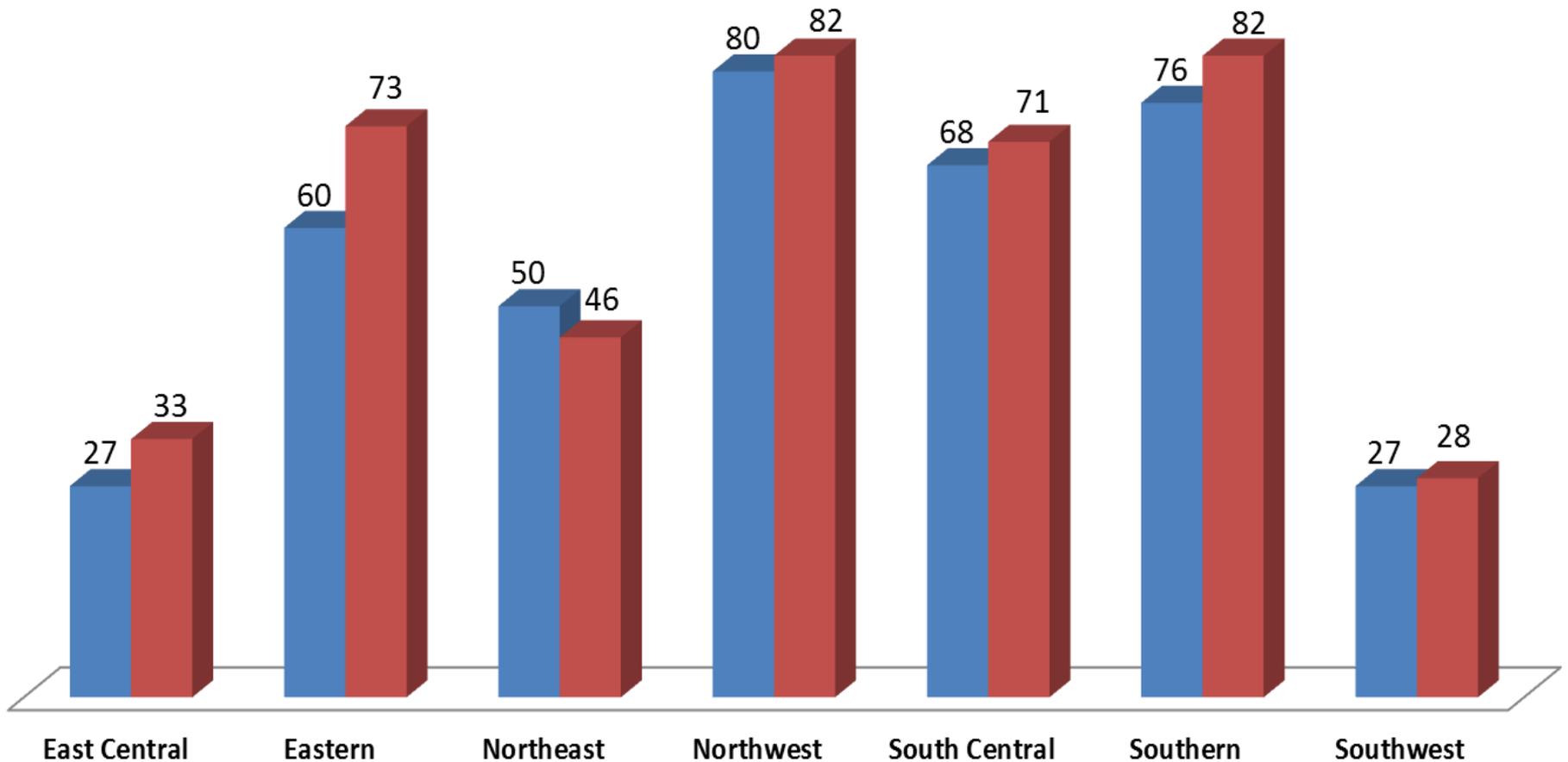
Ranking: 2016-2026 Openings

SOC	Description	Ranked by Total 2016-2026 Openings
29-1141	Registered Nurses	1
29-2061	Licensed Practical and Licensed Vocational Nurses	2
11-9111	Medical and Health Services Managers	3
29-2041	Emergency Medical Technicians and Paramedics	4
29-1089	Physicians and Surgeons, All Other	5
29-2071	Medical Records and Health Information Technicians	6
29-1062	Family and General Practitioners	7
29-1123	Physical Therapists	8
29-1051	Pharmacists	9
29-2012	Medical and Clinical Laboratory Technicians	10
21-1014	Mental Health Counselors	11
29-2011	Medical and Clinical Laboratory Technologists	12
31-9097	Phlebotomists	13
29-1171	Nurse Practitioners	14
29-1071	Physician Assistants	15
29-2034	Radiologic Technologists	16
29-1041	Optometrists	17
29-1021	Dentists, General	18
21-1094	Community Health Workers	19
29-1126	Respiratory Therapists	20
29-2032	Diagnostic Medical Sonographers	21
29-1087	Surgeons	22
29-1063	Internists, General	23
29-1151	Nurse Anesthetists	24
29-1066	Psychiatrists	25
29-1061	Anesthesiologists	26
29-2035	Magnetic Resonance Imaging Technologists	27
29-1065	Pediatricians, General	28

Supply and Demand: Regional Example

Respiratory Therapist SOC 29-1126

■ 2016 Jobs ■ 2026 Jobs



Align Health System Goals & Incentives

Opportunities

- Alignment of State Agency Goals
- DSRIP Waiver
- Alignment of Innovation Programs
- Improved Outcomes & Ease Regulatory Burden

Barriers

- Provider & Agency Capacity
- Funding
- Interoperability
- Transparency on Cost of Care
- Healthcare Policy Uncertainty

Measures of Success

- Agency Quality Measure Alignment
- Triple AIM



Accomplishments

- Draft Agency Quality Measure Set
- 1332 Waiver Authorization/Market Stabilization
- DSRIP Waiver Authority



HHS Quality Measures



- NQF 0018 - Controlling High Blood Pressure
- NQF 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- NQF 0028 - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- NQF 0032 – Cervical Cancer Screening
- NQF 0034 - Colorectal Cancer Screening
- NQF 0041 - Influenza Immunization
- NQF 0057 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- NQF 0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- NQF 0418 - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- NQF 0421 - Preventive Care and Screening: BMI Screening and Follow-Up
- NQF 1959 - HPV for Adolescents
- NQF 2372 - Breast Cancer Screening
- SBIRT – like Screening for Substance Abuse



Achieve Compatible HIE Across Public & Private Sectors

Opportunities

- Improved Healthcare Information
- Lower Costs
- Improved Outcomes
- Improved Patient and Caregiver Engagement

Barriers

- Governance
- Funding
- Resources

Measures of Success

- Established Governance Board
- Strategic Roadmap
- Federal Funding
- Increased Health Information Technology Usage



Accomplishments

- Federal 90/10 funding awarded for technical assistance to develop HIE plan/waiver
- Request For Proposal developed and under review
- Begin with 'Use Case' developed for Admission, Discharge, Transfer (ADT) Notifications
- Draft Governance Legislation under review



