

**Agenda for the 11:00 a.m., Tuesday, March, 12, 2013
Regular Meeting of the Oklahoma State Board of Health**

Posted at www.health.ok.gov

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

- I. CALL TO ORDER AND OPENING REMARKS
- II. REVIEW OF MINUTES
 - a) **Approval of Minutes for February 12, 2013 Board of Health Meeting**
- III. PROPOSED RULEMAKING ACTIONS

Discussion and possible action on the following:

PROTECTIVE HEALTH SERVICES

b) CHAPTER 400. LICENSED MARITAL AND FAMILY THERAPISTS [AMENDED]

[PERMANENT] Presented by Henry Hartsell

PROPOSED RULES: Subchapter 1. General provisions 310:400-1-3. Definitions [AMENDED]; Subchapter 5. Rules of professional conduct 310:400-5-3. Professional competence and integrity [AMENDED]; Subchapter 9. Licensure examinations 310:400-9-2. Format [AMENDED]; 310:400-9-4. Application [AMENDED]; Subchapter 15. Issuance and maintenance of license 310:400-15-3. License renewal [AMENDED]; 310:400-15-4. Continuing education. [AMENDED]; 310:400-15-8. Licensure by endorsement [AMENDED]; 310:400-15-9. Temporary license [REVOKED].

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 59 O.S. Section 1925.5 *et seq.*

SUMMARY: The proposed rules address those individuals who are a Licensed Marital and Family Therapist (LMFT), those persons who are LMFT candidates, and those individuals holding a license from another jurisdiction who wish to become an LMFT in the State of Oklahoma. The proposed rule modifications would more closely align the state program with national standards; provide professional standards for forensic services; remove the oral examination component thereby removing subjectivity from the scoring of results; simplify provisions for reporting continuing education; and revise requirements for licensure by endorsement, offering new avenues for licensure.

c) CHAPTER 405. LICENSED PROFESSIONAL COUNSELORS [AMENDED]

[PERMANENT] Presented by Henry Hartsell

PROPOSED RULES: Subchapter 1. General provisions 310:405-1-2.1. Definitions [AMENDED]; Subchapter 3. Rules of professional conduct 310:405-3-2. Competence [AMENDED]; Subchapter 9. Academic requirements 310:405-9-2. Knowledge area required [AMENDED]; Subchapter 17. Continuing education requirements 310:405-17-2. Number of hours required [AMENDED]; 310:405-17-3. Acceptable continuing education [AMENDED]; 310:405-17-4.1. Continuing education accrual from home-study or technology-assisted distance learning courses [AMENDED]; Subchapter 21. License and specialty renewal 310:405-21-5. Requirements for renewal [AMENDED]; Subchapter 27. Licensure by endorsement 310:405-27-3. License by endorsement [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 59 O.S. Section 1905 *et seq.*

SUMMARY: The proposed rules address those individuals who are a Licensed Professional Counselor (LPC), those persons who are LPC candidates, and those individuals holding a license from another jurisdiction who wish to become an LPC in the State of Oklahoma. The proposed rule modifications would more closely align the state program with national standards; provide professional standards for forensic services; remove the oral examination component thereby removing subjectivity from the scoring of results; simplify provisions for reporting continuing education; and revise requirements for licensure by endorsement, offering new avenues for licensure.

d) **CHAPTER 451. FIRE EXTINGUISHER INDUSTRY [AMENDED]**

[PERMANENT] Presented by Henry Hartsell

PROPOSED RULES: Subchapter 1. General Provisions 310:451-1-3. Adopted references [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 59 O.S. Section 1820.19.

SUMMARY: The current rule references building and fire safety codes that are incorporated by reference as the minimum standard of installation for the fire extinguisher industry in Oklahoma. These codes are consensus standards adopted by the International Code Council, the Oklahoma Uniform Building Code Commission, and the National Fire Protection Association with the participation of state, county and municipal code officials and fire officials, architects, engineers, builders, contractors, elected officials, manufacturers and others in the construction industry. These codes are updated by these bodies periodically. The proposed change would update the references to more recent versions of the codes. The result of this change will be to apply current building and fire codes to the fire extinguisher industry.

e) **CHAPTER 667. HOSPITAL STANDARDS [AMENDED]**

[PERMANENT] Presented by Henry Hartsell

PROPOSED RULES: Subchapter 15. Nursing Service 310:667-15-6 [AMENDED]; Subchapter 19. Medical records department 310:667-19-2 [AMENDED]; Subchapter 21. Drug distribution 310:667-21-8 [AMENDED]; Subchapter 39. Critical access hospital 310:667-39-9 [AMENDED]; Subchapter 40. Emergency hospital 310:667-40-9 [AMENDED]; 310:667-40-11 [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Sections 1-104 and 1-705

SUMMARY: This proposal removes the 48 hour time limit for authentication of certain verbal orders given by physicians and practitioners. The current rule requires signatures by physicians or practitioners within 48 hours after giving verbal orders for medications, treatments and tests. After the change, telephone or verbal orders will be authenticated pursuant to each hospital's medical staff bylaws. The proposal will enable hospitals to implement recent changes in federal rules governing Medicare certification of hospitals at Title 42 of the Code of Federal Regulations, Section 482.24(c) with the purpose of reducing a regulatory and financial burden on hospitals.

IV. STRATEGIC MAP UPDATE PRESENTATION: Mark Newman, Ph.D., Director, Office of State and Federal Policy

V. CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee – Dr. Krishna, Chair

Discussion and possible action on the following:

f) Update

Finance Committee – Dr. Woodson, Chair

Discussion and possible action on the following:

g) Update

Accountability, Ethics, & Audit Committee – Mr. Smith, Chair

Discussion and possible action on the following:

h) Update

i) Internal Audit Charter

Public Health Policy Committee – Mr. Gerard, Chair

Discussion and possible action on the following:

j) Update

VI. PRESIDENT'S REPORT

Related discussion and possible action on the following:

k) Update

l) Assign members to Nominating Committee

VII. COMMISSIONER'S REPORT

Discussion and possible action

VIII. NEW BUSINESS

Not reasonably anticipated 24 hours in advance of meeting.

IX. PROPOSED EXECUTIVE SESSION

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

Possible action taken as a result of Executive Session.

X. ADJOURNMENT

STATE BOARD OF HEALTH

Cleveland County Health Department
424 S Eastern
Moore, OK 73160

Tuesday, February 12, 2013 11:00 a.m.

R. Murali Krishna, President of the Oklahoma State Board of Health, called the 376th regular meeting of the Oklahoma State Board of Health to order on Tuesday, February 12, 2013 at 11:01a.m. The final agenda was posted at 5:31 a.m. on the OSDH website on February 8, 2013, and at 10:00 a.m. at the Cleveland County Health Department building entrance on February 11, 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; Jenny Alexopoulos, D.O.; Barry L. Smith, J.D.; Timothy E. Starkey, M.B.A.;

Members Absent:

Terry Gerard, D.O.; Cris Hart-Wolfe

Central Staff Present: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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, Office of State & Federal Policy; Dan Durocher, Director of the Office of Accountability; Lloyd Smith, Director of Internal Audit; Don Maisch, Office of General Counsel; Leslea Bennett-Webb, Office of Communications; Joyce Marshall; Jay Holland; Commissioner's Office; Janice Hiner, VaLauna Grissom.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Dr. Krishna called the meeting to order. Dr. Krishna thanked Shari Kinney, Administrator for Cleveland County Health Department for hosting the February Board meeting. He also recognized guests in attendance, Rod Cleveland, Rusty Sullivan, Darry Stacy, Candida Manion, Travis Humpry, Sara Raney, Patty Johnson, Paula Price.

REVIEW OF MINUTES

Dr. Krishna directed attention to review of the minutes of the January 8, 2013, Regular Board meeting.

Ms. Burger moved Board approval of the minutes of the January 8, 2013, Regular Board meeting, as presented. Second Dr. Alexopoulos. Motion carried.

AYE: Alexopoulos, Burger, Krishna, Smith, Starkey, Woodson

ABSENT: Gerard, Wolfe

APPOINTMENTS

Dr. Hank Hartsell requested advice and consent from the Oklahoma State Board of Health for appointment of four new members to the Hospital Advisory Council by the State Commissioner of Health. The proposed appointees are: Heather L. Holmes Bell, Darrel Morris, Dave Wallace, and Darin L. Smith. With no discussion or objections noted, Dr. Krishna thanked Dr. Hartsell for his recommendations.

Mr. Smith moved Board approval of the four recommendations to the Hospital Advisory Council, as presented. Second Dr. Alexopoulos. Motion carried.

AYE: Alexopoulos, Burger, Krishna, Smith, Starkey, Woodson

ABSENT: Gerard, Wolfe

CLEVELAND COUNTY HEALTH DEPARTMENT PRESENTATION

Shari Kinney, Dr.PH, RN, Administrator for Cleveland County Health Department

Cleveland and McClain County Health Departments

presentation to the
State Board of Health
February 12, 2013



Cleveland County, Oklahoma
January 2012



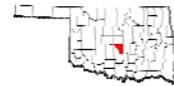
www.shapeyourfutureok.com

Mobilizing for Action through Planning & Partnerships (MAPP)

- The Cleveland County Turning Point Coalition along with community partnerships participated in a year long assessment process
- The committee conducted 4 assessments to look at health status, community assets, the local public health system, and forces of change
- The group summarized the 4 assessment findings to prioritize goals and strategies for the county
- The action cycle begins



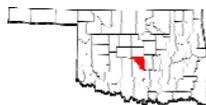
Cleveland County Health Status Assessment



2010 US Census	Oklahoma	Percent (%)	Cleveland County	Percent (%)
Total Population	3,751,351		255,755	7%
Age				
Under 19 years	929,666	25%	59,176	23%
18-64 years	2,314,970	62%	170,402	67%
65+ years	506,715	14%	26,177	10%
Race/ethnicity				
White	2,706,845	72%	202,811	79%
Hispanic/Latino	332,007	9%	17,892	7%
African American	277,644	7%	10,848	4%
Asian	65,076	2%	9,698	4%
Native American	321,687	9%	11,978	5%

2011 State of the State's Health Report Cleveland County

- Leading causes of death were heart disease, cancer and stroke.
- Increased prevalence of diabetes, obesity.
- Increase in physically inactive adults.
- Decrease in children with complete primary immunization series.



Priority Area- Tobacco Use Prevention

- Objectives:
- By 2016, reduce Cleveland County's adult smoking rate from 21.6% to 20%
- By 2016, reduce tobacco use in Cleveland County from 21.4% to 20%
- By 2016, increase annual average utilization of the Oklahoma Tobacco Helpline in Cleveland County from 140 to 150 clients.

