

**Agenda for the 11:00 a.m., Tuesday, February 9, 2016
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 January 12, 2016, Regular Meeting**
- III. PROPOSED RULEMAKING ACTIONS

Discussion and possible action on the following:

PROTECTIVE HEALTH SERVICE

b) **CHAPTER 641. EMERGENCY MEDICAL SERVICES**

[PERMANENT] Presented by Henry F. Hartsell, Jr.

PROPOSED RULES:

- Subchapter 1. General EMS Programs [AMENDED]
- Subchapter 3. Ground Ambulance Services Service [AMENDED]
- Subchapter 5. Personnel Licenses and Certification [AMENDED]
- Subchapter 7. Training Programs [AMENDED]
- Subchapter 11. Specialty Care Ambulance Service [NEW]
- Subchapter 13. Air Ambulance Service [NEW]
- Subchapter 15. Emergency Medical Response Agency [NEW]
- Subchapter 17. Stretcher Aid Van Services [NEW]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; House Bill 1083 (2013), HB 1467 (2013), and Title 63 O.S. Section 1-2501et seq.

SUMMARY: The proposed language will:

1. Re-organize the current document. The re-organization separates the different license and certification types. Currently, an applicant, certificate holder, or licensee must review the entire rule document to determine the compliance requirements. The reorganization allows stakeholders to be able to find all rules that affect their type of license within one subchapter.

2. Update and amend rules pursuant to HB 1083 (2013) and HB 1467 (2013). HB1083 amended the Oklahoma Emergency Response Systems Development Act (OERSDA) (63 O.S. § 1-2501 et seq.) HB 1083 (2013) updated language to make personnel, emergency medical personnel and emergency medical responders licensed personnel; redefined certified emergency medical responder and certified emergency medical response agency; defined critical care paramedic as a license paramedic who successfully completed critical care training and testing requirements in accordance with the OERSDA; defined use of letters of review as an official designation for paramedic programs becoming accredited; redefined the license levels as an emergency medical technician, an intermediate or advanced emergency medical technician or paramedic licensed by the Department to perform emergency services; allows any hospital or health care facility in Oklahoma to use emergency medical technicians (EMTs), intermediate or advanced EMTs, paramedics or critical care paramedics for the delivery of emergency medical patient care within the hospital or facility and for on-scene patient care; allows advanced EMT students to perform in the hospital, clinic or prehospital setting while under direct supervision. The bills redefine EMT to omit technician or EMT basic; allow an EMT training program to be administered by the Department or its designees; define an advanced EMT to mean a person who has completed advanced EMT training and passed the licensing exam. The bills provided that for any licensed emergency medical personnel or certified emergency medical responder who dies while performing official duties in the line of duty, a beneficiary of the deceased will receive \$5,000. The bills authorized the Department of Health to charge a fee for various stages of application of licensed emergency medical personnel. The bills

charged the Department with creation of a registry of critical care paramedics. The bills amended requirements for specialty care ambulance services to be solely used for inter-hospital transport of patients who require specialized enroute medical monitoring and advanced life support which exceeds the capabilities of the equipment and personnel of paramedical life support.

HB 1467 (2013) created the Trauma and Emergency Response Advisory Council which replaced two formerly designated advisory bodies.

These legislative actions required several additions and/or amendments to this Chapter.

3. Clarify language and minimize conflicts in the rule. Since the original chapter was created in 1991, there have been six (6) regulatory revisions to this chapter. Those revisions have created contradictory or conflicting rules. The proposed language eliminates contradictions and the new organization format will minimize the possibility of conflicting language in future revisions. Additionally, a review of the Federal Aviation Administration regulations pertaining to Air Ambulances resulted in the removal of several Air Ambulance rules because of Federal jurisdiction.

4. Establish new standards for existing agencies and create a new certification type. The new certification type is for Standby Emergency Medical Response Agencies. This certification proposes to establish a minimum standard for individuals and agencies that provide emergency medical care at public events. Another new standard requires all Emergency Medical Response Agencies to submit data to the Department through the Oklahoma Emergency Medical Services Information System. The remaining new standards relate to adding details to existing rules or regulatory concepts.

IV. ZIKA VIRUS BRIEFING

Kristy Bradley, D.V.M., M.P.H., State Epidemiologist & State Public Health Veterinarian

V. 2015 NATIONAL HEALTH SCORECARDS PRESENTATION

Derek Pate, Dr.P.H., Director of Health Care Information; Julie Cox-Kain, M.P.A., Senior Deputy Commissioner & Deputy Secretary of Health & Human Services

VI. BUDGET PRIORITIES

Deborah Nichols, Chief Operating Officer; Mark Davis, CPA, Chief Financial Officer

VII. CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee – Dr. Woodson, Chair

Discussion and possible action on the following:

c) Update

Finance Committee – Ms. Burger, Chair

Discussion and possible action on the following:

d) Update

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

Discussion and possible action on the following:

e) Update

Public Health Policy Committee – Dr. Stewart, Chair

Discussion and possible action on the following:

f) Update

VIII. PRESIDENT'S REPORT

Related discussion and possible action on the following:

Discussion and possible action

IX. COMMISSIONER'S REPORT

Discussion and possible action

X. NEW BUSINESS

Not reasonably anticipated 24 hours in advance of meeting.

XI. PROPOSED EXECUTIVE SESSION

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

Possible action taken as a result of Executive Session.

XII. ADJOURNMENT

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

Tuesday, January 12, 2016 11:00 a.m.

Ronald Woodson, President of the Oklahoma State Board of Health, called the 405th regular meeting of the Oklahoma State Board of Health to order on Tuesday, January 12, 2016 at 11:03 a.m. The final agenda was posted at 11:00 a.m. on the OSDH website on January 11, 2016, and at 11:00 a.m. at the building entrance on January 11, 2016.

ROLL CALL

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

Absent: Terry Gerard, D.O.; Murali Krishna, M.D.

Central Staff Present: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Neil Hann, Assistant Deputy Commissioner, Community and Family Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Director of Office of State and Federal Policy; Deborah Nichols, Chief Operating Officer; Don Maisch, Office of General Counsel; Jay Holland, Director of Internal Audit and Office of Accountability Systems; Tony Sellars, Director of Office of Communications; VaLauna Grissom, Secretary to the State Board of Health.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Dr. Woodson called the meeting to order. He welcomed special guests in attendance.

REVIEW OF MINUTES

Dr. Woodson directed attention to review of the minutes of the December 8, 2015, regular meeting.

Ms. Burger moved Board approval of the minutes of the December 8, 2015, regular meeting, as presented. Second Dr. Grim. Motion carried.

AYE: Alexopoulos, Burger, Grim, Stewart, Woodson

ABSTAIN: Wolfe, Starkey

ABSENT: Gerard, Krishna

APPOINTMENTS

Oklahoma Food Service Advisory Council (Presented by Lynette Jordan)

Appointments: One Member

Authority: 63 O.S., § 1-106.3

Members: The Advisory Council shall consist of thirteen (13) members. Membership is defined in statute. Eight (8) members shall be appointed by the Commissioners with the advice and consent of the State Board of Health, from a list of three names for each position provided by an association representing the majority of the restaurant owners in the state. One (1) member shall represent the Oklahoma Food Processor.

Ms. Wolfe moved Board approval to appoint Kirby Childs to the Oklahoma Food Service Advisory Council, as presented. Second Dr. Alexopoulos. Motion carried.

AYE: Alexopoulos, Burger, Grim, Starkey, Stewart, Wolfe, Woodson

1
2 **ABSENT: Gerard, Krishna**

3
4 PROPOSED RULEMAKING ACTIONS

5
6 **CHAPTER 257. FOOD SERVICE ESTABLISHMENTS**

7 [PERMANENT] Presented by Don Maisch

8 **PROPOSED RULES:**

9 Subchapter 1. Purpose and Definitions [AMENDED]

10 Subchapter 3. Management and Personnel [AMENDED]

11 Subchapter 5. Food [AMENDED]

12 Subchapter 7. Equipment, Utensils and Linens
13 [AMENDED]

14 Subchapter 9. Water, Plumbing and Waste [AMENDED]

15 Subchapter 11. Physical Facilities [AMENDED]

16 Subchapter 13. Poisonous or Toxic Materials [AMENDED]

17 Subchapter 15. Compliance and Enforcement
18 [AMENDED]

19 Subchapter 17. Mobile Pushcarts, Mobile Food Service
20 Establishments, and Mobile Retail Food Service
21 Establishments [AMENDED]

22 Appendix A. Tables [NEW]

23 **AUTHORITY:** Oklahoma State Board of Health, Title 63 O.S. Section 1-104, and Title 63 O.S. §§ 1-106.3
24 and 1-1118.

25 **SUMMARY:** These proposed regulations will bring the chapter into compliance with 2013 model food
26 code, published by the U. S. Food and Drug Administration (FDA). The model assists food control
27 jurisdictions at all levels of government by providing them with a scientifically sound technical and legal
28 basis for regulating the retail and food service segment of the industry (restaurants and grocery stores and
29 institutions such as nursing homes). Local, state, tribal, and federal regulators use the FDA Food Code as a
30 model to develop or update their own food safety rules and to be consistent with national food regulatory
31 policy. According to the FDA:

32 "The Food Code is a model for safeguarding public health and ensuring food is unadulterated and honestly
33 presented when offered to the consumer. It represents FDA's best advice for a uniform system of provisions
34 that address the safety and protection of food offered at retail and in food service.

35 "The 2013 edition of the model code reflects the input of regulatory officials, industry, academia, and
36 consumers that participated in the 2012 meeting of the Conference for Food Protection (CFP). Collaboration
37 with the CFP and our partners at the U.S. Department of Agriculture's Food Safety and Inspection Service
38 and the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services
39 helps ensure the Food Code establishes sound requirements that prevent foodborne illness and injury and
40 eliminates the most important food safety hazards in retail and foodservice facilities.

41 Source: Food Code 2013, U.S. Food and Drug Administration, July 2, 2015,
42 <http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm374275.htm> (August 3,
43 2015).

44 A summary of changes to the 2013 FDA Food code is linked here:

45 **Summary of Changes In the FDA Food Code 2013**

46 [<http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm374759.htm>].