Reduce Regulatory Barriers

Opportunities

- Ease Regulatory Burden on Healthcare
- Assess Health Impacts of Regulation
- Administrative Efficiency
- Engagement

Barriers

- Agency Capacity

Measures of Success

- Analysis of State to Federal Regulations
- Analysis State Regulation to Best Practice
- Analysis of Internal OSDH Administrative Breakdowns



Accomplishments

- Request For Proposal Development for External Contractor (Objective 1 & 2)
- Prioritized Objective 3
- Engaged Hospital Advisory Council



QUESTIONS



High Level Strategic Plan Update

Oklahoma State Department of Health (OSDH)

2015 - 2020 Core Measure Performance Scorecard for SFY 2017

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

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

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

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

-  Current Year Target Met or Exceeded
-  Within 5% or Less of Current Year Target
-  Greater Than 5% From Current Year Target

The scorecard is concluded with a brief explanation of why particular performance measures did not meet the current year target as evidenced by assignment of yellow or red to the measure.

Oklahoma State Department of Health (OSDH) 2015-2020 Core Measures Scorecard - SFY 2017

The measures in this Scorecard were established in the 2015-2020 OSDH Strategic Plan.

Strategic Map Reference	Measure	Year 1 Actual	Year 2 Actual	Year 2 Target	Trend
A2	Inspection - Percent of state mandated inspection frequency and complaint investigations are achieved annually.	100%	100%	100%	→
A2	Infectious Disease - % of immediately notifiable reports received by phone consultation or PHIDDO submission in which investigation is initiated within 15 minutes.	95%	96%	96%	↑
A2	Infectious Disease - Average number of reported Tuberculosis, Pertussis and Salmonella cases per 100,00 population.	27.2	30.3	24.42	↑
A1	Children - Infant deaths per 1,000 live births (3 year rolling average) ¹	7.4	7.6	7.3	↑
A1	Children - Maternal deaths per 100,000 ¹	19.4	17.6	26.3	↓
A1	Children - Birth rate to adolescents age 15-17 ¹	15.9	14.3	19.98	↓
A1	Injury - Reduction in the age-adjusted motor vehicle crash hospitalization rate per 100,000 population	60	57.9	67.8	↓
A2	Injury - Prevent any increase in the rate per 100,000 of fall-related hospitalizations among persons age 65 and older.	1175.9	1145	1289.7	↓
A2	Prevention - Reduce the rate, per 100,000, of potentially preventable hospitalizations.	1702.9	1483.3	1689.3	↓
A2	Immunization - 4:3:1:3:3:1:4 immunization coverage rates of children 19-35 months of age	73.3%	75.4%	76%	↑
A2	Immunization - Percent of adolescents age 13 - 17 receiving meningococcal vaccine	70.8%	68.1%	71.08%	↓
A2	Immunization - Percent of adults age 65 and over receiving influenza vaccine ²	68.9%	-	72.20%	→
A1	Obesity - Percent of adults who are obese ²	34%	-	31.60%	→
A1	Obesity - Percent of adolescents who are obese ³	17.3%	-	11.30%	→
A1	Obesity - Percentage of the population that has participated in any physical activity in the last 30 days ²	66.8%	-	71.88%	→
A1	Tobacco - Percent of adults who smoke ²	22.2%	-	19.86%	→
A1	Tobacco - Percent of high-school adolescents who smoke ³	14.6%	-	13.06%	→
A1	Tobacco - Percent of middle-school adolescents who smoke ³	4.1%	-	3.68%	→
A2	Cardiovascular - Cardiovascular disease deaths per 100,000	288.5	297	279.88	↑
A1	Behavioral Health - Suicide deaths per 100,000	26.9	26.3	22.58	↓
A1	Behavioral Health - Unintentional poisoning deaths per 100,000	18.88	17.69	18.87	↓
B1/B2	Policy - # of community organizations supporting OHIP legislation	60	67	24	↑
B3	Public Health Partnerships - # of certified healthy community	78	95	84	↑
B3	Public Health Partnerships - # of certified healthy schools	683	806	685	↑
D1	Workforce - % of turnover agency wide	12.18%	12%	11.74%	↓
D2	Accreditation - # of PHAB accredited OSDH Health Departments in OK	2	3	5	↑

¹ Provisional Data, subject to slight change

² Embargoed data.

³ Data only available biennially.

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

- ↑ Desired Increase
- ↑ Undesired Increase
- ↓ Desired Decrease
- ↓ Undesired Decrease
- No change

2017 Scorecard Explanation for Unmet Performance Measures

Infectious Disease - Reported Cases: An increase in the number of pertussis and salmonella cases increased the average case rate to 30.3 per 100,000 population. Pertussis is a naturally cyclic disease, with periodic peaks in disease. The reasons for the fluctuation are not clearly understood, but are likely due to multiple factors which present a challenge when using incidence rates as a performance measure. Based on data from 2010 through 2014, we expected minor declines each year but will need to adjust the targets as the shifts in trends have changed from decreasing from 2010 through 2014 to increasing from 2014 to 2016.

Children - Infant deaths per 1,000 live births: Provisional 2014-2016 data show an increase of 2.7% from 7.4 in 2013-2015. The 2013-2015 IMR benefited from the all-time low for the rate of infant mortality (6.8) in 2013; the fewest number of infant deaths recorded while births were at a relative high. Year 2013 was followed by a recent high of 434 infant deaths in 2014. Years 2015 and 2016 have moderated downward. The long-term trend shows improvement in the rate of infant death.

Immunization - Children and Adolescents: The Immunization Service continues to work to increase adolescent vaccination coverage rates, including one dose of quadrivalent meningococcal vaccine (MCV4) among Oklahoma teens. No factors have been identified to account for the decrease in the MCV4 rate as measured by the 2015 National Immunization Survey (NIS) compared to the 2014 survey results. The Immunization Service has replicated the CDC-mandated AFIX project for adolescent vaccinations beginning in calendar year 2017. Based on the success of the Childhood AFIX project in helping to increase coverage rates of the primary childhood series, we are anticipating improvement will be replicated with adolescent vaccinations leading to an increase in MCV4 rates in the future (beginning with the 2018 NIS).

Cardiovascular Disease Deaths: The numbers of deaths, from heart disease, decreased from 2011 to 2012 and were followed by a consistent increase each year between 2013 and 2015. The Center for The Advancement of Wellness and the Center for Health Innovation and Effectiveness (CHIE) are currently conducting an in-depth analysis of all available and relevant data to better understand what is contributing to the increase in deaths over time and where the majority of the deaths are occurring in the state.

Behavioral Health - Suicide: Trending slightly downward from last year.

- Suicide rates are up across all age, gender and race/ethnicity categories.
- Oklahomans ages 25-54 have the highest rates of suicide.
- White, non-Hispanics have the highest rate of suicide death 30.2 per 100,000 (ages 25+).
- 50% of suicide victims aged 25 and older had at least one diagnosed mental health issue.
- 33% of suicide victims aged 25+ were experiencing intimate partner problems at the time of death.