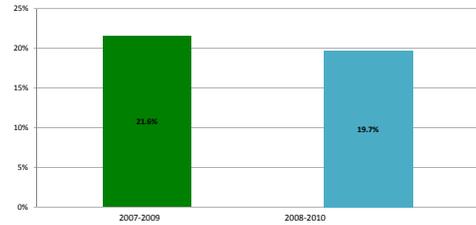
Tobacco Prevention

- 8th year for Cleveland County to receive TSET tobacco control grant funding
- Work with the two remaining school districts in Cleveland County - Robin Hill and Lexington - to adopt a 24/7 tobacco free policy
- Educate and assist organizations and businesses in Cleveland County in adopting a tobacco free worksite policy
- Provide technical assistance in the adoption of a tobacco free policy for all parks in the City of Moore
- Advocate for H.B. 2267, which will restore local rights



Tobacco Use Prevention Outcomes

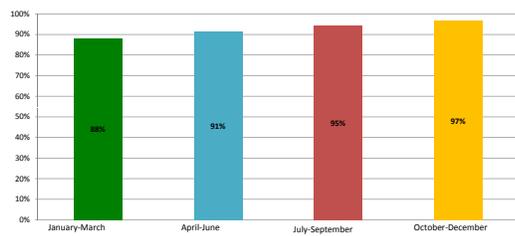
Percent of Current Smokers in Cleveland County



Data Source: BRFSS

Tobacco Use Prevention Outcomes

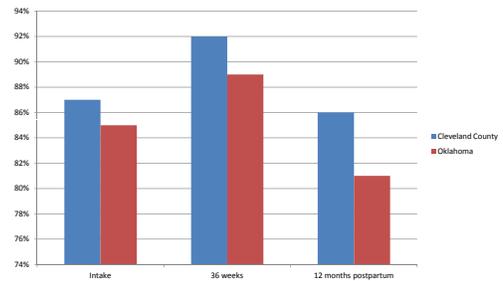
Cleveland County Health Department 5 A's Program Completion, 2012



Data Source: Cleveland County Health Department Internal Quality Review Audits

Tobacco Use Prevention Outcomes

Children First Client Smoking Cessation, SFY 2012



Data Source: Oklahoma State Department of Health Public Health Client Information System (PHOCIS)

Priority Area- Obesity Reduction

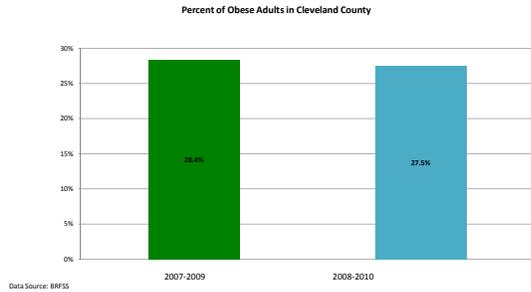
- Objectives:
- By 2016, reduce Cleveland County's obesity rate from 28.4% to 27%.
- By 2016, increase Cleveland County's fruit and vegetable consumption from 16.1% to 20%
- By 2016, increase Cleveland County's physical activity percent from 73.7% to 76%

Obesity Reduction

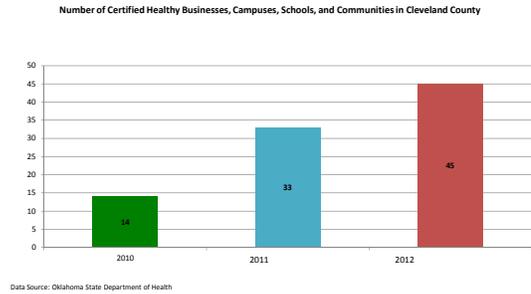
- Promote and increase Certified Healthy Restaurants, communities, and schools
- Increase worksites, schools, and after-school programs with a nutrition policy supporting healthy eating
- Improve access to affordable healthy foods
- Increase utilization of farmers markets
- Increase communities with a land use or master plan that includes safety and mobility of all users of all transportation systems
- Increase worksites, schools, and after-school programs with a policy that allows and encourages daily physical activity



Obesity Reduction Outcomes



Obesity Reduction Outcomes



Obesity Reduction Outcomes

- Cleveland County Nutrition & Fitness Community Forum
 - featuring the “Weight of the Nation Event” HBO Series
 - 75 in attendance including all school districts in Cleveland County.

Priority Area- Children’s Health

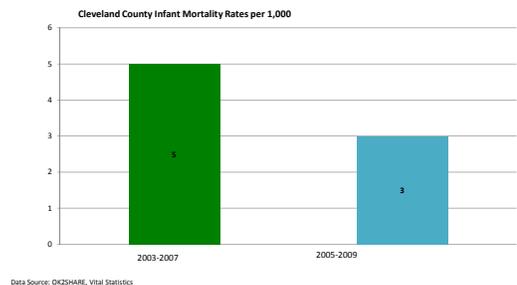
- Objectives:
 - By 2016, reduce Cleveland County’s infant mortality rate from 6.3 to 6 per 100,000 population.
 - By 2016, reduce sleep-related deaths for infants.
 - By 2016, increase Cleveland County’s completed immunizations < 3 years from 70.9% to 75%

Children’s Health

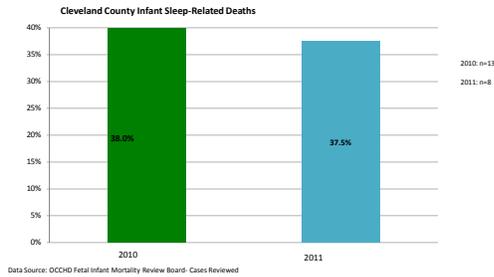
- Provide local clinics quarterly immunization rate assessments to increase immunization rates
- Provide oral health education in schools and communities
- Perform infant death case reviews
- Provide safe sleep education
- Provide car seat checks
- Implement Coordinated Approach to Child Health (CATCH) Program
- Perform tobacco & alcohol compliance checks



Children’s Health Outcomes



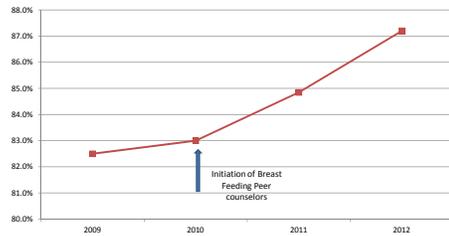
Children's Health Outcomes



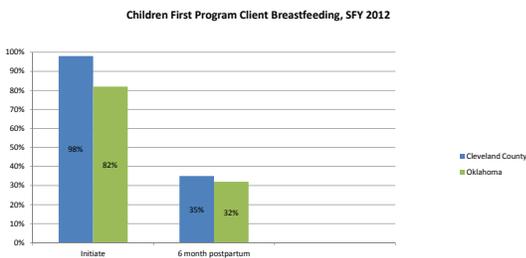
Data Source: OCHHO Fetal Infant Mortality Review Board: Cases Reviewed

Children's Health Outcomes

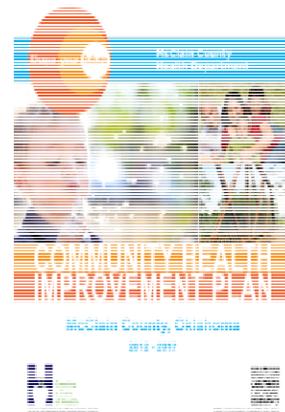
Breastfeeding Initiation Rates in WIC Mothers by Calendar Year
Cleveland County
Breastfeeding Peer Counselors Initiated 2010



Children's Health Outcomes



Data Source: Oklahoma State Department of Health Public Health Client Information System (PHOCIS)



Mobilizing for Action through Planning & Partnerships (MAPP)

- The McClain County Turning Point Coalition along with community partnerships participated in a year long assessment process
- The committee conducted 4 assessments to look at health status, community assets, the local public health system, and forces of change
- The group summarized the 4 assessment findings to prioritize goals and strategies for the county
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McClain County Health Status Assessment



2010 US Census	Oklahoma	Percent (%)	McClain County	Percent (%)
Total Population	3,751,351		34,506	1%
Age				
Under 19 years	929,666	25%	59,176	26%
18-64 years	2,314,970	62%	170,402	61%
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Race/ethnicity				
White	2,706,845	72%	202,811	85%
Hispanic/Latino	332,007	9%	17,892	7%
African American	277,644	7%	10,848	1%
Asian	65,076	2%	9,698	<1%
Native American	321,687	9%	11,978	6%

2011 State of the State's Health Report McClain County

- Leading causes of death were heart disease, cancer and chronic lower respiratory disease.
- Increased prevalence of diabetes (21%), obesity (34%) and asthma (69%).
- Increase in physically inactive adults, with double the number of limited activity days.



2011 State of the State's Health Report McClain County

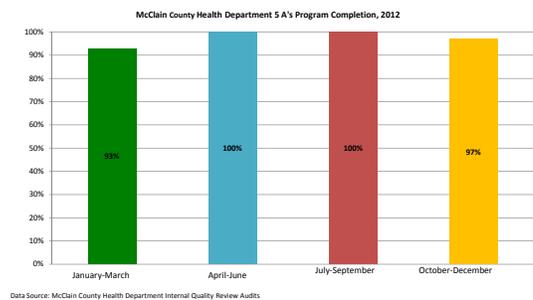
- Decrease in adults who consumed the recommended serving of fruits and vegetables daily.
- Decrease in children with complete primary immunization series.



Priority Area- Tobacco Use Prevention

- Objectives:
- By 2017, reduce McClain County's adult smoking rate from 17.2% to 16%.
- By 2017, reduce tobacco use in McClain County from 16.8% to 15.8%
- By 2017, increase annual average utilization of the Oklahoma Tobacco Helpline in Cleveland County from 25.7% to 28%.

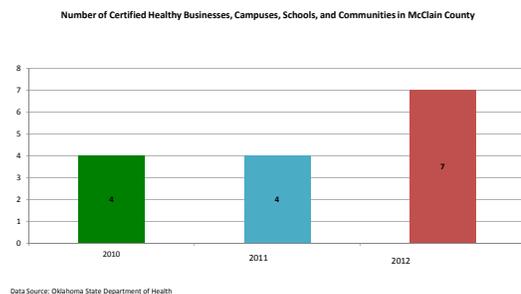
Tobacco Use Prevention Outcomes



Priority Area- Obesity Reduction

- Objectives:
- By 2017, reduce McClain County's obesity rate from 35.1% to 34%
- By 2016, increase McClain County's access to healthy foods from 33% to 48%
- By 2016, increase Cleveland County's physical activity within the last month from 27.3% to 31%.

Obesity Reduction Outcomes



Priority Area- Children's Health

- Objectives:
- By 2017, decrease McClain County low birth weight from 8.6% to 8 %.
- By 2017, increase McClain County completed immunizations <3 years from 70.7% to 74%.
- By 2017, increase McClain County completed car seat checks.

Priority Area- Children's Mental Health and Substance Abuse

- Objectives:
- By 2017, decrease the percent of McClain County youth who report current alcohol use in the past 30 days from 15% to 10%.
- By 2017, decrease the percent of McClain County youth who report favorable attitudes towards drug use from 51.6% to 46.6%.
- By 2017, increase school participation in state youth risk behavior survey data collection.

Partnerships, Grants & Recognition

- National Leadership Academy for the Public's Health Award- Cleveland County Health Department, City of Moore, Norman Regional Health System and Absentee Shawnee Tribe
- National Networks of Public Health Institutes/Robert Wood Johnson Quality Improvement Grant
- Tobacco Free Cleveland County TSET funding- 9th grant year \$340,000

Partnerships, Grants & Recognition

- Tobacco Free McClain County- TSET funding 2nd grant year \$142,000
- Cleveland County Nutrition & Fitness- TSET funding 2nd grant year \$142,000
- City of Noble – Oklahoma Turning Point Excellence Award in Child Health 2012 and Excellence Certification Certified Healthy Community

Questions?



1 Dr. Krishna commented that obesity rates in Cleveland County appear to be lower than in Oklahoma County and
2 asked Mrs. Kinney to what does she attribute the lower rates. Mrs. Kinney indicated that most indicators for
3 Cleveland County, although not lower than the national average, are lower than the state average. She attributed
4 these outcomes to the successful community partnerships in Cleveland County as well as the amount of revenue
5 received through local millage.

6
7 **COMMITTEE REPORTS**

8 **Executive Committee**

9 Dr. Krishna provided the following reminders Board:

- 10 • The April Board of Health meeting will take place at the Woodward High Plains Technology Center in
11 Woodward, OK. VaLauna will follow up with each of you with travel details.
12 • Please remember to follow up with VaLauna regarding submission of the annual ethics forms due by May
13 15, 2013.
14 • March is the timeframe in which the Nominating Committee will be assigned for the election of officers.
15 The Committee recommendations and election will take place in June, and new officers will become
16 effective July 1, 2013.
17 • Please mark your calendars to attend the Annual Employee of the Year Recognition Ceremony to be held in
18 May directly following the Board meeting.

19
20 **Finance Committee**

21 **Expenditure Forecast Assumptions**

22 Dr. Woodson directed attention to the Financial Brief provided to each Board member and presented the following
23 Finance Report and Board Brief as of January 29, 2013:

- 24 • Payroll forecasted through June 30, 2013 including vacancies likely to fill within the current budget period
25 • Encumbrances shown as actual as of the report date.
26 • Expenditure forecasts limited to realistic amounts expected to spend out during the current budget period.
27 • Surplus/(Deficit) is projected as of June 30, 2013.