47
48 **Dr. Grim moved Board approval for Permanent Adoption of Chapter 257. Food Service**
49 **Establishments as presented. Second Dr. Stewart. Motion carried.**

50
51 **AYE: Alexopulos, Burger, Grim, Stewart, Starkey, Wolfe, Woodson**

52 **ABSENT: Gerard, Krishna**

STRATEGIC MAP UPDATE PRESENTATION: THE LIFECOURSE APPROACH TO A HEALTHY OKLAHOMA

Timothy Cathey, M.D., Medical Director for Protective Health Services
See Attachment A

CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee

Dr. Woodson reminded the Board that the March meeting would take place in Pottawatomie County. The annual ethics commission forms will be sent to the Board of Health in during the month of January 2016.

Finance Committee

Ms. Burger directed attention to the Financial Brief provided to each Board member and presented the following SFY 2016 Finance Report and Board Brief as of December 18, 2015:

- OSDH has approximately \$403 million budgeted for state fiscal year 2016
- The forecasted expenditure rate is projected at 97.63% through June 30, 2016
- The department is in "Green light" status overall
- Health Improvement Services are in "yellow light" status, with expenditures forecasted to spend between 90 and 95 percent
- The "yellow light" status for these two divisions is due to items budgeted, but not yet obligated or forecasted such as supplies, travel and contracts

The Financial Brief covered fund restrictions and voluntary out benefits option (VOBO) offered to Department employees eligible for retirement.

Accountability, Ethics, & Audit Committee

The Accountability, Ethics, & Audit Committee met with Jay Holland. Ms. Wolfe indicated there were no known significant audit issues to report at this time and were continuing review of the Office of Accountability policies.

Public Health Policy Committee

The Policy Committee met on Tuesday, January 12, 2016. The Committee reviewed proposed legislation, the budget situation, and potential actions of the Department. Members will begin receiving the legislative update report around February 1st. If Board members have any policy questions, they should feel free to contact Carter Kimble or Mark Newman at any time. The next meeting of the Policy Committee will be prior to the February Board Meeting.

PRESIDENT'S REPORT

Dr. Woodson invited the Board of Health members to attend the annual Certified Healthy Awards Ceremony on March 2, 2016, 11:30 am at the Embassy Suites in Norman, Ok.

COMMISSIONER'S REPORT

Dr. Cline highlighted the ASTHO Million Hearts Collaborative. Oklahoma is 1 of 5 states to join this initiative early with the goal of reducing cardiovascular disease and reducing hearth attacks across the nation. He was able to present the success Oklahoma has seen through this initiative to encourage other states to participate. Dr. Cline indicated this was a compliment to the Oklahoma State Department of Health and the work of local partners as well.

Dr. Cline briefly commented on the upcoming legislative session. There has been a significant increase in activity and conversations around legislative priorities for the Department this next year.

The report concluded.

NEW BUSINESS

No new business.

PROPOSED EXECUTIVE SESSION

DRAFT

OKLAHOMA STATE BOARD OF HEALTH MINUTES

January 12, 2016

1 **Ms. Burger moved Board approval to go in to Executive Session at 11:51 AM** pursuant to 25
2 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation,
3 investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring,
4 appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or
5 employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of
6 information would violate confidentiality requirements of state or federal law.

- 7 • Annual performance evaluation for the Commissioner of Health

8 **Second Dr. Stewart. Motion carried.**

9
10 **AYE: Alexopulos, Burger, Grim, Stewart, Starkey, Wolfe, Woodson**

11 **ABSENT: Gerard, Krishna**

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13 **Ms. Burger moved Board approval to move out of Executive Session. Second Ms. Wolfe. Motion carried.**

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15 **AYE: Alexopulos, Burger, Grim, Stewart, Starkey, Wolfe, Woodson**

16 **ABSENT: Gerard, Krishna**

17
18 **ADJOURNMENT**

19 **Ms. Wolfe moved Board approval to Adjourn. Second Grim. Motion carried.**

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

22 **ABSENT: Gerard, Krishna**

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26 The meeting adjourned at 12:30 p.m.

27
28 Approved

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33 _____
34 Ronald W. Woodson, M.D.
35 President, Oklahoma State Board of Health
February 9, 2016

The Life Course Approach to a Healthy Oklahoma

Implementing a winning strategy



Timothy Cathey, MD, Team Leader
Henry F. Hartsell Jr., PhD, Team Champion
Oklahoma State Board of Health Meeting
January 12, 2016



Why Life Course?

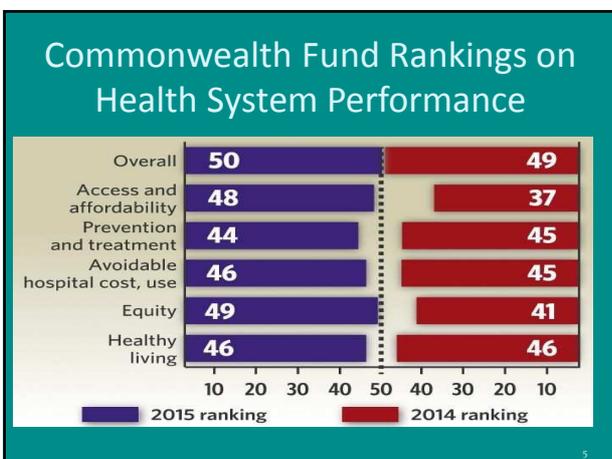
OHIP 2020 Flagship Issues

- Tobacco Use
- Adolescent Obesity
- Children's Health
- Behavioral Health



Team Members

- Nancy Atkinson
- Sheryll Brown
- Dawn Butler
- Janette Cline
- Neil Hann
- Annette Jacobi
- Kristi Kear
- Alesha Lilly
- Jon Lowry
- Joyce Marshall
- Beth Martin
- Derek Pate
- Stephanie U'ren
- Sharon Vaz
- Timothy Cathey, Team Leader
- >200 years of Public Health experience

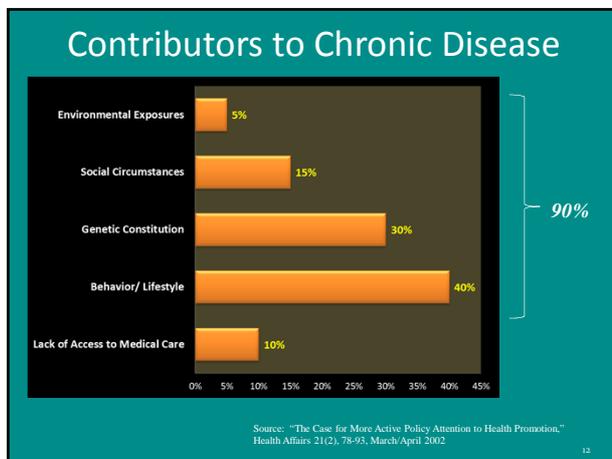
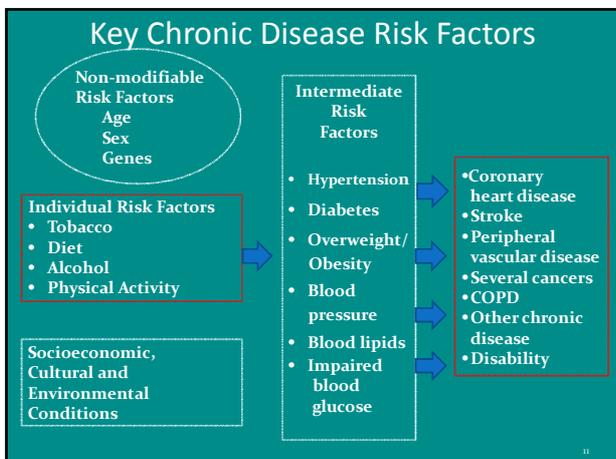
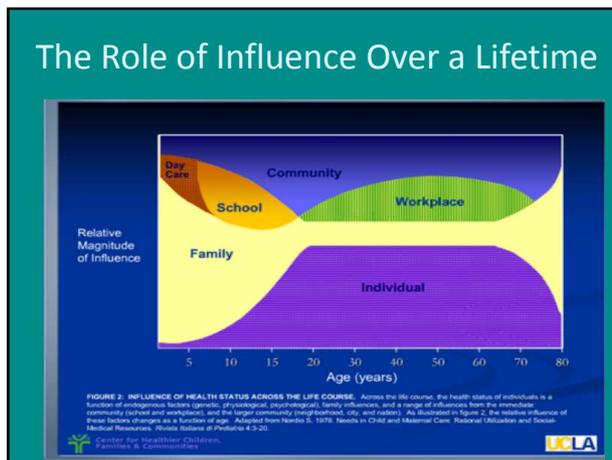
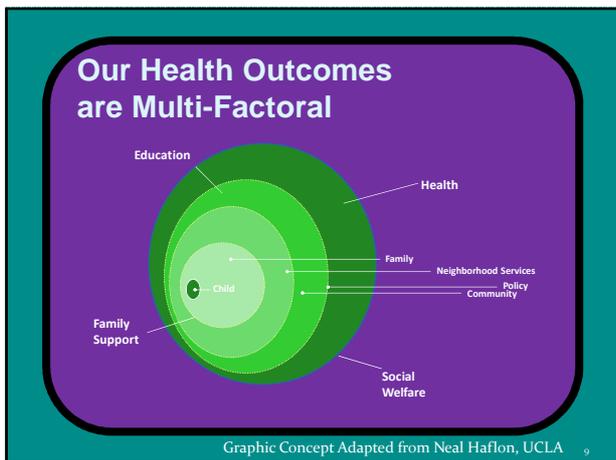