Workforce - % of turnover agency wide: Although the target was not met, it is lower than last year and the trend is heading in the desired direction.

Accreditation: While not achieving the benchmark, Cleveland County Health Department received accreditation. Logan and Washington Counties are completing action plans to become accredited following their PHAB site visits. Delaware County has completed and submitted documentation to PHAB, which will be reviewed by PHAB by mid-July. Garfield County is working on their accreditation process.

O K L A H O M A S T A T E B O A R D O F H E A L T H

High Level Strategic Plan Update
Budget Priorities



Julie Cox-Kain, Senior Deputy Commissioner
Brian Downs, Director of State and Federal Policy

July 24, 2017

SFY 2019 Budget Request Priorities

OKLAHOMA STATE DEPARTMENT OF HEALTH BUDGET REQUEST SFY 2018



PUBLIC HEALTH Delivering essential services to prevent and treat illness, protect Oklahomans from health hazards and promote wellness where people live, learn, work, play and pray.

PUBLIC HEALTH LAB

OKLAHOMA'S ONLY PUBLIC HEALTH LAB

Critical public health infrastructure necessary for detecting and preventing emerging pathogens (Ebola, Zika, etc.), infectious diseases, foodborne illness and newborn genetic disorders

Infrastructure is aging impacting laboratory testing and results

Lab accreditation and continued operation is threatened

Only lab in state testing of high-risk specimens like Anthrax (white powder) and rabies

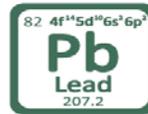
20 year bond for \$58,553,298

SFY-19 bond payment \$4,023,270



\$632,040
Interest Only

CHILD LEAD EXPOSURE



High lead levels result in loss of IQ, behavioral problems, and damage to the nervous system and kidneys

Children with elevated lead levels will receive public health case management

Funding supports the identification of the source(s) of lead exposure to children

\$632,366

IMMUNIZATION



Provides an additional 3,700 vaccinations for children with no access to vaccines

Every dollar spent on childhood vaccines saves \$16.50 in future health care costs

\$1,537,296

INFECTIOUS DISEASE



OSDH investigates more than 60 reportable diseases

Funding provides medications and prevention efforts necessary to stop the spread of infectious diseases

\$602,642

FEDERAL MEDICAL ASSISTANCE PERCENTAGE



The percentage of federal contribution for public health services has decreased by more than 5% since 2014

The requested appropriation is necessary to maintain Medicaid funding for critical public health services

Will bring in \$1,811,482 in federal funding

\$1,281,368

TOTAL = \$4,685,712

SFY 2018 Budget Shortfall

- The OSDH continues to experience a budget shortfall in SFY '18
- Revenue is anticipated to be below the current budget even after being adjusted for state appropriation reductions
- A full analysis is being completed to identify:
 - The total amount of the shortfall
 - The programs contributing to the shortfall either due to revenue reduction or cost overruns
- This issue began in prior state fiscal years also leaving the agency with prior year obligations that need to be made current
- This situation will result in additional budget reductions in SFY '18



SFY 2018 Budget Shortfall

The SFY 2018 Budget Shortfall is due to a number of factors including the following:

- Federal funding reductions
- Increased costs
- Delayed or discontinued billing
- Programmatic cost overruns
- Long term vacancies and significant reductions in accounting staff



SFY 2018 Budget Shortfall

ACTION PLAN

- Incident Command Structure (ICS) has been implemented to manage agency response
- Immediate actions will be taken to reduce cost or increase available cash
- Longer term program reductions are likely as determined by ICS
- Formal request to Internal Audit to review accounting processes and internal controls
- Communication plan will be developed for staff
- Ongoing status reports will be available to the board via the Finance and Audit Committee



POLICY PRIORITIES



2017 Legislative Recap

- Public Health Laboratory Bond Authorization (HB 2389)
- Administrative Rules Promulgated by BOH Approved
- Smoking Cessation and Prevention Act of 2017 (SB 845)



Smoking Cessation and Prevention Act Update

- Oral arguments were presented to the Oklahoma Supreme Court on Tuesday, August 8, 2017
- Potential impact of \$214MM for SFY'18 budget (DHS, ODMHSAS, OHCA)
- If law is upheld, the \$1.50 increase will become effective later this month
- If law is overturned, the legislature must close funding gap, most likely mechanism is Governor calling a special legislative session



2018 Legislative Priority

The Oklahoma State Board of Health supports increasing the price point of cigarettes by a \$1.50 per pack in order to achieve the following:



- *Prevent 28,200 kids alive today from becoming adult smokers*
- *Reduce cigarette consumption by 26 million fewer packs in the first year*
- *Lead to 29,600 current adult smokers quitting in the first year*
- *Prevent 18,000 premature smoking-caused deaths*
- *Save \$1.25 billion in long-term health care costs*

2018 Policy Discussion

- Immunization Strategy
- Good Samaritan Law
- Comprehensive Smoke Free
- State Question 788 – Medical Marijuana



2018 Policy Discussion

- Vital Records
 - Judicial Determination of Death
 - Issuance of Identity Document
- Community Health Worker Certification
- Confidential QI Reviews for Stroke/Heart Attack Cases
- Promulgation of Administrative Rules
 - Several chapter revisions will most likely come back before Board of Health prior to legislative deadline



Important Dates

1. OHIP Support for Policy Priorities – 8/17/2017
2. Oklahoma Turning Point Council Policy Day – 8/31/2017
3. Tri-Board Adoption of Budget/Policy Priorities – 10/3/2017
4. Final Date to Request Drafting of Measures – 12/8/2017
5. Final Date for Introduction of Bills and Joint Resolutions – 1/18/2018
6. Second Regular Session (56th Legislature) Convenes – 2/5/2018



Payne County Health Department Presentation

Partnerships Are Paramount

Kelli D. Rader, MS, RN

Regional Administrative Director

Kay, Noble, Pawnee and Payne

County Health Departments



Community Partnerships

- Healthy community partnerships are essential
- Partnerships are true relationships
 - Great partnerships involve knowing one another, honesty, mutual respect, open dialogue, and common goals and objectives
- Do not pigeonhole a partnership
 - Communities must be open to traditional and non-traditional partnerships and methods



Community Partnership

- Communication
- Planning
- They are mutually dependent and beneficial
- They are intertwined from start to finish



Communication



Partnerships and Communication

- Relationship
- Honesty
- Open dialogue
- Unified voice
- Example - Responding to communicable disease situations in a public school
 - The multi-faceted role of the local County Health Department
 - Confidential investigation/follow-up
 - Communication with the State Epidemiologist, Acute Disease Division, school administration, staff, parents, and students
 - Media relationships and practices
 - Parallel communication



Planning



Partnerships and Planning

- Relationship
- Good communication
- Goals and objectives that benefit everyone
- Examples
 - Stillwater Public Library Health Literacy Project
 - Mass Fatality Planning
 - Responding to a large disease outbreak that would require mass vaccination or prophylaxis
 - Community Health Assessments and Community Health Improvement Plans



Questions?



