

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

**Tuesday, October 8, 2013, 1:00 p.m.
Northeast Regional Health and Wellness Campus
2600 NE 63rd Street, Room 100
Oklahoma City, OK 73111**

- I. CALL TO ORDER, OPENING REMARKS, INTRODUCTIONS**
Dr. Stephen Cagle, Chair, OCCBH
Dr. Patrick Grogan, Chair, TCCBH
Dr. R. Murali Krishna, President, OSBH
- II. REVIEW OF MINUTES – OCCBH**
Approval of Minutes for September 17, 2013
- REVIEW OF MINUTES – TCCBH**
Approval of Minutes for September 18, 2013
- REVIEW OF MINUTES – OSBH**
Approval of Minutes for July 9, 2013; August 16-18, 2013, Annual Retreat
- III. OKLAHOMA HEALTH IMPROVEMENT PLAN (OHIP)**
State and Local Perspectives; Terry Cline (OSDH), Gary Cox (OCCHD), Bruce Dart (THD)
Discussion and possible action
- IV. LEGISLATIVE REPORT**
Mark Newman (OSDH), Tammie Kilpatrick (OCCHD), Scott Adkins (THD),
Discussion and possible action
- V. BUDGET PRIORITIES**
Julie Cox-Kain (OSDH), Reggie Ivey (THD), Bob Jamison (OCCHD)
Discussion and possible action
- VI. CHAIRMAN’S REPORT – OCCBH**
Update
- CHAIRMAN’S REPORT – TCCBH**
Update
- PRESIDENT’S REPORT – OSBH**
Discussion and possible action
Proposed 2014 Board of Health Meeting Dates (second Tuesday of each month at 11:00 a.m.):
January 14, 2014
February 11, 2014
March 11, 2014
April 8, 2014
May 13, 2014

June 10, 2014

July 8, 2014

August 15-17, 2014 (Location TBD)

October 14, 2014 - Tri-Board (Tulsa Health Department North Regional Health and Wellness Center 1:00 p.m.)

December 9, 2014

VII. NEW BUSINESS

Not reasonably anticipated 24 hours in advance of meeting.

Discussion and possible action

VIII. ADJOURNMENT

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STATE BOARD OF HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH
1000 N.E. 10th
Oklahoma City, Oklahoma 73117-1299

Tuesday, July 9, 2013 11:00 a.m.

R. Murali Krishna, President of the Oklahoma State Board of Health, called the 381st regular meeting of the Oklahoma State Board of Health to order on Tuesday, July 9, 2013 at 11:03 a.m. The final agenda was posted at 10:19 a.m. on the OSDH website on July 8, 2013, and at 10:01 .m. at the building entrance on July 8, 2013.

ROLL CALL

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

Absent: Jenny Alexopulos, D.O.; Robert S. Stewart, M.D.

Central Staff Present: Terry Cline, Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Steve Ronck, Deputy Commissioner, Community and Family 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; Lloyd Smith, Director of Internal Audit and Office of Accountability Systems; Leslea Bennett-Webb, Director of Office of Communications; Joyce Marshall, Director of Office of Performance Management; John Giles, Director of Health Planning and Grants; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office; Janice Hiner, Felesha Scanlan.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Dr. Krishna called the meeting to order. He welcomed special guests in attendance the newest member appointed to the State Board of Health, Dr. Charles A. Grim. Dr. Grim is a former Director of Indian Health Services and current Deputy Director for Health Services for the Cherokee Nation. Dr. Grim is a dentist by profession and also a retired Assistant Surgeon General and Rear Admiral in the Commissioned Corps of the United States Public Health Services. Dr. Krishna invited Dr. Grim to say a few words about his background. Dr. Grim indicated he is excited to serve on this Board and hopes his 30 years of public health experience and broad background will lend to this Board.

REVIEW OF MINUTES

Dr. Krishna directed attention to review of the minutes of the June 11, 2013, Regular Board meeting.

Dr. Woodson moved Board approval of the minutes of the June 11, 2013, Regular Board meeting as presented. Second Dr. Gerard. Motion carried.

AYE: Gerard, Krishna, Starkey, Woodson

ABSTAIN: Burger, Grim, Wolfe

ABSENT: Alexopulos, Stewart

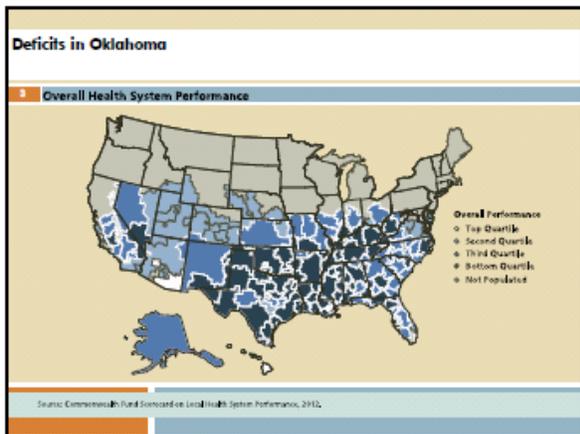
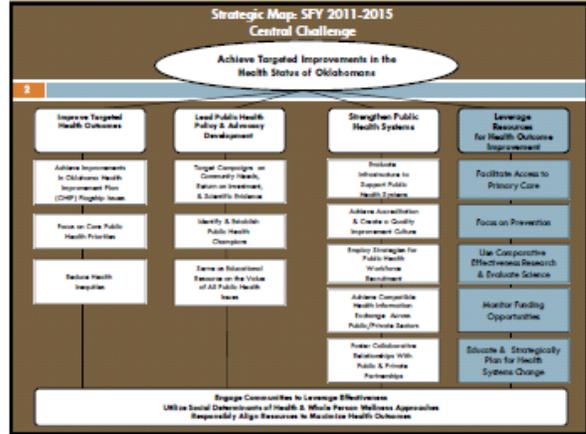
STRATEGIC MAP UPDATE PRESENTATION: Julie Cox-Kain, M.P.A., Chief Operating Officer; Toni Frioux, M.S., APRN, CNP, Deputy Commissioner for Prevention and Preparedness Services



OKLAHOMA STATE DEPARTMENT OF HEALTH

LEVERAGE RESOURCES FOR HEALTH OUTCOME IMPROVEMENT

July 2013



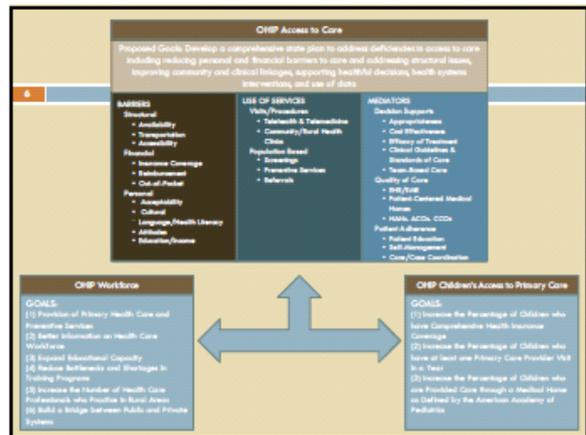
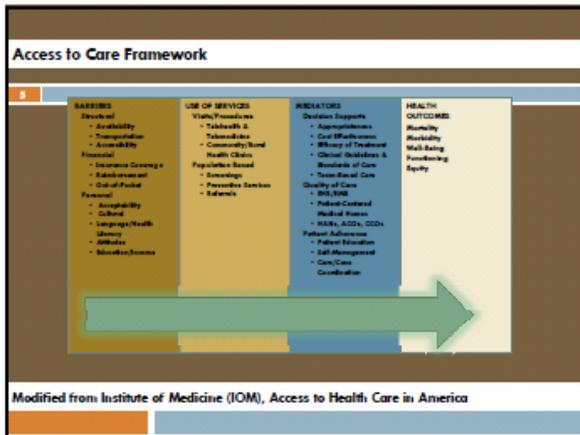
Facilitate Access to Primary Care

Performance Measure

- By June 30, 2013 perform comprehensive assessment of access to primary care, including:
 - Primary Care Advisory Taskforce (PCAT) recommendations
 - Provider surveys and establishing Medically Underserved and Health Professional Shortage Areas
 - Medicaid panel data and shortages
 - Additional healthcare workforce data prepared by CHIP Workforce Workgroup

Target: On Schedule

- Workforce data via surveys complete & additional data through CHIP
- PCAT recommendations complete & provided to CHIP Access to Care
- Expanded function of Office of Primary Care to focus on healthcare shortages
- Developed and refined Access to Care Model for CHIP



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Focus on Prevention

Performance Measures

- By June 30, 2017 develop plan to promote clinical preventive services
- By June 30, 2017 develop 5 sustainable, integrated community/clinical health improvement projects

Target: On Schedule

- In 2013 Published Toolkit Trilogy
 - Chronic Disease in Oklahoma Data Book
 - MONAHRG® Data Guide for Preventable Hospitalizations
 - Community and Clinical Evidence-Based Strategies and Preventive Services

Chronic Disease Data Book

- Reframing
- Data is organized using the Access to Care Framework

Barriers

Use of Services

Mediators

Health Outcomes

MONARQH®

Hospital discharge data are collected



MONARQH®



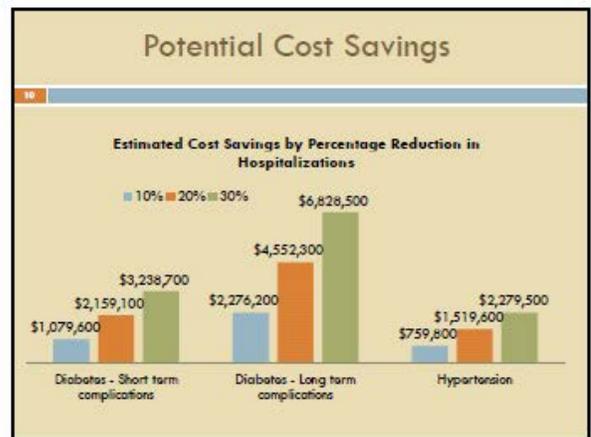
Discharge Data

Through MONARQH®, hospital discharge data is used to generate health care indicators in a user-friendly format

Indicators can be used by state and local organizations, including hospital systems, health plans and coalitions, for planning purposes



Community Coalitions



Toolkit Trilogy Connections

- Relationships exist between chronic diseases, risk factors, and populations at risk
- Influences how and where evidence-based strategies and preventive services are incorporated into the community effectively
- Partners & coalitions discuss the meaning of the data, evidence-based prevention, and clinical and community perspective



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Use Comparative Effectiveness Research and Evaluate Science

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Performance Measure

- By June 30, 2013 develop a plan for assessing & evaluating use of A & B rated clinical preventive services
 - Building partnerships and sharing data
 - Health Information Exchange (HIE)
 - Medicaid claims
 - Analyzing data and identifying barriers
 - Mapping access to preventive services
 - Developing and proposing interventions

Target: Behind Schedule

Monitor Funding Opportunities

14

Performance Measures

- By June 2017 identify one major funding source to further develop access to care in Oklahoma
- By June 2017 award 90% of funding appropriated for new Federally Qualified Health Centers (FGHC) start up

Target: On Schedule

- Essential Community Providers (ECPs)
- Collaborating across multiple proposed Innovation Grant Projects
- Public Health Specific Grants - State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health
- FGHC expenditures vary with HRSA funding announcements

Educate and Strategically Plan for Health Systems Change

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Performance Measure

- By June 2017 establish 5 state-level interventions to facilitate health systems changes

Target: On Schedule

- Evaluation of current Oklahoma SoonerCare program
- Recommendations for a Medicaid demonstration proposal in Oklahoma
 - Integrating population health initiatives to improve health outcomes
- Analyzing uncompensated care in Oklahoma and impacts to access to care
- Six Tribal Listening Sessions with Tribal Nations

Educate and Strategically Plan for Health Systems Change

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Oklahoma Plan Recommendations (Leavitt Partners)

- Maintain Employer Sponsored Insurance (ESI) program
- Leverage & Support the Use of Premium Tax Credits
- Integrate Public Health Initiatives to Focus on Health Outcome Improvement
- Modify Insure Oklahoma and Use as the Framework for Demonstration Model
- Work Toward Multi-Payer Models
- Create Steering Committee (Includes Mental and Public Health)
- Develop Strong Evaluation Component
- Demonstrate Cost Effectiveness
- Leverage Current Program Initiatives
- Develop Complementary Proposal for Indian Health

Links and Resources

17

- [Institute of Medicine, Primary Care and Public Health, Exploring Integration to Improve Population Health](#)
- [PCAT Recommendations](#)
- [Tribal Listening Sessions](#)
- [Maps and Data](#)
- [Workforce Materials](#)
- [Leavitt Reports](#)

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

Questions?

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

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The presentation concluded.

COMMITTEE REPORTS**Executive Committee**

Dr. Krishna provided the following reminders Board of Health Reminders:

The annual Board of Health retreat will be held August 16-18, at the Roman Nose State Park Lodge in Watonga. VaLauna will be in touch with you this week to provide logistical details to include lodging. The Executive Committee has met with Dr. Arnold Baciagalupo, the retreat facilitator to finalize the agenda. The agenda includes a joint presentation with the OSDH and the Tobacco Settlement Endowment Trust on Wellness strategic planning; a year end review of the OSDH strategic plan; mission, vision, values discussion; and a business plan and budget update.

Finance Committee**Expenditure Forecast Assumptions**

Dr. Woodson directed attention to the Financial Brief provided to each Board member and presented the following Finance Report and Board Brief as of June 20, 2013:

Payroll forecasted through June 30, 2013 including vacancies likely to fill within the current budget period

- Encumbrances shown as actual as of the report date
- Budget forecasts do NOT include projections of sequestration or budget reductions in the current fiscal year nor have written notifications been received

Dr. Woodson provided an explanation of the Dashboard Warning(s):

- Overall the Department is forecasted to spend 98.97% of its budget and maintain "Green Light" status through June 30, 2013.
- At this time there are no "Dashboard Warnings" as all performance rates are above 95%.

Dr. Woodson directed Board attention to the Finance Board Brief contained in the packet. The Financial Brief this month focuses on the Public Health Priority Number 1, Public Health Imperatives, with a specific focus on the Trauma Care Assistance Revolving Fund.

Table detail is provided this month to illustrate Trauma Fund Distributions.

- Trauma funds comprise 6.65% of the total agency budget.
- The Trauma Care Assistance Revolving Fund (Trauma Fund) was established in 1999 and codified in Oklahoma Statute, Title 63, Chapter 1, Section 1-2530.9, for the purpose of reimbursing uncompensated costs associated with trauma care provided by trauma facilities, emergency medical providers and physicians.
- Sources of revenue for the Trauma Fund include tobacco taxes; fees from drivers license renewals & reinstatements; and fines from various traffic violations and drug-related convictions.
- Ninety percent (90%) of funds shall be used to reimburse recognized trauma facilities, licensed ambulance service providers and physicians for uncompensated trauma care expenditures.
- Ten percent (10%) of funds shall be used to support the duties of the Department as set forth in the Oklahoma Emergency Response System Development Act which includes trauma systems development.
- In SFY12, the Department processed approximately 1,089 claims from various physicians (859), hospitals (137) and EMS agencies (93) for a total reimbursement amount of approximately \$28 million.

Accountability, Ethics & Audit Committee

The Accountability, Ethics, & Audit Committee met with Lloyd Smith and Don Maisch. Ms. Wolfe indicated there were no known significant issues to report.

The report concluded.

Public Health Policy Committee

The Policy Committee met on Tuesday, July 9, 2013. Dr. Gerard and Mr. Starkey welcomed Dr. Grim as the newest member of the Policy Committee. All met with Mark Newman at the Oklahoma State Department of Health in Oklahoma City, Oklahoma. The Policy Committee discussed possible policy areas and potential legislation for the next legislative session which will be considered at the Board Retreat in August at Roman Nose State Park. Some of the issues discussed included children's health, youth access to tobacco and e-cigarettes, and voluntary school fitness programs.

Members of the Board of health may contact Mark Newman for any questions regarding any policy issues or proposed legislation.

The next meeting of the Policy Committee will be prior to the October Tri-Board Meeting.

PRESIDENT'S REPORT

Dr. Krishna reported that subcommittee assignments have been made and will remain the same with the exception of the Finance Committee. The Finance Committee will consist of the Executive Committee and 1 additional Board member. The remaining Board members will have an opportunity to rotate onto the Finance Committee for a period of 6 months. Tim Starkey will be the first to rotate onto the Finance committee.

Dr. Krishna briefly highlighted a conference he attended on the future of healthcare. He emphasized the need for high quality, better results, better outcomes, and lower costs. He also referenced an 18 year study measuring the effects of stress. Individuals with high levels of stress have a much higher risk for heart attacks. He concluded by reiterating the importance of individual health both medical and nonmedical.

COMMISSIONER'S REPORT

Dr. Cline started by thanking Bruce Dart and Gary Cox for their attendance at the Board meeting.

Dr. Cline encouraged Board members to attend the College of Public Health Grand Round featuring Tom Frieden, Director of the Centers for Disease Control on Thursday, July 11, 2013.

In last month, Dr. Cline gave a brief presentation at the Blue Cross Blue Shield Board meeting held at the OCCHD Wellness Campus. Additionally, he presented at the National Indian Health Board Conference on Accreditation. Oklahoma has been a prominent player in the field of accreditation and had worked closely with the Cherokee Nation as a beta test site. Oklahoma is the only state in the nation to have had beta test sites at the local, tribal and state levels.

Lastly, he highlighted his attendance at Governor Mary Fallin's Cabinet meeting where the focus was strategic planning for the state. During this meeting, public health played a prominent role. He commended her administration for concrete strategic planning and goal setting.

He concluded his report by thanking Dr.'s Grim and Stewart for committing time to attend the new Board member orientation and asked Toni to provide a brief introduction to a video selected for viewing.

Toni Frioux revealed that the Office of Emergency Preparedness and Response in collaboration with the Office of Communications has developed a series of 7 short videos for the purpose of helping the public to prepare for and respond to potential disasters. The video selected for viewing is focused on tornado preparedness response. All videos will be available through the OSDH website, YouTube, various social media outlets Toni developed series of 7 very short videos that help the public to learn to prepare for disaster response.

NEW BUSINESS

No new business.

EXECUTIVE SESSION

No Executive Session.

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ADJOURNMENT

Mr. Starkey moved Board approval to Adjourn. Second Dr. Woodson. Motion carried.

AYE: Burger, Gerard, Grim, Krishna, Starkey, Woodson, Wolfe

ABSENT: Alexopulos, Stewart

The meeting adjourned at 12:06 p.m.