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

- 29 • Overall the Department is forecasted to spend 97.45% of its budget.
30 • Community and Family Health Services and Protective Health Services have “Green Lights” as they have
31 had for the last several months.
32 • Health Improvement Services currently has a “Red Light” due to a recently budgeted carryover of \$1.9
33 million. These funds are dedicated to access to care, primarily for expanding and sustaining Federally
34 Qualified Health Centers. This funding will be used to continue to study barriers to access to care in
35 Oklahoma and identify solutions in accordance with OHIP Access to Care action plan. As these plans are
36 formalized, the “Red Light” should improve.
37 • Prevention and Preparedness Services and Public Health Infrastructure have “Yellow Lights” with
38 performance rates of 93.53% and 94.64%, respectively. These have not significantly changed since the
39 December report but are expected to improve over the next six months.
40 • All expenditures will be monitored closely and adjustments in spending will be made as needed to ensure
41 optimal budget performance for the Department.

42
43 Dr. Woodson indicated that the Department is making contingencies in the event of federal budget cuts. He
44 directed attention to the Financial Statement Audit from the Office of the State Auditor and Inspector. The letter
45 indicates there are no significant reportable findings as a result of the State’s Comprehensive Annual Financial
46 Audit for the State Fiscal Year ending June 30, 2013. There were no questions or comments related to the finance
47 report, the financial statement, or the quarterly performance and operational dashboard found in the Board packet.

48
49 The report concluded.

50
51 **Accountability, Ethics & Audit Committee**

52 The Accountability, Ethics, & Audit Committee met with Lloyd Smith, Jay Holland, and Dan Durocher. Mr.
53 Smith reported that there are no known significant issues to report at this time.

1 The report concluded.
2

3 **Public Health Policy Committee**

4 The Policy Committee met on Tuesday, February 12, 2013. Mr. Starkey met with Mark Newman at the
5 Cleveland County Health Department in Moore, Oklahoma. Mark Newman provided an update regarding
6 legislation requested by the agency. Electronic copies of the Policy Committee Report for February 11, 2013
7 were emailed to all BOH members by VaLauna. These reports will continue to be sent each Monday
8 throughout the legislative session.
9

10 The local rights legislation may be found in **SB 36** authored by Sen. Frank Simpson and Rep. Doug Cox has
11 been assigned to the Senate Health and Human Services Committee chaired by Sen. Brian Crain. Governor
12 Mary Fallin declared her support for the local rights issue in her State of the State address on the first day of the
13 legislative session. The Policy Committee recommends that each member of the BOH take the time to
14 personally thank Governor Fallin for her courageous stand in support of allowing communities to shape their
15 economic future and improve the health outcomes of their citizens by supporting this issue.
16

17 **SB 347**, which would transfer the Fire Extinguisher Licensing program from the State Department of Health to
18 the Office of the State Fire Marshall, has passed out of the General Government Committee and is headed to the
19 Senate Floor.
20

21 **SB 578**, which would establish a revolving fund for civil monetary penalties, and **SB 795**, which would clarify
22 unclassified positions within the department, are assigned to the Senate Appropriations Committee and are
23 expected to receive a hearing this week.
24

25 **HB 1083**, which clarifies terms in the Emergency Medical Services program to comply with national
26 accreditation, and **HB 1356**, which would extend for three years the ability to partially compensate restaurant
27 owners which voluntarily close their smoking rooms, have been assigned to the House Public Health Committee
28 and should be heard next week.
29

30 If members of the Board have any questions regarding policy issues, proposed legislation, or would like to
31 provide input, please contact Mark Newman. The next meeting of the Policy Committee will be prior to the
32 March Board Meeting.
33

34 The report concluded.
35

36 **BOARD DEVELOPMENT COMMITTEE**

37 Cris Hart-Wolfe was unable to attend due to inclement weather. Barry Smith indicated that the full committee was
38 unable to meet; however, the committee continues to review the Board Bylaws as well as seek out local and
39 statewide advocacy opportunities for members of the Board.
40

41 The report concluded.
42

43 **PRESIDENT'S REPORT**

44 Dr. Krishna indicated that following the Public Health Accreditation (PHAB) site visit, the Department
45 received a very favorable preliminary report and responded with factual corrections on January 15th. The
46 report indicates that 99% of the PHAB measures received a rating of "Largely to Fully Demonstrated" with
47 "Fully Demonstrated" being the highest rating. The final report has been submitted to the PHAB
48 Accreditation Committee the Department expects to receive notification of accreditation status by mid-
49 March.
50

51 Dr. Krishna briefly discussed his attendance at a recent press conference regarding the health impact of tobacco in
52 Oklahoma. Dr. Krishna indicated the issue of Senate Bill 36 is extremely important. He referenced studies
53 published in peer-reviewed medical journals indicating that smoke-free policies can expect to reduce smoking
54 rates and secondhand smoke exposure. He further commented that the scientific evidence around this issue is
55 very clear and encouraged the Board to continue to advocate for strategies to positively impact the health of all

1 Oklahomans.

2
3 **COMMISSIONER'S REPORT**

4 Dr. Cline began his report with a few pictures from a Mission of Mercy event in Lawton held February 1-, 2013.
5 The event is a free, two-day dental clinic open to people of all ages and backgrounds. The outreach is intended
6 for the uninsured, the underinsured, or those who would otherwise not be able to obtain dental care.
7 Approximately 1800 volunteers provided services to approximately 1786 patients. Services included
8 restorations (Fillings), extractions, cleanings, root canals, immunizations, and screenings from community
9 nurses and physicians. Dr. Cline recognized the Comanche County Health Department for providing heated
10 tents for those waiting in the cold to receive services. He also recognized local partners for providing meals to
11 individuals during the event. Dr. Woodson also attended the event and commented that the community
12 partnerships were very impressive.

13
14 Dr. Cline asked Leslea Bennett-Webb, Office of Communications, to give a brief summary of media inquiries in the
15 week leading up to the Board meeting. Leslea indicated that Governor Fallin's recent announcement to lead an
16 initiative aimed at reducing second hand smoke has produced a lot of public activity and media response around the
17 issue. She referenced recent editorials in the Oklahoman, the Journal Record, and other media outlets. Media
18 outlets as well as communities are affirming their support of the initiative.

19
20 Next, Dr. Cline mentioned the upcoming Certified Healthy Awards event scheduled for February 28th at the Cox
21 Convention Center. There were over 1,000 applications for business and organizations to receive Certified Healthy
22 status. All Board members are invited to attend.

23
24 Dr. Cline concluded his report by highlighting his attendance at a meeting sponsored by the National Safety Council
25 to around the misuse of prescription drugs. Prescription drug misuse has become a primary issue nationally. Deaths
26 due to misuse of prescription drugs now kill more Oklahomans than motor vehicle accidents, approximately 620
27 deaths annually. There has been great collaboration with the Department of Mental Health and Substance Abuse to
28 tackle this issue in Oklahoma.

29
30 The report concluded.

31
32 **NEW BUSINESS**

33 No new business. Dr. Krishna asked each member of the Board as well as Bruce Dart and Gary Cox to give a brief
34 1 minute introduction. Dr. Woodson announced that a 5k dash/run has been organized for Friday, March 29th, at the
35 OU Health Sciences Center campus. The purpose of the run is both to support individual health but will also help
36 to support a series of free health clinics in the Oklahoma City area. He encouraged all to participate.

37
38 **EXECUTIVE SESSION**

39 **Mr. Smith Board approval to move into Executive Session at 1:25p.m.** pursuant to 25 O.S. Section
40 307(B)(4) for confidential communications to discuss pending department litigation and investigations;
41 pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion,
42 disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section
43 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements
44 of state or federal law.

- 45 • Annual performance evaluation for the Commissioner of Health and Office of Accountability
46 Systems Director.

47 **Second Dr. Alexopulos. Motion carried.**

48
49 **AYE: Alexopulos, Burger, Krishna, Smith, Starkey, Woodson**

50 **ABSENT: Gerard, Wolfe**

51
52 **Mr. Starkey moved Board approval to move out of Executive Session at 2:20 p.m. Second Ms. Burger.**
53 **Motion Carried.**

54
55 **AYE: Alexopulos, Burger, Krishna, Smith, Starkey, Woodson**

1 **ABSENT: Gerard, Wolfe**

2
3 **Ms. Burger moved Board approval to form an Ad Hoc committee to review the role of the Office of**
4 **Accountability and other investigations conducted by the Department. Second Dr. Woodson. Motion**
5 **carried.**

6
7 **AYE: Alexopulos, Burger, Krishna, Smith, Starkey, Woodson**

8 **ABSENT: Gerard, Wolfe**

9
10 **ADJOURNMENT**

11 **Dr. Woodson moved Board approval to Adjourn. Second Ms. Burger. Motion carried.**

12
13 **AYE: Alexopulos, Burger, Krishna, Smith, Starkey, Woodson**

14 **ABSENT: Gerard, Wolfe**

15
16 The meeting adjourned at 1:26 p.m.

17
18 Approved

19
20 _____
21 R. Murali Krishna, M.D.

22 President, Oklahoma State Board of Health

23 February 12, 2013



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T.C.*
Commissioner

Through: James Joslin, Chief *J.J.*
Health Resources Development Service
Agency Rule Liaison

Through: Hank Hartsell, Jr. *H.H.*
Deputy Commissioner

From: Don Maisch *Don D. Maisch*
General Counsel

Date: February 8, 2013

Subject: Rule Packet Submission for Distribution to Board of Health
Chapter 400, Licensed Marital and Family Practice

The attached documents are submitted for **PERMANENT ADOPTION** by the State Board of Health at their March 12, 2013, meeting.

There has been only once additional change proposed since the last review. This proposed change is in response to comments received from Dr. Laura Boyd, Executive Director, Oklahoma Therapeutic Foster Care Association. The proposed change is specific located in OAC 310:400-5-3 (n) (6). The change was the addition of new language in this rule section (please see the Rule Text or the Rule Comment Summary) for the language.

Attachments:

- **RIS (Rule Impact Statement)**
- **Rule Text**
- **Rule Comment Summary**

(Please contact Leslie Roberts at x57205 for corrections, pick-up and delivery.)

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 400. LICENSED MARITAL AND FAMILY THERAPISTS**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General provisions

310:400-1-3. Definitions [AMENDED]

Subchapter 5. Rules of professional conduct

310:400-5-3. Professional competence and integrity [AMENDED]

Subchapter 9. Licensure examinations

310:400-9-2. Format [AMENDED]

310:400-9-4. Application [AMENDED]

Subchapter 15. Issuance and maintenance of license

310:400-15-3. License renewal [AMENDED]

310:400-15-4. Continuing education. [AMENDED]

310:400-15-8. Licensure by endorsement [AMENDED]

310:400-15-9. Temporary license [REVOKED]

SUMMARY:

The proposed rules address those individuals who are a Licensed Marital and Family Therapist (LMFT), those persons who are LMFT candidates, and those individuals holding a license from another jurisdiction who wish to become an LMFT in the State of Oklahoma. The proposed rule modifications would more closely align the state program with national standards; provide professional standards for forensic services; remove the oral examination component thereby removing subjectivity from the scoring of results; simplify provisions for reporting continuing education; and revise requirements for licensure by endorsement, offering new avenues for licensure.

310:400-1-3. This rule provides definitions in support of this Chapter. The proposed change adds a definition for “Forensic services” which means the application of knowledge, training and experience from the mental health field to the establishment of facts and/or the establishment of evidence in a court of law or ordered by a court of law. A definition for the acronym OAC, which means the Oklahoma Administrative Code, is added.

310:400-5-3. This rule addresses standards of professional competence and integrity. The proposed modifications are prescribed for in Title 59 of the Oklahoma Statutes in Section 1925.5, which authorizes the Department, with regard to the recommendations of the Oklahoma Licensed Marital and Family Therapist Advisory Board, to adopt and establish rules of professional conduct. These proposed rule modifications are to notify LMFT and LMFT Candidates of the requirements that must be met when performing forensic services. These requirements will make clear the relationship between the LMFT or LMFT candidate and the client during the time forensic services are being provided. This will allow clients to make informed decisions concerning their lives. The language removed from (n)(2) covered activities that were not within the control of the LMFT or LMFT Candidate or the agency, but under the control of the court and handled by court order.

310:400-9-2 and 310:400-9-4. These rules address the examination format and the process for applying for the examination, respectively. The proposed modifications are prescribed for in Title 59 of the Oklahoma Statutes in Section 1925.7. These proposed rule modification will remove the oral part of the Oklahoma exam and give the exam a title. The exam is changing from an oral exam to a written exam which removes the subjectivity from the scoring of the results of the exam. Over

the past two years, the OSDH has reviewed the scores of the oral exams and have found wide variations of the scoring reports between examiners.

