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7.	<b>STATE INNOVATION MODEL / NATIONAL GOVERNOR'S ASSOCIATION PRESENTATION</b>
8.	<b>LEGISLATIVE PRIORITIES PRESENTATION</b>
9.	<b>FINANCE COMMITTEE REPORT</b>
10.	<b>QUARTERLY PERFORMANCE AND OPERATIONAL DASHBOARD</b>
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SECTION 1  
TRI-BOARD AGENDA  
OCTOBER 6, 2015

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

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

**I. CALL TO ORDER, OPENING REMARKS, INTRODUCTIONS**

Dr. Ronald Woodson, M.D., President, OSBH  
Dr. Stephen Cagle, Chair, M.D., OCCBH  
David Johnson, Chair, TBH

**II. REVIEW OF MINUTES**

**OSBH** - Approval of Minutes for July 14, 2015, Approval of Minutes for August 14-16, 2015, Annual Retreat

**OCCBH** - Approval of Minutes for September 1, 2015

**III. HEALTH DEPARTMENT UPDATES**

Terry Cline, Ph.D. (OSDH), Gary Cox, J.D. (OCCHD), Bruce Dart, Ph.D. (THD)  
Discussion and possible action

**IV. STATE INNOVATION MODEL / NGA WORKFORCE PRESENTATION**

Julie Cox-Kain, M.P.A., Senior Deputy Commissioner, Oklahoma State Department of Health  
Discussion and possible action

**V. LEGISLATIVE PRIORITIES PRESENTATION**

Mark Newman, Ph.D., Director, Office of State and Local Policy, Oklahoma State Department of Health  
Discussion and possible action

**VI. CHAIRMAN'S REPORT – OCCBH**

Update

**PRESIDENT'S REPORT – OSBH**

Discussion and possible action

*Proposed 2016 Board of Health Meeting Dates (second Tuesday of each month at 11:00 a.m., no meeting September or November of 2016, and annual retreat in August date/location TBD)*

**VII. NEW BUSINESS**

Not reasonably anticipated 24 hours in advance of meeting.  
Discussion and possible action

**VIII. ADJOURNMENT**

SECTION 2  
STATE BOARD OF HEALTH MINUTES  
JULY 14, 2015

**STATE BOARD OF HEALTH**  
Oklahoma State Department of Health  
1000 NE 10 Street, Room 1102  
Oklahoma City, OK 73117

Tuesday, July 14, 2015 10:00 a.m.

Martha Burger, Vice President of the Oklahoma State Board of Health, called the 401<sup>th</sup> regular meeting of the Oklahoma State Board of Health to order on Tuesday, July 14, 2015 at 10:10 a.m. The final agenda was posted at 10:00 a.m. on the OSDH website on July 13, 2015, and at 10:00 a.m. at the building entrance on June 13, 2015.

**ROLL CALL**

Members in Attendance: Martha Burger, M.B.A., Vice-President; Charles W. Grim, D.D.S.; R. Murali Krishna, M.D.; Timothy E. Starkey, M.B.A.;

Absent: Terry Gerard, D.O.; Robert S Steward, M.D.; Cris Hart-Wolfe, Secretary-Treasurer; Ronald Woodson, M.D., President

Central Staff Present: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Jr., Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Stephen W. Ronck, Deputy Commissioner, Community & Family Health Services; Mark Newman, Director of Office of State and Federal Policy; Don Maisch, Office of General Counsel; Matt Terry, 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; Janice Hiner, Sr. Advisor to the Commissioner of Health; Felesha Scanlan, Maria Souther, Diane Hanley, Mark Nichols, Fiscal Policy Analyst; Terri White, Commissioner of Mental Health and Substance Abuse Services.

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Martha Burger called the meeting to order. She welcomed special guests in attendance.

**REVIEW OF MINUTES**

Martha Burger directed attention to review of the minutes of the Regular Board meeting.

**Mr. Starkey moved Board approval of the minutes of the June 9, 2015, regular Board meeting, as presented. Second Ms. Wolfe. Motion carried.**

**AYE: Grim, Krishna, Starkey**

**ABSTAIN: Alexopulos, Burger**

**ABSENT: Gerard, Stewart, Wolfe, Woodson**

Martha Burger welcomed special guests in attendance, and introduced Commissioner Terri White, guest speaker.

**Oklahoma’s Behavioral Health Care System: ODMHSAS**

Terri L. White, M.S.W., Department of Mental Health and Substance Abuse

**Oklahoma's Behavioral Health Care System: ODMHSAS**

*Presented by Terri White, MSW, Commissioner, Oklahoma Department of Mental Health and Substance Abuse Services*



**Mental Health Matters**

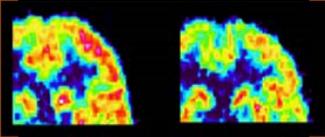
**Mental Illness and Addiction: Diseases of the Brain**

Both mental illness and addiction are real medical conditions, just like diabetes, cancer and heart disease.

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**Mental Health Matters**

**Mental Illness: A Disease of the Brain**

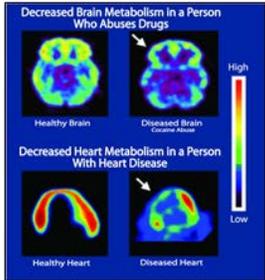


The brain scan on the left reflects normal activity; the scan on the right shows a person affected with schizophrenia.

Source: PBS.org

**Mental Health Matters**

**Addiction: A Disease of the Brain**



Decreased Brain Metabolism in a Person Who Abuses Drugs

Healthy Brain vs. Diseased Brain (Drug Abuse)

Decreased Heart Metabolism in a Person With Heart Disease

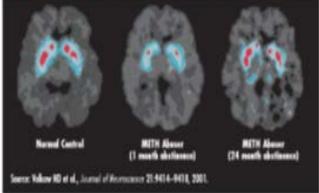
Healthy Heart vs. Diseased Heart

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**Mental Health Matters**

**Addiction: A Disease of the Brain**

**Recovery of Brain Dopamine Transporters in Chronic Methamphetamine (METH) Abusers**



Normal Control, METH Abuser (1 month abstinence), METH Abuser (24 month abstinence)

Source: Volkow ND et al., Journal of Neuroscience 25:9014-9021, 2005.

**Behavioral Health in Oklahoma**

**Oklahoma Among the Highest Rates Nationally for Mental Illness and Substance Abuse Disorders**

*Behavioral Health United States, 2012 (Adults 18+)*

Any Mental Illness	Any Substance Use Disorder
22.4%	11.9%
3 <sup>rd</sup> highest among all states	2 <sup>nd</sup> highest among all states

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- Between 700,000 and 950,000 adult Oklahomans are in need of services; most are not receiving the care they need to fully recover from their illnesses.
- Approximately 190,000 Oklahomans received services in FY14.