Approved

R. Murali Krishna, M.D.
President, Oklahoma State Board of Health
October 9, 2013

1 STATE BOARD OF HEALTH
2 OKLAHOMA STATE DEPARTMENT OF HEALTH
3 Roman Nose State Park Lodge
4 Watonga, Oklahoma
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6 August 16-18, 2013
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8 R. Murali Krishna, President of the Oklahoma State Board of Health, called the 382nd special meeting of the
9 Oklahoma State Board of Health to order on Friday, August 16th, 2013, at 7:01 p.m. The final agenda was
10 posted at 10:57 a.m. on the OSDH website on August 15, 2013; at 10:55 a.m. on the OSDH building entrance
11 on August 15, 2013; and at 1:00 p.m. on the Roman Nose State Park Lodge Building entrance on August 15,
12 2013.
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14 ROLL CALL
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16 Members in Attendance: R. Murali Krishna, M.D., President; Ronald Woodson, M.D., Vice-President;
17 Martha A. Burger, M.B.A, Secretary-Treasurer; Jenny Alexopoulos, D.O.; Terry R. Gerard, D.O.; Charles W.
18 Grim, D.D.S.; Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.; Cris Hart-Wolfe.
19

20 Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; Henry F. Hartsell,
21 Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and
22 Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of General
23 Counsel; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley,
24 Janice Hiner.
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26 Visitors in attendance: See list
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28 Call to Order and Opening Remarks

29 Dr. Krishna called the meeting to order. He thanked all distinguished guests and staff for their
30 attendance. He acknowledged special guests Senator Patrick Anderson; Senator Ron Justice;
31 Representative Harold Wright; Tracey Strader, the Executive Director of the Tobacco Settlement
32 Endowment Trust; and Dr. George Foster, Vice-Chair of the Tobacco Settlement Endowment Trust.
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34 Dr. Krishna introduced Dr. Arnold Bacigalupo as the retreat facilitator and founder & President of Voyageur
35 One. He briefly described the partnership between the Board and Dr. Bacigalupo explaining that Dr.
36 Bacigalupo has been involved in the OSDH strategic planning process since 2008.
37

38 Dr. Bacigalupo thanked Dr. Krishna for the welcome. He briefly recounted the objectives of previous
39 Board retreats since 2008 and then proceeded to discuss the 2013 retreat objectives:
40 *To orient OSDH and TSET Board members to each organization, their integrated strategic priorities and*
41 *programs to improve wellness; Review of Strategic Planning Framework: Mission, Vision, Values; and*
42 *Develop Recommendations for Legislative Priorities.*
43

44 Dr. Krishna extended a special thanks to Department staff and Dr. Cline for their continued quality
45 improvement efforts and thanked Board members for their commitment to public health.
46

47 ADJOURNMENT

48 **Ms. Wolfe moved to adjourn. Second Dr. Alexopoulos. Motion carried.**
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50 **AYE: Alexopoulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**
51 The meeting adjourned at 7:29 p.m.

1 Saturday, August 17, 2013

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3 ROLL CALL

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

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9 Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; Henry F. Hartsell,
10 Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and
11 Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of General
12 Counsel; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley,
13 Janice Hiner.

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15 Visitors in attendance: See list

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17 Call to Order and Opening Remarks

18 Dr. Krishna called the meeting to order at 8:35 a.m. and welcomed those in attendance. He acknowledged
19 special guests Gary Cox, Director of the Oklahoma City-County Health Department; Gary Raskob, Dean of
20 the OU College of Public Health and member of the Oklahoma City-County Board of Health; Pam Rask of
21 the Tulsa Health Department; and Brent Wilborn of the Oklahoma Primary Care Association.

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23 WELLNESS INTEGRATED STRATEGIC PLAN

24 Julie Cox-Kain, M.P.A., Chief Operating Officer; Tracey Strader, M.S.W., Executive Director, Tobacco
25 Settlement Endowment Trust; Keith Reed, outgoing Director for the Center for the Advancement of
26 Wellness.

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OSDH Center for the Advancement of Wellness/TSET Partnership

August 17, 2013

Oklahoma State Department of Health

- State’s primary public health organization
- Budget total \$404,696,849
- Approximately 2,061 employees
- 68 organized county health departments
- Mission: *To Protect And Promote Health Of The Citizens of Oklahoma, To Prevent Disease And Injury, and Assure The Conditions By Which Our Citizens Can Be Healthy.*

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Improve Targeted Health Outcomes

CHIP	Mandates/Imperatives	PH Priority Programs	Reduce Health Inequities (inclusive of):
<ul style="list-style-type: none"> • Tobacco Use • Obesity • Children's Health 	<ul style="list-style-type: none"> • All Hazards Preparedness • Infectious Disease Control • Regulatory Functions 	<ul style="list-style-type: none"> • Motor Vehicle Crashes • Immunization • Preventable Hospitalizations 	<ul style="list-style-type: none"> • Health Disparities • Unequal Access to Health • Social Determinants

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Oklahoma Tobacco Settlement Endowment Trust
TRACEY STRADER, MSW, EXECUTIVE DIRECTOR

About TSET

- Created by a constitutional amendment approved by voters 69% to 31% in 2000.
- 75% of Master Tobacco Settlement Agreement payments are invested through an endowment, and **only the earnings** are spent for programs to improve health.
- Governed by a seven-member, bipartisan, Board of Directors to fund and oversee programs. A separate five-member Board of Investors manages the endowment funds.

TSET - BETTER LIVES THROUGH BETTER HEALTH

About TSET

- Our mission:** To improve the health and quality of life of all Oklahomans by addressing the hazards of tobacco use and other health issues.
- Our strategic plan** focuses on addressing the leading causes of preventable death – cancer and cardiovascular disease – by targeting tobacco use and physical activity and nutrition.
- What we fund:**
 - Prevention
 - Research
 - Emerging Opportunities
- Guided by evidence** of effectiveness and evaluation

TSET - BETTER LIVES THROUGH BETTER HEALTH

Determinants of Health and Their Contribution to Premature Death

Determinant	Contribution (%)
Genetic Predisposition	40%
Behavioral Patterns	30%
Health Care	10%
Environmental Exposure	5%
Social Circumstances	15%

TSET - BETTER LIVES THROUGH BETTER HEALTH

TSET – OSDH Partnership

- Shared goals in tobacco control and obesity
- Strategies defined together, playing on the strengths of each organization
- Strategies based on state plans and available evidence, and tailored to Oklahoma culture.
- TSET focus on **grant making** - what is funded, who is funded, and how the grants are funded. Monitoring measures of progress and assuring technical assistance, consultation, and training are available to support grantees.
- OSDH focus on providing expert resources and consultation to entire state. Specific focus on providing the technical assistance, consultation, and training for TSET-funded grants in illness.

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - TOBACCO CONTROL

Communities of Excellence in Tobacco Control

34 grantees - 51 counties - 1 tribal nation - 85% of state's population

TSET - BETTER LIVES THROUGH BETTER HEALTH

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PROGRAMS FUNDED - TOBACCO CONTROL

Oklahoma Tobacco Helpline

- funded by TSET in partnership with Department of Health, Health Care Authority, and Employees Group Insurance Division
- served over 250,000 since 2003
- quit coaching™ significantly increases quit rates (approx. 35%)
- patches, gum, or lozenges sent via mail order
- estimated savings of \$67 million annually for direct medical cost from smokers who have quit
- ranked second in the nation in reach
 - over 60% with incomes of \$20,000 or less
 - 6,971 callers from Oklahoma Co., FY12
 - 1,902 callers from Cleveland Co.
 - 801 callers from Canadian Co.



TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - PHYSICAL ACTIVITY & NUTRITION

Physical Activity & Nutrition

- strategies similar to tobacco prevention
- create comprehensive program over time
- first initiative: community-based programs
- originally funded a three-year pilot project in Tulsa



TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - PHYSICAL ACTIVITY & NUTRITION

Communities of Excellence in Physical Activity & Nutrition

County	Year	Status
Adair	2011	Basic
Adair	2012	Merit
Adair	2013	Excellence
Adair	2014	Excellence
Adair	2015	Excellence
Adair	2016	Excellence
Adair	2017	Excellence
Adair	2018	Excellence
Adair	2019	Excellence
Adair	2020	Excellence
Adair	2021	Excellence
Adair	2022	Excellence
Adair	2023	Excellence
Adair	2024	Excellence
Adair	2025	Excellence
Adair	2026	Excellence
Adair	2027	Excellence
Adair	2028	Excellence
Adair	2029	Excellence
Adair	2030	Excellence

15 grantees - 21 counties - 55% of state's population

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - INCENTIVE GRANTS

Healthy Communities & Healthy Schools Incentive Grants

- communities and schools earning basic, merit, or excellence levels of certification under the Certified Healthy Communities program may be eligible for incentive grants
- grant funding may be used on a variety of criteria to promote health in local communities



TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - HEALTH SYSTEMS

Health Systems Grants

- Oklahoma Department of Mental Health and Substance Abuse Services
- Oklahoma Health Care Authority
- Oklahoma Hospital Association

Each organization works to support their networks in leading a culture of health improvement, infusing tobacco dependence treatment into their routine care, with active linkages to the Oklahoma Tobacco Helpline. Also promotes physical activity and healthy nutrition through provider organizations and practices.

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - HEALTH COMMUNICATIONS

Health Communications





Tobacco companies are making a killing off you.

TSET - BETTER LIVES THROUGH BETTER HEALTH

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PROGRAMS FUNDED - EVALUATION

- University of Oklahoma
 - College of Public Health – Dr. Laura Beebe
- Oklahoma State University
 - Department of Nutritional Sciences – Dr. Deanna Hildebrand

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - RESEARCH CENTERS

Research Centers

- Peggy and Charles Stephenson Cancer Center
 - TSET Cancer Research Program
 - Oklahoma Tobacco Research Center
- Oklahoma Center for Adult Stem Cell Research

Providing research and treatment in cancer and tobacco-related diseases

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - UNSOLICITED PROPOSALS

Unsolicited Proposals

- Oklahoma Afterschool Network
- OSU Dining Services
- Rescue Social Change Group
- Physician Manpower Training Commission

Addressing any of TSET's Constitutional purposes.

TSET - BETTER LIVES THROUGH BETTER HEALTH



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Creation of the Center for the Advancement of Wellness

- Board of Health Retreat August 2011
- Consolidate obesity programs within the agency
- Leverage knowledge and infrastructure built in tobacco to accelerate obesity efforts
- Utilize evidence-base, strategic and business planning processes to target achievements in Tobacco use and obesity prevention & reduction



Center for the Advancement of Wellness

- **Purpose:** Reduce/prevent tobacco use and obesity
- **Distinctive Competence:** Provide data, best practices, expert consultation
- **Method:** Impact policy, environment, social norms
- **Key goals by 2017:**
 - Reduce smoking prevalence from 26.1% to 23.1% of adults and from 17.9% to 15.8% of adolescents.
 - Reduce obesity prevalence from 31.1% to 29.6% of adults and from 16.7% to 15.9% of adolescents.



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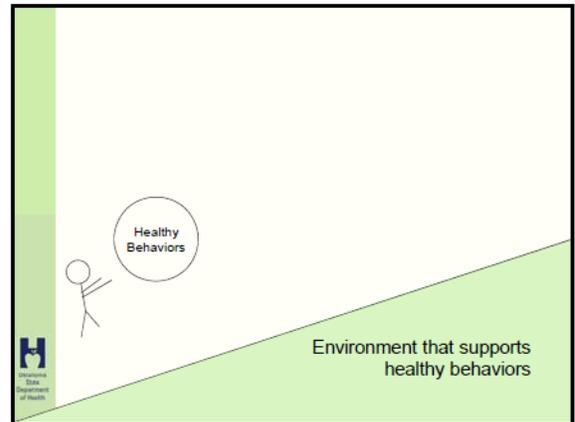
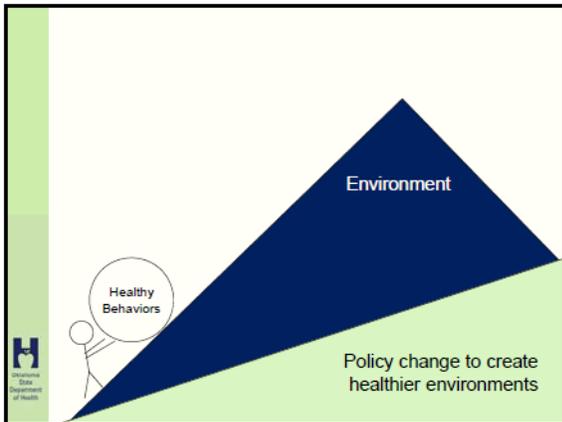
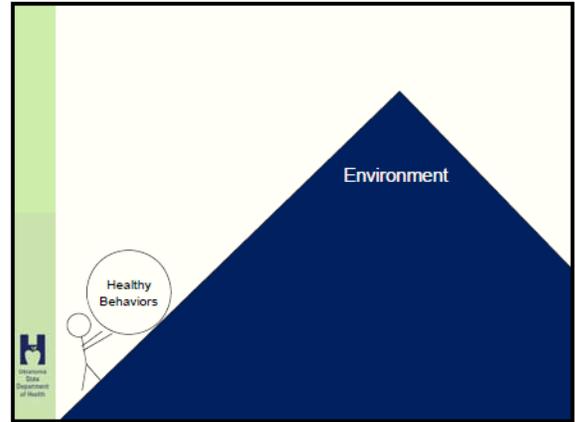
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Oklahoma Adults – 2011 BRFSS

- 26.1% Smoke
- 31.1% Obese
- 34.4% Overweight
- 55.2% Not getting minimal Physical Activity
- 84.5% Not consuming minimum of 5 fruits and vegetables/day

ASTHO Multistate Collaborative

- ASTHO/United Health Foundation effort to improve health rankings of low ranking states
- Kansas, Georgia, Rhode Island, Arkansas, Oklahoma
- Center partnering with ODMHSAS and Tourism/Recreation on worksite wellness projects
- HealthLead assessment for baseline data to guide improvement areas
- Goal is to create scalable model for worksite wellness in state agencies to impact both employees and agency's target population



Governor's Get Fit Challenge

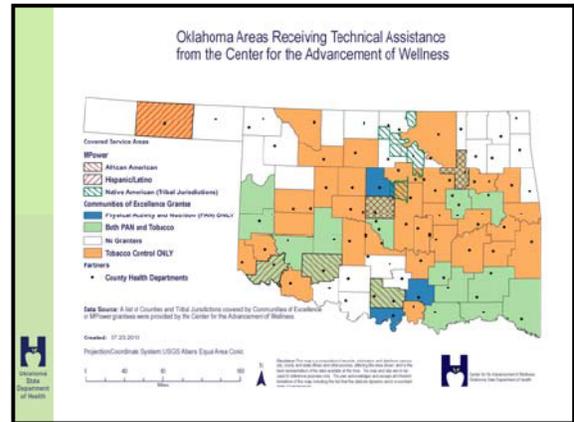
- Program for before, during or after school designed to get kids moving more and eating better
- Grades 4 through 8
- Pending IRB approval, will evaluate selected schools in the fall
- Includes DVD of warm up and core exercises plus 20 minutes of cardiovascular activity 3 days per week
- Also includes nutrition and physical activity worksheets
- Through the program, help shape healthier school environments for kids



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Partnership with TSET

- One of multiple funding sources for Center
- Partners in tobacco, physical activity, and nutrition initiatives
- TSET Communities of Excellence (CX) grants in tobacco and physical activity/nutrition
- Center provides expert consultation to CX grantees, as well as schools, businesses, communities and others around the state

Strategic Priorities

Smokefree environments

- Sector-based education about voluntary smokefree/tobacco free policies
 - ✓ Entertainment industry – bars, casinos, restaurants with smoking rooms
 - ✓ Career technical centers
 - ✓ Focus on importance of clean indoor air and voluntary policies to promote health

Strategic Priorities

Registry of smokefree places

- Allows for monitoring/tracking smokefree policies around the state for goal-setting and reporting purposes
- Possible searchable public site to help connect citizens with smokefree places, including housing, bars, entertainment, etc

Strategic Priorities

Cessation

- Cessation through systems change
 - ✓ Assess state agencies and populations served
 - ✓ Work with health care systems, insurance, county health departments, other agencies
- Cessations communications
 - ✓ Mass media campaign (with TSET)
 - ✓ Materials for providers, insurance companies, and others

Strategic Priorities

Youth engagement

- Tobacco and Physical Activity/Nutrition focus for youth advocacy
- Survey youth, look at available research
- Explore partnerships for training, support

School-based strategies

- Access to fruits and vegetables
- Wellness policies
- 24/7 tobacco free

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Strategic Priorities

State agency collaboration

- Worksite wellness – ASTHO collaborative project with Department of Mental Health and Substance Abuse Services and Department of Tourism and Recreation
- Looking at additional partnerships with state agencies to embed education and policy change for target populations



Challenges, Successes & Opportunities

Challenges

- Existing state law
- Future state-level policy
- Emerging technologies and limited research

Successes

- Governor’s Executive Order
- Certified Healthy Incentive Grants
- 2012 BRFSS numbers

Opportunities

- Enhanced and expanded partnerships
- Sector-based approach
- Social Media



Lessons Learned Center/TSET Partnership

- Leverage strength of each organization to improve mutual goals
- The partnership is an investment, not a collaboration
- Each partner is accountable to the other for performing their area of distinctive competence
- Without this unique partnership we wont be successful in Oklahoma



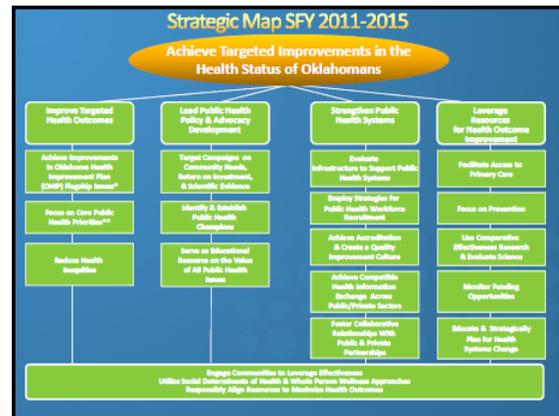
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2 The presentation included a media advertisement about multiunit housing units as an example of media
3 campaigns that have resulted from the collaboration between the OSDH and TSET. See Attachments 1-3.

4
5 The presentation concluded.