Current Health Issues Presentation

DISEASE UPDATE



*Kristy K. Bradley, DVM, MPH
State Epidemiologist
Oklahoma State Dept of Health*



Disease Detection and Control: Most Work is “Behind the Scenes”

- Total of 23 outbreaks in 2016 investigated by Acute Disease Service, including multi-state outbreaks
 - 13 enteric (foodborne, animal contact, unknown transmission)
 - 4 influenza or respiratory disease
 - 4 vaccine-preventable disease
 - 1 healthcare-associated
 - 1 botulism in federal prison system
- Ongoing mumps and syphilis outbreaks demanded greatest resources
 - National problems as well: 5,151 cases of mumps reported from 47 states during 2016 (AR and IA contributed 53% of case reports)
 - During 2014-2015, national rates of primary & secondary syphilis increased 19% to 7.5 cases/100,000 (highest rate since 1994)



Multistate Outbreak of Shiga toxin-producing *Escherichia coli* (STEC) Infections Linked to Flour

- 63 people from 24 states infected with outbreak strain of STEC O121 or STEC 026 between December 21, 2015 - September 5, 2016.
- First time STEC has been definitively linked to flour – an unusual food vehicle for this bacteria.
- **Oklahoma:**
 - Investigated 3 cases associated with outbreak
 - Obtained flour from a case and isolated STEC O121 from flour
 - Collaborated with Dept. of Agriculture, OSDH PHL, and OCCHD
 - Oklahoma investigation led to expanded product recall preventing additional illnesses
 - Co-author of manuscript accepted for publication in New England Journal of Medicine describing outbreak and findings
 - <https://www.cdc.gov/ecoli/2016/o121-06-16/index.html>



Mycobacterium chelonae Skin Infections linked to Tattoo Studio Artist

- Acute Disease Service received multiple reports of individuals with skin infections after receiving a tattoo
 - Investigation identified 8 persons with a tattoo-related skin infection; all received from same artist, Oct – Dec 2016
 - *Mycobacterium chelonae* isolated from wound specimens collected from two persons
- All 8 cases had tattoos that included a grey wash method using commercial black ink diluted on-site by the tattoo artist
 - Investigation indicated tattoo artist likely diluted the black ink using tap water instead of sterile water; a known risk factor for tattoo-associated *M. chelonae* skin infections
- This outbreak further contributed to the evidence regarding risk of non-tuberculosis *Mycobacterium* skin infections with improper tattoo practices.



Pontiac Fever/Legionella outbreak linked to hotel pool and spa

- 33 persons with respiratory illness after a child's birthday party hosted at a hotel pool/spa in northeast Oklahoma, March – April 2017
 - All reported recreating around the indoor pool/spa area of the affected hotel
 - *Legionella* identified in swab of spa jet pump tested by the OSDH Public Health Laboratory
- Environmental assessment identified several violations; health officials worked with facility staff on corrective actions to resume operation
- Highlights importance of prompt epidemiologic and environmental investigation to identify common exposure and recommend appropriate remediation steps to stop disease transmission



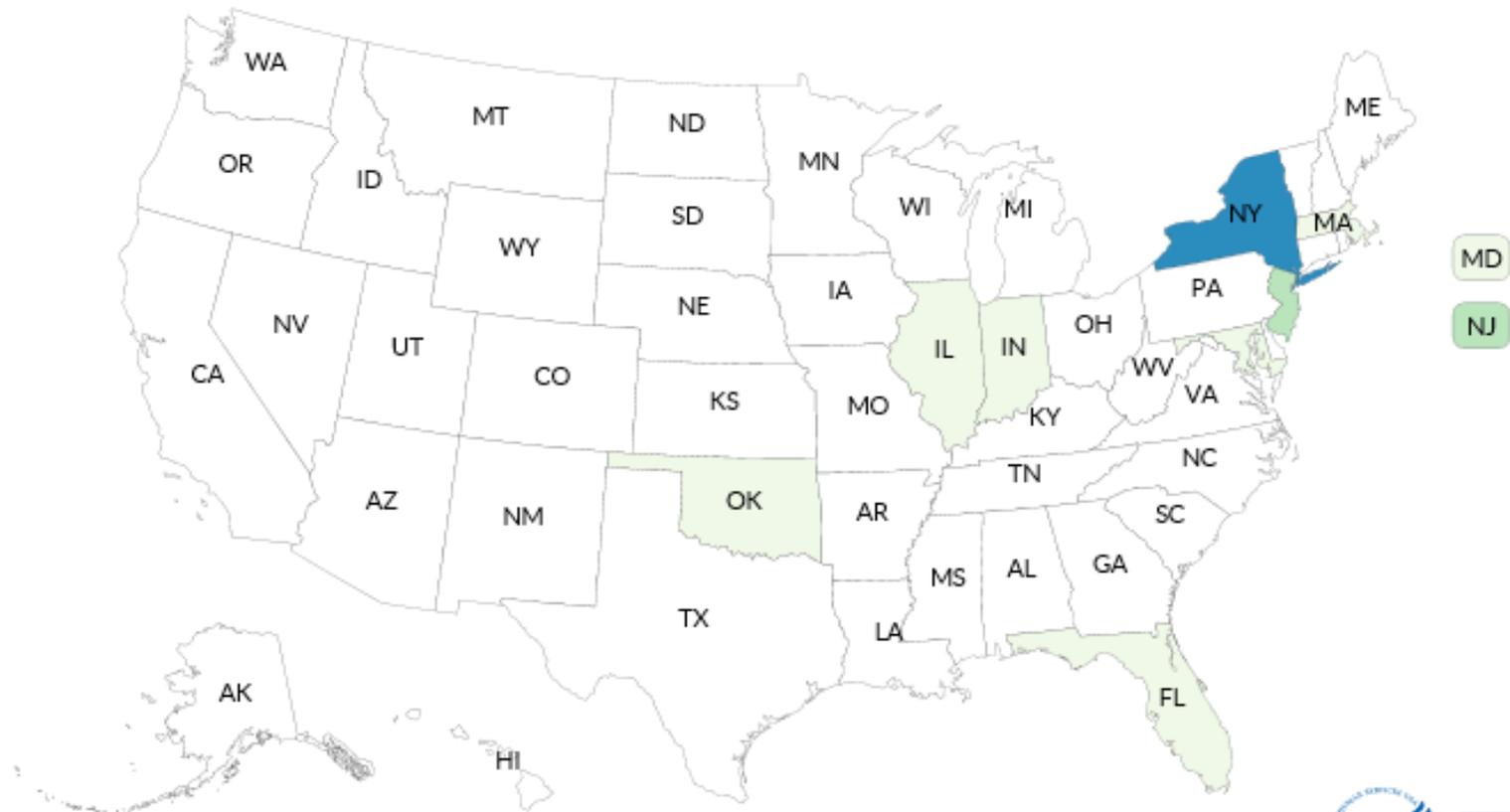
Keeping abreast of emerging threats...