**Oklahoma consistently has some of the highest rates nationally for both mental illness and addiction**

**Mental Health Matters**

**ODMHSAS Overview**

The Oklahoma Department of Mental Health and Substance Abuse Services is the state's primary behavioral health network, operating and/or contracting with mental health and addiction treatment facilities across the state. These include:

- 14 Community Mental Health Centers.
- 3 psychiatric hospitals (adult, children's, forensic)
- 3 children's crisis centers in Oklahoma City, Norman and Tulsa; and 12 adult crisis intervention centers in Ardmore, Clinton, Ft. Supply, Lawton, McAlester, Muskogee, Norman, Oklahoma City, Sapulpa and Tulsa.
- 80 alcohol and drug treatment programs, including 14 residential programs
- 17 Regional Prevention Coordinators (RPCs) serving all 77 counties
- 22 residential care homes
- More than 300 Medicaid agency providers, and 825 individual providers

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**Behavioral Health Transfer**

**Effective Medicaid Management**

Medicaid Growth at 14% annually under OHCA (FY07-FY12)			
ODMHSAS Budget Request	FY14	FY13	FY12
(% Medicaid Growth)	7%	9.4%	1.7%

**Annual Medicaid Growth OHCA and ODMHSAS Comparison**

Fiscal Year	Annual Medicaid Growth
FY07	\$29.2M
FY08	\$45.8M
FY09	\$41.6M
FY10	\$31.0M
FY11	\$43.1M
FY12	\$39.8M
FY13	\$34.6M
FY14	\$8.5M

ODMHSAS has reduced Medicaid growth every year since taking over program responsibility (1st full year beginning FY13), and by nearly 50% overall

**Oklahoma Health Improvement Plan Activities**

ODMHSAS and OSDH have been actively working to reduce prescription drug overdose deaths through involvement in such activities as promoting passage of the PMP, training in use of naloxone kits, and working with Gov. Mary Fallin on other elements of the State Plan to Reduce Prescription Drug Abuse, including training physicians on safe prescribing methods.

The two agencies also have collaborated on suicide prevention efforts, as well as concentrating heavily on infant/early childhood mental health programs.

ODMHSAS also has been working on other OHIP goals for some time now, and continues to strengthen programs in those areas.

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**Early Childhood Partnership**

ODMHSAS and OSDH have partnered to house "co-leadership" positions within OSDH Child Guidance Services and ODMHSAS CMHCs to further an early childhood System of Care in Oklahoma. The partnership has 4 goals, which are to:

- Promote awareness of the significance of infant/early childhood mental health (IECMH).
- Enhance the competency of the infant/early childhood workforce to meet the needs of children birth to 8, their families and caregivers.
- Develop, enhance and expand programs for IECMH promotion, prevention, early intervention and treatment to support the well-being of children birth to 8, their families and caregivers.
- Establish infrastructure and develop policies to support the integrated Early Childhood System of Care.

**Early Childhood Partnership**

Activities within the partnership:

- State Co-leads serve as the state wellness expert and state wellness partner for SAMHSA Grant Oklahoma Project LAUNCH (Linking Actions for Unmet Needs in Child Health) implementing an Early Childhood System of Care for families with children birth to 8.
- Assure that the plan is aligned with other health and mental health plans in Oklahoma.
- Support DHS to develop screening, assessment, coordinated case planning and connection to appropriate mental health resources for children birth to 4 in foster care.
- Develop and coordinate a statewide mental health consultation network for child care facilities struggling with the social, emotional, mental health, and behavioral needs of children in their care.
- Pilot the Early Childhood Mental Health Consultation (ECMHC) practice in early head start and head start, and then support local head start grantees in developing contracts with local service providers.
- Identify workforce development needs and coordination of these efforts across the ECSC to include mental health providers, home visitors, SoonerStart Part C, early care and education, public schools, and the judicial system.
- Current focus involves developing a plan to help current providers learn the knowledge and skills required to focus on this specialized population, to address a shortage of providers in this area.

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**Prescription Drug Abuse Prevention**

- Statewide task force/workgroup;
- Developed Governor's strategic plan;
- Initiated policy change;
- Created a public messaging campaign;
- Statewide prevention network;
- Naloxone Initiative
  - First responder pilot effort
  - Pharmacy chains

**Integration**

**Integrating Behavioral/Primary Care**

- Primary care and emergency room settings offer an incredible opportunity to identify mental illness and addiction, and the opportunity for early intervention. Depression and suicide risk are two areas that can be easily assessed. Substance abuse is another. We have been working to partner with health-care agencies in all these areas.
- A 2013 SAMHSA study indicated nearly 45% of people with a co-occurring mental illness/substance abuse disorder had visited the emergency room in the past year, compared with only 25% who had neither present. More than 30% of people with an addiction issue and 40% of those with a mental illness had visited the ER.
- Some studies also have shown that a third of those who died by suicide visited a physician in the week before they died – and 45% had visited their primary care doctor within the month. SAMHSA

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**Screening**

**Substance Abuse Screening: SBIRT**

Screening, Brief Intervention and Referral to Treatment targets those with non-dependent substance use and provides strategies for intervention prior to the need for more extensive or specialized treatment.

- Studies have shown a 80% decrease in substance use following a single brief intervention, as well as successful referral to and participation in alcohol treatment programs, and reduction in repeat injuries and injury hospitalizations.
- The resulting reduction in alcohol misuse may reduce diseases related to alcohol abuse such as cancer, liver and heart problems, as well as public safety issues such as DUIs.

ODMHSAS is prepared to go statewide with SBIRT. For the past several years, technical assistance has been provided to medical facilities that addresses:

- Infrastructure
- Referral
- Medicaid billing issues
- Electronic medical records
- ODMHSAS hosts online CME training for providers seeking Medicaid reimbursement

**Health Homes**

**Health Homes**

ODMHSAS employed a rigorous RFP process to choose 22 qualified Health Home Providers for statewide coverage.

Programs serve both adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) with specific care management protocols tied to these co-occurring conditions:

- Substance Use Disorder
- Diabetes
- Heart Disease
- BMI over 25
- Hypertension
- COPD/Asthma/Moderate Chronic Respiratory Problems
- Tobacco Use

**Criminal Justice**

- ODMHSAS has introduced a "Smart on Crime" proposal with interventions across the spectrum of criminal justice engagement.
- Independent studies confirmed the proposal's merits and ability for the state to avoid millions in future costs if funded in full.
- The proposal was endorsed by numerous law enforcement and community organizations (including the 2008 Oklahoma Academy Town Hall).