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7 STRATEGIC PLAN REVIEW
8 Terry L. Cline, Ph.D., Commissioner of Health

**SFY 2011-2015
OSDH Strategic Map Update**

Board of Health
Annual Retreat
SFY 2013 Update

Oklahoma Health Improvement Plan (OHIP) Flagship Issues

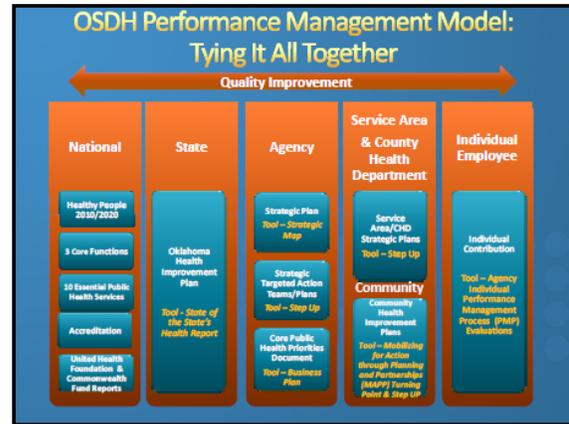
- Tobacco Use Prevention
- Children's Health Improvement
- Obesity Reduction

Core Public Health Priorities

- Children's Health
 - Infant Mortality
 - Prenatal Care
- Disease & Injury Prevention
 - Immunization
 - Motor Vehicle Crashes
 - Preventable Hospitalizations
- Imperatives
 - All Hazards Preparedness
 - Infectious Disease
 - Mandates
- Strong & Healthy Oklahoma (Wellness)
 - Cardiovascular Health
 - Obesity
 - Tobacco

LSTAT Strategic Planning Priority Area Lead Champions

- OHIP Flagship & Core Public Health Services**
 - Strong & Healthy Oklahoma /Wellness (Keith Reed)
 - Children's Health (Dr. Edd Rhoades)
 - Disease & Injury Prevention/Imperatives (Toni Frioux/Drs. Kristy Bradley & Hank Hartsell)
 - Health Inequities (Neil Hann)
 - Policy & Advocacy (Dr. Mark Newman)
- Public Health Systems & Accreditation** (Joyce Marshall)
 - Workforce (Toni Frioux)
 - Health Information Exchange (HIE) (Julie Cox-Kain)
 - Public/Private Partnerships (Neil Hann)
 - Resources (Julie Cox-Kain)



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Core Performance Measures Scorecard Public Health Imperatives

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Inspection - % state mandated non-complaint activities meet PMs	92.3%	90%	86%	100%
Inspection - % state mandated complaint activities meet mandates	23.1%	80%	87%	100%
Infectious Disease - % immediately notifiable reports received by phone consultation/investigation initiated in 15 minutes	98%	95%	99%	95%
Infectious Disease - % immediately notifiable reports submitted in PHIDDO/investigation initiated in 15 minutes	92%	95%	97%	95%
Infectious Disease - Average # reported TB, pertussis, shigellosis, and cryptosporidiosis cases per 100,000 population	14.07	14.1	23.32	13.4
Preparedness - % of CHDs exercising COOP annually	100%	100%	100%	100%

Core Performance Measures Scorecard Public Health Priority Programs

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Children - # infant deaths per 1000 live births	7.6	7.6	7.6 (provisional)	7.2
Children - % first trimester prenatal care	67.2%	77%	60.6%	78%
Injury - # motor vehicle injuries in infants less than one year of age	121	113	107	97
Prevention - # preventable hospitalizations per 1000 Medicare enrollees	81.8	84.8	81.0	82
Immunization - % immunized (19-35 months)	70.3%	72.5%	77.3%	76.5%
Obesity - % adults who are obese	31.1%	31.1%	32.2%	30.2%
Tobacco - % adults who smoke	26.1%	25.6%	23.3%	24.1%
Cardiovascular - cardiovascular deaths/100,000	292.8	272.6	303.9	236.9

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**Core Performance Measures Scorecard
Infrastructure & Policy**

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Accreditation - # of PHAB accredited OSDH Health Departments in OK	0	2	2	7
PH Partnerships - # certified healthy communities	43	25	31	75
PH Partnerships - # certified healthy schools	155	11	214	71
Workforce - % of plans completed to address job classification and compensation	50%	100%	97%	100%
Performance Mgt - # nationally recognized quality performance improvement processes and tools	10	10	17	10
Health Information Exchange - % IPHS Stage 1 strategic planning completed	0%	100%	100%	100%
Infrastructure - % of PHAB state health dept governance and operations standards fully met	N/A	90%	100%	100%
Policy - # community organizations supporting OHP legislation	10	11	11	14

Achievements

- OSDH and CCHD among **first in nation** to be accredited health departments in February 2013! OSDH and CCHD were further recognized by the Public Health Accreditation Board in **39 "areas of excellence."**
- The OSDH largely to fully demonstrated **99% (104/105)** of all state PHAB measures and the CCHD largely to fully demonstrated **91% (88 /97)** of local PHAB measures.
- The **Governor's Executive Order for tobacco-free properties** took effect August 6th impacting almost **37,000** state employees and **countless** visitors to state properties.
- 28.4% increase** from 64% to 82.2% in proper child restraint use among infants less than 1 year of age

Achievements

- Over 100% increase** in certified healthy schools from 155 last year to **314** this year!
- Decrease by more than 1/3** from 48,393 to 32,421 child abuse and neglect reports in Oklahoma.
- Every Week Counts** campaign results are phenomenal with over **90%** of birthing hospitals voluntarily participating in the campaign. Results: Between 2011 and 2013, there was an **81%** decrease in early, elective scheduled births! Additionally, there is a **9%** increase in total births 39-41 weeks and a **14%** decrease in births at 36-38 weeks.

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2 The presentation concluded.

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4 **FOCUS ON CORE PRIORITIES & STRENGTHEN SYSTEMS**

5 Henry F. Hartsel, Ph.D., Deputy Commissioner, Protective Health Services

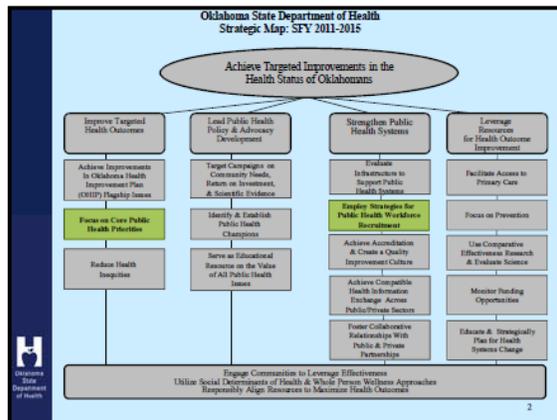
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Strategic Map Update

Focusing on Core Priorities and Strengthening Systems

State Board of Health Annual Retreat
August 17, 2013

Henry F. Hartsel Jr., Ph.D.
Deputy Commissioner
Protective Health Services

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Objectives for Inspection Frequency Mandates

Meet 100% of required time intervals and response deadlines by FY2014 for:

1. State mandated routine inspections
2. State mandated complaint inspections
3. Contract (federal) mandated routine surveys
4. Contract (federal) complaint investigations

(Fifty-two mandates were covered by the four objectives in FY2013.)



Inspection Frequency Mandates by Performance Objectives 2012 - 2013

Percentage of 52 Total Mandates Covered by the Objectives

Mandates by Objectives



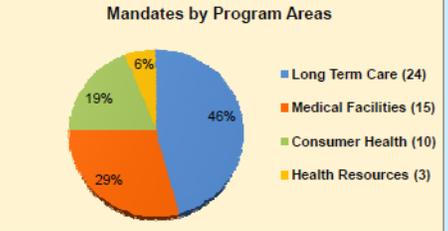
Source: OSDH StepUp Performance Management System.



Inspection Frequency Mandates by Program Areas 2012-2013

Percentage of 52 Mandates Administered by Program Areas

Mandates by Program Areas



Source: OSDH StepUp Performance Management System.



Highlights for State Fiscal Year 2013

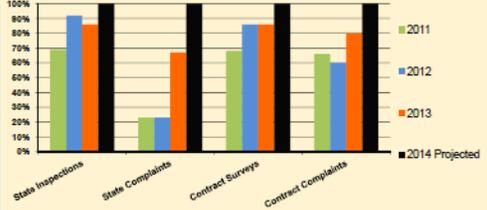
- All long term care inspections and investigations current on 6/30/2013
- Home health agency recertification surveys current on 9/30/2012
- Food service establishment, jail, and nurse aide training inspections timely performed for second straight year
- 48 of 52 (92%) mandates brought into compliance as of 6/30/2013



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Compliance with Inspection Frequency Mandates Fiscal Years 2011-2014

Percentage of inspections, complaint investigations and surveys conducted by OSDH in accordance with mandated time frames.



Source: OSDH StepUp Performance Management System. *Contract Complaints* are based on the previous federal fiscal year.



Compliance with Inspection Frequency Mandates Fiscal Years 2011-2014

Percent of Inspection Frequency Mandates in Compliance




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Surveyor Recruitment 2012-2013

CLINICAL HEALTH FACILITY SURVEYOR

The Oklahoma State Department of Health is seeking to fill positions around Oklahoma to conduct inspections in nursing facilities, hospital, surgery centers, home care agencies, dialysis centers, and other health care settings. Extensive 2-3 day overnight travel required. Extensive training provided.

Send a resume and letter of interest for the clinical health facility surveyor position to:

J. Matt
matthew@health.ok.gov
 For more applications, call (405) 271-4006.

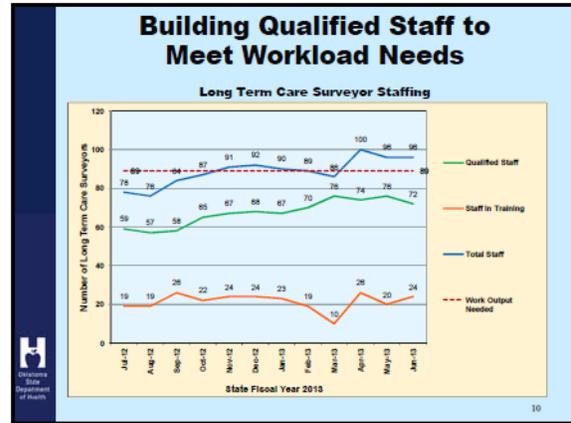
Jill
 Office of Human Resources
 Oklahoma State Department of Health
 1000 NE 19th Street
 Oklahoma City, OK 73117

QUALIFICATIONS: Registered nurses, licensed medical workers, registered medical technologists, and medical practitioners may qualify, depending on experience.

Full job descriptions and qualifications are available at:
<http://careers.ohs.ok.gov/>

Salary up to \$20K per year + benefits.

OSDH Oklahoma State Department of Health



Performance Measures for FY2014

- Maintain successes on objectives from FY2012, FY2013
- Achieve compliance by 09/30/2013:
 - Medium priority (45-day) complaints in accredited hospitals
 - 5 year survey interval for non-accredited hospitals
 - Clinical laboratory inspections
 - Clinical laboratory complaints

Action Plan Components for Objectives and Performance Measures

- Recruit/retain qualified surveyors & sanitarians
- Continue workload-based staffing
- Develop surge capacity
 - Targeted overtime
 - Contract out-of-state surveyors
 - Retired/former surveyors & sanitarians
- Conduct ongoing QA/PI

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Questions or Comments?

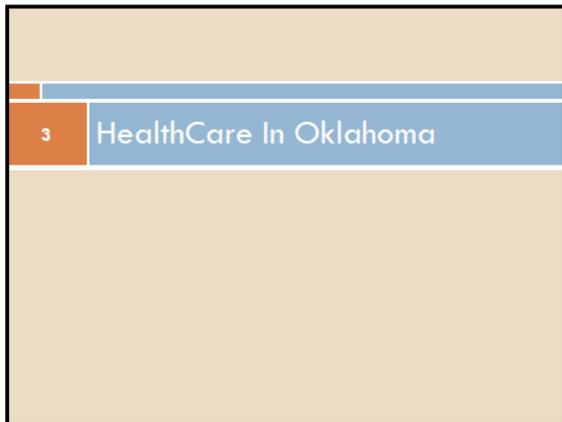
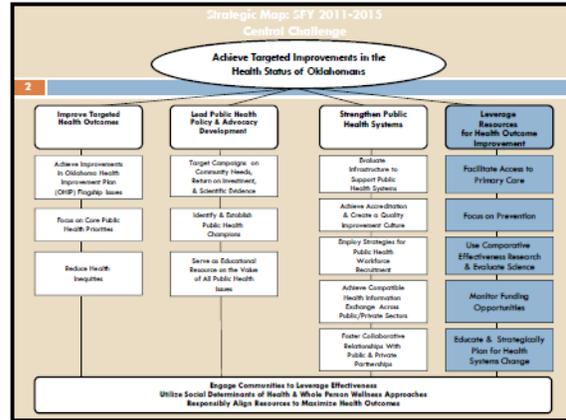
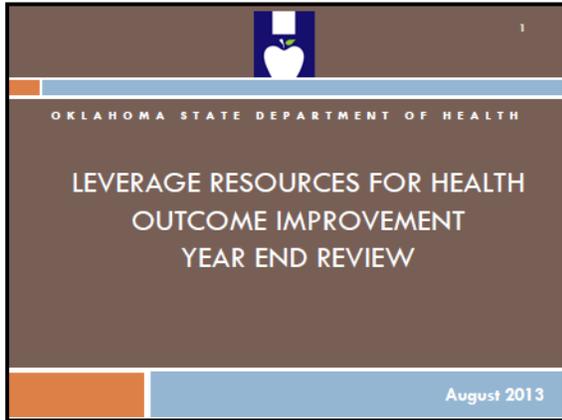
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The presentation concluded.

LEVERAGE RESOURCES FOR HEALTH OUTCOMES IMPROVEMENT YEAR END REVIEW

1 Julie Cox-Kain, M.P.A., Chief Operating Officer

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Patient Protection and Affordable Care Act

- Enacted March 23, 2010
- Establishes the Health Insurance Marketplace to help individuals and small business obtain health insurance coverage (including stand-alone dental)
- Provides premium tax credits and cost-sharing reductions for low and middle-income individuals who purchase health insurance through a Marketplace
- Provides a tax credit to eligible small businesses
- Originally required an expansion of Medicaid to cover additional adults and children with low incomes
- Simplifies the eligibility rules for Medicaid and the Children's Health Insurance Program (CHIP)

Patient Protection and Affordable Care Act

- Requires most individuals to purchase health insurance or pay a tax penalty
- Guaranteed issue (no pre-existing condition exclusion)
- American Indian/Alaskan Native (AI/AN) special provisions
- Children's coverage extended to age 26
- No co-pay for A & B rated clinical preventive services
- Medical Loss Ratio limitations – caps on administrative and overhead costs of insurance companies (80% - 85% must be spent on healthcare)
- Created the Prevention and Public Health Fund

Patient Protection and Affordable Care Act

- In June 2012, Supreme Court upheld insurance mandate requiring Americans to obtain insurance or pay a tax penalty.
- The ruling struck down the penalty requiring state Medicaid expansion, thereby allowing each state to decide.
- Oklahoma elected against Medicaid expansion and defaulted as a Federally Facilitated Marketplace (FFM).

Not Acting (Grey) Fully Expanded (Blue) Fully Opposed (Red)

Source: Status of State Action on the Medicaid Expansion Decision, as of July 1, 2013, Kaiser Family Foundation

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Types of Health Insurance Exchanges

- State-Based Marketplace**
 - States can create and operate their own marketplace
- Partnership Marketplace**
 - Hybrid in which the state runs certain functions. A Partnership Exchange allows states to make key decisions and tailor the marketplace to local needs and market conditions
- Federally-Facilitated Marketplace (FFM)**
 - The Federal government will establish and operate a marketplace in those states that do not establish their own



Source: "Establishing Health Insurance Marketplaces: An Overview of State Efforts", Kaiser Family Foundation, 2013

Health Insurance Exchange (Marketplace)

- New commercial insurance Marketplaces where qualified employers and individuals can shop for private health insurance plans.
- Consumers will have access to health plans and insurance affordability programs, if eligible.
- Health plans must be certified to be offered in a Marketplace, and must meet certain minimum standards.

**Enrollment starts October 1, 2013
Coverage starts as soon as January 1, 2014**

Category	Percentage of expenses paid by health plan	Percentage of expenses paid by individual
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

↑ Higher percentage of expenses covered by the plan
↓ Lower monthly premium payment

Actuarial Value of Plans Offered in the Exchanges	
"Bronze"	This plan represents the required minimum credible coverage standard; the actuarial value is 60%
"Silver"	Actuarial value of 70%
"Gold"	Actuarial value of 80%
"Platinum"	Actuarial value of 90%
"Catastrophic"	Provides catastrophic coverage along with some preventive and primary care benefits (only available in the individual market to young adults under age 30 and those to whom the individual mandate does not apply due to income reasons)

Source: "Health Insurance Marketplace: Agents and Brokers Meeting" presentation, CMS 2013

Individual/Family Tax Credits

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3 - 4% of income
150-200% FPL	4 - 6.3% of income
200-250% FPL	6.3 - 8.05% of income
250-300% FPL	8.05 - 9.5% of income
300-400% FPL	9.5% of income

- Beginning in January 2014, new tax credits will be available that will significantly reduce the cost of private health insurance for individuals and families.
- Provides refundable premium credits advanced to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges.
- Requires verification of both income and citizenship status in determining eligibility for the federal premium credits.

Source: Summary of Affordable Care Act, Kaiser Family Foundation, 2013

Small Business Health Options Program (SHOP)

- Starting in 2014, a SHOP will be available in each State.
- Starting October 1, plans will be available for review and enrollment for coverage starting as soon as January 1, 2014. Rolling monthly enrollments for employers after January 1.
- Once a group is enrolled, its rate is guaranteed for 12 months.

Available to those employers:

- With fewer than 25 full time equivalent employees
- Whose employees' wages average less than \$50,000 per year
- Who contribute at least 50% of employees' premium costs
- Who buy health insurance through the SHOP only, starting in 2014

It's worth:

- Up to 35% of employer's premium contribution (up to 25% for tax-exempt employers) now
- Up to 50% of employer's premium contribution (up to 35% for tax-exempt employers) starting in 2014

Individual Penalties

Do any of the following apply?
 • part of a religious opposed to acceptance of benefits from a health insurance policy
 • between jobs and without insurance for up to three months
 • undocumented immigrant
 • incarcerated
 • member of an Indian tribe
 • family income is below the threshold for filing a tax return (\$10,000 for an individual, \$20,000 for a family in 2013)
 • pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

YES → There is no penalty for being without health insurance.

NO → Were you insured for the whole year through a combination of any of the following sources?
 • Medicare
 • Medicaid or the Children's Health Insurance Program (CHIP)
 • TRICARE (for service members, retirees, and their families)
 • Veteran's health program
 • Plan offered by an employer
 • Insurance bought on your own that is at least at the Bronze level
 • Grandfathered health plan in existence before the health reform law was enacted

YES → The requirement to have health insurance is satisfied and no penalty is assessed.

NO →

Year	Penalty
2014	Penalty is \$95 per adult and \$47.50 per child (up to \$285 for a family) or 1.0% of family income, whichever is greater.
2015	Penalty is \$125 per adult and \$62.50 per child (up to \$375 for a family) or 2.0% of family income, whichever is greater.
2016 +	Penalty is \$695 per adult and \$347.50 per child (up to \$2,085 for a family) or 2.5% of family income, whichever is greater.

Source: "The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014", Kaiser Family Foundation, 2013

Employer Penalties DELAYED

Are you a large employer?
 • At least 50 FTE workers including full time (30+ hours per week) and part time workers (seasonal)
 • Excluding seasonal workers (up to 120 days per year)

YES → Are any of your full time employees in an exchange plan and receiving premium credit?

YES → Do you have more than 30 full time employees?

YES → Do you provide health insurance?

NO → NO PENALTY

NO → Pay monthly penalty, lesser of:
 1/12 x \$2,000 x (# of full time employees - 30)
 OR
 1/12 x \$3,000 x (# of full time employees who receive credits for exchange coverage)
 Delayed until 2015

NO → Pay monthly penalty: 1/12 x \$2,000 x (# of full time employees - 30)
 Delayed until 2015

Source: Coverage or Penalty, US Chamber of Commerce

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Essential Benefits

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- Essential Health Benefits (EHB) are a set of healthcare service categories that must be covered by certain plans, starting in 2014.
- Health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, must offer this comprehensive package of items and services; EHBs must include items and services within at least 10 categories.
- Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid State Plans must cover these services by 2014.

Source: "Health Insurance Marketplace Agents and Brokers Meeting" presentation, CMS 2013

Premium Rate Setting Factors

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Age	Smoking	Geography	Family Size
Plan premium rates can vary within a ratio of 3:1 for adults 21 and older. Rates also can vary for children under 21 based on actuarial justification. States can establish age curves or can default to the federal age curve. Age bands: 0-20, one-year bands between 21-63, 64 and older.	Premium rates can vary within 1.5:1 ratio. Can vary based on age. Small group plans may only impose a tobacco surcharge in connection with a wellness program allowing participating individuals to avoid the full amount of the surcharge. Tobacco use defined in terms of regular use and time of last use (i.e., average 4+ /week within the last 6 months).	States are permitted to establish rating areas. Based on Metropolitan Statistical Areas (MSAs)/non-MSAs, 3-digit ZIP codes or counties, and established as of January 1, 2013, no more rating areas than the number of MSAs plus one in the state. If a state did not establish rating areas, the federal default 15 area rating areas for each MSA and one rating for all non-MSA areas in the state.	The total premium for family coverage generally must be determined by summing the premiums for each individual family member. For family members under 21, total premium includes only the portion of the premium for no more than the three oldest covered children. Tobacco and age rating must apply only to the portion of the premium attributable to applicable covered family member.