- May 8, 2017 – urgent notification by CDC of confirmed isolate of *Candida auris* obtained from patient hospitalized in Oklahoma
- *C. auris* considered a serious global health threat
 - Emerging simultaneously on multiple continents
 - Fungus that behaves like a bacteria; spreads patient-to-patient and persists weeks in environment
 - Resistant to many commonly used hospital disinfectants
 - Isolates are resistant to at least one class of antifungal drugs
- May 15-17 – 3-member CDC site team visit, training, and expanded surveillance
 - Outstanding collaboration and communication
 - Patient point-prevalence survey and environmental swabbing did not indicate any further spread of *C. auris* in facility



Candida auris cases in the United States

Data as of June 16, 2017; total case count = 86

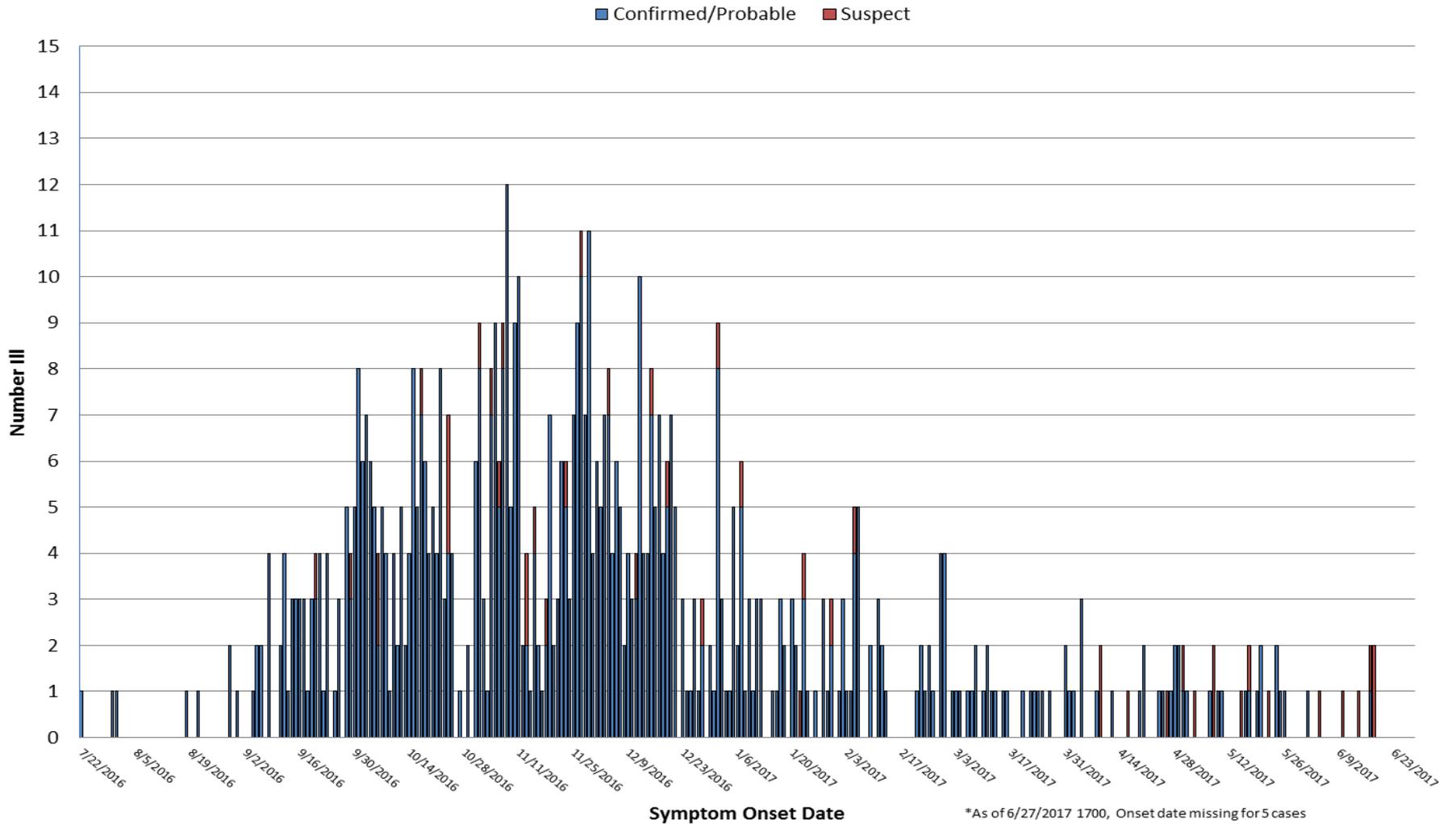


2016-2017 Mumps Outbreak - Oklahoma

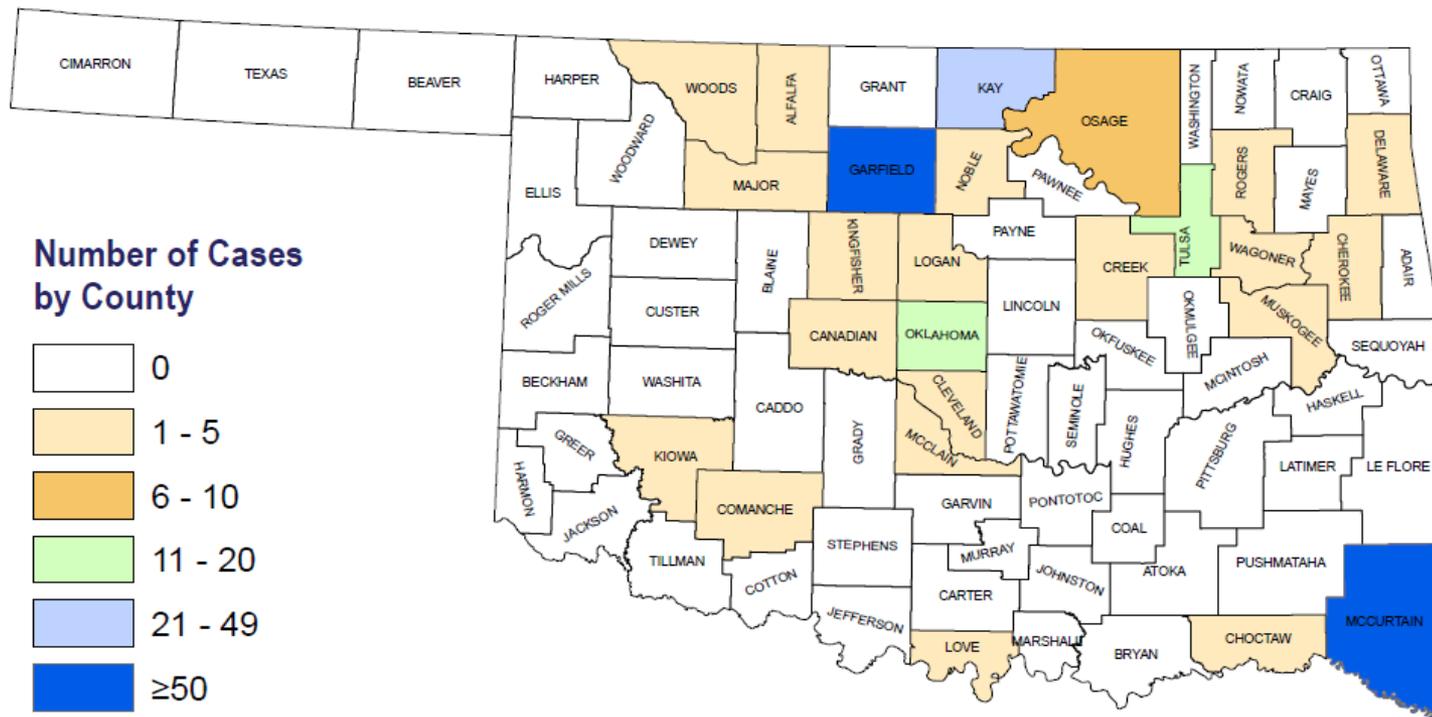
- Between July 1, 2016 and June 27, 2017, **638 cases** of mumps classified as probable/confirmed
- Previous mumps incidence (2000 – 2015): avg of 3 cases/yr, range: 0-11 cases
 - **25 Counties**
 - Counties experiencing the highest number of cases included Garfield (n=418, 66%), McCurtain (n=124, 19%), and Kay (n=31, 5%)
 - **118 businesses and schools have been affected** by the outbreak, including 3 Universities
 - 152 cases have been reported since January 1, 2017