**ODMHSAS has proposed a "Smart on Crime" package to reduce the fiscal impact of untreated mental illness and addiction on the state's criminal justice system and overall budget**

**Mental Health Matters**

Compare the cost of treatment against some of the alternatives:

Alternative	Cost
ODMHSAS Treatment	\$2,150
Drug Court	\$5,000
Mental Health Court	\$5,400
Single Hospital Stay	\$15,318
Person Incarcerated	\$19,000
Child Entering Foster Care	\$20,965
Person Incarcerated (SM)	\$23,000

**The cost to treat is significantly less than the cost to incarcerate or other alternatives**

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**Conclusion**

**Treatment works. There is hope, and there is help.**

**For more information, contact me directly at (405)522-3878.**

Website: [www.odmhsas.org](http://www.odmhsas.org)  
 Facebook: [www.facebook.com/ODMHSAS](http://www.facebook.com/ODMHSAS)  
 Department twitter: @ODMHSASINFO  
 Commissioner White twitter: @terriwhiteok

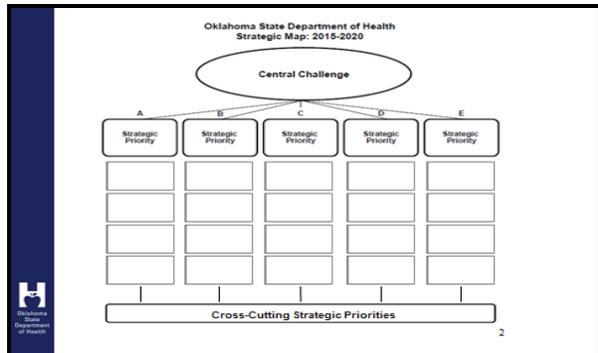
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The presentation concluded.

**Oklahoma State Department of Health Strategic Plan**

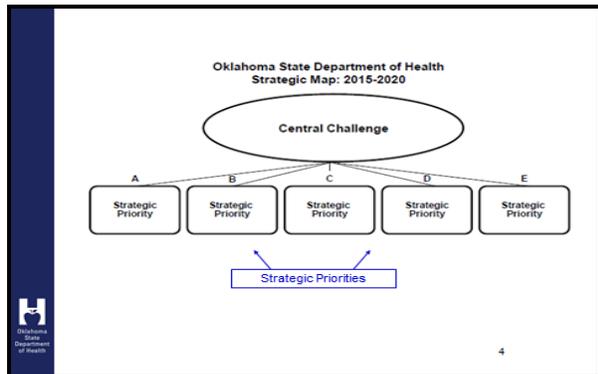
Terry L. Cline, Ph.D., Secretary of Health and Human Services and Commissioner of Health

**STRATEGIC PLAN FRAMEWORK**

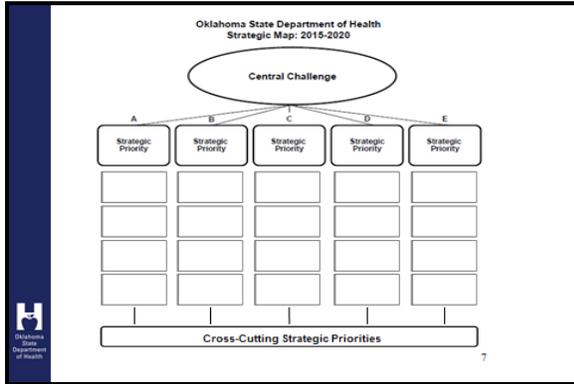


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Oklahoma State Department of Health Strategic Map: 2015-2020



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### Strategic Planning Timeline

Activity	Timeline
Board Consideration of Strategic Planning Timeline Overview	March - April 2015
- OSDH prepares strategic planning timeline for Board consideration	
- Board of Retreat Planning Committee	April 16, 2015
- OSDH Facilitated Strategic Planning Session	May 11, 2015
- Tim Fallon and Stakeholder Focus Group	May 11, 2015
- Tim Fallon and Board Retreat Planning Committee	May 11, 2015
- Tim Fallon and OSDH staff Facilitated Strategic Planning Session	May 14, 2015
- Board of Health Survey Strategic Map Input Period	May 28, 2015
- OSDH Employee Comment Period on Draft Strategic Map	June 9, 2015
- Refinement of Draft Strategic Map per Employee Comments	June 30, 2015
- Draft Strategic Map included in Retreat Packet for Board Consideration	July 24, 2015
- Board of Health Retreat / Finalize Strategic Planning	August 14-16, 2015
- Implementation	August 2015

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2 The presentation concluded.

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4 Dr. Cline asked if there we any questions. Dr. Krishna commented on the Federal Reserve Board’s presentation,  
5 and how it would be helpful to OSDH with regards to the financial piece. Dr. Cline commented on Julie Cox-  
6 Kain’s efforts in reaching out to the Federal Reserve Bank of Kansas City, they were excited to hear from  
7 OSDH. The Federal Reserve Bank is sending three representatives to Sulphur, OK and will present on the  
8 evening of Friday, August 14, 2015 at the Board of Health Retreat.

9  
10 Dr. Cline commented on how this is the beginning of a great partnership.

11  
12 **CONSIDERATION OF STANDING COMMITTEES’ REPORTS AND ACTION**

13 **Executive Committee**

14 Ms. Burger briefly updated the Board on the most recent meeting of the Tri-Board Joint Executive Committee  
15 meeting held on June 18, 2015. The meeting was productive and the joint committees will continue to build on  
16 the work they are doing. The next meeting will be scheduled for August.

17  
18 M. Burger reminded the Board of the retreat dates and location, August 14-16, 2015 at the Chickasaw Retreat  
19 and Conference Center. Ms. Burger indicated a large portion of time will be focused around strategic map  
20 development and thanked Dr. Cline for the strategic map framework which will be helpful for preparation of  
21 that work in August. There will also be a portion of the agenda dedicated to Board development  
22 opportunities as well as a special speaker from the Dallas Federal Reserve Bank. Ms. Burger thanked Tim,  
23 Dr. Gerard, and Dr. Grim for their efforts on the retreat planning committee.