310:400-15-3. This rule addresses requirements for license renewal. The proposed new rule implements Title 59 of the Oklahoma Statutes in Section 1925.8. The Department proposes to amend this section to require the submission of a Continuing Education Roster on an official Department form when a licensee is submitting an application for renewal of his or her license. The Department will gather all required information on the Continuing Education Roster needed to renew the license. This proposed rule modification will allow the Department to better utilize its limited resources by expediting the licensure renewal review process.

310:400-15-4. This rule addresses requirements for continuing education. The proposed modification implements Title 59 of the Oklahoma Statutes in Section 1925.8 and seeks to recognize the number of hours contributed by the members of the LMFT Advisory Board. The proposed changes would allow the hours contributed by the LMFT Advisory Board Members to be counted for compliance with the continuing education requirements required by both state statute and state regulations. Other licensure organizations in the State of Oklahoma, such as the Oklahoma State Board of Examiners of Psychologists, also contain a similar allowance in their continuing education scheme.

310:400-15-8. This rule addresses requirements for licensure by endorsement. The proposed modifications implement Title 59 of the Oklahoma Statutes in Sections 1925.8 and 1925.9 by removing provisions for a temporary license and requirements for licensure endorsement that were not contained in Section 1925.9. The remaining changes specify the requirements for an individual who is licensed in another state to obtain a license from the State of Oklahoma. The proposed rule modifications will allow an increase in the number of potential applicants to be accepted for licensure by endorsement. The rule modifications allow the Department to look at experience as an alternative to educational requirements that are currently required but may not have been applicable at the time the applicant for licensure by endorsement received their education. The Department has denied applicants for licensure by endorsement who would otherwise be qualified, but do not meet the current educational requirements as contained in statute or regulation that were not required at the time the applicant received his or her education.

310:400-15-9. This rule addressed requirements for temporary licenses. The proposed modification implements Title 59 of the Oklahoma Statutes in Sections 1925.8 and 1925.9 by revoking the rule authorizing a temporary license which was not authorized in Section 1925.8 or 1925.9. The rule allowed a temporary license without clear standards for their issuance while a license by endorsement was pending. In some cases the temporary license existed for an extended period while candidates sought to pass the test or exhaustion of appeals. The revoked rule ensures those applying for a license by endorsement meet those requirements before practicing in the State of Oklahoma.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 59 O.S. Section 1925.5 *et seq.*

COMMENT PERIOD:

January 2, 2013, through February 6, 2013. Interested persons may informally discuss the proposed rules with Mr. Don Maisch, General Counsel, Office of General Counsel, before February 6, 2013. Submit written comment to Mr. Don Maisch, General Counsel, Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall

be on February 6, 2013, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 1102 beginning at 11:00 a.m. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule;. Business entities may submit this information in writing before February 6, 2013, to Mr. Don Maisch, General Counsel, Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov; or via agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available at the location listed above for obtaining copies of the rule.

CONTACT PERSON:

Mr. Don Maisch, General Counsel, Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov, telephone 405-271-6017.



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T.C.*
Commissioner

Through: James Joslin, Chief *J.J.*
Health Resources Development Service
Agency Rule Liaison

Through: Hank Hartsell, Jr. *H.H.*
Deputy Commissioner

From: Don Maisch *Don D. Maisch*
General Counsel

Date: February 8, 2013

Subject: Rule Packet Submission for Distribution to Board of Health
Chapter 405, Licensed Professional Counselors

The attached documents are submitted for **PERMANENT ADOPTION** by the State Board of Health at their March 12, 2013, meeting.

There has been only once additional change proposed since the last review. This proposed change is in response to comments received from Dr. Laura Boyd, Executive Director, Oklahoma Therapeutic Foster Care Association. The proposed change is specific located in OAC 310:405-3-2 (i) (6). The change was the addition of new language in this rule section (please see the Rule Text or the Rule Comment Summary) for the language.

Attachments:

- **RIS (Rule Impact Statement)**
- **Rule Text**
- **Rule Comment Summary**

(Please contact Leslie Roberts at x57205 for corrections, pick-up and delivery.)

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 405. LICENSED PROFESSIONAL COUNSELORS**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General provisions

310:405-1-2.1. Definitions [AMENDED]

Subchapter 3. Rules of professional conduct

310:405-3-2. Competence [AMENDED]

Subchapter 9. Academic requirements

310:405-9-2. Knowledge area required [AMENDED]

Subchapter 17. Continuing education requirements

310:405-17-2. Number of hours required [AMENDED]

310:405-17-3. Acceptable continuing education [AMENDED]

310:405-17-4.1. Continuing education accrual from home-study or technology-assisted distance learning courses [AMENDED]

Subchapter 21. License and speciality renewal

310:405-21-5. Requirements for renewal [AMENDED]

Subchapter 27. Licensure by endorsement

310:405-27-3. License by endorsement [AMENDED]

SUMMARY:

The proposed rules address those individuals who are a Licensed Professional Counselor (LPC), those persons who are LPC candidates, and those individuals holding a license from another jurisdiction who wish to become an LPC in the State of Oklahoma. The proposed rule modifications would more closely align the state program with national standards; provide professional standards for forensic services; remove the oral examination component thereby removing subjectivity from the scoring of results; simplify provisions for reporting continuing education; and revise requirements for licensure by endorsement, offering new avenues for licensure.

OAC 310:405-1-2.1. This rule provides definitions in support of this Chapter. The proposed change adds a definition for "Forensic services" which means the application of knowledge, training and experience from the mental health field to the establishment of facts and/or the establishment of evidence in a court of law or ordered by a court of law. Revises the definition for "Home-study or technology-assisted distance learning" and adds a definition for the acronym OAC, which means the Oklahoma Administrative Code. These proposed rule modifications support the rule modifications for forensic services in OAC 310:405-3-2(i) and in the proposed rule modifications for continuing education accrual located at OAC 310:405-17-4.1. The public health purpose for the addition of the definition of the term "forensic services" is to provide a description of what constitutes a forensic service so that the regulated community can properly inform and provide quality care to the public that they serve. The public health purpose for the modification to the definition of "home-study or technology-assisted distance learning" is to provide parameters and updates to the regulated community concerning how the delivery of graduate course work or continuing education may be obtained through means other than direct contact with the educator. The proposed modifications to Oklahoma Administrative Code (OAC) 310:405-1-2.1 are prescribed for in Title 59 of the Oklahoma Statutes in Section 1905 and in Title 59 of the Oklahoma Statutes in Section 1902.

OAC 310:405-3-2. This rule addresses standards of professional competence regarding counseling, testing, specialties, diagnosis of mental disorders, impairment; and evaluations. The proposed modifications are prescribed in Title 59 of the Oklahoma Statutes in Section 1905 (A). These proposed rule modifications will govern the competency of the practice of an LPC. The public health purpose of the proposed modifications in paragraphs (a) through new (h) is to align the State of Oklahoma regulations concerning LPCs with the national model proposals from the American Counseling Association (ACA). These modifications will allow individual receiving services to either come into the state of Oklahoma or leave the state of Oklahoma and have the ability to have a continuation of care or receive consistent treatment. The public health purposes of the proposed modifications in new paragraph (i) are to notify LPC and LPC Candidates of the requirements that must be met when performing forensic services. These requirements will make clear the relationship between the LPC or LPC candidate and the client during the time forensic services are being provided. This will allow clients to make informed decisions concerning their lives. The language removed from new paragraph (i) covered activities that were not within the control of the LPC or LPC Candidate or the agency, but under the control of the court and handled by court order.

OAC 310:405-9-2. This rule addresses required knowledge areas for an LPC. The proposed modifications are prescribed in Title 59 of the Oklahoma Statutes in Section 1906 (C). These proposed rule modifications provide definitions of the elective course knowledge areas required for licensure. The definitions will provide clarity concerning the information required for an evaluation of the elective course work. The clarity of the definitions will provide direction to the applicant concerning what information to submit to the Department. This information will allow the Department to review the application without repeated requests for more information concerning elective course work. The additional information will allow the Department to more expeditiously review application materials and save the Department's limited resources. Each year the Department receives between 500 and 600 new applications per year. Approximately 25% or between 125 and 150 of these applications are delayed due to inadequate information concerning elective course work. These changes should reduce the number of applications per year that are incomplete due to lack of complete descriptions of elective course work.

OAC 310:405-17-2 and 310:405-17-3. These rules address the number of continuing education hours required and acceptable continuing education, respectively. The proposed modifications implement Title 59 of the Oklahoma Statutes in Section 1908. These proposed rule modifications recognize the number of hours contributed by the members of the LPC Advisory Board. These proposed rule changes would allow the hours contributed by the LPC Advisory Board Members to be counted for compliance with the continuing education requirements required by both state statute and state regulations. Other licensure organizations in the State of Oklahoma, such as the Oklahoma State Board of Examiners of Psychologists, also contain a similar allowance in their continuing education scheme.

OAC 310:405-17-4.1. This rule addresses home-study or technology-assisted learning programs for continuing education. The proposed modifications implement Title 59 of the Oklahoma Statutes in Sections 1906 and 1908. These proposed rule modifications include distance learning in reference to home-study and technology-assisted learning to make consistent with rules for Licensed Marital and Family Therapists (LMFT) and Licensed Behavioral Practitioners (LBP) concerning distance learning. The changes to the LMFT and LBP rules were completed a few years ago, but the LPC Rules were not updated. These proposed rule modifications will allow the Department to better utilize its limited resources by making all programs consistent, thereby assisting in expediting the licensure process.

OAC 310:405-21-5. This rule pertains to requirements for license renewal. The proposed

modifications implement Title 59 of the Oklahoma Statutes in Section 1908. The Department proposes to amend this section to require the submission of a Continuing Education Roster on an official Department form when a licensee is submitting an application for renewal of his or her license. The Department will gather all required information on the Continuing Education Roster needed to renew the license. This proposed rule modification will allow the Department to better utilize its limited resources by expediting the licensure renewal review process.

OAC 310:405-27-3. This rule pertains to requirements for licensure by endorsement. The proposed modifications implement Title 59 of the Oklahoma Statutes in Section 1909. These proposed rule modifications remove requirements for licensure by endorsement that were not contained in Section 1909. The remaining changes specify the requirements for an individual who is licensed in another state to obtain a license from the State of Oklahoma. The proposed rule modifications will allow an increase in the number of potential applicants to be accepted for licensure by endorsement. The rule modifications allow the Department to look at experience as an alternative to educational requirements that are currently required but may not have been applicable at the time the applicant for licensure by endorsement received their education. The Department has denied applicants for licensure by endorsement who would otherwise be qualified, but do not meet the current educational requirements as contained in statute or regulation that were not required at the time the applicant received his or her education.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 59 O.S. Section 1905 *et seq.*

COMMENT PERIOD:

January 2, 2013, through February 6, 2013. Interested persons may informally discuss the proposed rules with Mr. Don Maisch, General Counsel, Office of General Counsel, before February 6, 2013. Submit written comment to Mr. Don Maisch, General Counsel, Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on February 6, 2013, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 1102 beginning at 11:00 a.m. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule;. Business entities may submit this information in writing before February 6, 2013, to Mr. Don Maisch, General Counsel, Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov; or via agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available at the location listed above for obtaining copies of the rule.

CONTACT PERSON:

Mr. Don Maisch, General Counsel, Office of General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; via e-mail to DonM@health.ok.gov, telephone 405-271-6017.



Oklahoma State Department of Health
Creating a State of Health

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *TC*
Commissioner

Through: James Joslin, Chief *JJ*
Health Resources Development Service
Agency Rule Liaison

Through: Henry Hartsell, Ph.D. *HH*
Deputy Commissioner

From: Mr. K.C. Ely, Chief,
Consumer Health Services,

Date: February 8, 2013

Subject: Rule Packet Submission for Distribution to Board of Health
Chapter 451. Fire Extinguisher Industry

The attached documents are submitted for **PERMANENT ADOPTION** by the State Board of Health at their March 12, 2013, meeting.