Adverse Selection Mitigation Strategies: Risk adjustment, Reinsurance & Risk Corridors

Source: "Health Insurance Marketplace Agents and Brokers Meeting" presentation, CMS 2013

Online Enrollment Portal Healthcare.gov

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Open Enrollment October 1, 2013 – March 31, 2014

Enroll online or by phone Healthcare.gov 1-800-318-2596

Expected to include links to issuer and agent websites

Centers for Medicare and Medicaid Services Timeline (CMS)

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Anticipation - Get Consumers Ready

June: Rating Awareness/Education

July: Launch Medicare.gov 2.0 and Commercial/individual private marketplace information and work flow; CMS Call Center opens for local consumer assistance in English and Spanish; CMS launches website to track updates and get providers from Medicare.gov

August: Launch \$10 million to community health centers for outreach and enrollment; Training for in-person assistance personnel begins; CMS launches website to track updates and get providers from Medicare.gov

September: Launch \$4 million to grants for outreach; Open Call Center for Small Businesses; Consumers call their state help line for assistance to get help

October - March: Enroll Now

Open enrollment Applications and Plan Comparison available Targeted sites

Implementation Delays

17

- The Employee Choice provision in FFM-SHOP markets have been officially delayed until 2015 – In 2014 plan year, SHOP enrollees can only choose one Qualified Health Plan (QHP) selected by the employer.
- Guidance and operational/technical details and processes regarding the various provisions have yet to be finalized, including a paper-based verification process for American Indian/Alaska Natives (AI/ANs).
- In June 2013, the Government Accountability Office cited approximately 44% of key activities CMS targeted for completion by March 31, 2013, were behind schedule.
- The federal data hub, expected to power the exchange, remains behind schedule, including final testing with federal and state partners (and data sources).
- Many activities remain incomplete in the core functional areas of eligibility and enrollment, plan management, and consumer assistance.
- Funding awards and development of a training curriculum for a key program that will provide outreach and enrollment assistance to small employers and employees have been delayed by approximately 2 months.

CMS's timelines for the remaining key activities provide a roadmap for completion; however, many activities yet to be completed suggest future challenges

CMS has expressed its confidence that exchanges will be open and functioning in every state by October 1, 2013

PPACA Medicaid Changes

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- Use of the new Modified Gross Adjusted Income (MAGI) to calculate household composition and income to determine Medicaid eligibility
- Elimination of asset tests
- Implementation of passive renewals
- Automation of electronic verifications to determine Medicaid eligibility in real-time
- Streamlined eligibility and connection/hand-off with the Federally Facilitated Marketplace
- Former foster care children under age 26 will be eligible for Medicaid regardless of decisions about expansion, Federally Facilitated Marketplace or current Medicaid programs. According to OHCA rule impact statement, the cost for the second half of FY2014 to cover this group would be \$600k

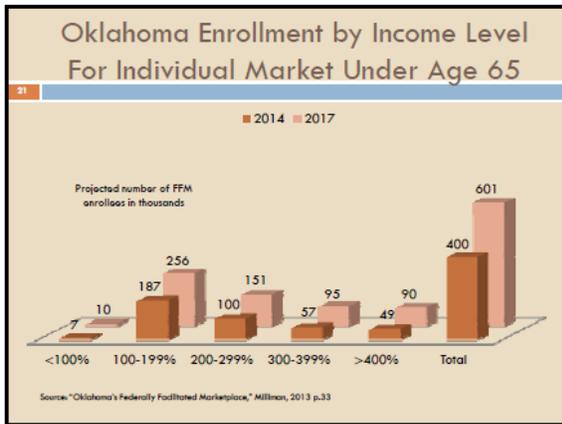
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19 Projected Insurance Enrollment

Future Insurance Market Enrollment without Medicaid Expansion

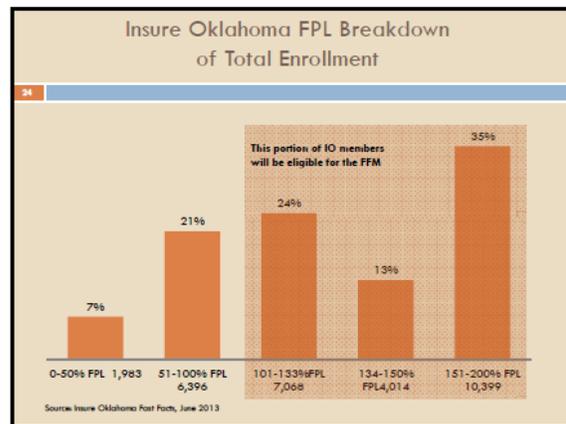
Based on 2013 Milliman "Best Estimate" Projections:

Market	2012	2014	2017
Individual	108,677	399,999	601,812
ESI Small Group	353,710	347,489	360,011
ESI Medium Group	181,468	187,651	203,126
ESI Large Group (Fully Insured)	365,467	362,769	376,741
ESI Large Group (Self Insured)	779,768	756,929	768,024
Medicaid/CHIP	524,877	592,935	641,814
Uninsured	644,843	425,088	268,084



22 Recommendations for Medicaid Waivers

- ### Leavitt Partner Recommendations
- Negotiate with the Centers for Medicare and Medicaid Services (CMS) to extend Insure Oklahoma (IO) through 2014
 - An extension will provide an estimated would continue insurance for approximately 9,000 individuals between 0-100% FPL
 - Areas of negotiation may be limited due to state and federal statutes and/or rules
 - Based written correspondence cost-sharing provisions and enrollment caps seem to be areas of primary concern for CMS
 - Modification of caps and cost sharing provisions may increase Oklahoma's financial liability



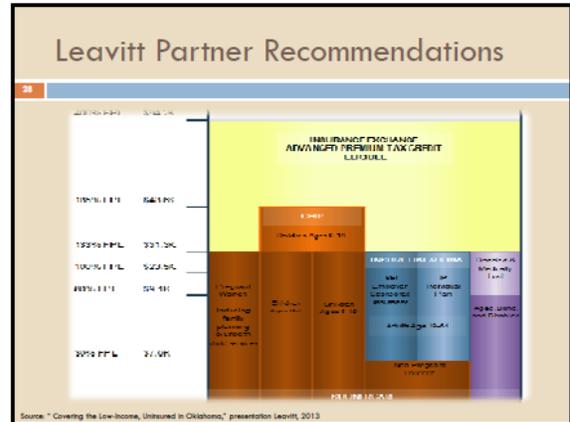
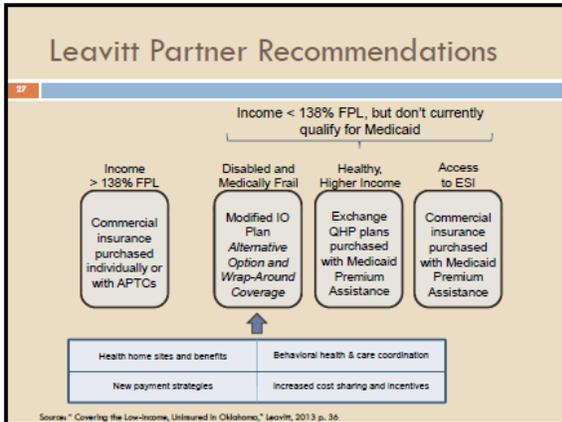
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Leavitt Partner Recommendations

- Prepare an alternative to PPACA Medicaid expansion through a demonstration waiver:
 - Create a steering committee
 - Leverage Insure Oklahoma (IO) as framework
 - Maintain Employer Sponsored Insurance (ESI) components of IO
 - Support premium assistance of private insurance coverage
 - Integrate public health and behavior health initiatives and infrastructure
 - Streamline Medicaid eligibility
 - Work toward multi-payer models
 - Develop a strong evaluation component
 - Demonstrate cost-effectiveness
 - Leverage current program initiatives

Leavitt Partner Recommendations

- Demonstration waiver (continued)
 - Projected outcomes
 - Reduce the number of uninsured individuals in Oklahoma
 - Opportunity for innovative approaches to improve health outcomes and slow the increase in healthcare costs
 - Reduce uncompensated care costs for healthcare providers and the State of Oklahoma
 - Protect Oklahoma employers with lower wage workers from shared responsibility payments (delayed until 2015)
 - Opportunity to realize program savings and increased tax revenue
 - Costs
 - State of Oklahoma appropriations to match the recommended demonstration proposal estimated at \$745 - \$939 million over 10 years



Leavitt Partner Recommendations Costs and Savings

Estimates of Ten Year Financial Cost and Economic Impact of the Proposed Demonstration Program, 2013

Take-Up	New Enrollees	Total Cost (Federal and State)	Net Cost to State (Surplus)	Total Economic Impact
Low	204,911	\$10.5 Billion	(\$486 Million)	\$13.6 Billion
Medium	233,334	\$12.0 Billion	(\$465 Million)	\$15.6 Billion
High	257,493	\$13.3 Billion	(\$447 Million)	\$17.3 Billion

Source: Leavitt Partners, 2013

Leavitt Partner Recommendations Costs and Savings

Estimates of Ten Year Net Surplus

Oklahoma's Total Match	OHCA Program Savings	Other State Agency Savings**	Total Increase in Tax Revenue	Net Surplus
\$745-\$939 million	\$211 million	\$482 million	\$538-\$693 million	\$447-\$486 million

**Other state agency savings (DMHSAS, OSDH, and Corrections) estimated from a high-level review of cost savings and warrant additional analysis

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Leavitt Partner Recommendations

31

- Develop complementary proposals to reduce uncompensated care costs for Native Americans seeking healthcare services at tribal and IHS facilities:
 - Limited federal resources make it difficult for IHS, Tribal, and Urban Indian (I/T/U) healthcare facilities to meet demand; this burdens private contract healthcare providers with uncompensated care costs
 - Uncompensated care waivers provide an opportunity for the federal government to meet their obligation to provide healthcare to Native Americans in Oklahoma
 - Allows the State of Oklahoma to mitigate costs associated with uncompensated care and improve health outcomes through greater healthcare access
 - Federal share of healthcare costs for AI/AN is 100%
 - Uncompensated care waivers are not a substitute for comprehensive insurance coverage

Leavitt Partner Recommendations

32

- Provide full reimbursement for current Medicaid program eligibility (pregnant women, family planning, and breast and cervical cancer) to reduce the potential for an increase in uncompensated care for I/T/Us
- Identify specific issues significantly impacting healthcare in Oklahoma, define quality measures and metrics, and implement new payment strategies that focus on provider incentives and shares savings with the I/T/U

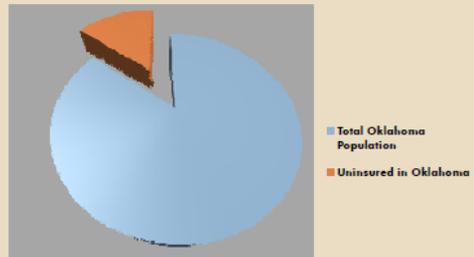
The Uninsured and Uncompensated Care in Oklahoma

33

The Uninsured in Oklahoma

34

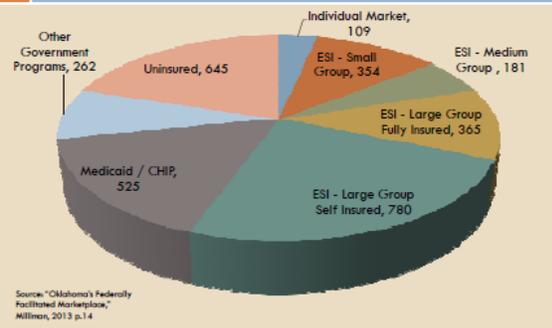
644, 843 or 17% of Oklahoma's population is uninsured



Source: Milliman's 2013 report, "Oklahoma Federally Facilitated Marketplace".

Oklahoma Population Under Age 65 by Type of Insurance in Thousands

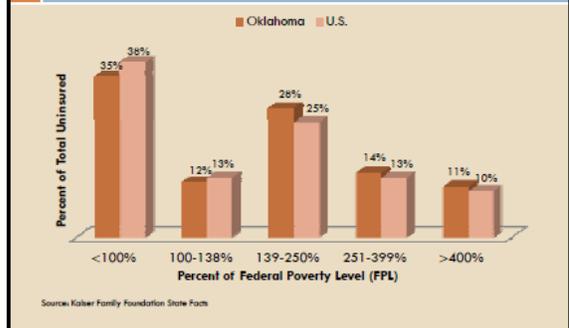
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Source: "Oklahoma's Federally Facilitated Marketplace," Milliman, 2013 p.14

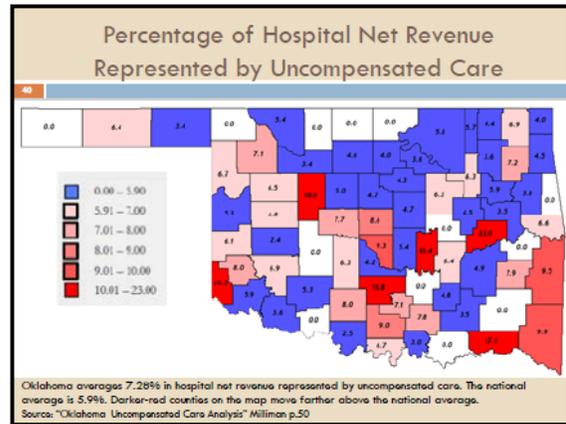
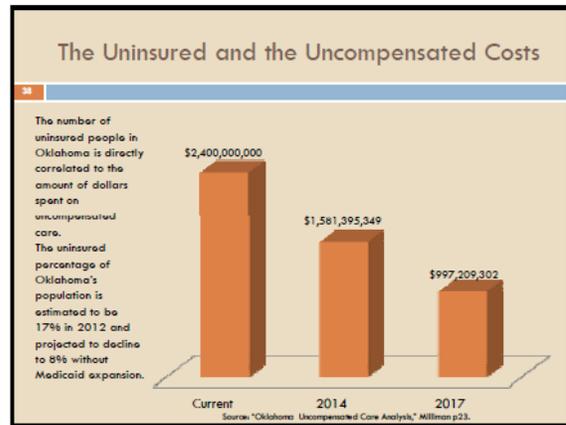
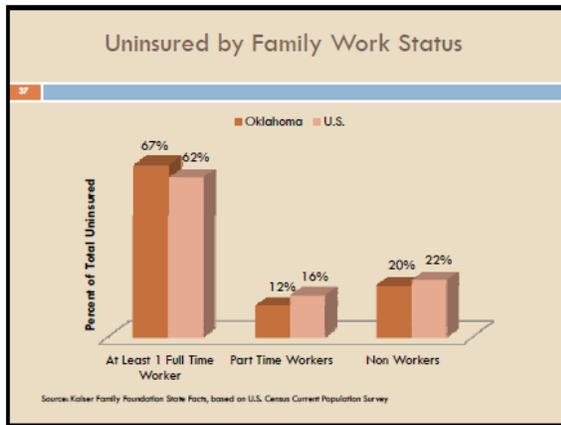
Uninsured by Income Level, 2011

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Source: Kaiser Family Foundation State Facts

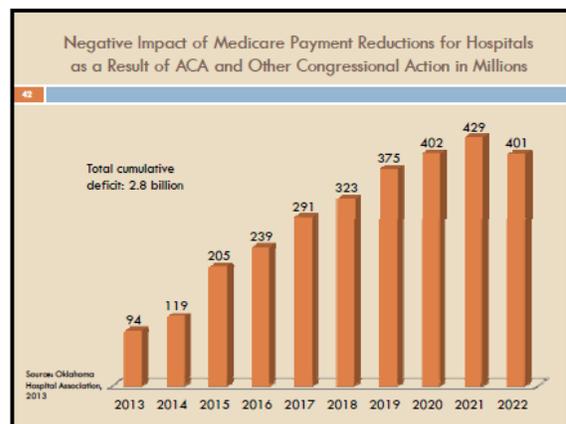
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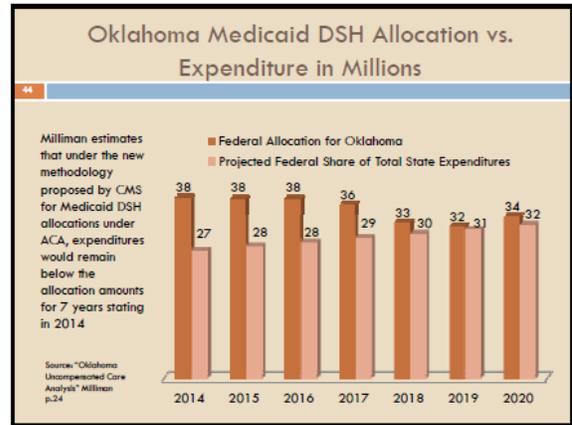
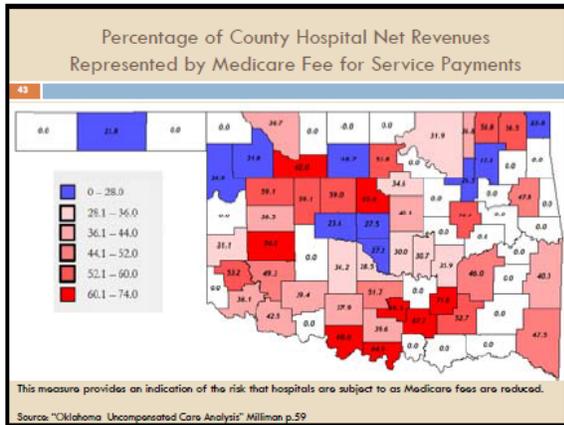
Reductions in Uncompensated Care Payments to Hospitals & The Impacts of Sequestration

- Sequestration - 2% reduction in Medicare Fee for Services (FFS) payments
- Both Medicaid and Medicare Disproportionate Share Hospital (DSH) allocations will be reduced as PPACA is implemented
- Offsets will be realized by a reduction in the number of uninsured but the net effect over the long run is still unclear

Source: "Oklahoma Uncompensated Care Analysis," Millman pp. 20

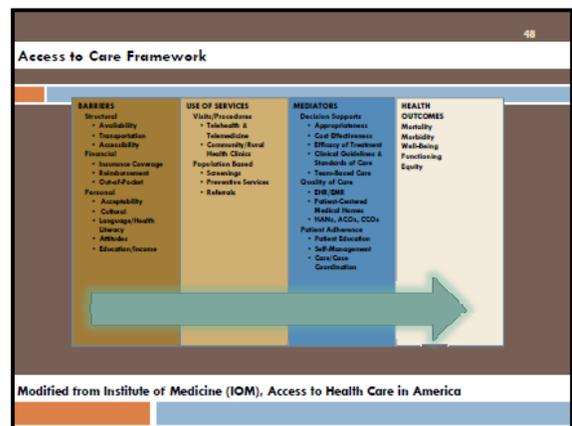
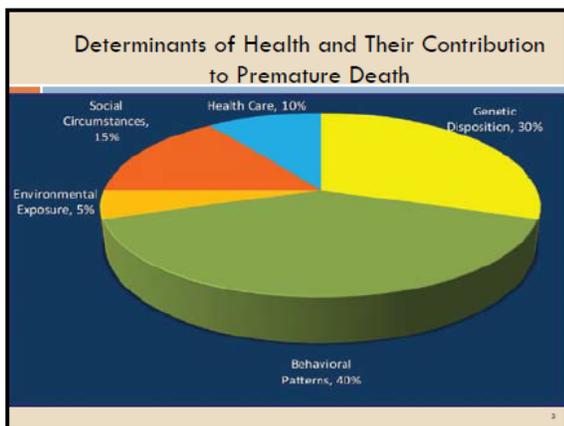


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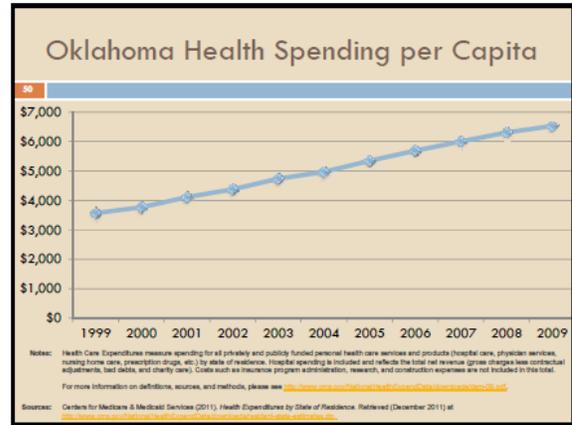
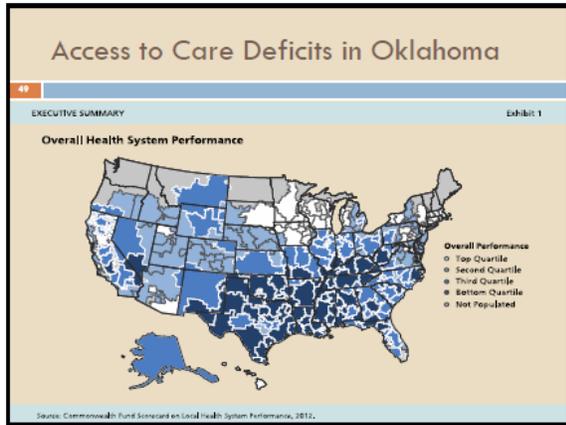


45 Challenges and Opportunities for Public Health

- ### Challenges for Public Health
- Integration of public health and healthcare
 - Maintenance and advancement of community level health protection & primary prevention
 - Reallocation of federal funds from public health to PPACA implementation
 - Diversification of revenue
 - Other barriers to access to care



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Opportunities for Innovation

- CMS recently announced a second round of healthcare innovation grants
- Focus areas include models that improve the health of populations through activities focused on engaging beneficiaries, prevention, wellness, and comprehensive care that extends beyond the clinical service delivery setting
- OSDH is collaborating with multiple partners on a statewide innovation grant from CMS

Questions?