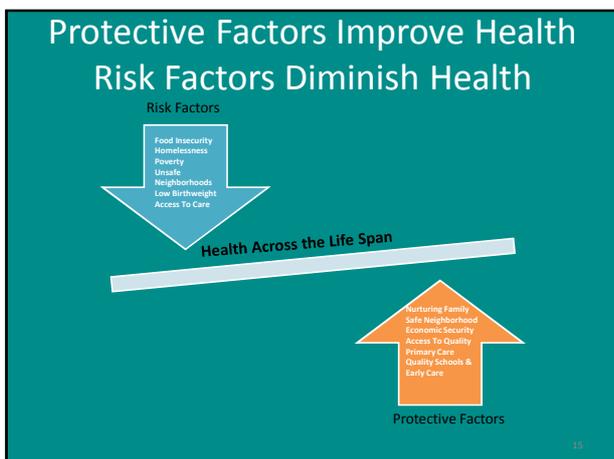
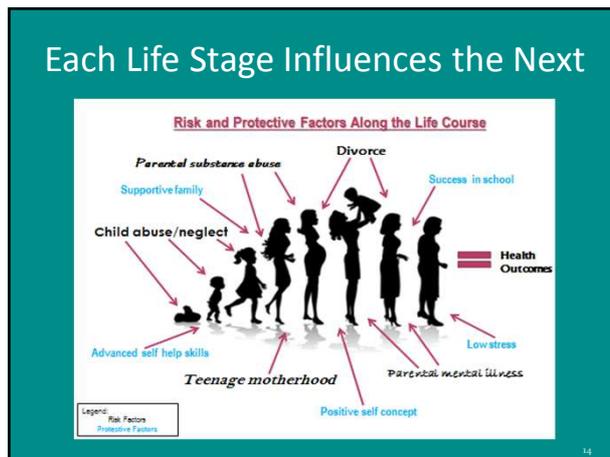
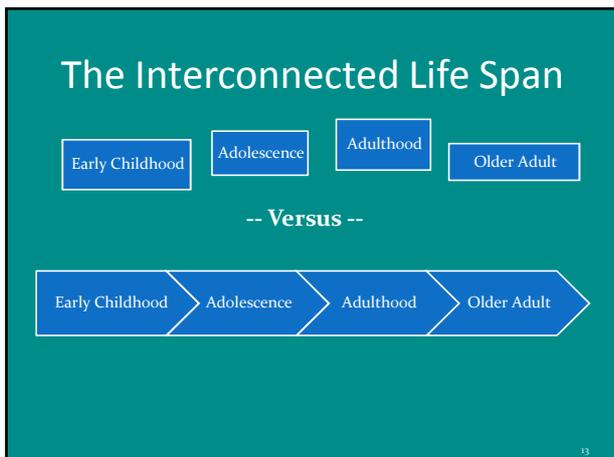
Paradigm Shift



Why the Life Course Perspective?

- A **paradigm shift away** from disease management toward fully averting disease and poor health outcomes
- The current system focuses enormous resources to do too much too late





What is the Life Course Perspective?

The importance of looking at health over a life span, not disconnected stages

A complex interplay of

- biological,
- behavioral,
- psychological, social
- And environmental factors

Identifying **protective factors as well as chains of risk** that contribute to health outcomes across the span of a person's life

- ## Key Terms
- **Critical /Sensitive Periods/Chains of Risk**
 - Timing of exposure to risk factors matters
 - Timing of exposure to protective factors matters
 - Windows of opportunity
 - **Trajectories**
 - A sequence of linked transitions and experiences
 - Long term patterns of stability and change
 - Includes risk and protective factors
- 17

The Quest For Positive Change

PLASTICITY (flexibility)

- The potential for change in intrinsic characteristics in response to environmental stimuli.

RESILIENCE

- A dynamic process of positive adaptation in the face of adversity.

18

Why the Life Course Perspective?

- This framework prioritizes life-long prevention and provides powerful rationale for health system transformation
- It has implications for the ways we will reduce racial and ethnic disparities as well as disparities across income groups
- It points out the importance of critical periods for intervention and cumulative impacts of multiple variables on health

19

Reducing Disparities in Health Outcomes

- Improve health care services and access for at-risk populations, including communities of color and low-income families
- Strengthen families and communities
- Achieve the highest level of health for all people

20

The Intergenerational Aspect of Life Course

Looking at health through a life course perspective hopes to address three key areas:

- Your health as an **individual**;
- Your health before your conception (i.e. your mom's **preconception** health);
- Your children's health (**intergenerational** component).



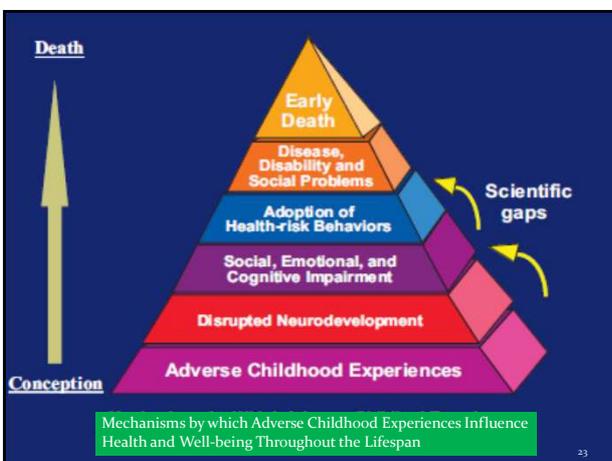
ACEs = ADVERSE CHILDHOOD EXPERIENCES

The three types of ACEs include:

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
Physical Abuse	Physical Neglect	Mental Abuse	Substance Abuse
Emotional Abuse	Emotional Neglect	Mild form of alcohol	Substance Abuse
Sexual Abuse	Sexual Neglect	Divorce	

HOW PREVALENT ARE ACEs?

The Initial ACE study and an analysis of Iowa's Behavioral Risk Factor Surveillance System (BRFSS)** participants revealed the following estimates:*



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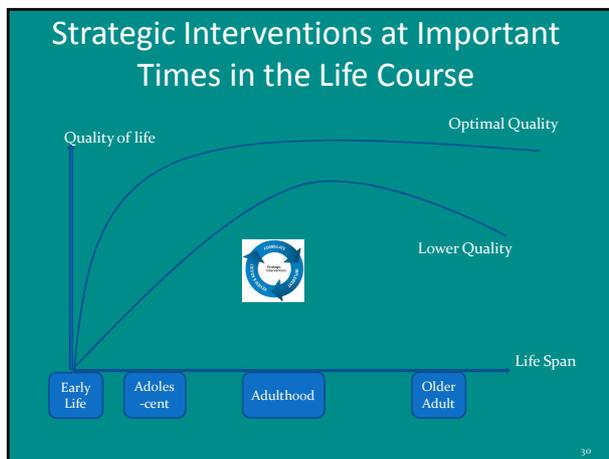
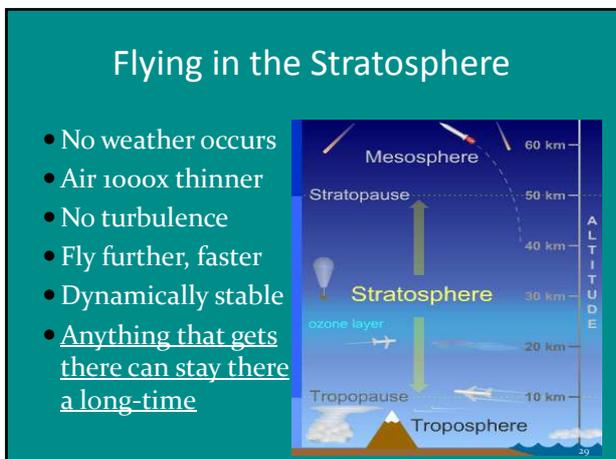
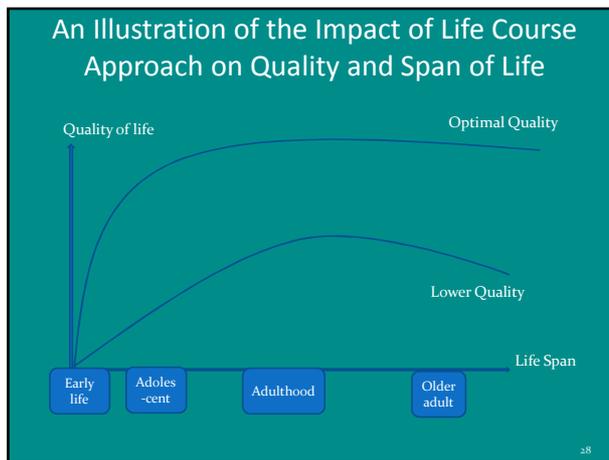
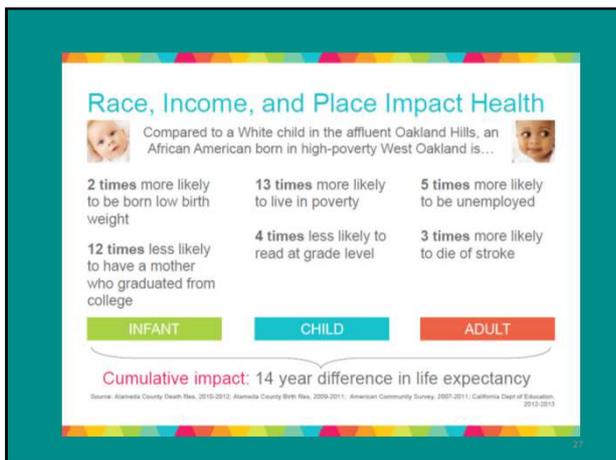
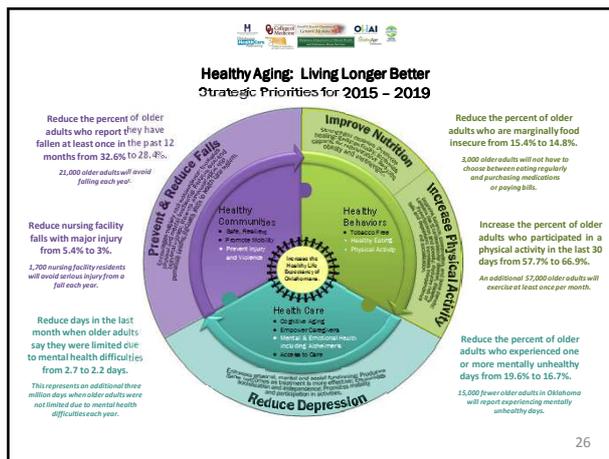
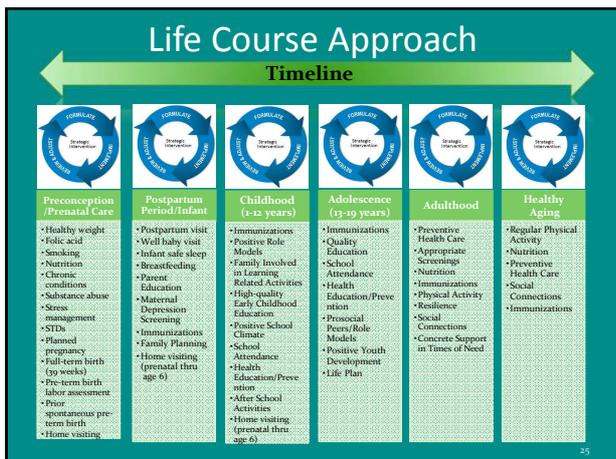
WHAT IMPACT DO ACEs HAVE?