NO CHANGES: No comments were received and no changes were made after prior Senior Leadership approval. The current rule references building and fire safety codes that are incorporated by reference as the minimum standard of installation for the fire extinguisher industry in Oklahoma. These codes are consensus standards adopted by the International Code Council, the Oklahoma Uniform Building Code Commission, and the National Fire Protection Association with the participation of state, county and municipal code officials and fire officials, architects, engineers, builders, contractors, elected officials, manufacturers and others in the construction industry. These codes are updated by these bodies periodically. The proposed change would update the references to more recent versions of the codes. The result of this change will be to apply current building and fire codes to the fire extinguisher industry.

Attachments:

- **RIS (Rule Impact Statement)**
- **Rule Text**
- **Rule Comment Summary**
-

(Please contact Jenni Shelton at x57205 for corrections, pick-up and delivery.)

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 451. FIRE EXTINGUISHER INDUSTRY**

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking

PROPOSED RULES:

Subchapter 1. General Provisions

310:451-1-3. Adopted references [AMENDED]

SUMMARY:

The current rule references building and fire safety codes that are incorporated by reference as the minimum standard of installation for the fire extinguisher industry in Oklahoma. These codes are consensus standards adopted by the International Code Council, the Oklahoma Uniform Building Code Commission, and the National Fire Protection Association with the participation of state, county and municipal code officials and fire officials, architects, engineers, builders, contractors, elected officials, manufacturers and others in the construction industry. These codes are updated by these bodies periodically. The proposed change would update the references to more recent versions of the codes. The result of this change will be to apply current building and fire codes to the fire extinguisher industry.

AUTHORITY:

Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 59 O.S. Section 1820.19.

COMMENT PERIOD:

January 2, 2013, through February 6, 2013. Interested persons may informally discuss the proposed rules with Mr. K.C. Ely, Chief, Consumer Health Services, before February 6, 2013, submit written comment to Mr. K.C. Ely, Chief, Consumer Health Services, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303 (A), the public hearing for the proposed rulemaking in this chapter shall be on February 6, 2013, at the Oklahoma State Department of Health, 1000 Northeast Tenth Street, Oklahoma City, OK 73117-1207, in room 1102 beginning at 11:00 a.m. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule;. Business entities may submit this information in writing before February 6, 2013, to Mr. K.C. Ely, Chief, Consumer Health Services, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, or by e-mail to Kcely@health.ok.gov.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from staff of the Occupational Licensing Division, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK

73117-1207, via electronic mail request to Kcely@health.ok.gov, or via agency website at www.health.ok.gov.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., §303(D), a rule impact statement is available at the location listed above for obtaining copies of the rule.

CONTACT PERSON:

Mr. K.C. Ely, Chief, Consumer Health Services, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207, phone (405) 271-5243, e-mail Kcely@health.ok.gov.



Oklahoma State Department of Health
Creating a State of Health

RECEIVED
489
FEB 15 2013
LEGAL DIVISION

To: Board of Health Secretary

Through: Terry Cline, Ph.D. *T.C. 2-26-2013*
Commissioner

Through: James Joslin *JJ. 2/15/13*
Agency Rule Liaison

Through: Don Maisch *DM 2-15-2013*
General Counsel

Through: Hank Hartsell, Ph.D. *HH 2/14/13*
Deputy Commissioner/Protective Health Services

Through: Lee Martin, Chief
Medical Facilities Service

From: Karla Cason, Director, *KC 2/14/13*
Facility Services Division/Medical Facilities Service

Date: February 14, 2013

Subject: Rule Packet Submission for Distribution to Board of Health
Chapter 667. Hospital Standards

RECEIVED

FEB 15 2013

OFFICE OF THE
COMMISSIONER

The attached documents are submitted for PERMANENT ADOPTION by the State Board of Health at their March 12, 2013, meeting.

The proposed amendments are supported by the Hospital Association and have received a favorable reception by the industry. The Department concurred with a comment recommending inserting language to require "The person taking the verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood." The proposed rules were amended in all announced sections referencing verbal orders.

The Department concurred and acted on public comment suggesting including the language "treatments and tests" where the rules only stipulated orders for medications, or drugs and biologicals.

One commenter recommended that hospitals be allowed to define the time frame for authenticating an order in policy rather than requiring it be written in the medical staff bylaws. This recommendation is interrelated with a number of rule sections not announced for amendment. The Department will evaluate this recommendation with its industry partners for future consideration.

Attachments:

- Rule Comment Summary
- RIS (Rule Impact Statement)
- Rule Text

(Please contact Jenni Shelton at x57205 for corrections, pick-up and delivery.)

RULE COMMENT SUMMARY AND RESPONSE

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH CHAPTER 667. HOSPITAL STANDARDS

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include a *summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules and a list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.*[75:303.1(E)(8)&(9)]

Rule Subchapter and Section: General

Name and Organization: Scarlett Young, Director Health Information, Oklahoma Surgical Hospital.

Comment: This organization provided correspondence in support of the proposed rule changes and noted the following regarding potential cost savings to the industry:

[Nursing staff are] "going through the record numerous times a day just to ensure that the flagged orders are signed. This process is not only time consuming but incredibly labor intensive. The nursing staff at OSH spends more than 3 hours a day reviewing records for signatures. On average \$50,000 is spent annually on clinical staff flagging records for physician signatures, when they could be spending time directly with the patients."

Rule Subchapter and Section: General

Name and Organization: Cheryl Wilkinson, Director of Performance Improvement, Stillwater Medical Center

Comment: This organization provided correspondence in support of the proposed rule changes and recommends that hospitals be allowed to define the time frame for authenticating an order in policy rather than requiring it be written in the medical staff bylaws.

Response: This recommendation is interrelated with a number of rule sections not announced for amendment. The Department will evaluate this recommendation with its industry partners for further consideration.

Rule Subchapter and Section: General

Name and Organization: Dale Bratzler, DO, MPH; Chief Quality Officer- OU Physicians, OUHSC

Comment: Doctor Bratzler provided written comment on the proposed rule and noted the following:

"I am certainly not opposed to striking the 48 hour requirement though I do think we should add language as stated in the Federal Register: "it is expected that the standard practice would be for the person taking the order to read the order back to the practitioner to ensure that they have

correctly understood it.” I think the proposed savings from this rule change are trivial (Federal Register estimates are frankly unrealistic), but as we discussed before, there are logistic reasons that make it difficult to have all verbal orders signed within 48 hours. What we all fear is that a verbal order will be incorrectly understood resulting in a medical error ... so having a verbal read back policy might help to prevent some events.”

Response: The Department concurs, noting that a read back policy for verbal orders has been part of the Joint Commission National Patient Safety Goals since 2006 and is a requirement of many accrediting agencies. The proposed rules were amended in all announced sections referencing verbal orders. An example is shown below with the inserted language shown in double underline.

Subchapter 15. Nursing service
310:667-15-6. Evaluation and review of nursing care

.....
(g) All medical orders shall be signed by the prescribing physician or practitioner. Telephone and verbal orders for medications shall be given only to the practitioner authorized by administration to receive these orders ~~and be signed by the prescribing physician or practitioner as soon as possible within forty-eight (48) hours.~~ Other orders may be accepted by staff as designated by medical staff policy, consistent with state and federal laws. The person taking the verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

Rule Subchapter and Section: 310:667-15-6 Evaluation and review of nursing care; 310:667-39-9. Nursing Service; and 310:667-40-9 Nursing Service

Name and Organization: Lawanna Halstead, Vice President/Quality & Clinical Initiatives, Oklahoma Hospital Association

Comment: In a telephone call to the Department, Ms. Halstead reported that her Association received feedback from several hospitals. She noted that there were no hospitals commenting against the removal of the requirement for signing orders in forty-eight (48) hours. She added that several hospitals suggested including the language “treatments and tests” where the rules stipulate medications only.

Response: The Department concurs that this edit will clarify the rule intent and makes the rule language more consistent throughout the rule. In the following sections the rule text is modified to include “treatments and tests” where the rules only stipulated medications, or drugs and biologicals.

The proposed changes from this and the previous comment are shown with double underline text:

Subchapter 15 Nursing Service
310:667-15-6 Evaluation and review of nursing care

.....
(g) All medical orders shall be signed by the prescribing physician or practitioner. Telephone and verbal orders for medications, treatments and tests shall be given only to the practitioner authorized by administration to receive these orders and be signed by the prescribing physician or practitioner ~~as soon as possible within forty-eight (48) hours.~~ Other orders may be accepted by staff as designated by medical staff policy, consistent with state and federal laws. The person taking the verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to

be placed on orders to demonstrate that the order was read back to the physician..

Subchapter 39- Critical Access Hospital

310:667-39-9. Nursing Service

.....
(e) Delivery of care.
.....

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs, ~~and biologicals,~~ treatments and tests shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, ~~or biologicals,~~ treatments and tests are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing practitioner ~~as soon as possible within forty eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician..

Subchapter 40- Emergency Hospital

310:667-40-9 Nursing Service

.....
(e) Delivery of care.
.....

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs and biologicals shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, ~~or biologicals,~~ treatments, and tests are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing physician or practitioner ~~as soon as possible within forty eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician..

Rule Subchapter and Section: 310:667-15-6, Evaluation and review of nursing care; 310:667-19-2, Reports and records; 310:667-21-8, Drug handling; 310:667-39-9, Nursing Service; 310:667-40-9, Nursing Service; and 310:667-40-11, Medical record services

Name and Organization: Oklahoma Hospital Advisory Council

Comment: At a meeting of the Council on February 28, 2013 to review comments and make final suggestions on the rule amendments, a change to the amendments was proposed. The Council suggested where the proposed rule says “verbal” orders the language be amended to say “telephone or verbal” orders.

Response: The Department concurs with this suggestion and modified the rule language throughout the proposed amendments.

AGENCY CONTACT PERSON:

Ms. Karla Cason, Director, Facility Services Division, Medical Facilities Service, phone (405) 271-6576, e-mail KarlaC@health.ok.gov.

RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH

CHAPTER 667. HOSPITAL STANDARDS

1. **DESCRIPTION:**

This proposal removes the 48 hour time limit for authentication of certain verbal orders given by physicians and practitioners. The current rule requires signatures by physicians or practitioners within 48 hours after giving verbal orders for medications, treatments and tests. After the change, verbal orders will be authenticated pursuant to each hospital's medical staff bylaws. The proposal will enable hospitals to take advantage of recent changes in federal rules governing Medicare certification of hospitals.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:** This change will most likely affect hospitals, physicians and practitioners, and patients by allowing physicians and practitioners some additional flexibility in authenticating verbal orders in compliance with hospital medical staff bylaws.

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

This proposal may benefit hospitals, physicians and practitioners, and patients. The benefit would be the relaxation of the 48-hour requirement that does not have a demonstrated impact on health outcomes in hospitals.

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

The Federal Register published to announce the new rules noted that allowing for orders to be authenticated by another practitioner who is responsible for the care of the patient, in accordance with hospital policy and State law, will result in a burden reduction. The Federal Register noted at page 29071, "We would expect a registered nurse or compliance officer to be responsible for checking medical records and flagging orders needing authentication, particularly those verbal orders nearing the current 48-hr timeframe. Based on our experience with hospitals and feedback from stakeholders on this issue, we believe that hospitals will save one hour of a nurse's time every day for 365 burden hours for each hospital annually." For all 153 licensed hospitals in Oklahoma, this would result in a reduction of 55,845 burden hours, valued at \$45 per hour for a savings of \$2,513,025. See, ["Medicare and Medicaid Programs; Reform of Hospital and Critical Access Hospital Conditions of Participation," Federal Register 77:95 \(16 May 2012\), p. 29034.](#)

One Hospital provided the following comment during the public comment period in support of the potential cost savings from the proposed rule amendment:

[Nursing staff are] "going through the record numerous times a day just to ensure that the flagged orders are signed. This process is not only time consuming but incredibly labor intensive. [Hospital staff spend] more than 3 hours a day reviewing records for signatures. On average \$50,000 is spent annually on clinical staff flagging records for physician signatures, when they could be spending time directly with the patients."

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

The cost to the Department to implement the amendments will be approximately \$1,700.00 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be

implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**

This rule may have an impact on hospitals operated by city, county or state government agencies. This proposal would allow such hospitals to replace the 48 hour requirement with a standard established in hospital medical staff bylaws.

7. **ADVERSE EFFECT ON SMALL BUSINESS:**

No adverse impacts on small businesses are anticipated.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:**

The proposal is made to enable hospitals to take advantage of recent changes in federal Medicare certification requirements that were promulgated to give hospitals additional flexibility.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**

The proposal does not address a significant risk to public health. Research indicates minimal improvements in outcomes under the current 48 hour requirement.