Number of Cases Associated with Mumps Outbreak, Oklahoma, 2016- 2017 (N=689)*



Counties with Mumps Cases, Mumps Outbreak 2016 - 2017, Oklahoma (N=638)*



*(Data as of June 27, 2017)

Created: 06.28.2017



Acute Disease Service
Oklahoma State Department of Health

Features of State's Mumps Outbreak

- **Case Demographics:**
 - Median Age: 17.5 years (range 5 months – 76 years)
 - Age categories most affected by the outbreak were those aged 20-45 years (38%, n=243) and those 10-19 years (37%, n=237)
 - Sex
 - Females: 53% (n=338)
 - 13 (4%) were currently pregnant at time of mumps illness
 - Males: 47% (n=299)
 - Race/Ethnicity
 - Native Hawaiian/Pacific Islander population was most affected by the mumps outbreak (62%, n=398), followed by those reporting their race as White (23%, n=145)
 - 5 individuals were hospitalized overnight due to mumps, no deaths



Immunization Profile of Outbreak-associated Cases

• MMR Vaccination History

- 379 (59%) are age-appropriately vaccinated with a mumps containing vaccine according to the ACIP recommendations
 - 339 (89%) of those age-appropriately vaccinated had ≥ 2 doses
- 4 (<1%) were underage for mumps-containing vaccination
- 20 (5%) reported never receiving a mumps-containing vaccine
- 224 (35%) had unknown mumps vaccination status (unable to verify vaccination history)
 - 122 (54%) of those were Native Hawaiian/Pacific Islander



2016- 2017 Oklahoma City Syphilis Outbreak

- ❖ Defining outbreak cases since Sept 1, 2016
- ❖ 145 cases as of 6/12/2017
 - Approx. 50% of cases identified during infectious stages; 90% within first year of infection
 - Heterosexual population; 52% of cases are female (14 pregnant)
 - 74% of cases are white, 17% black, 8% American Indian
 - >75% self report injection drug use; other risk factors are exchange of sex for drugs or money, or multiple sex partners
- ❖ 456 identified sexual contacts to cases
 - 23% still open for investigation, 22% preventatively treated, 19% tested negative, 11% infected & treated, 10% insufficient information to investigate or locate, 3% out-of-state



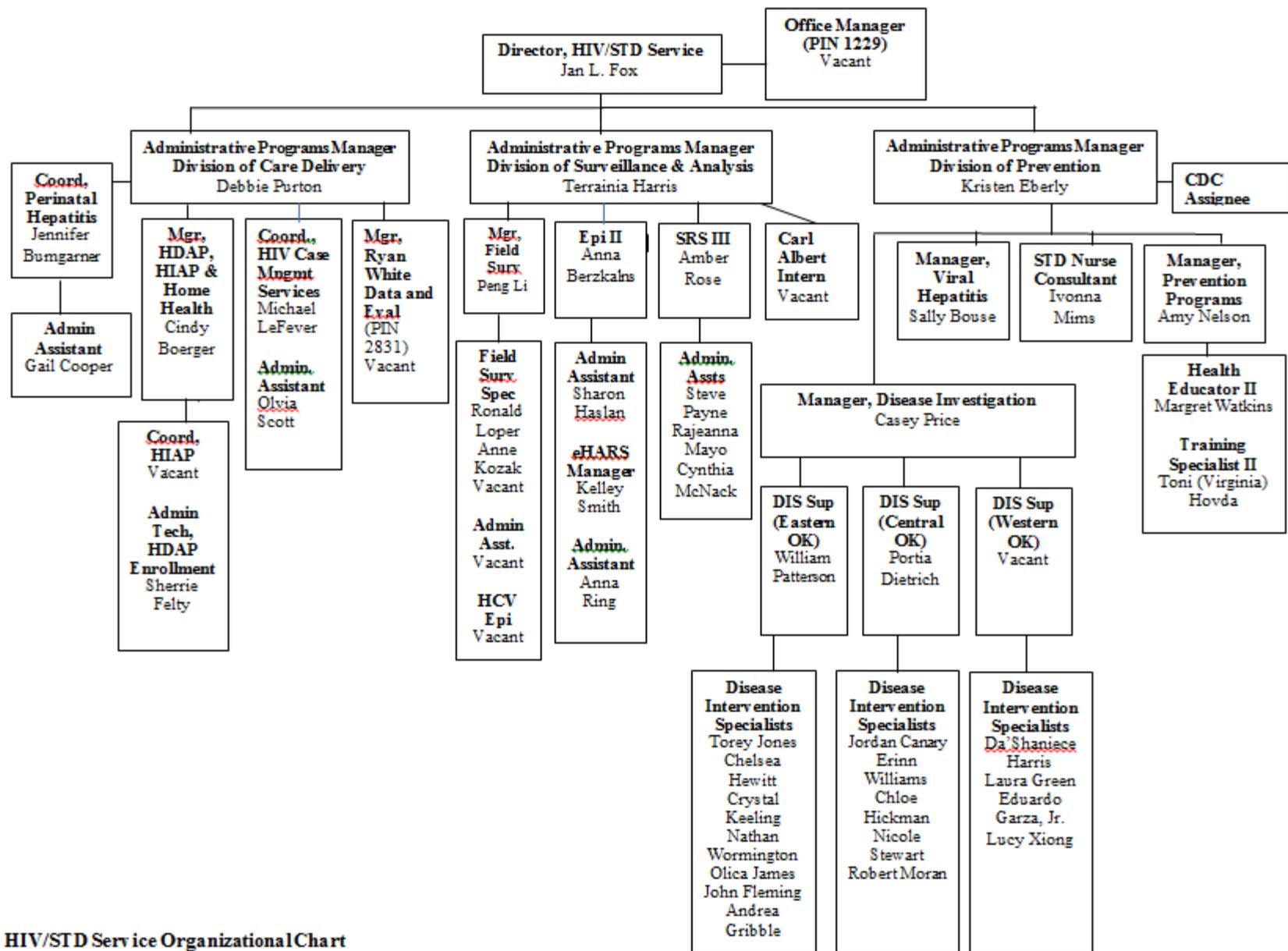
Outbreak Response Activities



- Collaboration with OCCHD, OKC Community-based Organizations, Variety Care, Mary Mahoney, and others to enhance testing and treatment
- Ensure access to Bicillin L-A® to meet needs
 - currently in short supply nationally; only single dose injectable treatment drug and only recommended treatment for pregnant women
 - Average of 250-300 doses given/week
- Outreach and training to jails, juvenile detention center, other county health departments
- Conducted two “DIS blitz” events to increase interviews and testing of contacts
 - 4/18/17 – 4/20/17 (18 DIS staff)
 - 6/13/17 – 6/14/17 (10 DIS staff)