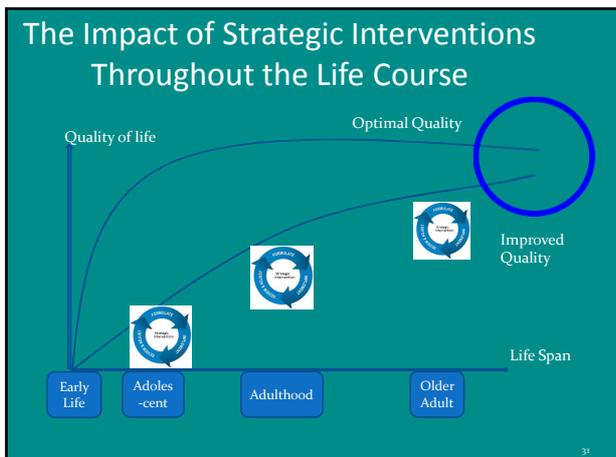
As the number of ACEs increases, so does the risk for negative health outcomes.

Possible Risk Outcomes:

BEHAVIOR				
Lack of physical activity	Smoking	Alcoholism	Drugs	Misconduct
PHYSICAL & MENTAL HEALTH				
Heart Disease	Cancer	Stroke	CHF	Diabetes
Depression	Substance Abuse	PTSD	Chronic Pain	Obesity

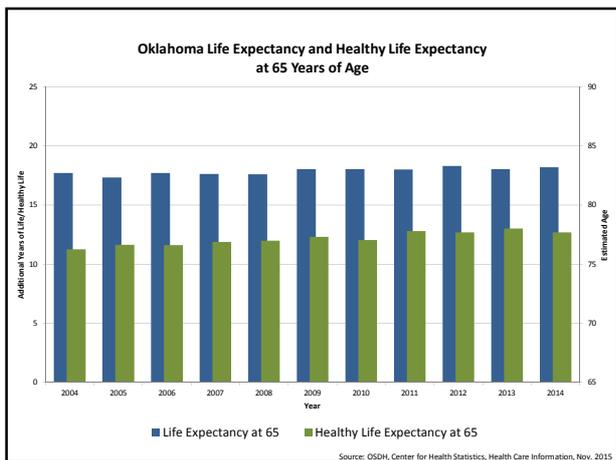
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Increase Healthy Life Expectancy

- Life Expectancy (LE) is the average remaining years of life a person can expect to live on the basis of the current mortality rates for the population.
- Healthy Life Expectancy (HLE) estimates the expected years of life in good health for persons at a given age.



Life Course Approach

- Focuses on the importance of considering health and wellness across the entire life span
- Pre-natal through end-of-life care
- Recognizes the critical role of adverse childhood experiences (ACEs)
- Works to place everyone into the highest trajectory and orbit

Implementing a Life Course Perspective

- **Involves three broad areas of change:**
 - Rethinking and realigning the organization and delivery of individual and population-based health services.
 - Linking health services with other services and supports (educational, social services, etc).
 - Transforming social, economic, and physical environments to promote health.

The Life Course Approach to a Healthy Oklahoma

Implementing a winning strategy
<https://www.youtube.com/watch?v=v1z5H1178o>

Timothy Cathey, MD, Team Leader
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Zika Virus Update for the Board of Health

February 9, 2016

Prepared by Kristy Bradley, DVM, MPH, State Epidemiologist

Background

- Zika is a virus that is spread by *Aedes* species of mosquitoes (primarily *Aedes aegypti*). It was first identified in Uganda in 1947 with later recognition in tropical Africa, Southeast Asia, and the Pacific Islands. In May 2015, the Pan American Health Organization (PAHO) issued an alert about the first confirmed Zika virus infections in Brazil. Since then, the virus has spread rapidly in South and Central America and the Caribbean (26 countries & territories to date). Active transmission in Puerto Rico was detected in December 2015.
- Zika virus is not currently spreading anywhere in the continental U.S., but as more travelers return to the U.S. while still infected with the virus, the risk increases for indigenous biting *Aedes* mosquitoes in the southern U.S. to pick up the virus and begin spreading it locally; 35 travel-associated cases of Zika have been reported by states to CDC (as of 2/3/16).
- The mosquitoes that spread Zika virus are also vectors for dengue and chikungunya viruses. Despite a large chikungunya outbreak in the Caribbean during 2014 and many travel-associated cases reported in the U.S., chikungunya has not established itself in the U.S. Small outbreaks of locally transmitted dengue virus periodically occur in southern Florida, Texas, and Hawaii.
- In infected persons, Zika virus can be found in blood, saliva, urine, and semen. Unborn babies can acquire infection while *in utero* or during birth (perinatal transmission). Three instances of sexual transmission from a man to a woman have been documented: 2008 in CO and recently in Dallas Co., TX.
- Person-to-person transmission by saliva has *not* been documented.
- Transmission is also possible through transfusion of contaminated blood or organ transplantation.

Zika Virus Disease

- About 1 in 5 people who are bitten by Zika virus-infected mosquitoes will experience symptoms of illness, including fever, rash, conjunctivitis, and joint pain.
- Most infected persons will not require hospitalization or medical care and will recover in a few days to 1 week. Deaths are rarely associated with Zika fever.
- There is no specific treatment for Zika virus disease and no preventive vaccine has yet been developed.
- Concurrent with the Zika virus outbreak in Brazil, officials in that country noticed a large increase in the number of babies born with microcephaly (>4,000 congenital microcephaly cases in 2015 compared to an average of 150/year). Although there appears to be a strong association between Zika virus infection during pregnancy and congenital microcephaly, more epidemiologic studies are ongoing to determine a causal association.
- In Brazil, a concomitant increase of persons affected with Guillain-Barre' syndrome, a condition where the immune system attacks its own peripheral nervous system, has also been reported.

Timeline

- January 15, 2016
 - CDC issues travel advisory for pregnant women traveling to countries and territories where Zika virus is spreading
- February 1, 2016: WHO declares Zika as a "Public Health Emergency of International Concern"

- February 5, 2016
 - “Interim Guidelines for Prevention of Sexual Transmission of Zika Virus — United States, 2016”
 - “Update: Interim Guidelines for Health Care Providers Caring for Pregnant Women and Women of Reproductive Age with Possible Zika Virus Exposure — United States, 2016”
- February 8, 2016
 - President requests \$1.8 billion from Congress for Zika virus-related emergency preparedness & response

State Preparedness Activities

- January 20: Distributed first OK-HAN with guidance for Zika virus screening of returning travelers and pregnant women with potential exposure.
- January 26: OSDH Public Health Laboratory (PHL) begins ordering supplies to establish diagnostic testing capacity for Zika and Chikungunya, including PCR testing and IgM serology.
- January 29: Highlighted OSDH web page on Zika virus launched.
- February 3: Began weekly multi-jurisdictional planning meetings with representatives from OSDH Office of State Epidemiologist, Emergency Preparedness and Response Service, Acute Disease Service, PHL, Office of Communications, Office of General Counsel, Maternal Child Health-Women’s Health, Screening and Special Services-Birth Defects Registry and Community and Family Health Services; representatives from THD and OCCHD will also be invited to participate in the planning sessions.
- Ongoing: Birth Defects Registry analyzing data on incidence of microcephaly in OK. Data available from 1992 to current year from Cleveland, Oklahoma and Tulsa Counties; from 1994 for entire state.
- Exploring options for contracting with entomologic professionals to provide mosquito surveillance, speciation, and vector control technical assistance; will also determine if PHL will provide Zika virus testing of speciated mosquitoes.
- Evaluating need and available personnel resources to provide expanded case investigation of any reported microcephaly cases.
- Continue educational outreach to physicians, hospitals and labs, especially those serving pregnant women or providing travelers’ health clinics.

Oklahoma’s Risk for Local Transmission of Zika Virus

This is dependent on whether *Aedes albopictus* (Asian tiger mosquito) is an effective vector of Zika virus in the US. Oklahoma has very few *A. aegypti* mosquitoes, but large populations of *A. albopictus*. These mosquitoes tend to bite aggressively and during the daytime hours. They are difficult to control.

Approximate distribution of *Aedes aegypti* in the United States*



Approximate distribution of *Aedes albopictus* in the United States*



2015 National Health Scorecards

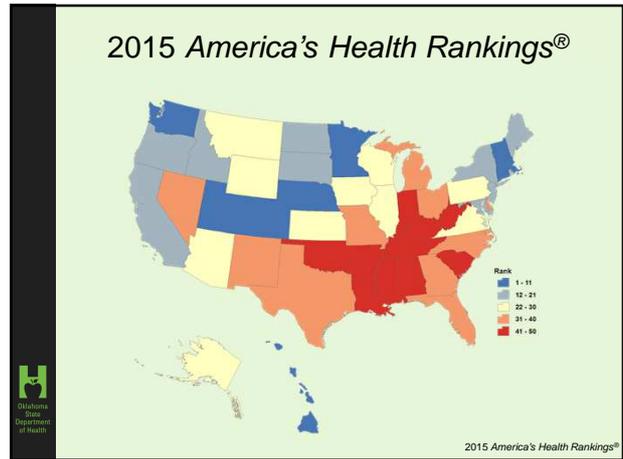
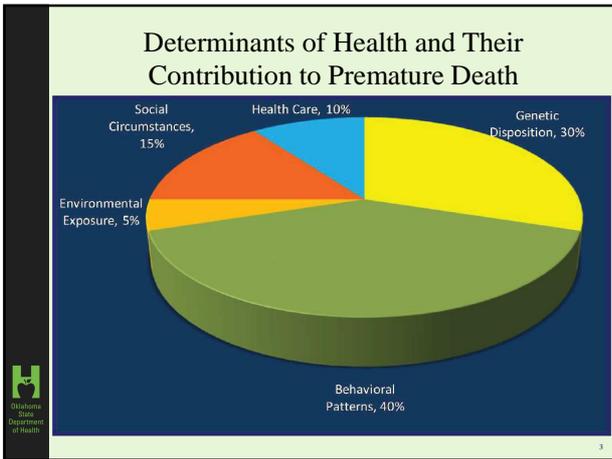
America's Health Rankings & Aiming Higher, Scorecard on State Health System Performance