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

If the rule change is not adopted, hospitals in Oklahoma will not be able to take advantage of changes in federal Medicare certification requirements intended to give hospitals additional flexibility in the authentication of verbal orders.

11. This rule impact statement was prepared on November 20, 2012. A revision based on public comment was made February 14, 2013.

**TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 667. HOSPITAL STANDARDS**

SUBCHAPTER 15. NURSING SERVICE

310:667-15-6. Evaluation and review of nursing care

- (a) There shall be a continuous review and evaluation of the nursing care provided for patients. There shall be written nursing care procedures and nursing care plans for patients.
- (b) Nursing care policies and procedures shall be written and be consistent with current standards of practice and be reviewed and revised as necessary.
- (c) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.
- (d) Nursing care plans shall include assessment, planning, intervention, and evaluation. Nursing care plans shall be established for each inpatient and be revised as necessary.
- (e) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.
- (f) Only the following shall be permitted to administer medications, and in all instances, in accordance with state and federal law:
- (1) A licensed physician or licensed independent practitioner;
 - (2) A registered nurse;
 - (3) A licensed practical nurse; or
 - (4) Other practitioners, if designated by the medical staff and authorized by law.
 - (5) Facilities participating in a program for training nursing students may permit nursing students to administer medications to patients provided the facility has on file an agreement between the nursing school and the facility, outlining protocols for participation, scope of involvement, education levels of students, level of supervision, and a current roster of nursing students in the program. Specific details relating to the operation of the program shall be included in the facility's policies and procedures manual.
- (g) All medical orders shall be signed by the prescribing physician or practitioner. Telephone ~~and~~ or verbal orders for medications, treatments and tests shall be given only to the practitioner authorized by administration to receive these orders and be signed by the prescribing physician or practitioner ~~as soon as possible within forty eight (48) hours~~. Other orders may be accepted by staff as designated by medical staff policy, consistent with state and federal laws. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.
- (h) ~~Verbal~~ Telephone or verbal orders may be authenticated as described at OAC 310:667-19-2(c)(4).
- (i) Blood product transfusions and intravenous medications shall be administered as required by written hospital policy in accordance with state and federal law. Hospital staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(j) An effective hospital procedure shall be established for reporting transfusion reactions and adverse drug reactions.

SUBCHAPTER 19. MEDICAL RECORDS DEPARTMENT

310:667-19-2. Reports and records

(a) Reports shall be made by each hospital to the appropriate agency, including but not limited to the following:

- (1) Communicable disease.
- (2) Births and deaths.
- (3) Periodic reports to the Department on forms supplied for this purpose.
- (4) Newborn hearing screening report.

(A) All hospital nurseries shall complete a newborn hearing screening report form on all live newborns discharged from their facility. For facilities with a two-year average annual birth census of 15 or greater, physiologic hearing screening results as well as "at risk" indicators must be recorded on the report form; for facilities with a two-year average annual birth census of fewer than 15, "at risk" indicators must be recorded and if physiologic hearing screening is conducted, those results also must be recorded on the report form. It shall be the responsibility of the hospital administrator to assure that the Newborn Hearing Screening Report Form is correctly completed and subsequently submitted to the Department. The hospital administrator may designate one individual, who shall then be responsible for review of all newborn discharge summaries to insure that a report form has been completed for each infant and that the report form is a permanent part of that infant's record. A copy of the hearing screening report form must be given to the infant's caregiver at discharge.

(B) If an infant is transferred from one hospital to another, the second hospital shall be responsible for providing physiologic hearing screening, "risk indicator" screening, and for completion of the report form.

(C) It shall be the responsibility of the hospital administrator to insure that all completed report forms are mailed to the Department within seven (7) days of an infant's birth.

(D) It shall be the responsibility of the attending physician or licensed independent practitioner to inform parents if their infant passed or was referred on the physiologic hearing screening and/or if the infant is to be considered "at risk" for hearing impairment. Prior to discharge, the attending physician or licensed independent practitioner shall review the completed report form and shall inform the parents of their infant's status. Infants who do not pass the physiologic screening shall be referred for a diagnostic audiological evaluation as soon as possible.

(E) It shall be the responsibility of the coordinator of the Newborn Hearing Screening Program at the Department to arrange for hospital in-service training for all hospital personnel involved in the process of completion of report forms. A manual of procedures shall be available in regard to processing of screening forms. The literature for distribution to parents shall be available from the Department.

(5) Newborn metabolic disorder screening.

(A) **Testing of newborns.** All newborns in Oklahoma shall be tested for phenylketonuria, hypothyroidism, galactosemia and sickle cell diseases by a Certified Newborn Metabolic Disorder Screening Laboratory as defined in Chapter 550 of this Title; a parent or guardian may refuse metabolic disorder screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices. A parent or guardian who refuses metabolic disorder screening of their newborn on the grounds that such examination conflicts with their religious tenets and practices shall also indicate in writing this refusal in the newborn's medical record with a copy sent to the Newborn Metabolic Disorder Screening Program, Maternal and Child Health Service, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299.

(B) **Specimen collection for hospital births.** For all live hospital births, the physician or licensed independent practitioner shall order the collection of a newborn metabolic disorder screening specimen on all newborns prior to transfusion, at three to five days of age or immediately prior to discharge, whichever comes first. Specimens shall be collected on the Newborn Metabolic Disorder Form Kit using capillary or venous blood. Cord blood is unacceptable. The hospital is responsible for collecting specimens on all infants.

(i) If the initial specimen for any infant is collected prior to 24 hours of age, the hospital and the physician or licensed independent practitioner are responsible for notifying the infant's parents that a repeat specimen is necessary at three to five days of age. The infant's physician or licensed independent practitioner is responsible for insuring that the repeat specimen is collected.

(ii) The hospital is responsible for submitting a satisfactory specimen and for documenting all requested information on the form kit including the parent/guardian's name, address, phone or contact phone number and the planned health care provider who will be providing well care for the infant after discharge, or if the infant is to be hospitalized for an extended period of time, the name of the infant's physician or licensed independent practitioner.

(iii) The hospital is responsible for documenting specimen collection and results in the infant's hospital record.

(iv) Infants transferred from one hospital to another during the newborn period shall have specimen collection documented in the infant's hospital record. It is the responsibility of the physician or licensed independent practitioner and the receiving hospital to insure a specimen is collected.

(v) It is the responsibility of the hospital and physician or licensed independent practitioner to insure that all infants are screened prior to discharge. If an infant is discharged prior to specimen collection, the Newborn Metabolic Disorder Screening Program Coordinator shall be notified by contacting Maternal and Child Health Service, Oklahoma State Department of Health, 1000 NE Tenth Street, Oklahoma City, Oklahoma 73117-1299, (405) 271-6617, FAX (405) 271-4892, 1-800-766-2223, ext.

6617. The physician or licensed independent practitioner is responsible for insuring the specimen is collected at three to five days of age.

(C) **Screening for premature/sick infants.** For all premature/sick infants, the physician or licensed independent practitioner shall order the collection of a newborn metabolic disorder screening specimen prior to red blood cell transfusion, at three to seven days of age, or immediately prior to discharge, whichever comes first. It is recommended that a repeat newborn metabolic disorder screening specimen be collected at 14 days of age. Specimens shall be collected on the Newborn Metabolic Disorder Form Kit using capillary or venous blood. The hospital is responsible for collecting specimens on all premature/sick infants.

(i) Premature/sick infants screened prior to 24 hours of age must be re-screened between 7-14 days of age.

(ii) Premature/sick infants who could not be screened prior to a red blood cell transfusion should be re-screened by the 7th day of life and a repeat specimen collected when plasma and/or red cells will again reflect the infant's own metabolic processes or phenotype. The accepted time period to determine hemoglobin type is 90 to 120 days after transfusion.

(iii) The recommended follow-up study for an abnormal thyroid screen in a premature infant is a serum free T4 (measured by direct dialysis or an equivalent method) at 7-14 days of age.

(D) **Hospital recording.** The hospital shall implement a procedure to assure that a newborn screening specimen has been collected on every newborn and mailed to the Newborn Metabolic Disorder Screening Laboratory within 24 - 48 hours of collection.

(i) The hospital shall immediately notify the infant's physician or licensed independent practitioner, and parents or guardians if an infant is discharged without a sample having been collected. This notification shall be documented in the infant's hospital record.

(ii) If no test results are received within fifteen (15) days after the date of collection, the hospital shall contact the Newborn Metabolic Disorder Screening Laboratory to verify that a specimen had been received. If no specimen has been received, the hospital shall notify the physician or licensed independent practitioner.

(iii) Any hospital or any other laboratory which collects, handles or forwards newborn metabolic disorder screening samples shall keep a log containing name and date of birth of the infant, name of the attending physician or licensed independent practitioner, name of the health care provider who will be providing well care for the infant after discharge, medical record number, serial number of the form kit used, date the specimen was drawn, date the specimen was forwarded, date the test results were received and the test results.

(iv) The hospital is responsible for assuring that employees who collect, handle or perform newborn metabolic screening tests are informed of their responsibilities with respect to screening procedures.

(E) **Parent and health care provider education.** The hospital will be responsible or designate a responsible party to distribute the Newborn Metabolic Disorder Screening Program's written educational materials on newborn metabolic disorder screening provided by the Department to at least one of each newborn's parent or legal guardian.

(F) **Training.** Hospitals shall provide ongoing training programs for their employees involved with newborn screening procedures. These training programs shall include methods of collecting a Satisfactory Newborn Metabolic Disorder Screening Specimen.

(6) **Birth defects.** Each hospital shall maintain a list of patients up to six (6) years of age who have been diagnosed with birth defects, and all women discharged with a diagnosis of stillbirth or miscarriage. On request, each hospital shall make the medical records of these individuals available to the State Department of Health.

(7) **Abortions.** Attending physicians shall complete and submit to the Department a report form for each abortion performed or induced as required by 63 O.S. 1999, Section 1-738.

(b) **Record of patient admission.**

(1) All persons admitted to any institution covered by these standards shall be under the care of a doctor of medicine (M.D.) or osteopathy (D.O.) duly licensed to practice medicine and surgery in the State of Oklahoma or a licensed independent practitioner, whose name shall be shown on the admitting record.

(2) The hospital admitting record also shall show the following for each patient.

(A) Full name of patient with age, sex, address, marital status, birth date, home phone number, date of admission, and admitting diagnosis.

(B) Next of kin, with address, phone number, and relationship.

(C) Date and time of admission, the admission and final diagnoses, and the name of physician or licensed independent practitioner.

(D) Any advanced directive for health care as defined in the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act.

(3) Special clinical reports shall be kept, including the following:

(A) Obstetrical patients throughout labor, delivery, and post-partum.

(B) Newborn, giving the infant's weight, length, and other notes relative to physical examination.

(C) Surgical and operative procedures, including pathological reports.

(D) Record of anesthesia administration.

(c) **Orders for medications, treatments, and tests.**

(1) All medication orders shall be written in ink and signed by the ordering physician or practitioner authorized by law to order the medication, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. The order shall be preserved on the patient's chart.

(2) All orders shall be written in ink and signed by the ordering physician or practitioner. Orders received by resident physicians shall be co-signed if required by medical staff bylaws. The order shall be preserved on the patient's chart.

(3) All orders taken from the physician or practitioner, for entry by persons other than the physician or practitioner, shall be countersigned ~~as soon as possible within forty-eight (48) hours.~~

(4) ~~Verbal~~ Telephone or verbal orders may be authenticated by an authorized physician or practitioner other than the ordering physician or practitioner when this practice is defined and approved in the medical staff bylaws. If allowed, medical staff bylaws must identify the physicians or practitioners who may authenticate another physician's or practitioner's telephone or verbal order, e.g. physician partners or attending physicians or practitioners, and define the circumstances under which this practice is allowed. The bylaws must also specify that when a covering or attending physician or practitioner authenticates the ordering physician's or practitioner's telephone or verbal order, such an authentication indicates that the covering or attending physician or practitioner assumes responsibility for his or her colleague's order and verifies the order is complete, accurate, appropriate, and final. The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

SUBCHAPTER 21. DRUG DISTRIBUTION

310:667-21-8. Drug handling

(a) Drugs shall be given to hospital patients only upon written order of a physician or practitioner legally authorized to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. No change in an order shall be made without the approval of the prescriber. ~~Verbal~~ Telephone or verbal orders are discouraged but, when necessary, shall be written by an authorized employee and signed by the person legally authorized to write a prescription ~~as soon as possible within 48 hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(b) Single unit units of controlled substances shall be used in the hospital except in the pharmacy where multiple dose vials may be used for IV admixtures.