HIV/STD Service Organizational Chart
Updated July 5, 2017

Disease Intervention Specialists

"DIS"

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Who are we and what do we do?

OBJECTIVE:

To Intervene in the spread of HIV/STDs

We do this by:

- Interviewing clients newly identified with HIV and syphilis
- Locating those who may have been exposed and provide testing and/or treatment
- Providing linkage to care

Investigators

Counselors

Phlebotomist

Experts

Taxi Drivers



Reportable Diseases

To Begin

- Provider reports positive test results to OSDH
- Surveillance determines if it is a newly identified infection
- Initiated field follow-up for disease intervention services



Receiving a New Investigation

Pre-Interview Analysis

- Record Search
 - Previous Tests/Treatment
 - Personal Information
 - Social Information
(hangouts, friends, roommates, criminal history, etc.)
- Contact the Provider
 - Patient aware of status?
 - Treatment
 - Signs/Symptoms
 - Risk
 - Locating/Social Information



Contacting the Infected Client

- Confidentiality must be maintained
- Set an appointment to meet with the client
 - Call – Can discuss syphilis over the phone but not HIV
 - Field visits
- Not that easy!
 - Go to the client's home, work, friend's house, hangouts, etc.....numerous times!
 - Client priorities
 - Misunderstanding of what we want
 - At the mercy of the client



Meeting the Infected Client

- Build trust
- Non-judgmental
- Address concerns
- Explain the disease
- Ensure treatment or linkage to care
- Offer additional testing (& Hep C to IVDU)
- Risk reduction counseling
- Make referrals

Additional Considerations:

- Sensitive information
- Client fears and other feelings
- Cooperation
- DIS/Client differences



Eliciting Partners from the Infected Client

Our opportunity to intervene in the spread of disease

- Persuade the client to disclose sexual partners and/or needle sharing partners' information
- Convince the client we will not disclose their information with others



Finding a Contact

- DIS are investigators
- Original patient (OP) may not have good locating information on a partner
- OP may not tell us all partners (especially a spouse)
- OP may have anonymous partners – only know the place they met and possibly a description
- Perform record searches, make phone calls, field visits, talk to others
- Conduct field investigations



Meeting with the Contact

- Meet in a confidential setting (clinic, home, car, etc.)
- Maintain original patient's confidentiality
- Explain they "may have" been exposed to the disease
- Provide a test. DIS are trained in phlebotomy and have rapid HIV and HCV tests
- Cluster interview the contact
- Setup treatment if needed
- Risk Reduction counseling

Additional Considerations:

- Do not know who we are
- Can only discuss HIV in person
- More concerned with finding out "who it was"
- Fear/Anger
- "No way, only been with on partner"

"Who told you?"

"Wasn't me!"

"Man or woman?"

"When was it?"

"They're lying!"

"I've only had sex with one person!"

"I have no reason to meet with you!"

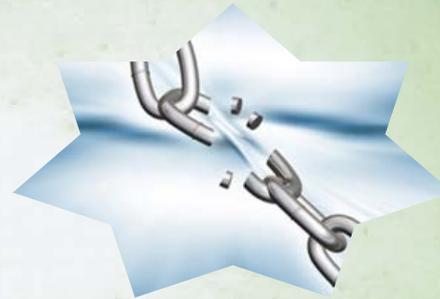
"THANK YOU!"



THE GOAL

The desired achievement of a DIS is to get all partners tested and treated before they become infected/infectious!

- Locate all partners
- Inform all partners
- Test all partners



BUT.....

When an infected person is identified through Partner Services, the circle begins again.....and again....



2016 DIS Workload

Partner Services Eligible Cases: 1,070

Partners Initiated: 1,865

New Cases Identified through Partner Services: 142

Partners Preventatively Treated for Syphilis: 256



Bartlesville Syphilis Outbreak, 2006-2007

- 33 Cases
- Sex:
 - Males: 13
 - Females: 20
- Age:
 - Males: 19-65, median: 39
 - Females: 0-60, median : 33
- Risk:
 - Sex For Drugs/Money: 76%
 - Males: 10
 - Females: 15



Legend

 Partner

 Cluster

 Male

 Female

Named in Original Interview



Named in Re-interview



Named as Cluster (white)