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

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Dr. Cline and the Board acknowledged Chris Bruehl, Director of Appointments for Governor Mary Fallin, for taking time from his schedule to thank the Board of Health for their efforts as he passed through the retreat facility.

Dr. Cline and the Board thanked Representative Jeff Hickman for the time he spent addressing the Board as well as advocacy efforts in public health. Representative Hickman thanked the Board for using their expertise in healthcare to improve public health and encouraged members to contact their local legislators and advocate for public health policy that will make a difference.

The presentation concluded.

MISSION, VISION, VALUES

Arnold Baciagalupo, Ph.D.

Dr. Baciagalupo briefly described the importance of an organization’s Mission, Vision, and Values statements. He emphasized that intermittent review of these statements is critical to the continued alignment of an organization. He drew Board attention to the handout in the packet which outlined the process used by the Department for the review of the current Mission, Vision, and Values statements.

The recommended Mission Statement is as follows: *To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy.*

Ms. Wolfe moved Board approval to adopt the Mission Statement as presented. Second Dr. Alexopulos. Motion carried.

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

There were no modifications to the current Vision Statement.

Mr. Starkey moved Board approval to table action on the values statements until August 18, 2013. Mr. Starkey moved Board approval to appoint an Ad Hoc Committee consisting of Ms. Burger, Dr. Stewart, and Dr. Alexopulos for the purpose of modifying the proposed values Statements, based on Board comments, and presenting recommendations back to the Board on August 18, 2013. Second Ms. Wolfe. Motion carried.

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

OSDH Vision Mission Value Process
Oklahoma State Board of Health
SFY 2014




PROCESS

1. Getting Started

- The Oklahoma State Board of Health (Board) determined the time was appropriate for review of the Oklahoma State Department of Health (OSDH) Vision, Mission, and Values.
- This review process occurs periodically to ensure that these guiding documents are a reflection of the organization, set the vision for the future, and capture the mission of the state's primary public health agency.

2. Process

- The first step of this process was a review at the 2012 Board Retreat which concluded a change was warranted as the agency had evolved since the Vision, Mission, and Values were last reviewed.
- The second step of the process included a review by the Senior Leadership of the OSDH to develop alternatives based on the Board's input.
- The next step included a second review with subsequent recommendations by the Board and creation of an employee and core partner electronic survey.
- The final stage of the process will occur at the 2013 Board of Health Retreat where survey results will be reviewed and the Board will consider adoption of Vision, Mission, and Values.

VISION

3. Vision

- The majority of employees who commented overwhelmingly agreed that the Vision of the OSDH "Creating a State of Health" should remain as is and appropriately sets our vision for the future we are striving towards.

MISSION

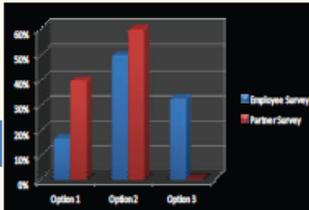
4. Mission

The Mission Statement answers the question "Why do we exist?" Employee and partner survey participants were given three options to choose from:

1st Place—Option 2
To protect and promote health, to prevent disease and injury, and to promote conditions by which Oklahomans can be healthy.

2nd Place—Option 1
To protect and promote health, to prevent disease and injury, and to assure the conditions by which Oklahomans can be healthy.

3rd Place—Option 3
To protect and promote health, to prevent disease and injury, and to cultivate thriving communities through healthy sustainable partnerships.



Option 2 was the clear winner from both survey results; however, there were a significant number of comments in which respondents preferred a synonym of "promote" without using the exact word as it is used in the beginning of the phrase.

VALUES

5. Values

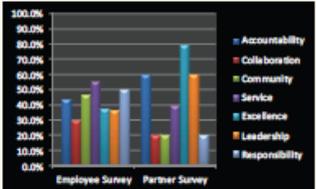
The Values statements reflect guiding principles of the OSDH and its employees. The proposed Values statements for consideration are:

- Accountability**—to competently improve the public's health on the basis of sound scientific evidence and responsible research.
- Collaboration**—to work jointly and mutually with our partners to maximize the value and impact of public health.
- Community**—to respect the importance, value, diversity, and contribution of communities and develop positive collaborations to create an environment conducive to good health.
- Service**—to demonstrate a commitment to public health through compassionate actions and stewardship of time, resources, and talents.
- Excellence**—to consistently reflect high standards in our work, services, processes, and operations.
- Leadership**—to provide vision and purpose in public health through knowledge, inspiration and dedication. To be identified as the leading authority on prevention, preparedness and health policy.
- Responsibility**—to steadfastly fulfill our obligations, maintain public trust, and exemplify uncompromising ethical conduct both as an organization and as individuals.

VALUES SURVEY

The most diversity was in the Values survey. The employees chose statements in the following rank order: Service, Responsibility, Community, Accountability, Excellence, Leadership, and Collaboration.

The core partners chose statements in the following rank order: Excellence in clear first place, Accountability and Leadership tied for second, Service in third place, and the final three significantly behind and tied for last place being Collaboration, Community, and Responsibility.



Below are the results of the Values survey both from the OSDH employees and core partners:

SUMMARY

6. Summary

- Surveys were sent to all staff and 12 key partners. The response rate was satisfactory with 51% of employees responding and 41.67% of key partners responding.
- The process is in the conclusion stage as final survey results are presented to the Board for discussion and final action on the OSDH Vision, Mission, and Values.

The presentation concluded.

1 2013 LEGISLATIVE AGENDA BREAKOUT

2 Mark Newman, Ph.D., Director, Office of State and Federal Policy

3
4 The Board discussed potential policy and legislative issues they would like to support during the upcoming
5 legislative session.

6
7 **Ms. Wolfe moved Board approval to explore and develop language to transfer hearing aid dealers and**
8 **fitters to the Board of Examiners of Speech Language Pathologists and Audiologists; Workplace Drug**
9 **and Alcohol Testing Program to the Department of Labor; and Certified Workplans and HMO's to**
10 **the State Department of Insurance. Second Ms. Burger. Motion carried.**

11
12 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

13
14 **Ms. Burger moved Board approval to explore and develop language prohibit the sale of ecigarettes to**
15 **minors. Second Dr. Alexopulos. Motion carried.**

16
17 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

18
19 **Dr. Gerard moved Board approval to explore and develop language to propose a tax credit for the**
20 **construction of tornado shelters or sales tax-free materials when constructing a tornado shelter.**
21 **Second Ms. Wolfe. Motion carried.**

22
23 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

24
25 **Dr. Grim moved Board approval to explore and develop language to support smoking policy**
26 **disclosure of multiunit housing. Second Dr. Stewart. Motion carried.**

27
28 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

29
30 ADJOURNMENT

31 Dr. Krishna advised the Board and Department staff that the proposed Executive Session on August 18, 2013
32 would need to be moved to the first item on the agenda in order to allow Dr. Alexopulos to attend. A motion
33 would be made the morning of August 18, 2013.

34 **Ms. Wolfe moved to adjourn. Second Dr. Stewart. Motion carried.**

35
36 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

37
38 The meeting adjourned at 4:37 p.m.

39
40 Sunday, August 18, 2013

41
42 ROLL CALL

43
44 Members in Attendance: R. Murali Krishna, M.D., President; Ronald Woodson, M.D., Vice-President;
45 Martha A. Burger, M.B.A, Secretary-Treasurer; Jenny Alexopulos, D.O.; Terry R. Gerard, D.O.; Charles W.
46 Grim, D.D.S.; Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.; Cris Hart-Wolfe.

47
48 Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; Henry F. Hartsell,
49 Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and
50 Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of General
51 Counsel; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley,
52 Janice Hiner.

1 Visitors in attendance: See list

2
3 Call to Order and Opening Remarks

4 Dr. Krishna called the meeting to order at 8:30 a.m.

5
6 **Ms. Burger moved Board approval to move the Proposed Executive Session to the first item on the**
7 **agenda. Second Ms. Wolfe. Motion carried.**

8
9 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

10
11 PROPOSED EXECUTIVE SESSION

12 **Dr. Grim moved Board approval to move into Executive Session at 8:32 a.m.** pursuant to 25 O.S.
13 Section 307(B)(4) for confidential communications to discuss pending department litigation,
14 investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring,
15 appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or
16 employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of
17 information would violate confidentiality requirements of state or federal law.

- 18 • Conflict of Interest discussion

19 **Second Alexopulos. Motion carried.**

20
21 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

22
23 **Dr. Alexopulos moved Board approval to come out of Executive Session at 9:19 a.m. and open**
24 **regular meeting. Second Dr. Gerard. Motion carried.**

25
26 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**

27
28 No action taken as a result of Executive Session

29
30 Dr. Baciagalupo thanked the Board and Department staff for their commitment and participation throughout
31 the meeting. He asked the Board if their expectations of him were met. He also encouraged them to provide
32 feedback as to his performance after they have had an opportunity to reflect on the outcomes of the retreat.

33
34 COMMUNITY RELATIONS/INVOLVEMENT

35 Arnold Baciagalupo, Ph.D.

36
37 Dr. Baciagalupo asked Board member to briefly provide an overview of local health issues from their
38 respective communities. Each Board member discussed outreach opportunities as a result of the previous
39 year President’s Challenge in which Dr. Krishna challenged each Board member to develop an individual
40 Board member action plan. Board members also highlighted opportunities for collaboration and
41 partnerships within their communities as well as the barriers faced by some communities such as access to
42 care, impacts of natural disasters, poverty, and increases in domestic violence.

43
44 2014 BUDGET / BUSINESS PLAN

45 Julie Cox-Kain, M.P.A., Chief Operating Officer

**OKLAHOMA STATE
DEPARTMENT OF HEALTH**

**BUDGET AND BUSINESS PLAN OVERVIEW
STATE FISCAL YEAR 2014**



OSDH SFY 2013 -2014 Budget Summary Comparison

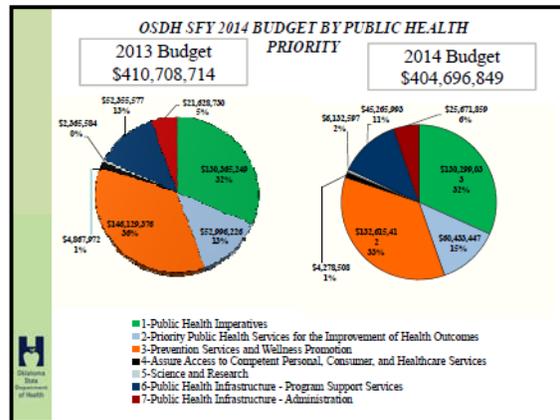
Revenue Source	2013 Budget	2013 % of Budget	2014 Budget	2014 % of Budget
Federal	\$231,869,055	56.48%	\$222,622,449	55.01%
Revolving (Includes Local Millage)	\$117,055,977	28.50%	\$119,090,718	29.43%
State	\$ 61,783,682	15.04%	\$62,983,682	15.56%
Total	\$410,708,714	100%	\$404,696,849	100%

Expenditure Category	2013 Budget	2013 % of Budget	2014 Budget	2014 % of Budget
Personnel	\$148,827,862	36.24%	\$144,029,554	35.59%
Professional Services	\$55,172,567	13.43%	\$65,739,335	16.24%
Travel	\$5,334,795	1.30%	\$5,382,438	1.33%
Equipment	\$2,659,321	0.65%	\$1,761,527	0.44%
Local Government Subdivisions	\$16,435,559	4.00%	\$14,664,362	3.62%
Trauma Distribution	\$28,324,000	6.90%	\$28,001,600	6.92%
WIC Food Costs	\$66,748,068	16.25%	\$65,550,000	16.20%
Other Expenditures	\$87,206,542	21.23%	\$79,568,033	19.66%



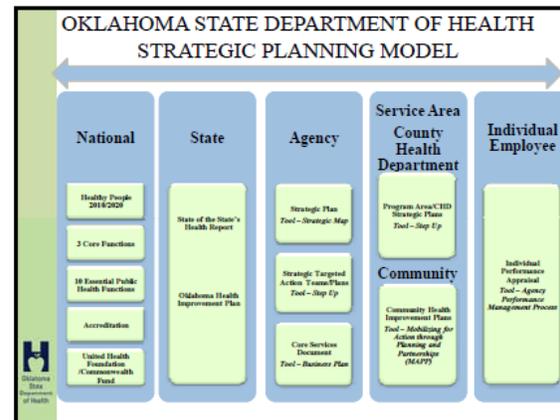
2014 Funding Public Health Priority

1 - Public Health Imperatives	\$130,299,033
2 - Priority Public Health Services for the Improvement of Health Outcomes	\$60,433,447
3 - Prevention Services and Wellness Promotion	\$132,615,412
4 - Assure Access to Competent Personal, Consumer, and Healthcare Services	\$4,278,508
5 - Science and Research	\$6,132,597
6 - Public Health Infrastructure - Program Support Services	\$45,265,993
7 - Public Health Infrastructure - Administration	\$25,671,859
Total	\$404,696,849

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**BUSINESS PLAN
UPDATE**

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Core Public Health Priorities

Mandates

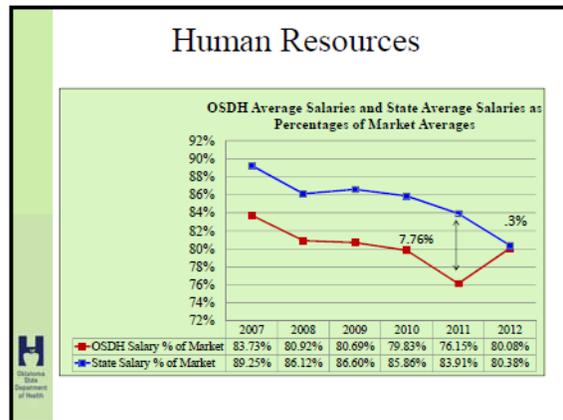
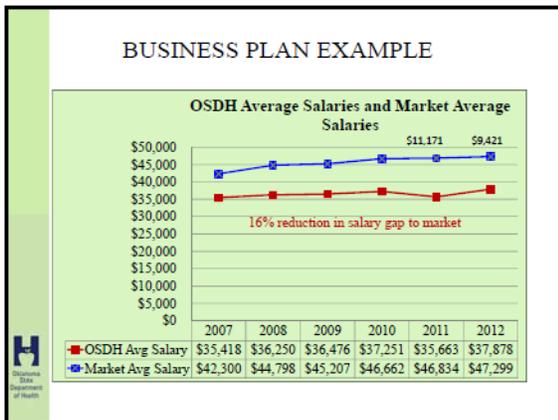
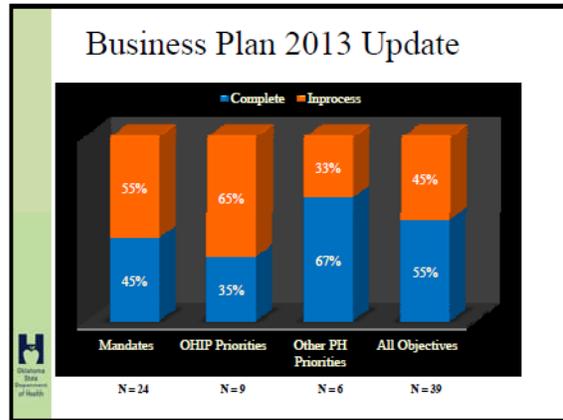
- Mandates
- Emergency Preparedness & Response
- Infectious Disease Control

OHIP Priorities

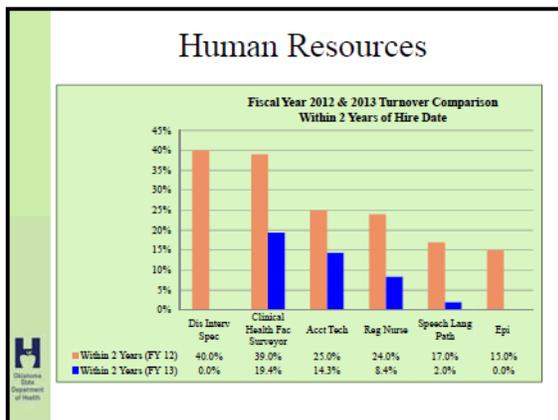
- Tobacco
- Obesity
- Children's Health

Other Public Health Priorities

- Preventable Hospitalizations
- Immunization
- Motor Vehicle Crash Death

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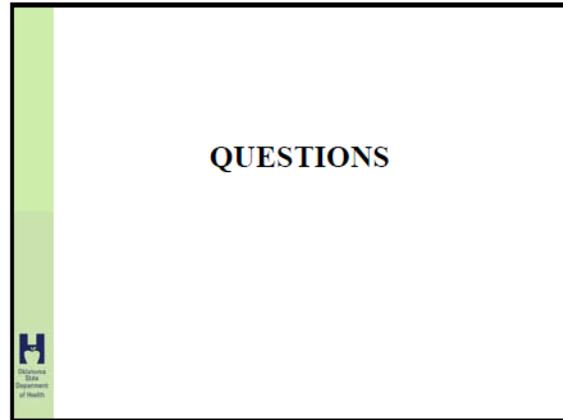


- ### 2014 Key Focus Area
- Develop additional health informatics capacity
 - Necessary to create data architecture and govern the use and exchange of public health information:
 - Between public health registries and programs
 - Between Health and Human Service agencies
 - Between the OSDH and medical providers
 - The deadlines for Meaningful Use Stage 2 are intensifying focus on the following:
 - Public health Meaningful Use activities
 - Public Health Information Network (PHIN) Activities
 - Interoperable Public Health Information System (PHIS)
 - Laboratory Information Management System (LIMS)
 - Oklahoma State Immunization Information System (OSIIS)
 - Case Management Client Information System (CMCIS)
 - Privacy & Security
 - Other agency registries and systems
 - IT consolidation process has complicated efforts
 - All state public health agencies are dealing with these issues currently
- 

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Proposed Informatics Unit Functions

Vision and Strategy	Portfolio and Resource Management	Informatics Capacity	Regulatory	Standards and Quality	Performance Improvement
<ul style="list-style-type: none"> Vision (Big Picture thinking) Strategic Direction and Planning Directing Strategic Projects Prioritizing When projects should be pursued 	<ul style="list-style-type: none"> Funding Leveraging resources ISD Contract Management 	<ul style="list-style-type: none"> Workforce development Collaboration with stakeholders and partners Facilitating relationships between programs and ISD 	<ul style="list-style-type: none"> Governance Technology Data IT Security Policy Legal strategy across systems and states Laws and policies Privacy Security 	<ul style="list-style-type: none"> Infrastructure standards Data standards Analytics standards Integration and interoperability standards 	<ul style="list-style-type: none"> System evaluation COJ of the system Desired outcomes Quality of measures Data Quality Applied research
Project Management					
Policy					
Internal Capacity – Dedicated Access (availability) – Healthcare IT, State IT, Department IT					



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The presentation concluded.