Board of Health Meeting
February 9, 2016



Publications/Scorecards

PUBLICATION	RANK
United Health Foundation America's Health Rankings (2015)	Overall Ranking: 45
United Health Foundation Senior Health Rankings Report (2015)	Overall Ranking: 46
Commonwealth Fund (2015)	Overall Ranking: 50
Trust for America's Health (2015)	No Overall Ranking
March of Dimes Prematurity Report Card	Overall Grade: C
National Health Security Preparedness Index (2014)	Overall Score: 7.6
CDC Prevention Status Reports (2013)	N/A

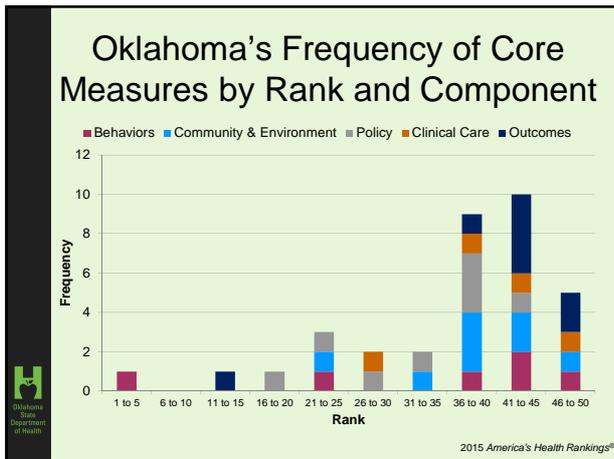
2015 America's Health Rankings®

Top Ten	Bottom Ten	Other (Region VI)
1 - Hawaii (IX)	41 - Indiana (V)	34 - Texas (VI)
2 - Vermont (I)	42 - S Carolina (IV)	37 - New Mexico (VI)
3 - Massachusetts (I)	43 - Tennessee (IV)	45 - Oklahoma (VI)
4 - Minnesota (V)	44 - Kentucky (IV)	48 - Arkansas (VI)
5 - New Hampshire (I)	45 - Oklahoma (VI)	50 - Louisiana (VI)
6 - Connecticut (I)	46 - Alabama (IV)	
7 - Utah (VIII)	47 - W Virginia (III)	
8 - Colorado (VIII)	48 - Arkansas (VI)	
9 - Washington (X)	49 - Mississippi (IV)	
10 - Nebraska (VII)	50 - Louisiana (VI)	

2015 America's Health Rankings®



- ### Changes
- Excessive Drinking replaced Binge Drinking as a core measure.
 - Chronic Drinking was added as a supplemental measure.
 - Revised definition of High School Graduation
 - Moved to National Center for Education Statistics measure of high school graduation.
 - The definition of Immunizations for Adolescents was revised.
 - Coverage estimates provided for the 3 individual vaccines
 - Male HPV coverage was added to a composite HPV coverage
 - Added Injury Deaths as a supplemental measure
- 2015 America's Health Rankings®
- 



Behaviors

Metric	2015 Value (Rank)	2014 Value (Rank)	2013 Value (Rank)	Top State Value
Smoking (Percent of Population)	21.1 (40)	23.7 (45)	23.3 (39)	9.7
Binge Drinking (Percent of Population)	-	12.7 (7)	14.4 (9)	-
Excessive Drinking (Percent of Population)	13.5 (5)	13.4 (5)	-	10.3
Drug Deaths (deaths per 100,000 population)	20.3 (45)	19.8 (45)	18.8 (46)	2.7
Obesity (Percent of Population)	33.0 (45)	32.5 (44)	32.2 (45)	21.3
Physical Inactivity (Percent of adult population)	28.3 (46)	33.0 (47)	28.3 (44)	16.4
HS Graduation (Percent of Incoming 9 th graders)	-	79.0 (30)	78.5 (27)	89.7
HS Graduation (Percent of Students)	84.8 (21)	-	-	-

2015 America's Health Rankings®

Community & Environment

Metric	2015 Value (Rank)	2014 Value (Rank)	2013 Value (Rank)	Top State Value
Violent Crimes (Offenses /100,000 population)	441.2 (39)	469.3 (40)	469.3 (40)	121.1
Occupational Fatalities (/100,000 workers)	7.6 (46)	7.1 (44)	7.8 (42)	2.0
Children in Poverty (% of children)	25.0 (40)	17.8 (26)	27.4 (46)	10.6
Infectious Disease (/100,000)	0.49 (42)	(25)	-	-
- Chlamydia (cases per 100,000 population)	479.1 (37)	444.2 (27)	377.9 (19)	236.2
- Pertussis (cases per 100,000 population)	6.7 (22)	4.1 (6)	1.8 (7)	1.0
- Salmonella (cases per 100,000 population)	23.9 (44)	20.1 (39)	22.2 (41)	8.4
Air Pollution (micrograms of fine particles/cubic meter)	9.5 (34)	9.7 (33)	9.7 (32)	5.0

2015 America's Health Rankings®

Policy

Metric	2015 Value (Rank)	2014 Value (Rank)	2013 Value (Rank)	Top State Value
Lack of Health Insurance (percent of population)	16.5 (44)	18.0 (44)	17.1 (39)	3.5
PH Funding (\$/person)	\$74 (24)	\$79 (24)	\$80 (26)	\$227
Immunizations—Children (% of children aged 19 to 35 months)	73.3 (18)	62.7 (47)	61.0 (48)	84.7
Adolescents (combined value)	(36)	-	-	1.31
- HPV Females (% of females aged 13 to 17 yrs)	36.4 (32)	35.4 (29)	-	54.0
- HPV Males (% of males aged 13 to 17 yrs)	19.9 (29)	-	-	42.9
- MCV4 (% of adolescents aged 13 to 17 yrs)	70.8 (37)	66.2 (37)	-	95.2
- Tdap (% of adolescents aged 13 to 17 yrs)	82.6 (39)	78.1 (43)	-	94.8

2015 America's Health Rankings®

Clinical Care

Metric	2015 Value (Rank)	2014 Value (Rank)	2013 Value (Rank)	Top State Value
Low Birthweight (% of live births)	8.1 (28)	8.0 (24)	8.5 (33)	5.8
Primary Care Physicians (number per 100,000 population)	85.2 (48)	84.8 (48)	82.7 (48)	206.7
Dentists (number per 100,000 population)	50.4 (38)	50.4 (35)	50.5 (33)	81.2
Preventable Hospitalizations (discharges per 1,000 in Medicare)	62.6 (41)	71.4 (42)	76.9 (43)	24.4

2015 America's Health Rankings®

Outcomes

Metric	2015 Value (Rank)	2014 Value (Rank)	2013 Value (Rank)
Diabetes (% of adult population)	12.0 (43)	11.0 (39)	11.5 (43)
Poor Mental Health Days (days in previous 30)	4.1 (39)	4.3 (44)	4.2 (41)
Poor Physical Health Days (days in previous 30)	4.5 (44)	4.4 (42)	4.4 (42)
Disparity in Health Status (% difference by education level)	25.1 (11)	32.1 (38)	29.8 (27)
Infant Mortality (deaths per 1,000 live births)	7.1 (41)	7.4 (43)	7.7 (44)
Cardiovascular Deaths (deaths per 100,000 population)	322.5 (48)	322.0 (48)	330.5 (48)
Cancer Deaths (deaths per 100,000 population)	215.8 (45)	214.1 (45)	209.6 (43)
Premature Death (years lost per 100,000 population)	9,799 (46)	9,654 (46)	9,838 (47)

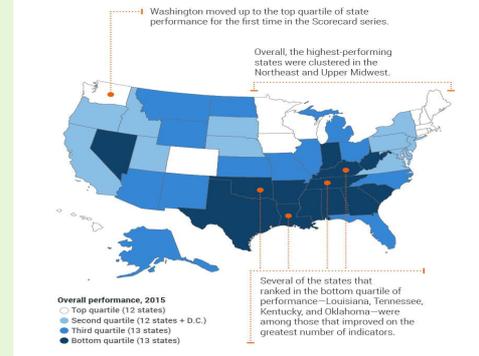
2015 America's Health Rankings®

Commonwealth Fund

Aiming Higher: Scorecard on State Health System Performance 2015



HIGHLIGHTS FROM THE SCORECARD



Scorecard Rankings

America's Health Rankings		State Health Systems Performance	
Top Ten	Bottom Ten	Top Quartile	Bottom Quartile
1 - Hawaii	41 - Indiana	1 - Minnesota	39 - W. Virginia
2 - Vermont	42 - S Carolina	2 - Vermont	40 - Kentucky
3 - Massachusetts	43 - Tennessee	3 - Hawaii	40 - S. Carolina
4 - Minnesota	44 - Kentucky	4 - Massachusetts	40 - Texas
5 - New Hampshire	45 - Oklahoma	5 - Connecticut	43 - Indiana
6 - Connecticut	46 - Alabama	6 - New Hampshire	43 - Nevada
7 - Utah	47 - W Virginia	7 - Rhode Island	43 - Tennessee
8 - Colorado	48 - Arkansas	8 - Colorado	46 - Georgia
9 - Washington	49 - Mississippi	9 - Iowa	47 - Alabama
10 - Nebraska	50 - Louisiana	10 - Washington	48 - Louisiana
		11 - Maine	49 - Arkansas
		11 - Wisconsin	50 - Oklahoma
			51 - Mississippi



Commonwealth Fund Report State Health System Performance

- Measures 42 indicators across 5 dimensions:
 - Access
 - Prevention and Treatment
 - Avoidable Use and Cost
 - Healthy Lives
 - Equity
- Oklahoma improved on 14 indicators, second highest among the jurisdictions
- While not ranking as low as 50th across any of the 5 dimensions, Oklahoma ranked 50th (of 51 jurisdictions) overall.