(c) All Schedule drugs in the hospital, except those in the pharmacy, shall be verified by actual count at the change of shift by two (2) licensed nurses and documented. Schedule drugs outside the pharmacy which are contained in, and controlled by, an automated dispensing device may be verified by actual count at the time of each access and documented. Adequate day-to-day accountability-of-use records shall be maintained and shall include the date and time of each check of a schedule drug substance supply, the balance on hand, the names of patients receiving drugs, the physician's or prescribing practitioner's name, quantity of medication used and wasted, and the signatures of the two persons making the check. Wastage of schedule drugs shall be witnessed by at least two (2) persons, one (1) of which shall be a licensed health professional. Witnesses shall document wastage by signature.

(d) The medical staff shall establish a written policy that all toxic or dangerous drugs not specifically prescribed as to time or number of doses shall be automatically stopped after a reasonable time limit set by the staff. Examples of drugs ordinarily thought of as toxic or dangerous drugs include: controlled substances, sedatives, anticoagulants, antibiotics, oxytocics, and steroids.

(e) The administrator, or his or her authorized representative, shall inventory pharmacy controlled substances and alcohol at least annually.

(f) Drugs past the date of expiration shall be removed from stock and shall not be available for patient use.

SUBCHAPTER 39. CRITICAL ACCESS HOSPITAL

310:667-39-9. Nursing service

(a) **General.** Each CAH shall have an organized nursing service which provides twenty-four (24) hour nursing services for patients. The nursing service shall be supervised by a registered nurse.

(b) **Organization.** The nursing service shall be well-organized with written policies delineating administrative and patient care responsibilities. The director of nursing shall be a registered nurse who shall be responsible for the operation of the service, including determining the staff necessary to provide nursing care for all areas of the CAH. Nursing care shall be provided as specified by written procedures approved by the director of nursing and the governing body. All nursing procedures shall be consistent with state and federal law and current standards of practice. Procedures shall be reviewed and revised as necessary.

(c) **Staffing.** The nursing service shall have adequate numbers of licensed nurses and other nursing personnel available to provide nursing care to all patients as needed based on patient census and acuity. At least one (1) registered nurse shall be on duty on-site to furnish or supervise all nursing services whenever patient care is provided. If the CAH has no inpatients, the registered nurse may be available on an on-call basis provided he or she is available to return to the CAH in a period of time not to exceed twenty (20) minutes.

(d) **Qualifications.**

(1) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned. The CAH shall verify current licensure of licensed nurses and maintain documentation of verification.

(2) The selection and promotion of nursing service personnel shall be based on their qualifications and capabilities. The director of nursing shall have input regarding the employment, promotion, evaluation and termination of all nursing service personnel.

(3) The qualifications required for each category of nursing staff shall be in written policy and job descriptions, and shall be available in the CAH for reference. The functions of all nursing service personnel shall be clearly defined by written policy.

(e) **Delivery of care.**

(1) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(2) Each inpatient shall have a nursing care plan that includes assessment, planning, intervention, and evaluation. Nursing care plans shall be revised as necessary.

(3) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

- (4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs, ~~and biologicals, treatments and tests~~ shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, ~~or biologicals, treatments and tests~~ are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing practitioner ~~as soon as possible within forty-eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.
- (5) Blood products and intravenous medications shall be administered as required by CAH written policy in accordance with state and federal law. CAH staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.
- (6) There shall be an effective procedure for reporting transfusion and adverse drug reactions to the attending physician or licensed independent practitioner and the prescribing physician or practitioner. Errors in drug administration and adverse reactions shall be compiled and reported through the quality assurance committee to the medical and professional staff.
- (7) All nursing service personnel shall be trained and currently certified to perform cardio-pulmonary resuscitation (CPR) and shall be knowledgeable of all CAH emergency protocols.
- (f) **Patient restraint.** If patients are physically restrained, the CAH shall comply with all requirements specified in OAC 310:667-15-8. If patients are chemically restrained, the CAH shall comply with all requirements specified in OAC 310:667-15-9.

SUBCHAPTER 40. EMERGENCY HOSPITAL

310:667-40-9. Nursing service

- (a) **General.** Each EH shall have an organized nursing service which provides twenty-four (24) hour nursing services for patients. The nursing service shall be supervised by a registered nurse.
- (b) **Organization.** The nursing service shall be well-organized with written policies delineating administrative and patient care responsibilities. The director of nursing shall be a registered nurse who shall be responsible for the operation of the service, including determining the staff necessary to provide nursing care for the EH. Nursing care shall be provided as specified by written procedures approved by the director of nursing and the governing body. All nursing procedures shall be consistent with state and federal law and current standards of practice. Procedures shall be reviewed and revised as necessary.
- (c) **Staffing.** The nursing service shall have adequate numbers of licensed nurses and other nursing personnel available to provide nursing care to all patients as needed based on patient census and acuity. At least one (1) registered nurse shall be on duty on-site to furnish or

supervise all nursing services whenever patient care is provided. If the EH has no inpatients, the registered nurse may be available on an on-call basis provided he or she is available to return to the EH in a period of time not to exceed twenty (20) minutes.

(d) Qualifications.

(1) Individuals selected for the nursing staff shall be qualified by education and experience for the positions they are assigned. The EH shall verify current licensure of licensed nurses and maintain documentation of verification.

(2) The selection and promotion of nursing service personnel shall be based on their qualifications and capabilities. The director of nursing shall have input regarding the employment, promotion, evaluation and termination of all nursing service personnel.

(3) The qualifications required for each category of nursing staff shall be in written policy and job descriptions, and shall be available in the EH for reference. The functions of all nursing service personnel shall be clearly defined by written policy.

(e) Delivery of care.

(1) A registered nurse shall assess, plan, supervise, and evaluate the nursing care for each patient.

(2) Each inpatient shall have a nursing care plan that includes assessment, planning, intervention, and evaluation. Nursing care plans shall be revised as necessary.

(3) Nursing notes shall be informative and descriptive of the nursing care given and include assessment, interventions, and evaluation.

(4) All drugs and biologicals shall be administered in accordance with state and federal laws by authorized individuals. Orders for drugs and biologicals shall be in writing and signed by the prescribing physician or practitioner who shall be authorized by law to write a prescription, with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment for contraindications. When telephone or verbal orders for drugs, ~~or biologicals, treatments, and tests~~ are used, they shall be given only to a practitioner authorized by administration to receive these orders and signed by the prescribing physician or practitioner ~~as soon as possible within forty-eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician.

(5) Blood products and intravenous medications shall be administered as required by EH written policy in accordance with state and federal law. EH staff administering blood products or intravenous medications shall be trained regarding hospital policies before they are allowed to carry out these responsibilities.

(6) There shall be an effective procedure for reporting transfusion and adverse drug reactions to the attending physician or licensed independent practitioner and the prescribing physician or practitioner. Errors in drug administration and adverse reactions shall be compiled and reported through the quality assurance committee to the medical and professional staff.

(7) All nursing service personnel shall be trained and currently certified to perform cardio-pulmonary resuscitation (CPR) and shall be knowledgeable of all EH emergency protocols.

(f) **Patient restraint.** If patients are physically restrained, the EH shall comply with all requirements specified in OAC 310:667-15-8. If patients are chemically restrained, the EH shall comply with all requirements specified in OAC 310:667-15-9.

310:667-40-11. Medical record services

(a) **General.** The EH shall have medical record services that ensure a medical record is maintained for every patient evaluated or treated in the facility. Medical record services shall be appropriate to the scope and complexity of the services performed and shall ensure prompt completion, filing, and retrieval of records. In general, services such as transcription, computer indexing and coding, and electronic storage may be performed off-site as a contracted service as long as the medical record remains under the control of the EH. The EH shall ensure that medical records maintained by a contracted service remain confidential and can be immediately accessed by EH staff.

(b) **Reports to agencies and the Department.** The EH shall comply with all requirements specified in OAC 310:667-19-2(a) regarding the reports made to agencies and the Department.

(c) **Content.** The medical record shall contain information to justify patient admission and treatment, support the diagnosis, and describe the patient's progress and response to treatment and services received. All entries shall be legible and complete, and shall be authenticated and dated promptly by the person, identified by name and discipline, who is responsible for ordering, providing or evaluating the service furnished.

(1) The author of each entry shall be identified and shall authenticate their entry. Authentication may include written signatures or computerized or electronic entries. If computerized or electronic authentications are used, the EH shall comply with all requirements specified at OAC 310:667-19-10(e). Telephone ~~and~~ or verbal orders shall be authenticated by the physician or practitioner giving the order ~~as soon as possible within forty-eight (48) hours~~ or meet the requirements at OAC 310:667-19-2(c)(4). The person taking the telephone or verbal order shall read the order back to the physician or practitioner to ensure it was correctly understood and verify on the order the fact that the order was read back. Each facility, within its own procedures and protocols, shall establish a verification process to be placed on orders to demonstrate that the order was read back to the physician. Reports of history and physical examinations and discharge summaries shall be authenticated by the authorized physician or practitioner who performed the examination or produced the summary or meet the requirements at OAC 310:667-19-10(e) if authenticated by another physician or practitioner. Signature stamps may be used to authenticate entries in the medical record provided the requirements at OAC 310:667-19-10(d) are met.

(2) All inpatient records shall document the following as appropriate:

(A) Patient identifying information including individuals to be contacted in case of an emergency.

(B) Evidence of a physical examination, including a health history, performed not more than thirty (30) days prior to admission or within forty-eight (48) hours after admission. The history and physical examination shall be completed, signed and placed in the record within 48 hours of admission.

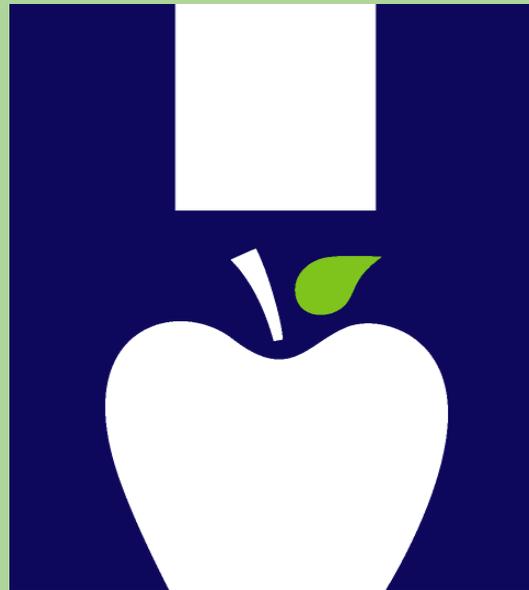
- (C) Admitting diagnosis.
- (D) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
- (E) Documentation of complications, hospital acquired infections, and unfavorable reactions to any drug or biological.
- (F) Properly executed informed consent forms for procedures and treatments performed. The medical and professional staff shall establish which procedures or treatments require informed consent consistent with Federal and State law.
- (G) All physicians' and practitioners' orders, nursing notes, reports of treatment, medication records, diagnostic reports, vital signs and other information necessary to monitor the patient's condition.
- (H) Discharge summary with outcome of hospitalization, disposition of case, medications at the time of discharge, and provisions for follow-up care.
- (I) Reports. All reports and records shall be completed and filed within a period consistent with good medical practice and not longer than thirty (30) days following discharge.
- (J) Final diagnosis.

(d) **Maintenance of records.** The EH shall maintain a medical record for each emergency, stabilization, or observational patient. Medical records shall be accurately written, promptly completed, properly filed and retained, and accessible. The EH shall use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries.