OFFICE OF ACCOUNTABILITY SYSTEMS POLICIES AND PROCEDURES

Terry L. Cline, Ph.D., Commissioner of Health

Dr. Cline presented the Office of Accountability Systems Policy with highlighted additions for approval to the Board of Health. He briefly discussed the controls built into the policy to ensure consistent and fair review and the creation of the Coordinating Complaint Council, which will serve to maximize the resources of the Board and Department and eliminate the duplication of investigations.

Office of Accountability Systems

Background

The Office of Accountability Systems (OAS) was created pursuant to Title 63 of the Oklahoma Statutes, Section 1-105f (63 O.S. § 105f) by the Oklahoma Legislature in 2006. Pursuant to statute, there is a Director for OAS who reports directly to and under the direct supervision of the Board of Health, but is also under the general supervision of the Commissioner of Health, 63 O.S. § 105f (B)(2). The duties of the OAS are established at 63 O.S. § 105f (A) & (B) as:

1. Coordinate audits and investigations and make reports to the State Board of Health and State Commissioner of Health within the State Department of Health and State Health Officer relating to the administration of programs and operations of the State Department of Health, see, 63 O.S. § 105f (A) (1);
2. Except as otherwise prohibited by current law, access all records, reports, audits, reviews, documents, papers, recommendations, or other material which relate to programs and operations with respect to which the Director of the Office of Accountability Systems has responsibilities, see, 63 O.S. § 105f (A) (2);
3. Request assistance from other state, federal and local government agencies, see, 63 O.S. § 105f (A) (3);
4. Issue administrative subpoenas for the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence, see, 63 O.S. § 105f (A) (4);

- 1
- 2 5. Administer to or take from any current or former employee of the State Department of Health
- 3 an oath, affirmation, or affidavit, see, 63 O.S. § 105f (A) (5);
- 4
- 5 6. Receive and investigate complaints or information from an employee of the Department,
- 6 service recipient or member of the public concerning the possible existence of an activity
- 7 within the State Department of Health constituting a violation of law, rules or regulations,
- 8 mismanagement, gross waste of funds, abuse of authority or a substantial and specific danger
- 9 to the public health and safety, see, 63 O.S. § 105f (A) (6);
- 10
- 11 7. Cause to be issued on behalf of OAS credentials, including an identification card with the
- 12 State Seal, see, 63 O.S. § 105f (A) (7);
- 13
- 14 8. Keep confidential all actions and records relating to OAS complaints, see, 63 O.S. § 105f (A)
- 15 (8);
- 16
- 17 9. Keep the State Board of Health and the State Commissioner of Health fully informed of
- 18 matters relating to fraud, abuses, deficiencies and other serious problems of which the
- 19 Director is aware relating to the administration of programs and operations within the State
- 20 Department of Health. Further, the Director shall recommend corrective action concerning
- 21 such matters and report to the State Board of Health and the State Commissioner of Health on
- 22 the progress of the corrective matters, see, 63 O.S. § 105f (B) (1); and
- 23
- 24 10. Report expeditiously to the appropriate law enforcement entity whenever the Director has
- 25 reasonable grounds to believe that there has been a felonious violation of state or federal
- 26 criminal law, see, 63 O.S. § 105f (B) (3).
- 27

Policy Statement

28
29
30 In adopting this Policy Statement, the Board of Health has reviewed and takes into account certain
31 programs and policies of the OSDH, including the OSDH Personnel Advisory Committee, the Civil
32 Rights Administrator for the OSDH, the Internal Audit Unit of the OSDH and OSDH Administrative
33 Procedure 1-30a. OSDH Administrative Procedure 1-30a establishes a process for the handling and
34 referral of complaints and other inquiries received by OAS, which includes when OAS receives a
35 complaint or inquiry concerning the President of the Board of Health, any current member of the Board of
36 Health, the Commissioner of Health, a member of Senior Leadership of the OSDH, (for the purposes of
37 this policy "Senior Leadership of the OSDH" is defined as a Deputy Commissioner for the OSDH, the
38 Chief Operating Officer for the OSDH, the Director of State and Federal Policy for the OSDH, and the
39 Executive Assistant/Senior Advisor for the Commissioner of Health) any individual who directly reports
40 to the Board of Health, (including the Director of OAS, the Secretary of the Board of Health and the
41 Director of Internal Audit) and any other complaint or inquiry received by OAS, as follows:

- 42
- 43 A. If the complaint involves the President of the Board of Health, the OAS Director will inform the
- 44 Commissioner of Health and the Chair of the Accountability, Ethics and Audit Committee for the
- 45 Board of Health concerning the receipt and nature of the complaint and after consultation with the
- 46 Commissioner and Committee Chair, follow the procedures set forth in OSDH Administrative
- 47 Procedure 1-30a;
- 48 B. If the complaint involves a current member of the Board of Health, who is not the President, the
- 49 OAS Director will inform the Commissioner of Health, the President of the Board of Health and
- 50 the Chair of the Accountability, Ethics and Audit Committee concerning the receipt and nature of
- 51 the complaint and after consultation with the Commissioner and Board President, follow the
- 52 procedures set forth in OSDH Administrative Procedure 1-30a;

- 1 C. If the complaint involves the Board of Health in total, the OAS Director will inform the
2 Commissioner of Health concerning the receipt and nature of the complaint. After consultation
3 with the Commissioner of Health, if an investigation is required, the Director of OAS will follow
4 the procedures set forth in OSDH Administrative Procedure 1-30a;
- 5 D. If the complaint involves the Commissioner of Health, the OAS Director will inform the
6 President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee
7 for the Board of Health concerning the receipt and nature of the complaint and after consultation
8 with the Committee Chair and Board President, follow the procedures set forth in OSDH
9 Administrative Procedure 1-30a;
- 10 E. If the complaint involves a current member of Senior Leadership of the OSDH, the OAS Director
11 will inform the Commissioner of Health, the President of the Board of Health and the Chair of the
12 Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and
13 nature of the complaint and after consultation with the Committee Chair, Commissioner of Health
14 and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;
- 15 F. If the complaint involves a person in a position that directly reports to the Board of Health, the
16 OAS Director will inform the Commissioner of Health, the President of the Board of Health and
17 the Chair of the Accountability, Ethics and Audit Committee concerning the receipt and nature of
18 the complaint and after consultation with the Commissioner of Health and Board President,
19 follow the procedures set forth in OSDH Administrative Procedure 1-30a; and
- 20 G. If the complaint does not fall within any of the categories listed above, The OAS Director will
21 convene a meeting of the OSDH Coordinating Complaint Council and after consultation with the
22 Council follow the procedures set forth in OSDH Administrative Procedure 1-30a.

23
24 OSDH Administrative Procedure 1-30a establishes the Coordinating Complaint Council, the Council
25 members and the Council duties. It is the intent of the Board of Health that all OAS staff comply with the
26 requirements of OSDH Administrative Procedure 1-30a. This Board of Health Policy Statement is
27 written to provide a framework for the interaction between the OAS and the OSDH, and to maximize the
28 limited resources of the Board of Health and the OSDH.

- 29
30 H. Effective this date, the Director of OAS may exercise the duties listed in paragraphs (3), (4) and
31 (10), above with the written approval of the President of the Board of Health and/or the
32 Commissioner of Health.
- 33
34 I. Effective this date, the Identification Cards issued by the OSDH meet the requirements of
35 paragraph (7) above.
- 36
37 J. Effective this date, the Director of OAS may exercise the duties listed in paragraphs (1), (2), (5),
38 (6), (8) and (9), above, when a complaint is received by OAS concerning any member of the
39 Board of Health, the Commissioner of Health, a member of Senior Leadership of the OSDH or a
40 complaint alleging that an employee of the OSDH has committed a fraud or has abused his/her
41 authority to the community regulated by the OSDH or to the general public who is not an
42 employee of the OSDH, in the performance of his/her job duties.

43
44 The presentation concluded.

45
46 **Ms. Wolfe moved Board approval to approve the Office of Accountability Systems Policies and**
47 **Procedures as presented. Second Dr. Woodson. Motion carried.**

48
49 **AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson**
50
51

AD HOC COMMITTEE REPORT FOR PROPOSED VALUES STATEMENTS

Robert S. Stewart, M.D.; Martha A. Burger, M.B.A.; Jenny Alexopoulos, D.O.

Dr Stewart presented five (5) Values Statements proposed by the Ad Hoc committee. The committee felt these statements were representative of the feedback provided by the Board, Department employees, and Public Health Partners. The Board discussed possible modifications as well as the ordering of the Values Statements. The Board agreed that Leadership should lead the statements but did not have a preference for the ordering of the remaining statements.

1. **Leadership** - To provide vision and purpose in public health through knowledge, inspiration and dedication. To be identified as the leading authority on prevention, preparedness and health policy.
2. **Integrity** - To steadfastly fulfill our obligations, maintain public trust, and exemplify excellence and ethical conduct in our work ,services, processes, and operations.
3. **Community** - To respect the importance, diversity, and contribution of individuals and community partners.
4. **Service** - To demonstrate a commitment to public health through compassionate actions and stewardship of time, resources, and talents.
5. **Accountability** – To competently improve the public’s health on the basis of sound scientific evidence and responsible research.

Ms. Burger moved Board approval to approve the values statements as presented giving the Department Senior Leadership the flexibility to wordsmith. Second Dr. Stewart. Motion carried.

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

ADJOURNMENT

Dr. Woodson moved to adjourn. Second Mr. Starkey. Motion carried.

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

The meeting adjourned at 11:17 a.m.

LITTLE CIGARS AND PACK LIMITS

Description

Little cigars are almost identical to cigarettes in shape and size. They generally have filters like cigarettes, but are wrapped with either a tobacco leaf or a substance containing tobacco, and not solely paper, as is the case with cigarettes. Little cigars are often sold individually.

Health Harms

- Regular cigar smoking causes cancer, heart disease, and chronic obstructive pulmonary disease (COPD).¹
- Cigar smoke contains the same toxins as cigarette smoke. Any difference in risks between cigars and cigarettes is likely attributable to differences in frequency of use and the fact that not all cigar smokers inhale.
- Little cigars and cigarillos are more like cigarettes and therefore are more easily smoked and inhaled like cigarettes.
- Another use of cigars, known as "blunting," involves a cigar that is hollowed out and filled with marijuana.²

Youth Access

- Between 2001 and 2008, the sale of cigars increased by 87%. Little cigars contributed to that growth at a rate of 158%.³
- Nationally, high school students are about twice as likely as adults (13.1 percent vs. 6.6 percent) to report smoking a cigar in the past month.⁴ Nationally, high school students are about twice as likely as adults (13.1 percent vs. 6.6 percent) to report smoking a cigar in the past month.⁵
- In Oklahoma, 13% of high school students reported current use of cigars (10.6% of females and 15.9% of males).⁶ Almost two-thirds (63.5%) of high schools students who smoke cigars usually or always smoke flavored cigars (females: 58.4%, males: 67.3%).⁷
- Tax increases have not affected all tobacco products equally. Although cigarettes and little cigars are similar products, little cigars can be purchased for substantially less than cigarettes, making them more attractive to price-sensitive populations.⁸
- The state excise tax on little cigars is 3.6 cents each. A pack of 5 little cigars would result in 18 cents state excise tax and 25 cents federal (43 cents total).⁹
- Cheap, sweet cigars can serve as an entry product for kids to a lifetime of smoking.¹⁰
- Minimum pack size requirements would make the products less accessible by youth, since the prices would be higher.
- Most cigars are sold in convenience stores rather than in cigar shops.¹¹

¹ National Cancer Institute. Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9. 1998

² National Institute on Drug Abuse. *Marijuana: Facts for Teens* (<http://www.drugabuse.gov/publications/marijuana-facts-teens>). NIH Pub. No. 04-4037. Bethesda, MD. NIDA, NIH, DHHS. Revised March 2011. Retrieved December 2012.

³ Campaign for Tobacco Free Kids. Not Your Grandfathers Cigar. March 2013

⁴ U.S. Centers for Disease Control and Prevention (CDC). "Youth Risk Behavior Surveillance—United States, 2011," *Morbidity and Mortality Weekly Report (MMWR)* 61(SS-4), June 8, 2012.

⁵ U.S. Centers for Disease Control and Prevention (CDC). "Youth Risk Behavior Surveillance—United States, 2011," *Morbidity and Mortality Weekly Report (MMWR)* 61(SS-4), June 8, 2012.

⁶ Oklahoma State and National Trends in Youth Tobacco Use. Youth Tobacco Survey (YTS). Oklahoma State Department of Health. 1999-2011.

⁷ Youth Tobacco Survey 2011

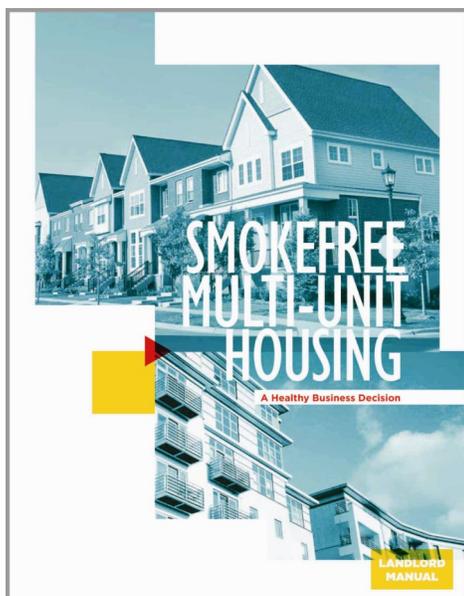
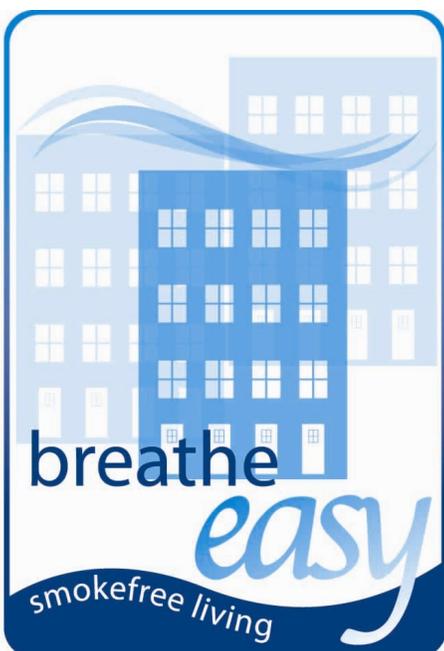
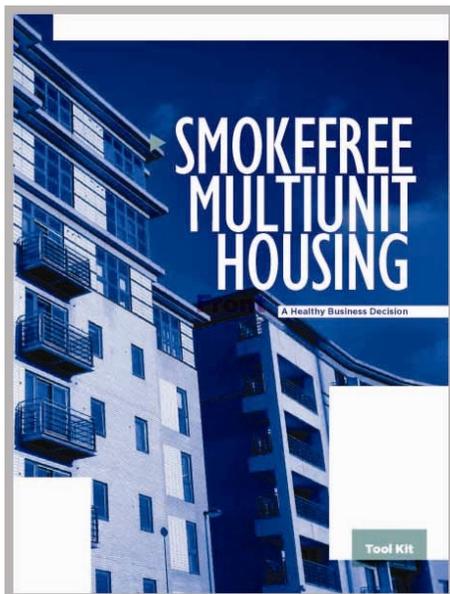
⁸ Tobacco Control Legal Consortium. Regulatory Options for Little Cigars

⁹ Oklahoma Tax Commission: Oklahoma tax rates

¹⁰ Campaign for Tobacco Free Kids. Not your Grandfathers Cigar. March 2013

¹¹ Zid, LA, "Savor the Flavor," *Convenience Store/Petroleum* magazine, October 2010.

Multiunit Housing Smoking Policy Disclosure



- About 10% of Oklahoma’s housing units are in multiunit housing (5 units or more).
- 80% of Oklahoma apartment residents live in buildings that have no policy on smoking.*
- State smoking laws protect hallways, offices and other areas that are indoor workplaces. Private residential areas are not protected by these laws.
- When smoking is allowed in one area, smoke can and will spread to other areas within the building.
- A majority of Oklahoma nonsmoking apartment residents report they have experienced smoke infiltration into their apartments.*
- 60% of Oklahoma apartment residents would prefer to be in an entirely nonsmoking building.*
- Secondhand tobacco smoke causes disease and premature death in nonsmokers. There is no safe level of exposure.**
- OSDH and the OHIP recommend smokefree homes, including multiunit housing.
- Consideration should be given to nonsmoking zones outside of entrances, open windows and patio doorways, especially in multiunit housing, to prevent smoke entering homes.
- Oklahoma’s Commissioner of Health has issued a public health warning advising persons with heart disease or at elevated risk for heart disease not to enter places where smoking is allowed.***
- O _____ unit housing residents and prospective residents _____

Footnotes from front (sources)

* 2011 survey of Oklahoma multiunit housing residents by Spears School of Business, Oklahoma State University
 ..
 ** 2006 US Surgeon General’s Report.
 ..
 *** April 2004 public health warning accessible at www.breatheeasyok.com.

E-Cigarettes

What is an e-cigarette?

- A battery-powered device that heats a liquid solution to produce a vapor for inhalation.
- Some look similar to cigarettes and even have a tip that lights up when the user inhales. Other vapor products look less like cigarettes but serve the same purpose. Some are refillable and rechargeable, while others are disposable.
- The liquid solution comes in various flavors and nicotine levels, including a 0% nicotine option.
- Use of an e-cigarette is often referred to as “vaping” rather than “smoking.”

Are they safe? Are they regulated?