24  
25 **Finance Committee**

26 Martha Burger, Chair of the Finance Committee speaking, received final report for budget for FY 2015.

27  
28 **Budget:**

- 29 ○ Last report showed all six line items were in the green, except for two in yellow status at >92%,  
30 green is 100%
- 31 ○ Public Health Infrastructure and Health Improvement Services
- 32 ○ Explained the underspending category and that funds will not be lost
- 33 ○ Underspending relates to programs that don’t terminate and those dollars carry-over and due to  
34 personnel vacancies and State Innovation Model, where not all fund have been spent
- 35 ○ Complemented staff on how they got so close on the percentile
- 36 ○ Discussed chart that shows through the year everything that the staff is working on to prepare for the  
37 next budget, building and seeking input for the next budget
- 38 ○ Discussed resource allocation and working on the budget for the next year

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40 **Accountability, Ethics, & Audit Committee**

41 Dr. Alexopulos indicated there were no known significant issues to report to the Commissioner or to the Board  
42 of Health at this time. Dr. Alexopulos directed attention to the 2016 Annual Internal Audit Plan reviewed and  
43 approved by the Committee. The plan is prepared and submitted for approval on an annual basis and takes into  
44 account resources that will provide the greatest benefit to the agency, management and Oklahoma tax payers.  
45 The plan is developed each fiscal year with input from each area of the Department and the Financial Officer.

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2 **Dr. Alexopoulos moved Board approval of the 2016 Annual Audit Plan and Risk Assessment, as presented.**  
3 **Second Dr. Grim. Motion carried.**  
4

5 **AYE: Alexopoulos, Burger, Grim, Krishna, Starkey**

6 **ABSENT: Gerard, Stewart, Wolfe, Woodson**  
7

8 Under the Office of Accountability Systems: OAS Cases No: 2015-005 and 2015-015 will be discussed in  
9 Executive Session.  
10

11 **Public Health Policy Committee**

12 Dr. Grim met with the Public Health Policy Committee on Tuesday, July 14, 2015. The committee reviewed  
13 potential 2016 legislative priorities and will discuss in detail at future Board meetings. The committee also  
14 reviewed a number of Interim Studies that came out of the House of Representatives and there are about 20  
15 that may be of interest to the State Department of Health and Board of Health. Please direct policy questions  
16 to Mark Newman. The next meeting of the policy committee will be prior to the October Tri-Board meeting.  
17

18 **PRESIDENT’S REPORT**

19 Ms. Burger announced the selection of a new Chief Operating Officer for the Department. She briefly spoke  
20 to her impressive background and credentials. The Board and Department are excited that she will be  
21 joining us in August.  
22

23 **COMMISSIONER’S REPORT**

24 Dr. Cline briefly mentioned the Governor’s Walk for Wellness, thanking staff, Leadership and Dr. Krishna  
25 for their participation. There were approximately 300 state employees from the Health Department and other  
26 state agencies.  
27

28 Dr. Cline highlighted a recent meeting with Michael Botticelli, Director for the Office of National Drug  
29 Control Policy which is a White House office in charge of all the drug control strategies for the United  
30 States. He has been following Oklahoma’s work around the legislation and around Naloxone. It is  
31 rewarding to see that the work taking place is being recognized by others and our PMP is held up as a  
32 standard.  
33

34 Lastly, Dr. Cline highlighted the third meeting of the Tribal Public Health Advisory Committee in which  
35 several representatives from the tribal nations have attended in order strategize about how to effectively  
36 leverage mutual resources for the improvement of services and making sure that we aren’t leaving any  
37 groups behind. This is a committed group of individuals who are smart and passionate about the work they  
38 are doing.  
39

40 The report concluded.  
41

42 Ms. Burger thanked Dr. Cline for his participation at the Go Red For Women Luncheon on May 15<sup>th</sup>, he was  
43 the keynote speaker, sponsored by the American Heart Association. The event received great reviews.  
44

45 **NEW BUSINESS**

46 No new business.  
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48

49 **PROPOSED EXECUTIVE SESSION**

50 **Dr. Alexopoulos moved Board approval to go into Executive Session at 12:20 PM** pursuant to 25 O.S.  
51 Section 307(B)(4) for confidential communications to discuss pending department litigation,  
52 investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring,  
53 appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or  
54 employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of  
55 information would violate confidentiality requirements of state or federal law.

- OAS Investigation, Number 2015-005 and 2015-015

**Second Dr. Grim. Motion carried.**

**AYE: Alexopulos, Burger, Grim, Krishna, Starkey**

**ABSENT: Gerard, Stewart, Wolfe, Woodson**

**Dr. Grim moved Board approval to move out of Executive Session. Second Dr. Alexopulos. Motion carried.**

**AYE: Alexopulos, Burger, Grim, Krishna, Starkey**

**ABSENT: Gerard, Stewart, Wolfe, Woodson**

**ADJOURNMENT**

**Mr. Starkey, moved Board approval to adjourn. Second Dr. Grim. Motion carried.**

**AYE: Alexopulos, Burger, Grim, Krishna, Starkey**

**ABSENT: Gerard, Stewart, Wolfe, Woodson**

The meeting adjourned at 12:30pm.

Approved

\_\_\_\_\_  
Ronald W. Woodson, M.D.  
President, Oklahoma State Board of Health  
October 6, 2015

SECTION 3  
STATE BOARD OF HEALTH MINUTES  
AUGUST 14-16, 2015



1 of this work, he has also organized national conferences on innovations in consumer financial services,  
2 asset-based approaches in rural development and workforce development strategies. Prior to joining the  
3 Kansas City Fed, Steven worked with national organizations focused on expanding the roles of financial  
4 institutions in low-income communities including leading banks and credit unions, microenterprise funds,  
5 and affordable housing loan funds throughout the country. Steven began his career by working  
6 internationally with microfinance, rural development, and refugee programs in Kenya, Burundi, and India  
7 for over six years. A native of Fort Worth, Texas, Steven is a graduate of Texas A&M University,  
8 Michigan State University, the Graduate School of Banking at the University of Wisconsin at Madison  
9 and, most notably, the 2012 Midwest Banjo Camp.

10 Federal Reserve Bank of Dallas

11  
12 Ms. Sobel-Blum is the community development research associate at the Federal Reserve Bank of Dallas,  
13 where she designs and executes extensive research; reports on her findings in Banking and Community  
14 Perspectives, e-Perspectives and special reports; and organizes and hosts conferences, other events and  
15 partnerships. Her areas of focus include healthy communities (the intersection of community development  
16 and health), small business and entrepreneurship, neighborhood stabilization and asset building. Before  
17 joining the Dallas Fed in 2004, Sobel-Blum worked in the fields of international development, socially  
18 responsible investing/corporate governance and market research. She earned a BA in history from  
19 Northwestern University, an MA in international affairs from American University and an MBA at the  
20 University of Texas at Dallas.

21  
22 See *Attachment A* for the Healthy Communities Presentation of the Federal Reserve Bank of Kansas City  
23 and Federal Reserve Bank of Dallas.

24  
25 ADJOURNMENT

26 **Dr. Krishna moved to adjourn. Second Ms. Wolfe. Motion carried.**

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

29  
30 The meeting adjourned at 7:31 p.m.