- (1) Medical records shall be retained at least five (5) years after the date the patient was last seen or at least of three (3) years after the date of the patient's death. Records of minors shall be retained three (3) years past the age of majority. Medical records may be maintained in their original form or may be preserved by other means as specified by OAC 310:667-19-14(b).
- (2) The EH shall have, or provide, a system of coding and indexing medical records. The system shall allow for timely retrieval by diagnosis and procedure, in order to support medical care evaluation studies.
- (3) Medical records shall be confidentially maintained. Information from, or copies of, records shall be released only to authorized individuals in accordance with state law, and the EH shall ensure that unauthorized individuals cannot gain access to, or alter medical records. Original medical records shall be released only in accordance with federal or state laws or by court order.
- (4) Facsimile copies shall be acceptable as any portion of the medical record. If the facsimile is transmitted on thermal paper, that paper shall be photocopied to preserve its integrity in the record. Facsimile copies shall be considered the same as original copies.
- (5) In the event of closure of the EH, the EH shall inform the Department of the disposition of the patient medical records. Disposition shall be in a manner to protect the integrity of the information contained in the medical record. These records shall be retained and disposed of as specified by OAC 310:667-19-14(b)(4).

Public Policy & Advocacy Development

OKLAHOMA STATE DEPARTMENT OF HEALTH · MARCH 2013



Mark S. Newman, Ph.D.

Director, Office of State and Federal Policy

Oklahoma State Department of Health
Strategic Map: SFY 2011-2015

Achieve Targeted Improvements in the Health Status of Oklahomans

Improve Targeted Health Outcomes

Achieve Improvements In Oklahoma Health Improvement Plan (OHIP) Flagship Issues

Focus on Core Public Health Priorities

Reduce Health Inequities

Lead Public Health Policy & Advocacy Development

Target Campaigns on Community Needs, Return on Investment, & Scientific Evidence

Identify & Establish Public Health Champions

Serve as Educational Resource on the Value of All Public Health Issues

Strengthen Public Health Systems

Evaluate Infrastructure to Support Public Health Systems

Employ Strategies for Public Health Workforce Recruitment

Achieve Accreditation & Create a Quality Improvement Culture

Achieve Compatible Health Information Exchange Across Public/Private Sectors

Foster Collaborative Relationships With Public & Private Partnerships

Leverage Resources for Health Outcome Improvement

Facilitate Access to Primary Care

Focus on Prevention

Use Comparative Effectiveness Research & Evaluate Science

Monitor Funding Opportunities

Educate & Strategically Plan for Health Systems Change

**Engage Communities to Leverage Effectiveness
Utilize Social Determinants of Health & Whole Person Wellness Approaches
Responsibly Align Resources to Maximize Health Outcomes**



Lead Public Health Policy & Advocacy Development

Goals



Target Campaigns on Community Needs, Return on Investment, & Scientific Evidence

- Work with community organizations to identify core public health issues for legislative emphasis on both an annual and long-term basis
- All Oklahoma State Department of Health (OSDH) proposed legislation incorporates population-based successes through scientific evidence

- County Health Departments and communities are constantly working to develop their own health improvement plans and community assessments
- Certified Healthy Program event at the Cox Convention Center on February 28th recognized 350 businesses, 314 schools, 28 campuses, 12 restaurants, and 52 communities this year



Identify & Establish Public Health Champions

Identify Champions

- Champions must believe in the issue and be willing to face criticism for taking a stand
- Finding and developing public health champions in the business community will be vital to future successes in public health

Establish Champions

- Provide the resources and knowledge to allow an individual to be considered a respected authority on a given issue
- Provide educational materials about public health issues or legislation to answer both the hard questions as well as the easy ones
- Meet with local boards of health and community leaders to help them understand how they may advocate for public health issues at the local level
- Demonstrate how investments in prevention produce both short and long-term savings in health care costs and is a driver for economic development



Serve as Educational Resource on the Value of All Public Health Issues

- OSDH must be the best and most reliable source for all information related to public health
- Lead the way in providing excellent customer service, find new and innovative ways to utilize technology, and demonstrate responsible use of taxpayer funds in each and every program
- Serve in leadership roles in both state and national organizations which represent or impact public health



Public Policy & Advocacy Development

Questions?



**Oklahoma State Department of Health
Board of Health – Financial Brief
March 2013**

**OKLAHOMA STATE DEPARTMENT OF HEALTH
SFY 2013 BUDGET AND EXPENDITURE FORECAST: AS OF 02/22/2013**

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	\$22,640,371	\$10,889,117	\$4,980,008	\$5,595,643	\$1,175,603	94.81%
Protective Health Services	\$66,058,327	\$31,033,004	\$4,991,659	\$28,399,527	\$1,634,138	97.53%
Prevention & Preparedness Services	\$61,556,530	\$26,923,185	\$21,013,103	\$10,331,336	\$3,288,906	94.66%
Information Technology	\$7,363,900	\$4,558,670	\$2,744,185	\$6,526	\$54,520	99.26%
Health Improvement Services	\$25,631,581	\$8,990,314	\$7,239,495	\$8,286,512	\$1,115,259	95.65%
Community & Family Health Services	\$240,513,346	\$116,428,535	\$22,824,138	\$100,096,058	\$1,164,614	99.52%
Totals:	\$423,764,055	\$198,822,825	\$63,792,588	\$152,715,601	\$8,433,040	98.01%



Expenditure Forecast Assumptions

- 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
- Expenditure forecasts limited to realistic amounts expected to spend out during the current budget period
- Surplus/(Deficit) is projected as of June 30, 2013

Explanation of Dashboard Warning(s)

- Overall the Department is forecasted to spend 98.01% of its budget, which is an increase from the previous month's 97.90%.
- Community and Family Health Services and Protective Health Services continue to have "Green Lights" as they have had for the last several months.
- Public Health Infrastructure has a "Yellow Light" with a performance rate of 94.81%. This has not significantly changed since the February report but is almost "Green Light" status and is expected to improve over the remainder of the fiscal year.
- The Health Improvement Services' budget performance rate of 95.65% is a significant improvement from last month's "Yellow Light". The improvement is due to the development and initiation of plans associated with improving access to care and the Shape Your Future program.
- All expenditures will be monitored closely and adjustments in spending will be made as needed to ensure optimal budget performance for the Department.

OKLAHOMA STATE DEPARTMENT OF HEALTH INTERNAL AUDIT CHARTER

MISSION

The mission of the Oklahoma State Department of Health (Agency) Internal Audit Department is to independently examine and evaluate the ongoing control processes of the Agency, provide counsel and recommendations for improvement, promote effective control at reasonable cost, and assist management in achieving its strategic vision under the **direction of the State Board of Health.**

SCOPE OF WORK

The scope of internal auditing shall encompass the examination and evaluation of the adequacy and effectiveness of the Agency's system of internal control and the quality of performance in carrying out assigned responsibilities. The Chief of Internal Audit and his/her staff shall:

- Review the reliability and integrity of financial and operating information and the means used to identify measure, classify, and report such information.
- Review the systems established to ensure compliance with those policies, plans, procedures, Federal and State Laws, and regulations which could have a significant impact on operations and reports.
- Review the means of safeguarding assets and, as appropriate, verify the existence of such assets.
- Review operations to ascertain whether results are consistent with established objectives and goals and whether the operations are being carried out as planned.
- Ensure quality and continuous improvement are fostered in the Agency's control process.

RESPONSIBILITY

It is the responsibility of the Chief of Internal Audit to:

- Develop an annual audit plan based on risk assessment. Risk assessment is a systematic process for assessing and integrating professional judgments about probable adverse conditions or events. The audit plan shall be submitted to the Board of Health and Commissioner for review and approval on an annual basis.
- Implement the annual audit plan, including any special tasks or projects assigned by management and the Agency.
- Maintain a professional audit staff with sufficient knowledge, skills and experience to meet the requirements of this charter.
- Furnish management with reports to evaluate the operations for which they are responsible.
- Offer advisory services to management that will allow them to decide the best use of Agency resources.
- Provide sufficient oversight of the fiscal management of and compliance with the federal and state requirements for the programs administered by the Agency.
- Investigate significant suspected fraudulent activities within the organization.
- Serve as a liaison with Federal, State and other external auditing entities.

AUTHORITY

The Chief of Internal Audit and Staff are authorized to:

- Have unrestricted access to all functions, records, property and personnel.
- Have full and free access to the Agency.
- Allocate resources, select subjects, determine scopes of work and apply the techniques required to accomplish audit objectives.
- Obtain the necessary assistance of personnel in units of the Agency where they perform audits.

STANDARD OF PRACTICE

The Internal Audit Unit will abide with the Standards for the Professional Practice of Internal Auditing of the Institute of Internal Auditors.

The Standards encompass:

- The independence of the internal auditing department from the activities audited and the objectivity of internal auditors.
- The proficiency of internal auditors and the professional care they should exercise.
- The scope of internal auditing work.
- The performance of internal auditing assignments.
- The management of the internal auditing unit.

CODE OF ETHICS

The Internal Audit Unit will abide with the standard of conduct promulgated by the Institute of Internal Auditors. The Chief of Internal Audit and staff will:

- Exercise honesty, objectivity, and diligence in the performance of their duties and responsibilities.
- Exhibit loyalty in all matters concerning the affairs of the Agency but not knowingly be a party to any illegal or improper activity.
- Not knowingly engage in acts or activities which are discreditable to the profession of Internal Auditing or to the Agency.
- Refrain from entering into any activity which may be in conflict with the interest of the Agency or which would prejudice their ability to carry out objectively their duties and responsibilities.
- Not accept anything of value from an employee, client, customer, supplier, or business associate of the Agency that would impair or be presumed to impair their professional judgment.
- Undertake only those services that they can expect to complete with professional competence.
- Adopt suitable means to comply with the Standards for the Professional Practice of Internal Auditing.

- Be prudent in the use of information acquired during their duties. They will not use confidential information for any personal gain nor in any manner that would be contrary to law or detrimental to the welfare of the Agency.
- When reporting on results of audit work, will reveal all material facts known to them which, if not revealed, could either distort reports of operations under review or conceal unlawful practices.
- Continually strive for improvement in their proficiency and in the effectiveness and quality of their service.
- Be ever mindful of their obligation to maintain the high standards of competence, morality, and dignity promulgated by The Institute. Abide by the Bylaws and uphold the objectives of The Institute.

INDEPENDENCE

The Internal Audit Unit is independent of all activities that they audit. The organizational status of the department is sufficient to permit the accomplishment of audit responsibilities. The Chief of the Internal Audit Unit reports directly and simultaneously to the Board of Health and the Commissioner of Health.

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

Terry Cline, Ph.D., Commissioner

March 12, 2013

PUBLIC RELATIONS/COMMUNICATIONS

Oklahoma City Council – speaker
Phil Bacharach, Gazette
PATCH 3rd Annual Legislative Breakfast, Shawnee – speaker
OSU Health Psychology Class – presenter
Oklahoma Editorial Board
Jeff Raymond, Oklahoma Impact – interview
Oklahoma State Medical Association Press Conference - speaker
Nellie Kelly, Tulsa People Magazine – interview
Patty Moon, KOCO television - interview
Ken Johnson KTOK Radio - interview
Ken Johnson, JAKE radio – interview

SITE VISITS (Programs/County Offices)

Payne County Health Department
Pittsburg County Health Department
Carl Albert Community Mental Health Center

STATE AGENCIES/OFFICIALS

Governor Fallin Cabinet Meeting
Denise Northrup, Chief of Staff & Katie Altshuler, Policy Director, Office of Governor Fallin
House of Representatives Performance Committee Hearing
Senate Performance Committee Hearing
 Attended ODMHSAS, JD McCarty Center, OHCA, University Hospital, Office of
 Disability Concerns Senate Hearings
General Government Committee Hearing
Dr. Royice Everett, OUHSC

OTHERS:

Bruce Lawrence, CEO, Integris Health
Patti Davis & Craig Jones, Oklahoma Hospital Association
Tribal Listening Sessions in Shawnee, Lawton & McAlester
Mission of Mercy, Lawton
Ted Haynes, CEO, Bev Binkowski, Division Vice President, Blue Cross Blue Shield & Tammie
and Ryan Kilpatrick, Kilpatrick Consulting
Gary Cox, Exec Director, OCCHD & Bruce Dart, Exec Director, THD
Chris Binge, Tulsa Chamber of Commerce
Ken Levit, George Kaiser Foundation
ASTHO & United Health Foundation Health Ranking Expert Panel – participant
Bart Connor & Nadia Comaneci Sports & Health Festival
OCCHD Board meeting
David Keith, CEO, McAlester Hospital