- As e-cigarettes are a relatively new product, there is limited research about them.
- E-cigarettes don't contain traditional tobacco, but they do contain nicotine, which is a tobacco-derived product. As a result, a federal court has determined they can be regulated as a tobacco product, and the FDA has announced its intent to regulate e-cigarettes.
- Because the products are not currently regulated and many are produced outside the United States, there is no oversight of manufacturer's claims or independent reseller's claims regarding ingredients, nicotine content, safety, or possible use as a cessation aid.
- The liquid nicotine solution can be dangerous to children or pets if ingested.
- Even with limited research, there is reason to believe that these products can cause harm. Certain metals have been found to be present in e-cigarettes which could be harmful if inhaled. Additionally, there have been incidents of the battery exploding or causing fire.
- Research on the health effects of secondhand vapor is limited. At one time in history, smoking in buildings and vehicles was considered a safe practice, but years of research have proved otherwise. Research on e-cigarettes is new and evolving, and it may be some time before we know the total health effects of these products to users and those exposed to secondhand vapor.

Where can e-cigarettes legally be used? Who can buy them?

- Because state clean indoor air laws were written before e-cigarettes, the law is silent on their indoor use. Organizations may pass voluntary policies that prohibit indoor use of e-cigarettes.
- The law does not prohibit the sale of e-cigarettes to minors, however, most stores have voluntary policies requiring a customer be 18 to purchase an e-cigarette product.

What other concerns exist about e-cigarettes?

- Kid-friendly flavors such as cherry and chocolate are banned by the FDA for cigarettes because of their potential to appeal to children; that is not the case with e-cigarettes. E-cigarettes come in many flavors, which may increase the appeal for youth.
- Because many e-cigarettes look like traditional cigarettes and emit a vapor that looks like traditional cigarette smoke, e-cigarettes also have the potential to impact social norms and public perception of smoking prevalence that the tobacco control community has worked so hard to change.

ATTACHMENT 3

- Laws that restrict cigarette advertising do not include e-cigarettes, so ads are appearing in magazines, on television, and in other public places, which also impacts the social norm regarding these products and potentially social norms about smoking overall.
- Even if future research finds that harm to the individual could be reduced, there could be increased harm to the *public* if 1) people who would have otherwise quit tobacco use e-cigarettes instead, and 2) people who would have otherwise not used a tobacco product take up e-cigarettes or other tobacco products.

Are e-cigarettes a proven cessation aide?

- There is limited research on the effectiveness of e-cigarettes as a cessation aide and their long-term safety is unstudied. However, there are multiple FDA-approved nicotine replacement therapy products available for individuals who wish to quit. These approved products, which have been studied for effectiveness and side effects, are available for free by calling 1-800-QUIT-NOW.
- Some people who have no intention of quitting traditional tobacco products may use e-cigarettes to get nicotine throughout the day and still comply with bans on traditional cigarette smoking in public. This is a form of “dual use” and has the potential to increase overall tobacco use, though more research is needed on this topic.
- Many people have shared anecdotal stories about switching from cigarettes to e-cigarettes; however, it is not clear in most cases if those individuals have quit using cigarettes but continue to use e-cigarettes, or if they have quit nicotine use entirely.

What action should we take related to e-cigarettes?

Note: These are possible actions if e-cigarettes are an area of focus relevant to your community and your organization’s work at this time. It is not required that you take any action.

- To protect other customers and employees who choose not to be exposed to chemicals, businesses should adopt policies that prohibit the use of e-cigarettes on their property as part of a comprehensive tobacco-free policy.
 - If local organizations have voluntary tobacco-free policies, revise those policies to include e-cigarettes.
 - If no voluntary policy exists, work toward passing a comprehensive tobacco-free policy that includes e-cigarettes.
- Although e-cigarettes are a popular topic right now because of their novelty, it’s important to continue working on evidence-based best practices for overall reduction in tobacco use. While it is important for us to address this new concern in tobacco control, we cannot lose sight of the still large problem of tobacco use, which kills about 6,200 people per year in Oklahoma. We have the 4th highest smoking rate in the country. Sales of e-cigarettes in the U.S. last year reached \$500 million, but e-cigarettes are still a small fraction (0.5%) of the total tobacco market in the U.S. (Source: New York Times)

A COMPREHENSIVE PLAN TO IMPROVE THE HEALTH OF ALL OKLAHOMANS · 2010-2014

OKLAHOMA HEALTH IMPROVEMENT PLAN





OHIP TEAM



Oklahoma Health Improvement Plan Team Members include:

- health leaders
- business
- tribes
- non-profits
- private citizens
- non-traditional groups
- labor
- academia
- state & local governments
- professional organizations

OHIP Mission: Working together to lead a process to improve and sustain the physical, social, and mental well being of all people in Oklahoma.



FLAGSHIP GOALS

Tobacco Use Prevention
Obesity Reduction
Children's Health

INFRASTRUCTURE GOALS

Workforce Development
Access to Care
Health Systems Effectiveness/Partnerships

SOCIETAL & POLICY INTEGRATION

Policies and Legislation
Social Determinants of Health & Health Equity



Team Leadership

OHIP Team (Dr. Terry Cline)

FLAGSHIP (Dr. Gary Raskob)

Tobacco Use Prevention (Tracey Strader & Jennifer Lepard)

Obesity Reduction (Dr. Bruce Dart)

Children's Health (Drs. Mary Anne McCaffree, Marny Dunlap, & Edd Rhoades)

INFRASTRUCTURE (Gary Cox)

Workforce Development (Monty Evans & Judy Grant)

Access to Care (Julie Cox-Kain)

Health Systems Effectiveness {P/P Partnerships} (Dr. Terry Cline & Ted Haynes)

SUCCESSSES

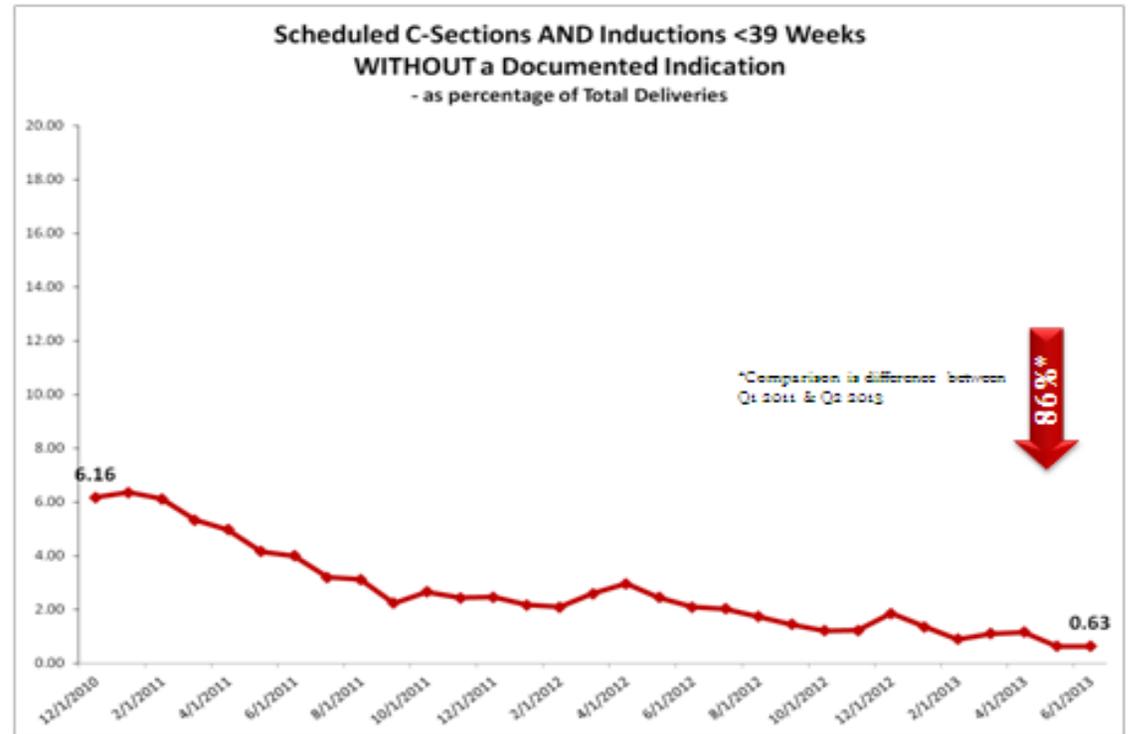


Tobacco Outcomes



- Adults who smoke in OK has **decreased by 10.7%** in the last year from 26.1 to **23.3%!**
- The number of schools with tobacco-free policies since 2012 has increased by **23%!**
- The Governor's Executive Order for tobacco-free properties impacted approximately **37,000** state employees and **countless** visitors to state properties.

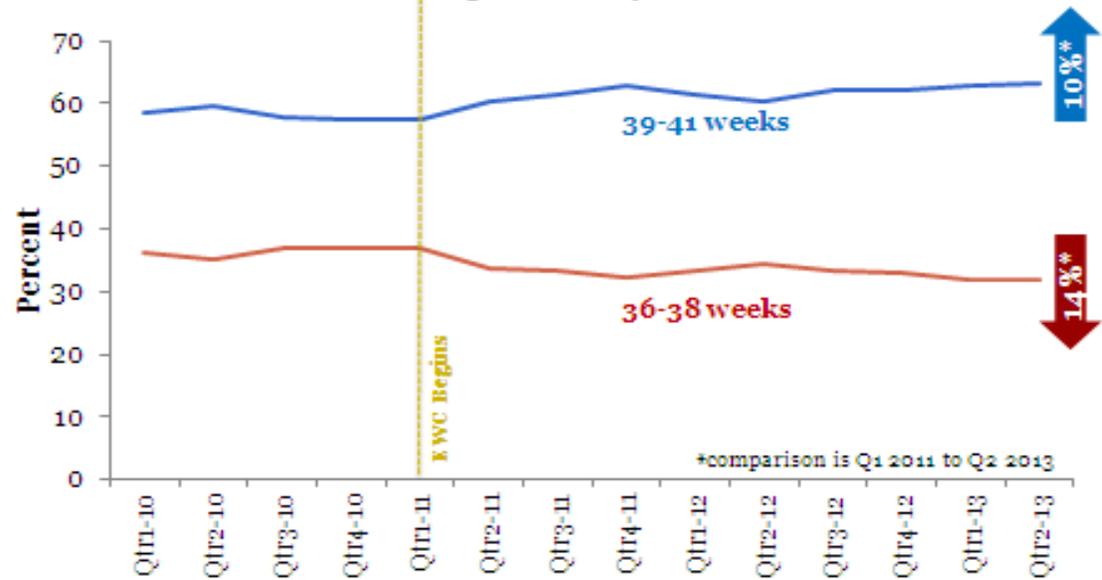
Every Week Counts



Every Week Counts



Percent of singleton births delivered at 36-38 weeks and 39-41 weeks: Oklahoma, Qtr1 2010 to Qtr2 2013, preliminary



Provisional Data provided by Oklahoma Vital Records

Infant Mortality Rate



- The Oklahoma Infant Mortality Rate has decreased **by 10.5%** in the last five years from 8.6 per 1000 in 2007 to 7.7 in 2012.

Certified Healthy Oklahoma

Growth in Number of Healthy Certifications



Obesity, Nutrition, and Physical Activity

2012 Certified Healthy Applications and Beyond



- **418** schools, **135** businesses, and **61** communities (**614** total organizations) implemented one or more policies related to physical activity or nutrition!
- In addition, **405** schools participated in non-policy related programs including breakfast nutrition program, backpack program, or summer food service.
- **Online Toolkit** being developed for communities, schools, and organizations in selection and implementation of nutrition and physical fitness activities and policies to assist in health improvement endeavors.



Certified Healthy Physical Fitness & Nutrition Incentive Grant Activities & Enhancements



Sidewalks

Skate Park

Community Garden

Exercise Equipment

Walking Trail Lights & Renovation

Bike Racks on Buses

Walking Trails

Basketball Courts

Benches & Soccer Field Equipment

Playground Equipment

Pedestrian Crosswalks

9 Station Disc Golf Course

Nutrition & Fitness Campaigns

Public Health Accreditation



- Oklahoma is the **only** state in the nation with the **state** and **three** local public health departments accredited! Our state also has the distinction of having the **most accredited departments in the US!**

Continued Successes!



- **Twenty-four (24)** Oklahoma birthing hospitals stopped providing formula gift discharge bags due to breastfeeding policies put into place.
- **28.4% increase** from 64% to 82.2% in proper child restraint use among infants less than one year of age.
- **SB 501** was passed and permits local counties and municipalities to pass ordinances to ban smoking on county or municipal properties, as well as codifying the portion of the Governor's Executive Order that makes all state properties smoke-free!



OHIP SFY 2013 Legislative Agenda

- Prohibit the sale of e-cigarettes to minors
- Require multi-unit housing to provide information about their smoking policies to prospective renters
- Provide a tax credit for the construction of residential storm shelters



Let's take these first steps to improve our health! 5,320 Oklahomans are counting on us.



OHIP PARTNERS

Oklahoma State Board of Health

Tulsa City-County Board of Health

Oklahoma City-County Board of Health

Oklahoma State Department of Health

Tulsa Health Department

Oklahoma City-County Health Department

Oklahoma Health Care Authority

Oklahoma Department of Mental Health & Substance Abuse Services

Oklahoma Tobacco Settlement Endowment Trust

Oklahoma Legislature

Oklahoma State Department of Education

Oklahoma Hospital Association

Oklahoma Osteopathic Association

Oklahoma State Medical Association

The State Chamber of Oklahoma

Cherokee Nation Health Services

Oklahoma Turning Point Council

Oklahoma Institute for Child Advocacy

Oklahoma Tobacco Research Center

American Lung Association

American Heart Association

American Cancer Society

OKC Area Inter-Tribal Health Board

Cheyenne-Arapaho Tribe

Muscogee Creek Nation

Indian Health Service

Blue Cross Blue Shield

Indian Health Care Resource Center of Tulsa

Oklahoma University Health Science Center



OHIP PARTNERS

Oklahoma Association of Health,
Physical Education, Recreation
and Dance

YMCA of Tulsa

Cimarron Alliance

Leadership Oklahoma

Schools for Healthy Lifestyles

Regional Food Bank of Oklahoma

Integrus Health

George Kaiser Family Foundation

Oklahoma Management Enterprise
Services

Oklahoma Policy Institute

Chickasaw Nation

Physician's Manpower Training
Center

Oklahoma Healthcare Workforce
Center

Oklahoma Employment Security
Commission

Oklahoma Primary Care Association

Oklahoma State University Center
for Health Sciences

AARP Oklahoma

Community Service Council of
Greater Tulsa

Oklahoma Nurses Association

Children's Hospital of Oklahoma/
American Academy of Pediatrics

Citizens at Large





WELLNESS NOW



OKC-County Health Department Northeast Regional Health & Wellness Campus



Northeast Regional Health & Wellness Campus Grand Opening May 1, 2013

WELLNESS NOW





NERHWC Grand Opening

WELLNESS NOW





NERHWC Community Festival

WELLNESS NOW



NE 63RD ST.

CAMPUS SITE PLAN



© MASS ARCHITECTS, INC. 2011

The Northeast Regional
Health and Wellness Center
for Oklahoma City & Oklahoma County





Telling the Story

WELLNESS NOW

<http://vzaar.com/videos/1294351>



Tulsa County's Community Health Improvement Plan

Pathways
to
Health

CHIP Journey



- In 2011, Pathways to Health began to facilitate a series of community assessments.
- The assessment process and the CHIP meet
 - Non-Profit Hospital IRS community benefit requirements
 - THD's National Accreditation requirement
- Many other agencies participated as well.

CHIP Journey



- Together, community partners worked to design a survey tool and facilitate 4 community assessments.
 - CHNA (facilitated by University of Nebraska Public Policy Center)
 - Focus Groups
 - NPHPSP
 - Forces of Change
- The CHIP is completely framed around these assessments.

CHIP Content



- CHIP Introduction:
 - Assessment Background
 - Tulsa County Demographics
 - Social Determinants of Health
 - Alignment with State and National Priorities
- The CHIP
 - 6 sections addressing the community's health concerns

CHIP Priorities



The CHNA revealed that Tulsa County's top six health concerns are:

1. Poor Diet and Inactivity
2. Obesity
3. Drug and Alcohol Abuse
4. Chronic Disease
5. Access to Health Care
6. Tobacco Use

CHIP Alignment with State & National Priorities



- OHIP
 - In order to show a broader impact, Tulsa County's CHIP goals and objectives are connected to the OHIP
- Healthy People 2020
 - This national standard sets goals for improvement
 - Provided indicators that are broad and impactful

Solution Focused

- Each priority section begins with CHNA data that demonstrates why these issues are concerning
- Potential challenges to making improvement in these areas are addressed
- Opportunities to make the greatest impact are highlighted

CHIP Goals and Objectives



Adapted from Healthy People 2020 national goals

Adapted from Healthy People 2020 national objectives

Performance indicator used to evaluate the effectiveness of strategies and tactics in each priority area

Data obtained through studies such as the Community Health Needs Assessment as a basis for comparison

The next CHIP will be released in 2016. This a short term goal.