Commonwealth Fund Report Oklahoma Highlights

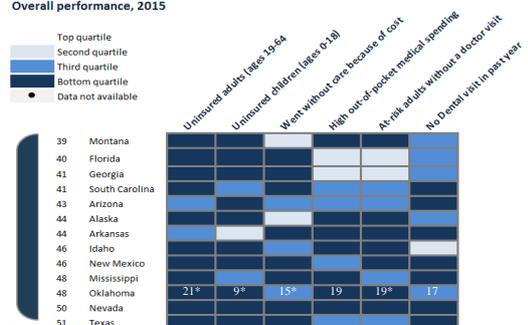
- Improved on 4 of 6 Access and Affordability indicators
- Largest reduction in hospitalizations among Medicare beneficiaries for ambulatory-care sensitive conditions
- Improved on 8 of 13 Racial/Ethnic disparity indicators



2015 Commonwealth Fund Scorecard on State Health System Performance

Access & Affordability

Overall performance, 2015

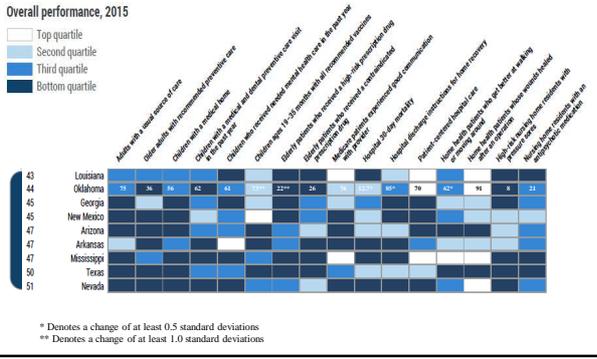


* Denotes a change of at least 0.5 standard deviations
 ** Denotes a change of at least 1.0 standard deviations

Prevention & Treatment

Overall performance, 2015

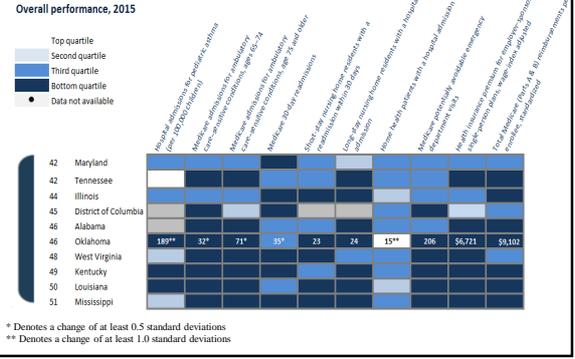
Top quartile
Second quartile
Third quartile
Bottom quartile



Avoidable Hospital Use and Cost

Overall performance, 2015

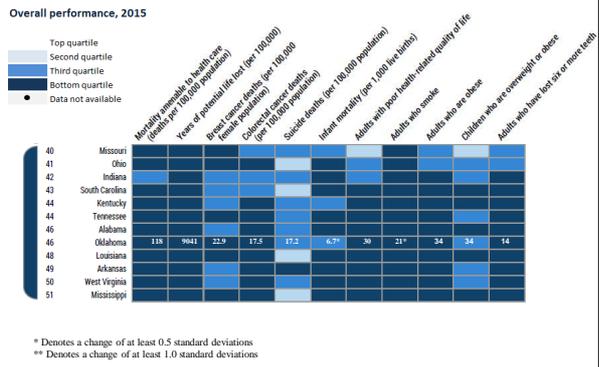
Top quartile
Second quartile
Third quartile
Bottom quartile
Data not available



Healthy Lives

Overall performance, 2015

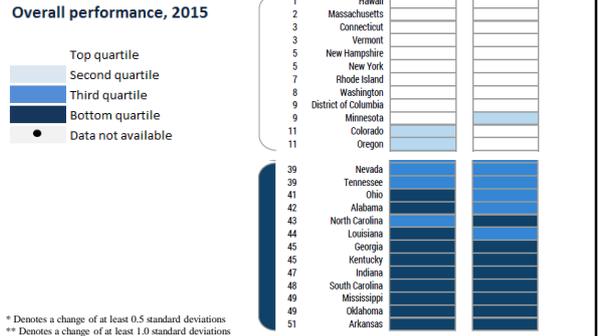
Top quartile
Second quartile
Third quartile
Bottom quartile
Data not available



Equity

Overall performance, 2015

Top quartile
Second quartile
Third quartile
Bottom quartile
Data not available



QUESTIONS



Voluntary Out Benefit Offer SFY 2016 Updates

OKLAHOMA STATE DEPARTMENT OF HEALTH · FEBRUARY 2016



Deborah J. Nichols, Chief Operation Officer
Mark Davis, Chief Financial Officer

Voluntary Out Benefit Offer 'VOBO's'

OKLAHOMA STATE DEPARTMENT OF HEALTH · CREATING A STATE OF HEALTH · WWW.HEALTH.OK.GOV 3

SFY 2016 VOBO's

- **VOBO Benefits**
 - Mandatory Benefits
 - Payment equal to 18 months of health insurance premiums (employee only)
 - Longevity payment that the employee would be paid at the next anniversary date
 - Non-Mandatory Supplemental packets
 - \$5,000 incentive bonus paid in lump sum payment
 - Other
 - Payout of accumulated annual leave up to 480 hours maximum leave allowed

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SFY 2016 VOBO's

- **Timeline**
 - January 29 – send retirement packets
 - February 1 thru May 19 – Fourteen VOBO Q&A sessions
 - Formal notice sent to Secretary Doerflinger, OMES Office of Finance requesting approval of OSDH VOBO
 - January 29 – Fact sheets and personalized summaries
 - **February 29 – Final decision from prospective participants due**
 - March 18 – Application deadline for retirement application submission to HR
 - April 4 – HR deadline for notice of retirement to OPERS (60 days)
 - May 31 – Last day of employment
 - June 1 – Effective day of retirement

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SFY 2016 VOBO's

- **Participation**
 - 317 OSDH Employees met the eligibility requirements for the VOBO
 - 100 – Estimated number of participants
- **Cost and Savings estimates for 100 VOBO retirees**
 - VOBO retirement costs - \$2,608,862 (incurred in FY 2016)
 - Recurring annual payroll cost for the 100 employees - \$7,271,595
 - Net Savings in first 12 month period – \$4,662,733 (realized in 2017)
 - Costs will be incurred in FY 2016, savings won't be realized until FY 2017
 - Cost include:
 - Employee payments
 - Agency cost, i.e. FICA

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Current Status of Participants

DATE	YES	Maybe	No response	No	Total
2/1/2016	77	117	36	87	317
2/4/2016	93	72	25	127	317
2/8/16	101	48	24	144	317

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SFY 2016 STATE REVENUE REDUCTIONS

State Revenue Reduction

For SFY 2016, State revenue has been collected at rates less than expected.

As a result, the Director of the Office of Management and Enterprise Services has directed the OSDH to reduce its SFY 2016 budget by 3% (6% annualized) (\$1,818,974).

State Revenue Reduction

- Federally Qualified Health Centers (FQHC) Start up Funding - \$319,531
- Cord Blood Bank - \$500,000
- OSDH Financial Services (Administration) - \$263,443
- Strategic Planning (STEP-UP) Software Purchase - \$220,000
- Dental Services - \$220,000
- Colorectal Cancer Screenings - \$100,000
- Injury Prevention Services - \$100,000
- Oklahoma State Athletic Commission - \$6,000
- Elimination of Position - \$90,000

Closing comments

Questions?

Oklahoma State Board of Health Dashboard

Public Health Infrastructure: County Health Department Visits

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

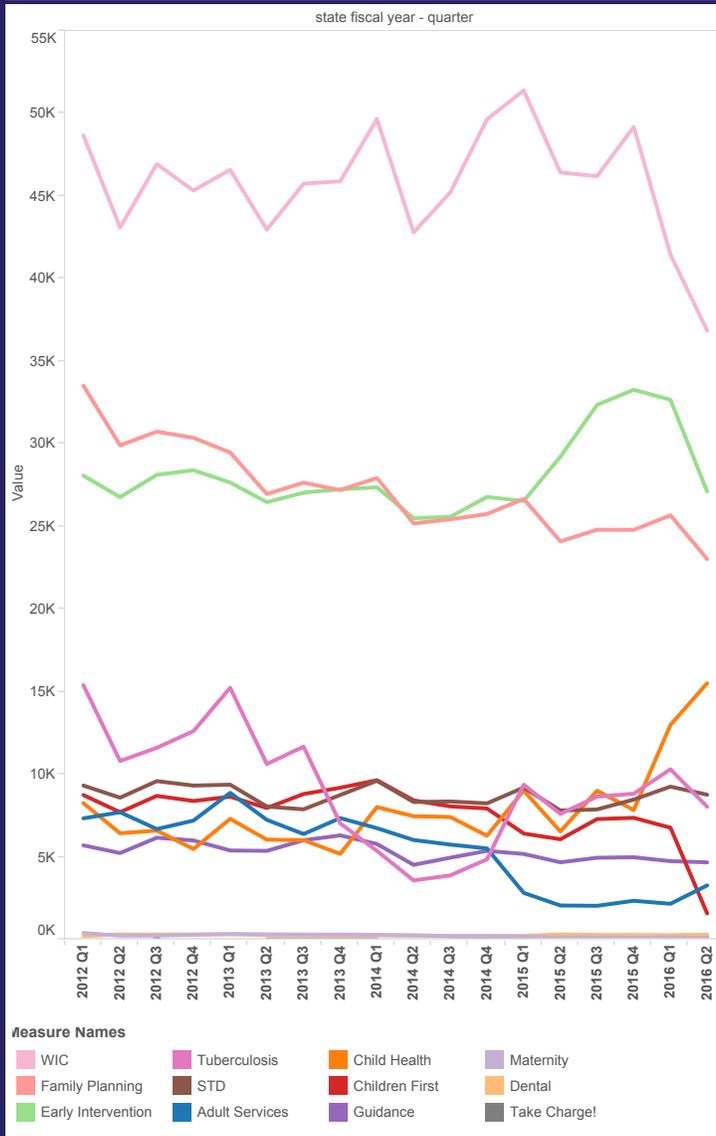


Figure 2: Total Immunization Visits by Quarter
Recorded in Oklahoma State Immunization Information System