31  
32 Saturday, August 15, 2015

33  
34 ROLL CALL

35  
36 Members in Attendance: Ronald Woodson, M.D., President; Martha A. Burger, M.B.A, Vice-President; Cris  
37 Hart-Wolfe, Secretary-Treasurer; Jenny Alexopoulos, D.O.; Terry R. Gerard, D.O.; Charles W. Grim, D.D.S.;  
38 R. Murali Krishna, M.D., Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.

39  
40 Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F.  
41 Hartsell, Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention  
42 and Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of  
43 General Counsel; Janice Hiner, Senior Advisor to the Commissioner; VaLauna Grissom, Secretary to the  
44 State Board of Health; Commissioner's Office: Diane Hanley, Maria Souther.

45  
46 Visitors in attendance: See list

47  
48 Call to Order and Opening Remarks

49 Dr. Ronald Woodson, President of the Oklahoma State Board of Health, welcomed participants to the  
50 meeting and thanked them for their commitment to improving the health of Oklahomans. He noted that  
51 the Board had a lot of work to do during the Retreat and emphasized that today is "the heavy lifting day."  
52 After having meeting participants introduce themselves, he invited Tim Fallon of **TSI Consulting**

1 **Partners** to facilitate the meeting.

2

3 Tim Fallon provided an overview of strategic effectiveness – an organization’s ability to set the right  
4 goals and consistently achieve them.



5

6 Organizations with high strategic effectiveness:

7 ● Quickly formulate a “good enough” strategic plan.

8 ● Move immediately to implementation – letting implementation teach them the ways that the strategy  
9 is on target and ways it needs to be improved.

10 ● Review progress on implementation regularly with honesty and candor.

11 ● Make needed adjustments based on what is working, what isn’t, and how the world has changed.

12 ● Focus on results, not activities.

13

14 Tim also provided an overview of the key elements of a strategic map to orient participants to the logic of  
15 strategic mapping.

16 ● The oval at the top of the strategic map is the central challenge.

17 ○ It is the focal point for the strategy.

18 ○ It focuses on what the organization needs to do in the next three years to support its mission and  
19 vision.

20 ● The central challenge is supported by some number of strategic priorities. Strategic priorities are the  
21 few critical things an organization must do in order to meet its central challenge. The number of  
22 strategic priorities can vary, but it is never fewer than three or more than six.

23 ● There are two tests of a strategic priority:

24 ○ Is each priority *necessary* to meet the central challenge?

25 ○ Are the strategic priorities taken together *sufficient* to meet the challenge?

26 ● In strategic map logic, cross-cutting strategic priorities:

27 ○ Are placed at the bottom of the strategic map to show that they are foundational to the strategy

28 ○ Span the map from left to right to demonstrate that efforts to achieve the cross-cutting strategic  
29 priorities will be embedded in the efforts to implement all other strategic priorities on the map

30 ○ No plan to implement the other strategic priorities will be considered adequate unless it includes  
31 emphasis on the cross-cutting strategic priorities.

32 ● The boxes under each strategic priority are strategic objectives. Strategic objectives spell out more  
33 specifically “what to do” in order to achieve the strategic priority.

34

### 35 **Overview of Efforts to Date**

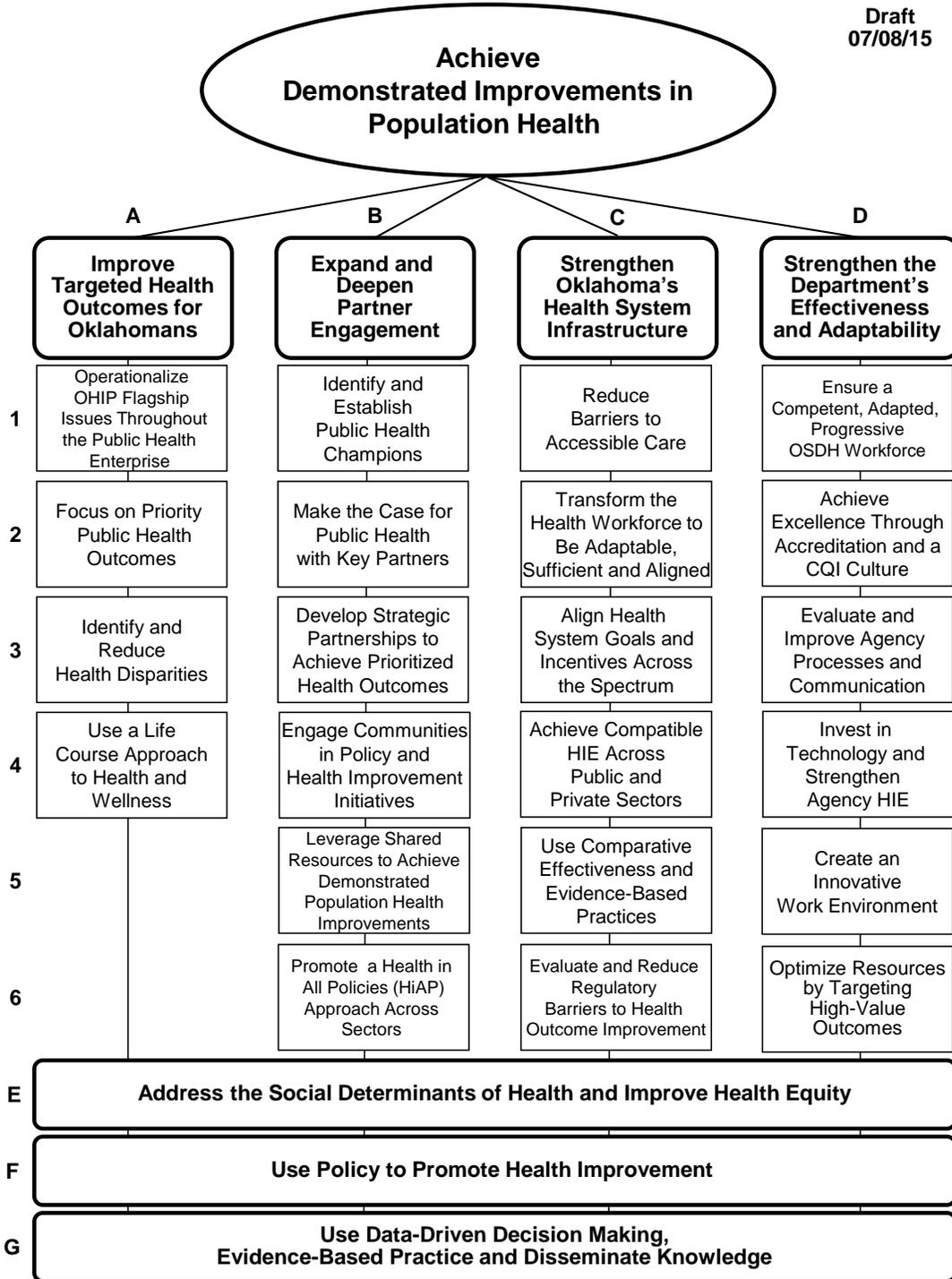
36 Dr. Terry Cline, Oklahoma Commissioner of Health, provided an overview of the draft strategic map,

37 presenting it to the Board for its review and consideration. A copy of the draft strategic map and timeline

38 appears on the next page.