The Healthy People 2020 strategy advocates for 10% improvement by 2020

Goals	Objectives	Indicators	Baseline	2016 5% decrease	2020 10% decrease
Reduce tobacco use	Reduce the proportion of adults who report using some kind of tobacco everyday or some days	Percentage of adults who report having smoked a cigarette or using tobacco products everyday or some days	25.6% (2012 CHNA)	24.32%	23.04%

CHIP Priority Champions



- Survey respondents are listed in the CHIP
- We will be able to show how the reach of P2H expands as more community partners respond to the survey

Evaluation & Next Steps



- Annual report of progress
- Updated CHIP every 3 years
- The role of P2H now becomes promoting the messages within the CHIP

Evaluation & Next Steps



- Alliance Groups
 - Healthy Kids
 - Healthy Aging
 - Healthy Worksites
 - Healthy Choices
 - Healthy Places
 - Access to Health Care
- Starting conversations about community health improvement with community partners and in Tulsa County neighborhoods
- Pathways to Health Block Party
 - 6 total in 2013-2014
 - September 19th

Follow P2H



- Keep the conversation going:

www.pathwaystohealthtulsa.org

Like us on Facebook: Pathways to Health

Follow us on Twitter: @TulsaP2H

Budget Presentation

TRI-BOARD MEETING · OCTOBER 2013



JULIE COX-KAIN, MPA

REGGIE IVEY, MHR

BOB JAMISON, MBA

Presentation Overview

- ❑ **SFY '15 Capital Improvement Budget – Public Health Laboratory**

- ❑ **SFY '13 & SFY '14 – Children's Health Budget Update**
 - Oklahoma State Department of Health
 - Tulsa Health Department
 - Oklahoma City-County Health Department



State Fiscal Year 2015 Public Health Laboratory

- Increase space
- Increase testing capacity
- Safety
- Improve Public Health Emergency Response Capabilities
- Improve efficiencies
- Accreditation



Public Health Laboratory

- ❑ Capital Improvement Budget for \$ **41.2** million
 - Site work and Parking Lot
 - Construction Costs
 - Professional Fees and Project Management

- ❑ Functional facility separated physically and mechanically from current structure
 - Increased security
 - Stronger controlled access
 - Specifically designed and engineered for lab services



Budget Update

State Fiscal Year 2013 & 2014
Children's Health Funding

\$1.7 Million



Evidence-Based Strategies



❑ Every Week Counts Collaborative

- March of Dimes Elimination of Non-medically Indicated Deliveries Before 39 Weeks Gestational Age Toolkit
- Contract: OUHSC Office of Perinatal Quality Improvement to work with birthing hospitals
- Achieved 86% reduction in early elective deliveries since January 2011
- Reduce the rate of premature births by 8% by 2014 (ASTHO Presidential and March of Dimes Challenge)

Evidence-Based Strategies

- ❑ **Becoming Baby-Friendly in Oklahoma Project (inclusive of Breastfeeding Education Project)**
 - A global program sponsored by the World Health Organization & United Nations Children's Fund
 - Women who breastfeed have shown decreased health risks
 - Contract: OUHSC Dept of OB-GYN to assist facilities to train/adopt policies that promote breastfeeding
 - 24 hospitals no longer providing formula gift discharge bags
 - Goal of engaging 10 new hospitals each year
 - Claremore Indian Hospital is Oklahoma's first Baby-Friendly Hospital





Strategies Continued

□ Infant Safe Sleep

- American Academy of Pediatrics (AAP) recommendations
 - Promoting environment which reduces risk of injury and death to infants when sleeping
- Targeting 10 hospitals that deliver the largest numbers of minority populations
 - Assisting hospitals in developing and implementing infant safe sleep policy
 - Providing safe sleep education to staff and families
 - Providing infant sleep sacks to families
 - 5 hospitals with agreements in place



Strategies Continued

❑ Abusive Head Trauma

- Period of PURPLE Crying® - 34 hospitals participating
- Assisting hospitals in developing and implementing policy
- Assisting parents with understanding normal part of infant development
- Providing parents with education and Period of Purple Crying DVDs to use in educating other family members and caretakers
- Click for Babies - collected/distributed nearly 3,000 purple baby caps

Community-Based Projects

OSDH County Health Departments (48 counties)

Focusing on:

- ❑ Preconception/interconception health, including tobacco
- ❑ Infant safe sleep
 - Pre-term birth
 - Activities:
 - ❑ Community health events
 - ❑ Community outreach
 - ❑ Public & provider education
 - ❑ Local media campaigns
- ❑ Placement of 6 Social Workers based on risk criteria such as infant mortality, poverty, education





TULSA HEALTH
DEPARTMENT

“Expansion of REACH and MCH Programs”

Tri-Board Meeting

October 8, 2013

The Plan:



In accordance with the Oklahoma Health Improvement Plan, Tulsa City-County Health Department (TCCHD) proposes to expand the REACH (Raising Educational Awareness for Community Health) Program as well as expand Maternal and Child Health (MCH) Case management services in Tulsa County to improve perinatal outcomes and reduce infant mortality. Staff will work through the TCCHD sites to assure services and linkage to resources to prevent adverse maternal and infant outcomes.

TCCHD hired two Clinical Social Workers (one bilingual) and two Community Outreach Workers (one bilingual)

A Clinical Social Worker and an Outreach Worker were hired in the first quarter of 2013. The second Outreach Worker was hired in July (2013) and the second Clinical Social Worker was hired in September (2013)



TULSA HEALTH
DEPARTMENT

Program Rationale

Preparing for a Lifetime Recommendations

Identify High Risk Clients; both during pregnancy and after (community and clinic)



Program Rationale (con't)

Provide intensive education; focused on the following:

- Early Entry into Prenatal Care
- Importance of Folic Acid
- Smoking Cessation
- Provide Linkage to Early Prenatal Care
- Safe Sleep for Infants
- Offer education about reproductive life planning

Program Rationale (con't)



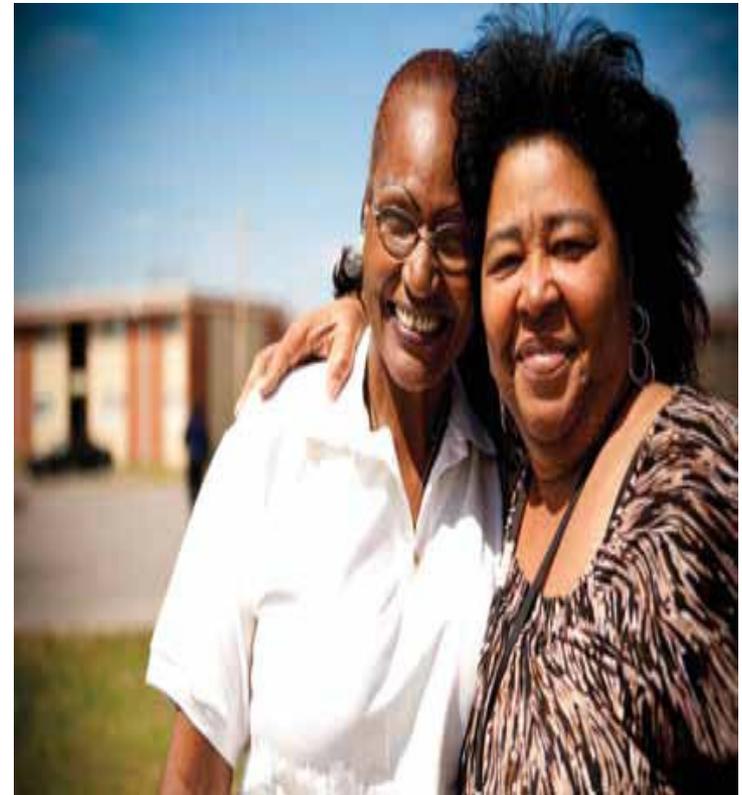
Education shared individually as well as in group settings (community and clinic)

Key feature of the Clinical Social Workers' role includes identifying and addressing domestic violence issues and depression screening specifically for clients who are pregnant or have children under the age of one.

Progress

Outreach Services:

- Provided 22 presentations to Childcare providers and parent groups; topic specific (Impact: 855)
- Spent 1,000 hours canvassing neighborhoods, to identify clients and connect patients to an OBGYN provider or other services. (Impact: 50 patients)
- Spent 263 hours following up with clients that miss appointments. (Impact: 77 patients)



Progress (con't)

Case Management Services (one case manager):

- Offer depression and tobacco screening assessments
- Spent 1,800 hours providing resources, information and education to high risk clients (Impact: 126 patients)

Progress (con't)

Maximized Funding:

Community Connector

Maternal and Child Health Initiative

- Safe Sleep Demonstrations (Hospitals, Baby Stores, Emergency Infant Services, etc.)
- In the process of planning a Safety Fair for Child Care Providers and Parents (10.12.13)

Internal Referrals

Impact: less than 0.50% of patients case managed have experienced a poor infant outcome



WELLNESS NOW

Maternal and Child Health Outreach

Tri-Board Meeting

October 8, 2013



Maternal and Child Health Outreach (MCHO)

The MCH Outreach Project will conduct outreach and educational activities to facilitate the reduction of infant mortality in the Oklahoma City metropolitan statistical area. Activities include:

- Provide leadership in initiating selected interventions recommended by the Community Action Team (CAT) of the Central Oklahoma Fetal and Infant Mortality Review (FIMR) Project while identifying and building relationships to transition interventions to appropriate community partners
- Provide consultation to health care professionals, community organizations, faith-based organizations, etc. on interventions/recommendations identified to reduce infant mortality
- Raise public awareness of positive health practices and lifestyle choices to improve overall health of mothers and infants and decrease infant mortality
- Promote interconception care for families experiencing a fetal/infant death targeted to high risk health or lifestyle behaviors affecting previous pregnancy loss
- Promote family planning for appropriate spacing of pregnancies to promote positive outcomes in future pregnancies as well as improve maternal and infant health



Strategies

Hospital Advocate Initiative was developed after educating over 1029 nurses in all 14 delivery hospitals in the metropolitan area. This initiative was developed to transition the education and awareness activities back to staff.

Faith-based Outreach has had multiple approaches. First, working with the Oklahoma Conference of Churches to reach faith-based groups with educational materials and resources on infant safe sleep. A second strategy has been developed to work within the African American Churches to address disparity issues within their community. Quarterly round table discussions are scheduled to identify specific strategies within the community to help reduce infant mortality.

Working with law enforcement agencies to assist in the data collection by standardizing the information documented during death scene investigations.

Staff positions funded include MCHO Epidemiologist and FIMR Specialist. EPI was hired to help identify and prioritize specific strategies identified through the Central Oklahoma Fetal and Infant Mortality Review process. Specialist was hired to conduct home interviews and outreach activities.

Two new **social worker positions** are in development and will be hired. These positions will work on outreach and case management of individuals/families who have experienced fetal/infant loss or other poor pregnancy outcomes.





Progress

Hospital Advocate Initiative. A hospital advocate has been named in all but one area delivery hospital plus St. Anthony's Shawnee Hospital. Monthly information and resources are sent to the 'Advocate' to be distributed to hospital staff. This effort continues to reach nurses in nearly every hospital while leveraging staff time and effort.

Faith-based Outreach. Working with the Oklahoma Conference of Churches we reach over 2000 faith-based groups with educational materials and resources on infant safe sleep. Second, quarterly round table discussions are scheduled to identify specific strategies within the community to help reduce infant mortality. To date we have approached over 34 African American Churches with information, presentations and resources on reducing infant mortality within their community. Information can now be downloaded from OCCHD website.

Twenty-three law enforcement agencies have pledged to utilize the CDC developed Sudden Unexpected Infant Death Investigation (SUIDI) form. An additional six more are pending.

MCHO Epidemiologist. The MCHO EPI has been instrument in identifying new zip code data allowing for targeted outreach activities that include addressing disparity issues. **FIMR Specialist have seen an increase in the number of home interviews conducted.** Of the families contacted only 15% conducted the interview in 2010 with expansion in 2011 and 2012 those numbers increased to 39% and 32% respectively.

Two new **social worker positions** are in development and positions are posted. These positions will work on outreach and case management of individuals/families who have experienced fetal/infant loss or other poor pregnancy outcomes. These social workers will be instrumental in the promotion of interconception care and family planning for appropriate spacing of pregnancies along with other lifestyle behaviors that affect birth outcomes.



**OKLAHOMA STATE DEPARTMENT OF HEALTH
SFY 2014 BUDGET AND EXPENDITURE FORECAST: AS OF 09/20/2013**

SUMMARY

<u>Division</u>	<u>Current Budget</u>	<u>Expenditures</u>	<u>Encumbrances</u>	<u>Forecasted Expenditures</u>	<u>Surplus/(Deficit)</u>	<u>Performance Rate</u>
Public Health Infrastructure	\$21,140,466	\$1,590,243	\$5,125,321	\$13,521,327	\$903,575	95.73%
Protective Health Services	\$67,450,071	\$2,843,941	\$9,149,423	\$53,739,797	\$1,716,910	97.45%
Prevention & Preparedness Services	\$58,775,866	\$3,957,961	\$25,743,694	\$28,163,748	\$910,464	98.45%
Information Technology	\$7,291,870	\$1,070,647	\$2,250,425	\$3,769,334	\$201,464	97.24%
Health Improvement Services	\$23,059,116	\$1,411,646	\$3,948,182	\$16,409,290	\$1,289,999	94.41%
Community & Family Health Services	\$251,202,052	\$20,820,449	\$37,209,259	\$182,160,443	\$11,011,901	95.62%
Totals:	\$428,919,441	\$31,694,886	\$83,426,305	\$297,763,938	\$16,034,312	96.26%
	< 90%	90% - 95%	95% - 102.5%	102.5% - 105%	>105%	

Expenditure Forecast Assumptions

- Payroll forecasted through June 30, 2014 based on projections of first three payrolls of SFY 2014
- Encumbrances shown as actual as of the report date
- Expenditure forecasts limited to realistic amounts expected to spend out during the current budget period
- Surplus/(Deficit) is projected as of June 30, 2014

Explanation of Dashboard Warning(s)

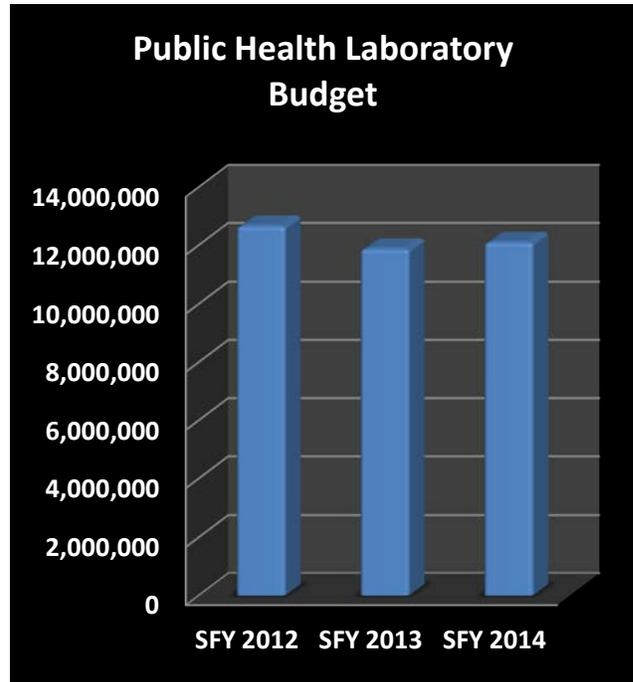
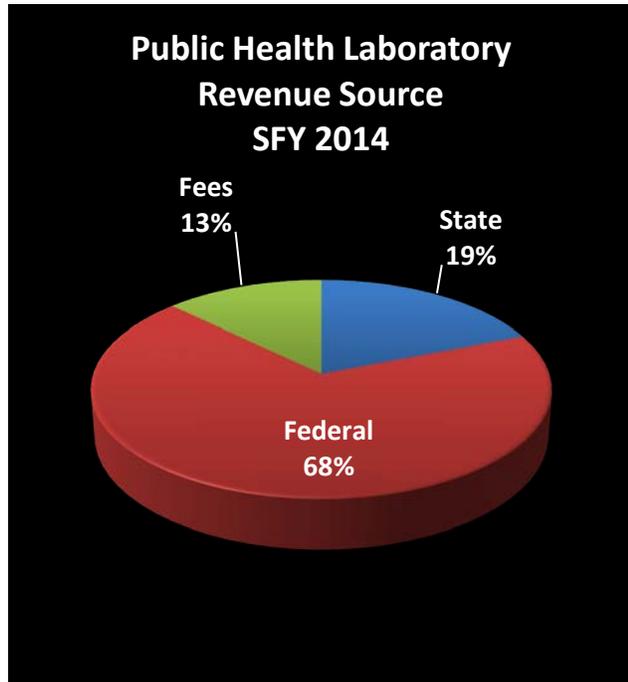
- The OSDH's overall budget performance rate is "Green Light" status at 96.26%.
- There is one division with a "Yellow Light" status, Health Improvement Services.
- The "Yellow Light" in Health Improvement Services is largely due to a Vital Records IT project which is still in the planning stage and the funding is not obligated. As the planning progresses, an encumbrance or forecast will be estimated.
- Other divisions are in "Green Light" status

October 2013

Public Health Imperative

Summary of Public Health Laboratory Budget Item

Public Health Imperatives are characterized by services that protect the health and safety of the citizenry against infectious, occupational and environmental hazards; ensure adequate health and medical emergency preparedness and response; and offer protection to vulnerable persons against exposure to severe harm. These services are typically mandated and the public health agency is the sole provider. These services include infectious disease control programs, sanitation services, emergency preparedness and response and public protection services. These programs encompass essential public health services number 1, 2, 6 & 9



- The existing structure that houses the Public Health Laboratory (PHL) is over 40 years old and is antiquated. The OSDH is pursuing options for \$41.2 million Capital Improvement budget to construct a public health laboratory building to meet current and emerging public health needs.
- The PHL provides essential public health laboratory testing such as hepatitis, and HIV as well as specialized testing and consultations for rare, high-risk diseases, such as tuberculosis, rabies, botulism, malaria and plague.
- The OSDH PHL is the state's only laboratory authorized to perform Laboratory Response Network procedures on select agents. The PHL is also a Biological Safety Level 3 laboratory capable of analyzing and reporting on microbial and toxin threat agents, such as smallpox, anthrax, plague, or ricin in suspect "white powders."
- In addition to testing, the PHL provides specialized emergency response and preparedness training to private labs across the state.
- The PHL plays a vital role in early detection of infectious and food-borne disease outbreaks, tracking disease trends in the State of Oklahoma and providing vital laboratory data in multi-state food outbreaks.
- Approximately 52,000 babies undergo newborn screening for 53 inherited metabolic disorders each year in the laboratory. Early identification allows for proper medical management of these disorders and prevents infant death.

**OKLAHOMA STATE BOARD OF HEALTH
COMMISSIONER'S REPORT**

Terry Cline, Ph.D., Commissioner
October 8, 2013

PUBLIC RELATIONS/COMMUNICATIONS

Fran Kritz, RWJ, NewPublicHealth – interview
Oklahoma Healthy Aging Initiative's Central Center of Healthy Aging Open House
Reception for Good Shepherd Ministries
KOMA Radio – interview & PSAs
Oklahoma PTA Conference - speaker
ASTHO Senior Deputy Meeting – speaker
Oklahoma Primary Care Health Center Week Kickoff Event - speaker
Jaclyn Cosgrove, Oklahoman - interview
The Oklahoma Association of Disability Examiners & National Association of Disability
Examiners national conference – speaker
Oklahoma Health Care Authority Board Retreat – speaker
Oklahoma Health Center Foundation Board of Directors/CEO/Exec Committee Meeting
OUHSC First Year Medical Students - lecturer
Annual National Prevention Network & Research Conference
Cardiovascular Symposium, Norman Regional Health System – speaker
Tobacco Settlement Endowment Trust Board Meeting – speaker
Turning Point Annual Conference – speaker & presenter

SITE VISITS

Texas County Health Department
Beaver County Health Department
Harper County Health Department
Woods County Health Department
Woodward County Health Department
Wagoner County Health Department Open House

STATE/FEDERAL AGENCIES/OFFICIALS

Dr. Tom Frieden, Director, CDC
Dr. Joseph Cunningham, Julie Sloan, Chip Edmunds, BC/BS
Tornado After Action Meeting
Chris Bruehl, Director of Appointments, Governor Fallin
Dr. Nicole Lurie, Assistant Secretary for Preparedness & Response, U.S. HHS
Governor Fallin's Cabinet Meeting
Fran Harding, Director & Rich Lucey, Special Assistant, HHS, SAMHSA/Center for Substance
Abuse Prevention Substance

Preston Doerflinger, Secretary of Finance, Administration and Information Technology
Deby Snodgrass, Secretary of Tourism
Tracey Strader, Executive Director, TSET & Ted Wagoner, E cig
Frank Wilson, Executive Director & Paul King, Compliance Officer, Oklahoma Employee
Group Insurance Division
IT Health & Human Services Shared Services Governance Meeting
Oklahoma Health & Human Services Cabinet Meeting

OTHERS:

Tulsa Health Department Board Meeting
Oklahoma City County Health Department Board Meeting
ASTHO Leadership for New Health Officials
Sheryl Lovelady, Executive Director, Oklahoma Afterschool Network & Angela Monson
Sterling Zearly, Executive Director, Oklahoma Public Employee Association
Advisory Committee to the Director of CDC, State, Tribal, Local and Territorial committee
ASTHO Prescription Drug Strategic Mapping
ASTHO/United Health Foundation Learning Collaborative Meeting
Jane Nelson & Kristy Baker, Oklahoma Nursing Association
Reforming States Group Steering Committee
ASTHO & Brandeis Meeting, Prescription Drug Monitoring Program
Oklahoma Health Improvement Plan Executive Team
ASTHO Annual Policy Summit & Annual Meeting