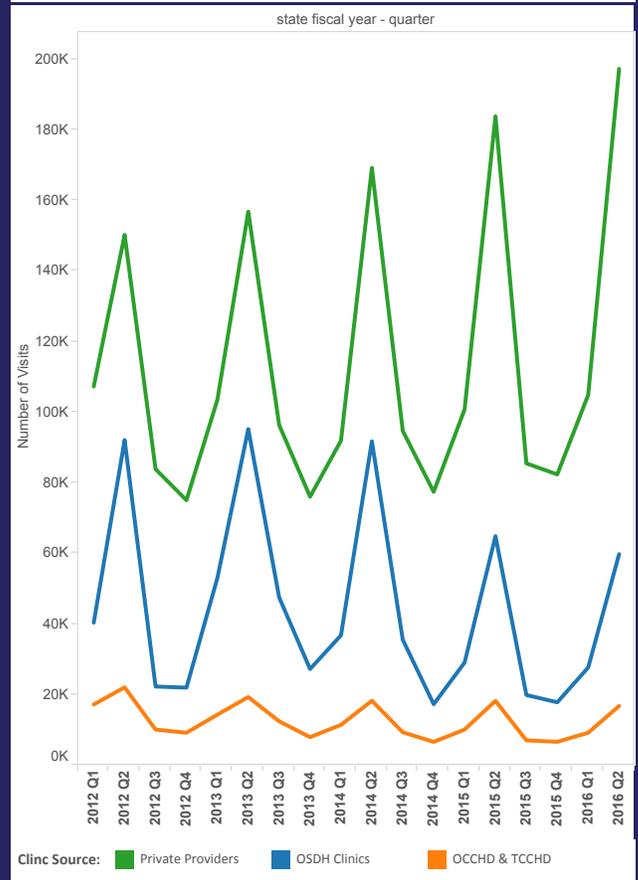


Table 1: OSDH + OCCHD + THD Clinic Services by Quarter

Qtr	2013	2014	2014-2013 %Change	2015	2015-2014 %Change	2016	2016-2015 % Change
Q1	618,908	596,597	-3.6	784,617	31.5	747,935	-4.7
Q2	559,408	653,474	16.8	723,643	10.7	695,283	-3.9
Q3	544,050	534,477	-1.8	681,690	27.5		
Q4	540,432	535,709	-0.9	702,318	31.1		
Total	2,262,798	2,320,257		2,892,268		1,443,218	

Explanation of Dashboard

Figure 1. Total Visits for OSDH + OCCHD + THD Clinics by Quarter. As seen in previous dashboards, the apparent dip in the number of visits for the most recent quarter may be due to a lag in reporting time. Notably, there has been an increase in the number of client visits for the Child Health program for the most recent two quarters. This uptick is mostly explained by increases in numbers from OCCHD and THD.

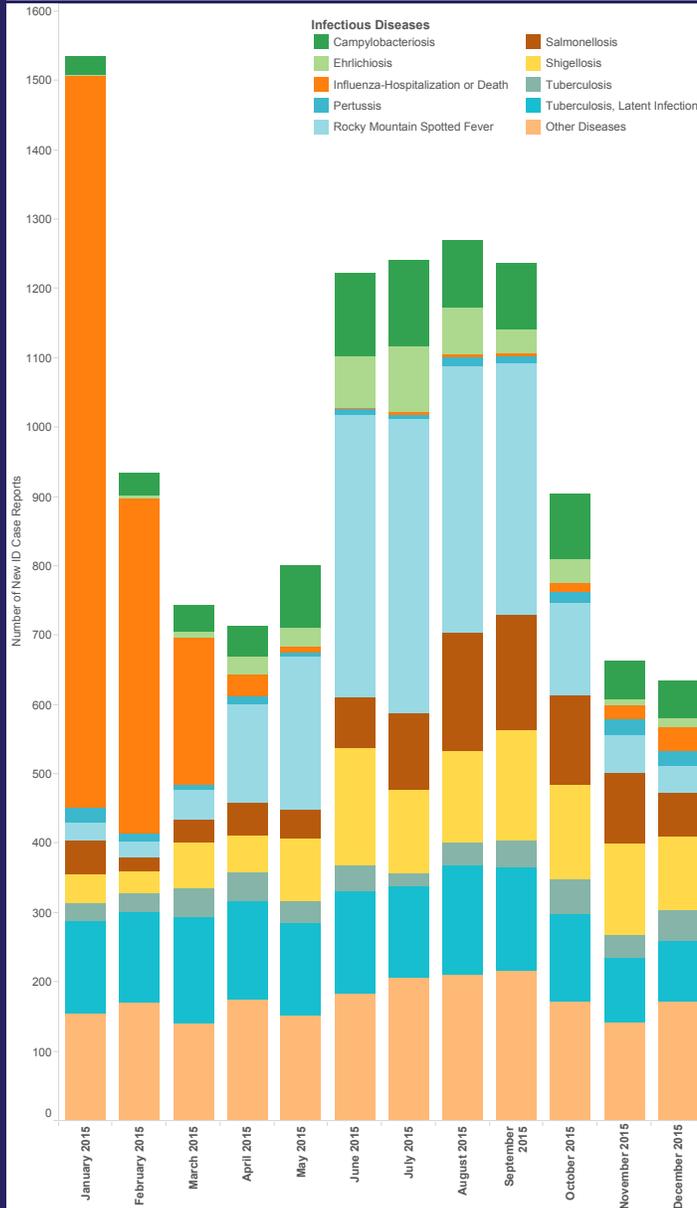
Figure 2. Total Immunization Visits by Quarter. The current data shows a decrease in immunizations for OSDH. However, there has been a corresponding increase in immunizations at private provider clinics, perhaps reflecting increased availability of flu shots at private clinics and drug stores. Large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

Table 1. OSDH + OCCHD + THD Clinic Services by Quarter. Services in county health department clinics appear to have decreased in the 1st quarter of SFY2016. The numbers are projected to increase when final data from several programs have been fully entered by the 3rd quarter of SFY 2016.

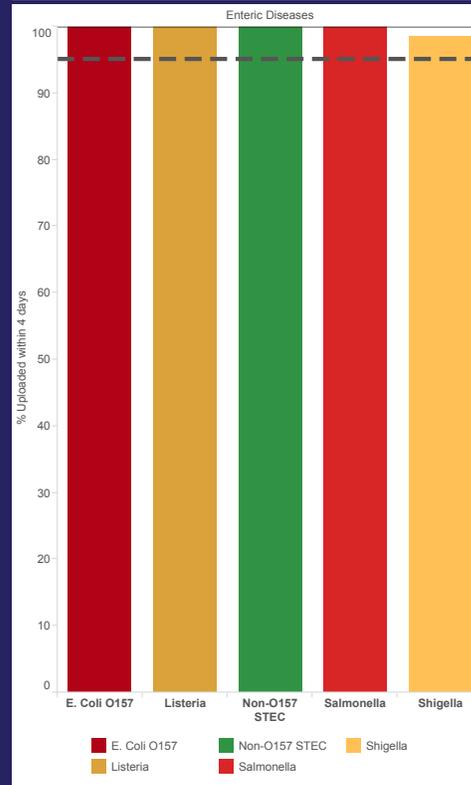
Oklahoma State Board of Health Dashboard

Public Health Imperative: Infectious Disease Measures

Number of New Infectious Disease (ID) Case Reports



Percentage of PH Lab Enteric Diseases Uploaded to PulseNet within 4 Days, January - December 2015
Benchmark = 95%



Number of New Infectious Disease Case Reports and Estimated Investigation Time (Hrs):
January - December 2015

Month of Month	# of Rep	Est. Hrs	# Specimens
January 2015	1,534	979	14,211
February 2015	935	964	13,022
March 2015	744	1,062	14,759
April 2015	717	1,137	15,220
May 2015	802	1,144	13,271
June 2015	1,227	1,542	15,795
July 2015	1,241	1,626	15,795
August 2015	1,269	1,915	15,952
September 2015	1,236	1,976	15,728
October 2015	904	1,214	15,658
November 2015	662	1,217	13,823
December 2015	635	1,653	14,867

Explanation of Dashboard

The **'Number of New Infectious Disease (ID) Case Reports'** graph shows the new cases of infectious disease received by the Acute Disease Service (ADS) by month. It reflects significant seasonal trends such as the increase of influenza hospitalizations/deaths in the winter months and increase in enteric and tickborne diseases in the summer months. Notable: The 2014-15 influenza season was remarkable for high incidence of influenza hospitalizations/deaths. H3N2 was the predominant strain which typically leads to higher morbidity and mortality. Additionally, there was a poor match between the vaccine strain and the circulating H3N2 strain. In comparison the 2015-16 influenza season is mild. Also notable, in the summer of 2015 there was an increase in Shigellosis. Shigellosis is a cyclic disease, and 2015 was an epidemic year for *Shigella*.

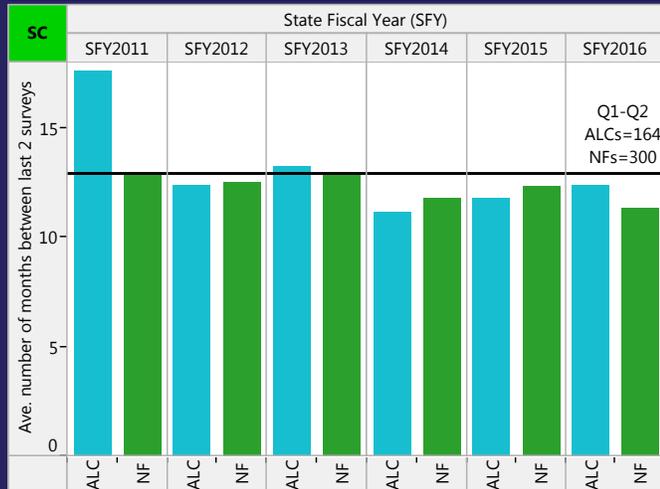
'Percentage of PH Lab Disease Uploaded to PulseNet within 4 Days' indicates that the benchmark of 95% has been met and exceeded for all factored enteric diseases. The PHL continues to exceed the CDC and PHEP grant guidelines for uploading data isolate data within the 4 days required. The PHL averages 1.2 days for uploading 99% of the isolates.

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

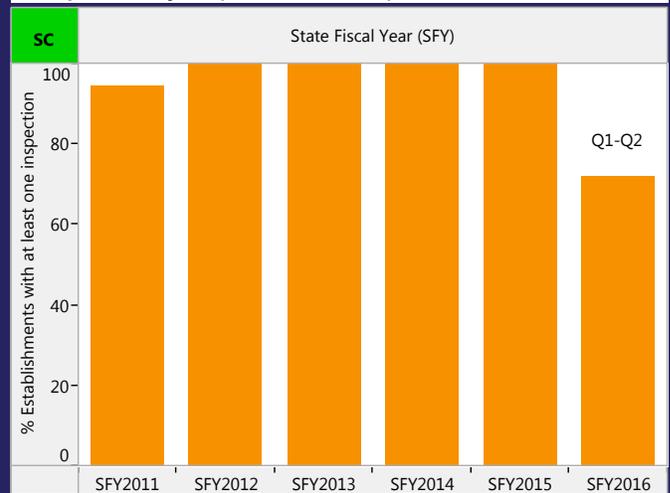
Oklahoma State Board of Health Dashboard

Public Health Imperative: Regulatory Measures

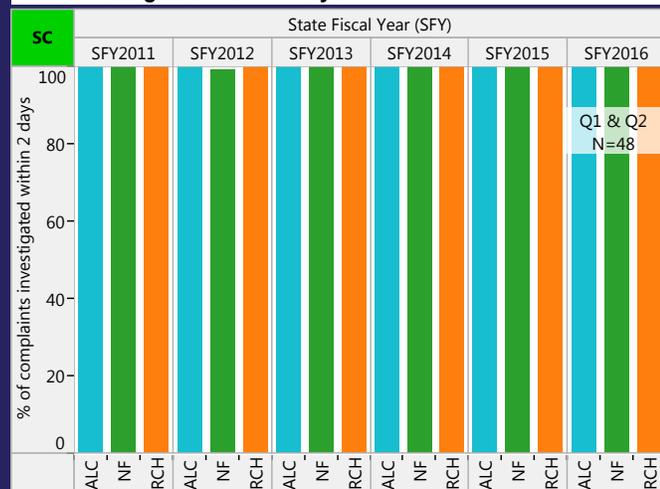
A. Average interval between inspections for ALCs and NFs is less than or equal to 12.9 months.