Oklahoma State Department of Health  
Strategic Map: 2015-2020

Draft  
07/08/15



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Timeline

OSDH prepares strategic planning timeline for Board consideration  
 Board Retreat Planning Committee Meeting  
 Tim Fallon and Stakeholder Focus Group  
 Tim Fallon and Board Retreat Planning Committee  
 Tim Fallon and OSDH staff facilitated strategic planning session

March – April 2015  
 April 16, 2015  
 May 11, 2015  
 May 11, 2015  
 May 14, 2015

1	Board of Health Survey Strategic Map Input Period	May 28, 2015
2	OSDH Employee Comment Period on Draft Strategic Map	June 9, 2015
3	Refinement of Draft Strategic Map per Employee Comments	June 30, 2015
4	Board of Health Retreat/Finalize Strategic Planning	August 14-16, 2015
5	Implementation begins	August 2015

6

7 Feedback on the Draft Strategic Map

8 Participants met in small groups to review the draft strategic map and respond to the following points:

- 9 ● Strengths of the draft strategic map
- 10 ● Issues or concerns with the draft strategic map
- 11 ● Suggestions for areas that require further consideration

12 Strengths of the Map13 **Group 1: Charles Grim, Cris Hart-Wolfe, Martha Burger, Mark Nichols, Mark Newman, Don Maisch**

- 14 ● Specific targeted issues
- 15 ● Workforce – work place
- 16 ● Easier to follow
- 17 ● Focused on internal process
- 18 ● Aligned goals across health systems
- 19 ● Open to innovation
- 20 ● Inclusiveness of people during the process

21 **Group 2: Gary Cox, Robert Stewart, Tracey Strader, Ronald Woodson, Murali Krishna, Terry Cline**

- 22 ● Gathered a lot of input from many different people
- 23 ● Emphasis on public-private partnerships
- 24 ● Informal mandate from the public among the people who participated
- 25 ● Overarching emphasis on health equity data
- 26 ● Innovation
- 27 ● Technology
- 28 ● Strategic Priority B is the most direct path to reaching the public.
- 29 ● Focus on health systems.
- 30 ● The overall map is good.

31 **Group 3: Hank Hartsell, Toni Frioux, Jenny Alexopoulos, Victoria Bartlett, Timothy Starkey**

- 32 ● Partner engagement
- 33 ● Evolution of Oklahoma Health Improvement Plan (OHIP) flagship issues
  - 34 ○ Emphasis on behavioral health
  - 35 ○ Inclusion of gaps in care
- 36 ● Involvement of broad representation
- 37 ● Evolved with more detail
- 38 ● May be closer to working with health care providers than ever before

39 **Group 4: Gary Raskob, Julie Cox-Kain, Stephen Cagle, Janice Hiner, Terry Deshong**

- 40 ● The map is comprehensive and balanced.
- 41 ● Collaboratively developed
- 42 ● Focuses on partner engagement; the health department can't achieve it alone.
- 43 ● Column D is a strength; it addresses weaknesses and is responsive to needs.
- 44 ● OHIP integration
  - 45 ○ Leverages opportunities
  - 46 ○ Avoids silos
- 47 ● Cross-cutting strategic priority on evidence-based practices and data-driven decision making
- 48 ● Policy is a way of making change.
- 49 ● Optimizing resources/leveraging them
- 50 ● Health in All Policies

Issues and Concerns**Group 1**

- The map is not all-inclusive of what the Department of Health does.
- Communication issues: where do I fit in?
- Are all departments/counties aligned?
- The process to join/meet organizational needs
- Should “partnerships” be a cross-cutting strategic priority?
- Innovation vs. government silo
- Foster innovative approaches.
- Is there sufficient emphasis on
  - Education?
  - Resources?

**Group 2**

- Technology
  - Using it for communication
  - OSIS
  - ROVER
  - How we interface with the public on apps, etc.
- Real-time data
- Technology is so broad; it needs to be more targeted.
- Challenge with operationalizing and changing the culture both internally and externally
- Define what the term “health champions” means in Strategic Objective B-1.
- Is anyone from the county health department meeting with hospital administration?
- Develop curriculum for speakers to use.
- Do county health departments send speakers to schools?
- Hospitals believe the connection to the health department is regulatory-based, and the interaction is negative.
- Hospitals aren’t really interested in reducing illness.
- A significant opportunity is that hospitals need to know how to do population health, and the health department knows how to do that.
- Engage employees – marketing it to the internal staff of the health department.
- Offer value to the health system.
  - Be a person at the table, but not someone who owns the table.
  - Offer data/evidence/solutions as a knowledge vendor.
  - Cultivate health champions – Community Health Improvement Organizations (CHIOs).
- Provide assistance in grant writing to secure a SIM grant for CHIOs.

**Group 3**

- No focus on educating specific groups
  - Eliminated the health advocacy role
  - Educating the public should be central to the Oklahoma State Department of Health’s work.
- Lack of uniformity in public school curriculum on health
- Health is a learned behavior.
- No mention of funding; “monitor funding opportunities” is weak.
- Health care funding generally
- Oklahoma’s reluctance to accept federal funding
- There are other ways to accept federal funding besides state government.
- Funding equals influence.
- Education/advocacy could be a cross-cutting issue; it’s foundational.
- Educate on the importance of taking care of our own health.
- “Focus on prevention” was clearer in the previous map.
- “Focus on funding” on the last map was clearer.

- 1 ● OSDH could be so focused on the details of the new plan that it could miss broader objectives and
- 2 priorities.
- 3 ● Not enough resources to close the gap on primary care
- 4 ○ There's a need to redistribute health care providers.
- 5 ○ We're at least a generation away.

#### 6 **Group 4**

- 7 ● Effectiveness in making policy because the Department's hands are tied
- 8 ○ Educated citizenry about public health
- 9 ○ Needs investment in culture of health – which will be a generational investment
- 10 ● Resources/legislation
- 11 ● Hard decisions to make
- 12 ● Column D could be expensive.