A – Preventative Treatment

B – Refused Preventative Treatment

C – Infected, Brought to Treatment

D – Infected, Not Treated

E – Previously Treated for this Infection

F – Not Infected

G – Insufficient Information to Begin Investigation

H – Unable to Locate

J – Located, Refused Examination

K – Out of Jurisdiction



May 2006

August 2006

Sept. 2006

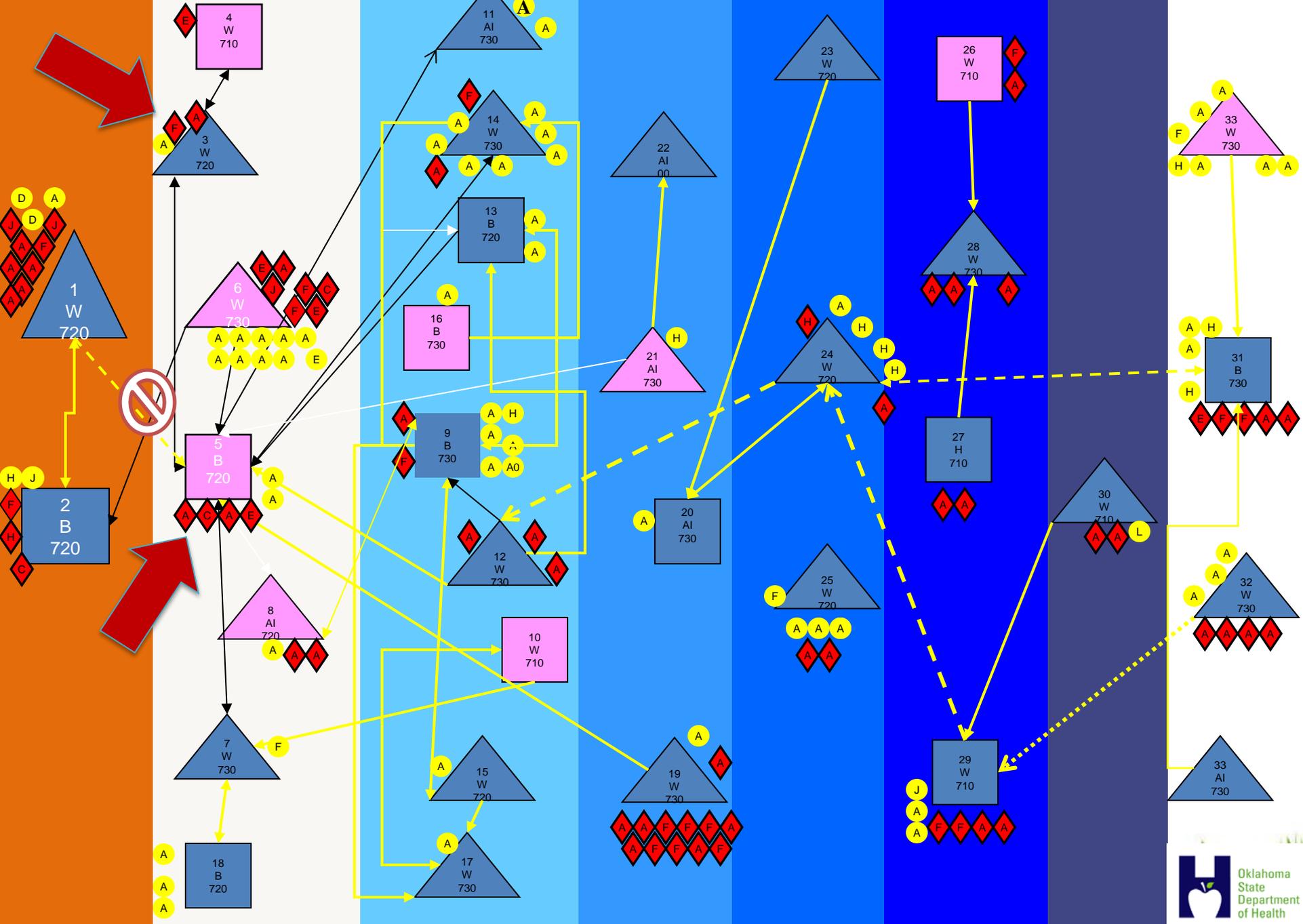
Oct. 2006

Nov. 2006

Dec. 2006

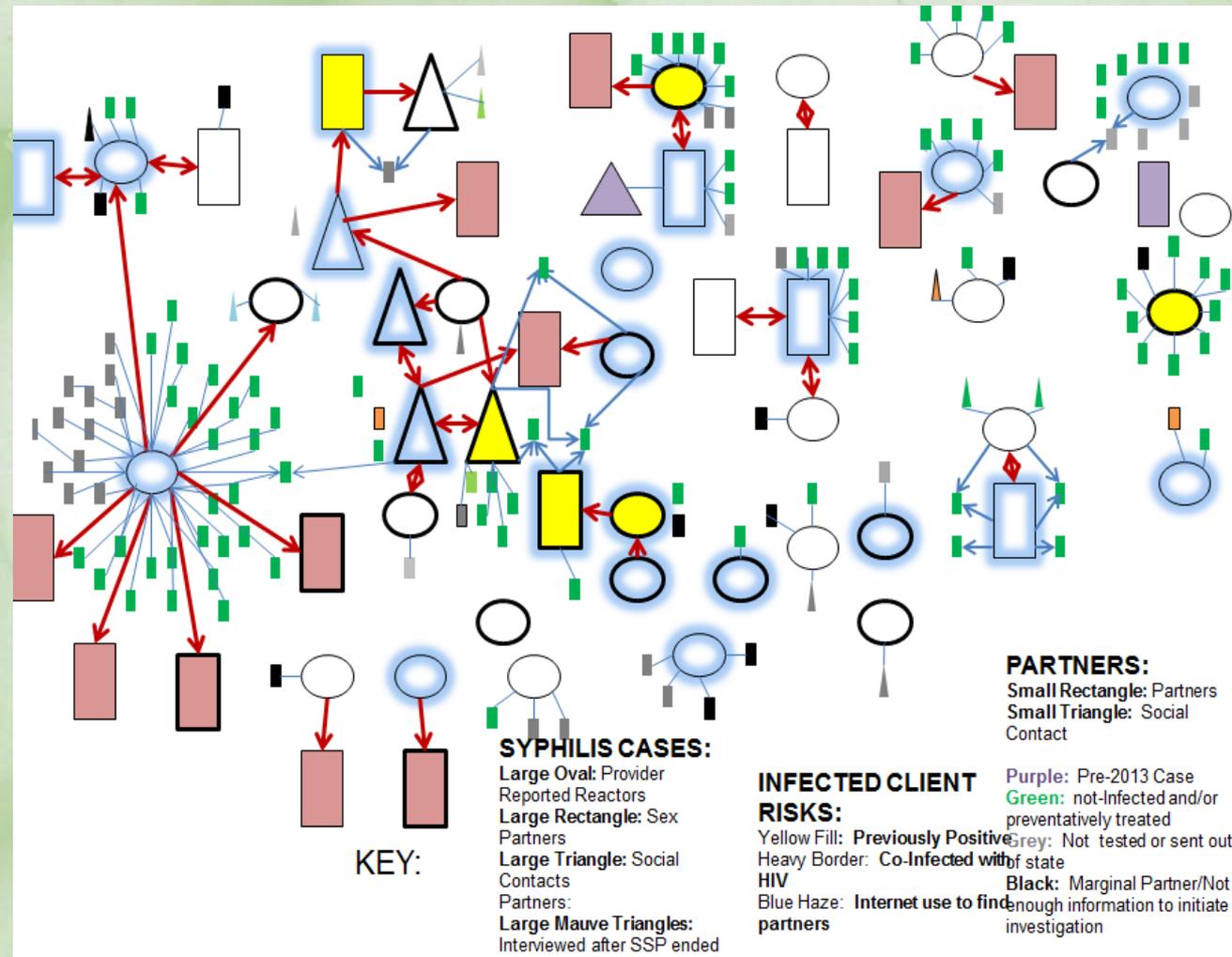
Jan. 2007

Feb. 2007



Syphilis Special Project

- Investigated 43 cases
- Initiated 186 Partners
- Preventatively treated 52 Partners
- Identified 21 new cases



Indiana HIV Outbreak 2015

- 2004-2013: 5 HIV infections reported
- December 2014: 3 new HIV diagnoses in Austin
- April 2015: Governor of Indiana declared a State of Emergency (79 cases)
- May 10, 2016: Oklahoma deployed 6 DIS to Indiana to assist with outbreak response efforts (149 cases)
- As of February 2016: Total of 189 HIV diagnoses linked to Austin

https://www.youtube.com/edit?o=U&video_id=ZH8SQ7ZfeyM



THANK YOU



*Video Storyboards will be available for viewing on August 11, 2017.
Please contact VaLauna Grissom at VaLaunag@health.ok.gov or (405)
271-4200 for more information.*