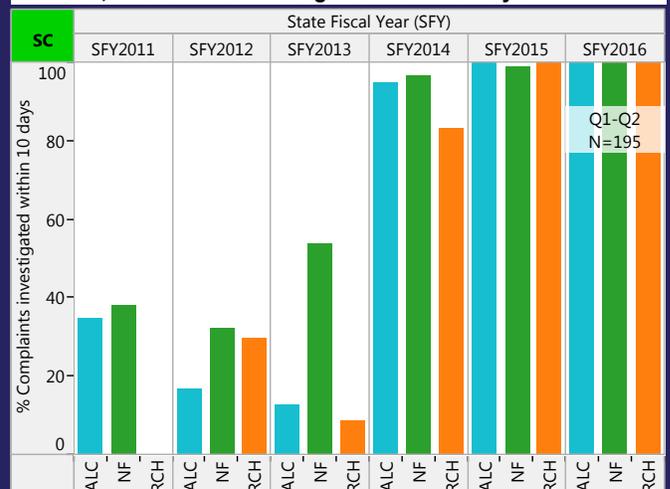
B. Percentage of food service establishments inspected at least once per fiscal year (N=22,014 for Q2)



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



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



Explanation of Dashboard

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

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

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

**OKLAHOMA STATE DEPARTMENT OF HEALTH
BOARD OF HEALTH FINANCE COMMITTEE BRIEF
FEBRUARY 2016**

SFY 2016 BUDGET AND EXPENDITURE FORECAST: AS OF 01/25/2016

<u>Division</u>	<u>Current Budget</u>	<u>Expenditures</u>	<u>Obligations</u>	<u>Forecasted Expenditures</u>	<u>Not Obligated or Forecasted</u>	<u>Performance Rate</u>
Public Health Infrastructure	\$ 16,705,026	\$ 7,341,487	\$ 4,084,008	\$ 4,851,012	\$ 428,518	97.43%
Protective Health Services	\$ 61,280,456	\$ 29,454,876	\$ 11,444,941	\$ 20,251,988	\$ 128,651	99.79%
Prevention & Preparedness Services	\$ 63,196,442	\$ 22,510,421	\$ 24,695,383	\$ 13,094,600	\$ 2,896,038	95.42%
Health Improvement Services	\$ 25,450,971	\$ 9,114,369	\$ 6,860,383	\$ 8,280,671	\$ 1,195,548	95.30%
Community & Family Health Services	\$ 231,743,453	\$ 96,360,566	\$ 34,739,958	\$ 100,928,427	\$ (285,498)	100.12%
Totals:	\$ 398,376,349	\$ 164,781,719	\$ 81,824,674	\$ 147,406,699	\$ 4,363,258	98.90%
< 90%	90% - 95%		95% - 102.5%		102.5% - 105%	>105%

Expenditure Forecast Assumptions

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

Explanation of Change

- The amounts reported as 'Not Obligated or Forecasted' are not an estimate of lapsing funds. This represents planned expenditures that OSDH is currently taking action to execute.
- The 3% reduction of SFY 2016 state appropriations (\$1,818,974) is reflected.
- All divisions are in a "green light" status.
- The overall Department performance rate of 98.90% is a 1.27% increase from the previous month's 97.63%.

**OKLAHOMA STATE DEPARTMENT OF HEALTH
BOARD OF HEALTH FINANCE COMMITTEE BRIEF
FEBRUARY 2016**

SFY 2016 STATE REVENUE REDUCTIONS

For SFY 2016, State revenue has been collected at rates less than expected. As a result, the Director of the Office of Management and Enterprise Services has directed the OSDH to reduce its SFY 2016 budget by 3% (\$1,818,974).

- Federally Qualified Health Centers (FQHC) Start Up Funding- \$319,531
OSDH will eliminate funds in the amount of \$319,531 that support the FQHC Startup Program and will prevent the OSDH from contracting and assisting with the expansion of FQHCs in Oklahoma communities, such as contracts for community needs assessment, strategic planning, community development, grant application development, and/or additional technical assistance regarding FQHC startup and development. Note: This will not impact FQHC uncompensated care disbursements.
- Cord Blood Bank - \$500,000
The OSDH will eliminate support in SFY 2016 for cord blood bank planning efforts in the amount of \$500,000.
- OSDH Financial Services (Administration) - \$263,443
OSDH will make a one-time reduction to Financial Management Services that impact the ability to fill eight critical positions for SFY-16 that have gone unfilled due to difficulty recruiting qualified applicants.
- Strategic Planning (STEP-UP) Software Purchase - \$220,000
The OSDH will not pursue an update to the Strategies Toward Excellent Performance – Unlimited Potential (STEP-UP) system in SFY-16. STEP-UP is the mechanism by which OSDH maintains compliance with the Public Health Accreditation Board (PHAB) requirement for the maintenance of a performance management system. The OSDH will continue to utilize the current system and not pursue the system upgrades (cost include software and IT support).
- Dental Services - \$220,000
Dental health education services will be eliminated. The efforts of dental health educators will be redirected to non-state funded programs.
- Colorectal Cancer Screenings - \$100,000
Contract amounts to provide colorectal cancer screenings to low income adults will be reduced. This reduction will result in 87 less screenings.
- Injury Prevention Services - \$100,000
The Injury Prevention Service will not refill on vacant position responsible for surveillance and data analysis for violent death reporting across Oklahoma. Position is responsible for the dissemination of information to public and private partners and other interested stakeholders. Responsibilities are currently being managed by a student apprentice.
- Oklahoma State Athletic Commission - \$6,000
The reduction impacts the training opportunities for the Athletic Commission inspectors and reduction of attendance by Board Commissioners to national conferences.
- Elimination of Position - \$90,000
OSDH will eliminate one management position within the Commissioner's Office which was vacated due to a retirement.

**OKLAHOMA STATE DEPARTMENT OF HEALTH
BOARD OF HEALTH FINANCE COMMITTEE BRIEF
FEBRUARY 2016**

SFY 2016 VOLUNTARY OUT BENEFIT OFFER (VOBO)

- VOBO Benefits
 - o Mandatory Benefits
 - Payment equal to health insurance premiums (employee only) for eighteen (18) months
 - Longevity payment employee would be paid at the next anniversary date
 - o Non-Mandatory Supplemental Benefits
 - \$5,000 lump sum payment
- Timeline
 - o January 29 – Send retirement packets
 - o February 1 through May 19 – Fourteen VOBO Q & A sessions for prospective participants
 - o January 29 – Fact sheets and personalized benefit summaries to prospective participants
 - o February 29 – Final decision must be made by prospect participants
 - o March 18 – Application deadline for employees to submit paperwork to Human Resources
 - o April 4 – Deadline for Human Resources to submit applications to OPERS
 - o May 31 – Last day of employment
 - o June 1 – Effective day of retirement
- Participation
 - o 317 OSDH Employees met the eligibility requirements for the VOBO
 - o 100 – Estimated number of participants
- Cost and savings estimates for 100 VOBO retirees
 - o VOBO retirement costs - \$2,608,862 (incurred in FY 2016)
 - o Recurring annual payroll cost for the 100 employees - \$7,271,595
 - o Net savings in first 12 month period - \$4,662,733 (realized in FY 2017)
 - o Costs will be incurred in FY 2016, savings won't be realized until FY 2017
 - o Costs include:
 - Employee payments
 - Eight (18) months of insurance premiums
 - Next longevity payment
 - \$5,000 lump sum payment
 - Up to 480 hours of accumulated annual leave
 - Agency costs
 - FICA costs associated with employee payments
 - OPERS cost for accumulated sick leave applied for additional service credit

OKLAHOMA STATE BOARD OF HEALTH
COMMISSIONER'S REPORT
Terry Cline, Ph.D., Commissioner
February 9, 2016

PUBLIC RELATIONS/COMMUNICATIONS

Mattie Quinn, Governing Magazine – interview
Edmond Noon Rotary Club – speaker
Jaclyn Cosgrove, The Oklahoman – interview
OU College of Public Health Spring Orientation - speaker
Oklahoma City Chamber of Commerce Legislative Breakfast
The Oklahoman Editorial Board

STATE/FEDERAL AGENCIES/OFFICIAL

Terri White, Commissioner, ODMHSAS
Governor Fallin's Cabinet Meeting
Joy Hofmeister, State Superintendent of Public Instruction, OSDE
Natalie Shirley, Secretary of Education & Workforce Development
U.S. Congressman Tom Cole
Tribal Public Health Advisory Committee

SITE VISITS

Caddo County Health Department
Choctaw County Health Department
Grady County Health Department
Johnston County Health Department
Marshall County Health Department
McClain County Health Department
McCurtain County Health Department
Murray County Health Department

OTHERS:

Ted Haynes, President, Blue Cross and Blue Shield of Oklahoma
Gary Cox, Executive Director, Oklahoma City County Health Department
Bruce Dart, Executive Director, Tulsa Health Department
Mary Melon, President/CEO, The Foundation for Oklahoma City Public Schools
Bruce Lawrence, President/CEO, Integris Health
Nazette Zuhdi-Cleaver, President Junior League of Oklahoma City & Sara Sweet, President Elect
ASPEN Institute Teamwork
Craig Jones, President, Oklahoma Hospital Association
Oklahoma City County Health Department Board Meeting
Tulsa Health Department Board Meeting
Sarah Greenwalt, Assistant Solicitor General, Oklahoma Office of the Attorney General