#### 13 **Suggested Areas for Further Consideration**

#### 14 **Group 1**

- 15 ● Matching the plan to the Department structure in order to ensure Department-level alignment
- 16 ● Consider making “deepen partner engagement” a cross-cutting strategic priority.
- 17 ● Not sure of the intent of Cross-cutting Strategic Priority G on evidence-based practice and data-
- 18 driven decision making
- 19 ● Role of the Board/Department as resources
- 20 ● Define “terms” rather than using acronyms.
- 21 ● Some wordsmithing is necessary.

#### 22 **Group 2**

- 23 ● Public relations by the county health departments – reaching out to:
- 24 ○ Farmers markets
- 25 ○ Hospitals
- 26 ○ Schools
- 27 ● Reorganize to cut back on FTEs in some areas.
- 28 ○ Put money/resources into efficient programs.
- 29 ○ Need a liaison within each institution.
- 30 ● Three areas not mentioned:
- 31 ○ Business community
- 32 ○ Faith communities
- 33 ○ Education
- 34 ○ Coordinating with these sectors includes prevention and health clinics
- 35 ● Be careful about “intrusive government.”
- 36 ● Make regulation more pleasant – consultative, collaborative.
- 37 ● Work with the Federal Reserve to leverage funding to address evidence-based programs like:
- 38 ○ Teen pregnancy
- 39 ○ Education
- 40 ○ Healthy food, etc.

#### 41 **Group 3**

- 42 ● Add new cross-cutting goal on advocacy and education, emphasizing the value of:
- 43 ○ Public health
- 44 ○ Healthy communities
- 45 ○ Healthy lifestyle choices
- 46 ● Evolve the relationship with future health care providers at the high school level.
- 47 ● Continuous advertisement for prescription drugs

#### 48 **Group 4**

- 49 ● Legislation/policy strategy
- 50 ● Cultural change

- 1     • The need to look at culture with a long view  
2

3     Following the small group reports, discussion included the following points.

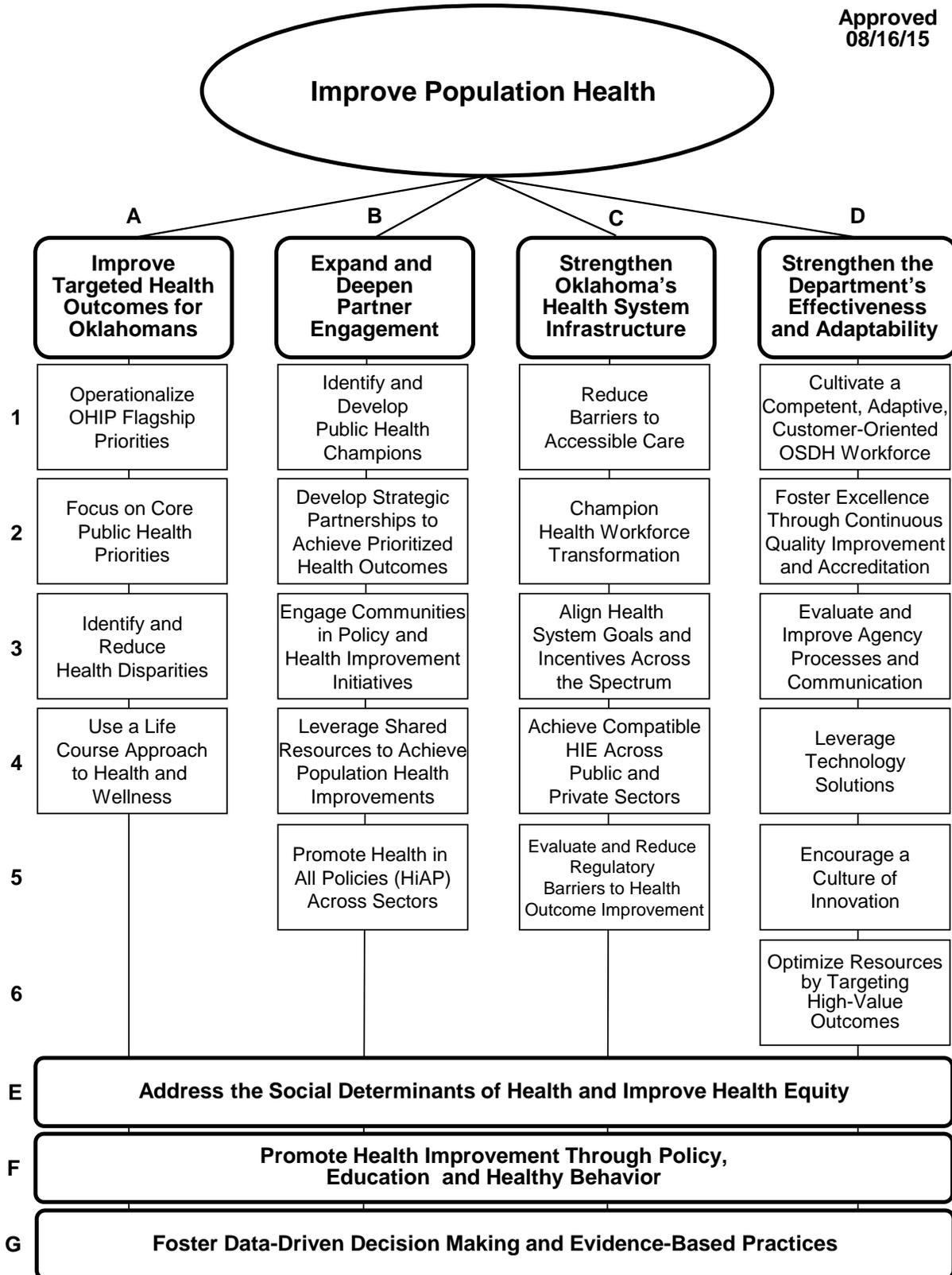
- 4     • We need to ensure that each of us is an ambassador for health, wellness and prevention.  
5     • It's important for each of us to "practice what I preach."  
6     • In Column C, the emphasis on transforming the health workforce may be overreaching. That is, it  
7     may be more than the Department of Health can do.  
8     • In considering the relationship between the Department of Health and health systems, it's important  
9     to be clear about the appropriate future role.  
10     ○ At present, the Department of Health is often considered a hammer because of its regulatory  
11     role.  
12     ○ How does it reposition itself to become a leader and partner?  
13     • In order to reach youth and young adults, the Department needs to make much more effective use of  
14     social media. This is an area for further development.

15     **Revising the Strategic Map**

16     Based on the points above and extensive discussion that followed, participants made a number of  
17     modifications to the draft strategic map. The final version of the strategic map for the Board to consider  
18     for approval appears on the following page.

**Oklahoma State Department of Health  
Strategic Map: 2015-2020**

Approved  
08/16/15



1  
2 Discussion of the strategic map included the following points.

- 1 ● The central challenge, “Improve population health:”
  - 2 ○ Emphasizes “moving the needle” – achieving measureable improvements on specific health
  - 3 issues that impact Oklahomans
  - 4 ○ Stresses using a population health approach – including working effectively with partners to
  - 5 address the needs of populations with unique health needs
- 6 ● Strategic Priority A, “Improve targeted health outcomes for Oklahomans:”
  - 7 ○ Focuses on addressing specific health issues that Oklahomans face
  - 8 ○ Emphasizes improving specific health issues identified by Oklahoma’s State Health
  - 9 Improvement Plan
  - 10 ○ Stresses achieving targeted outcomes that demonstrate health improvement
- 11 ● Strategic Priority B, “Expand and deepen partner engagement:”
  - 12 ○ Recognizes that the Department of Health will have limited impact if it works alone
  - 13 ○ Stresses working collaboratively with both public and private partners in order to achieve
  - 14 significant improvements in population health
  - 15 ○ Includes engaging communities and supporting their efforts to improve population health
- 16 ● Strategic Priority C, “Strengthen Oklahoma’s health system infrastructure:”
  - 17 ○ Focuses on using all of Oklahoma’s health assets to address and improve population health
  - 18 ○ Emphasizes increasing collaboration across such partners as public health, the health care
  - 19 delivery system and the entire public and private sectors
  - 20 ○ Includes aligning incentives and strengthening essential aspects of the health infrastructure –
  - 21 such as the health care workforce and Health Information Exchange – to achieve this priority
- 22 ● Strategic Priority D, “Strengthen the Department’s effectiveness and adaptability:”
  - 23 ○ Recognizes the need for the Department to develop the required capabilities to achieve Strategic
  - 24 Priorities A, B and C
  - 25 ○ Focuses on addressing the Department’s needs and issues in order to increase its effectiveness
  - 26 and adaptability
  - 27 ○ Includes increasing the Department’s emphasis on future requirements, innovation, and
  - 28 adapting to a changing external environment
- 29 ● At the bottom of the strategic map there are three cross-cutting strategic priorities. In strategic map
- 30 logic, cross-cutting strategic priorities:
  - 31 ○ Are placed at the bottom of the strategic map to show that they are foundational to the strategy
  - 32 ○ Span the map from left to right to demonstrate that efforts to achieve the cross-cutting priorities
  - 33 will be embedded in the efforts to implement all the other strategic priorities on the map
  - 34 ○ No plan to implement the other strategic priorities will be considered complete unless it
  - 35 includes emphasis on the cross-cutting priorities.
- 36 ● Cross-cutting Strategic Priority E, “Address the social determinants of health and improve health
- 37 equity:”
  - 38 ○ Recognizes the importance of addressing issues related to health equity in order to improve the
  - 39 health status of groups within the state that are disadvantaged in terms of health
  - 40 ○ Emphasizes the critical role that the social determinants of health – such as education, poverty
  - 41 and the built environment – have on the health status of Oklahomans
- 42 ● Cross-cutting Strategic Priority F, “Promote health improvement through policy, education and
- 43 healthy behavior:”
  - 44 ○ Focuses on the essential role of the Department of Health in promoting health improvement by
  - 45 emphasizing prevention
  - 46 ○ Emphasizes three ways the Department promotes health improvement: public policy,
  - 47 educational efforts, and promoting healthy behavior
- 48 ● Cross-cutting Strategic Priority G, “Foster data-driven decision making and evidence-based
- 49 practices:”
  - 50 ○ Emphasizes the Department’s efforts to model data-driven decision making and the effective
  - 51 use of evidence-based practice

- 1           ○ Includes encouraging partners and other organizations throughout the state to incorporate these  
2           capabilities into their efforts to improve the health of Oklahomans  
3
- 4 Strategic Priority A, “Improve targeted health outcomes for Oklahomans,” is supported by the following  
5 strategic objectives.
- 6 ● Strategic Objective A-1, “Operationalize the Oklahoma Health Improvement Plan flagship  
7 priorities:”  
8           ○ Focuses on OHIP’s four flagship issues:  
9               ■ Children’s health improvement  
10              ■ Tobacco use prevention  
11              ■ Obesity reduction  
12              ■ Behavioral health improvement  
13           ○ Emphasizes continuing efforts to reach the targeted goals established by the Oklahoma Health  
14           Improvement Plan
- 15 ● Strategic Objective A-2, “Focus on core public health priorities:”  
16           ○ Recognizes their critical importance in improving targeted health outcomes for Oklahomans
- 17 ● Strategic Objective A-3, “Identify and reduce health disparities:”  
18           ○ Recognizes that even though many Oklahomans have optimal health, a number of populations  
19           in the state experience significant disparity in areas such as infant mortality, life expectancy,  
20           and so on  
21           ○ Stresses efforts to identify, address and reduce these disparities
- 22 ● Strategic Objective A-4, “Use a life course approach to health and wellness:”  
23           ○ Focuses on the importance of considering health and wellness across the entire life span from  
24           prenatal care through end-of-life care  
25           ○ Recognizes the significance of adverse childhood experiences (ACEs) and the impact these  
26           experiences have on health throughout a person’s life  
27           ○ Emphasizes using a life course approach in developing and delivering the Department’s  
28           programs and services as a key strategy for achieving targeted health outcomes for Oklahomans  
29
- 30 Strategic Priority B, “Expand and deepen partner engagement,” is supported by the following strategic  
31 objectives.
- 32 ● Strategic Objective B-1, “Identify and develop public health champions:”  
33           ○ Focuses on identifying thought leaders and other influential leaders throughout the state to serve  
34           as champions for public health and advocates for health improvement efforts  
35           ○ Emphasizes providing support, development and encouragement for these champions to help  
36           them carry out efforts to improve health and encourage others to do so
- 37 ● Strategic Objective B-2, “Develop strategic partnerships to achieve prioritized health outcomes:”  
38           ○ Focuses on extending the Department’s effectiveness by engaging both public and private  
39           partners in carrying out health improvement efforts  
40           ○ Emphasizes aligning the Department’s efforts to improve targeted health outcomes with the  
41           health improvement agendas of partner organizations in order to increase effectiveness and  
42           optimize resources
- 43 ● Strategic Objective B-3, “Engage communities in policy and health improvement initiatives:”  
44           ○ Recognizes the critical role that communities health improvement efforts plan in improving the  
45           health of Oklahomans  
46           ○ Stresses supporting community health improvement initiatives, encouraging the use of best  
47           practices in achieving population health improvements  
48           ○ Emphasizes working with communities to identify and implement appropriate policies that  
49           address the social determinants of health and foster improvements in population health
- 50 ● Strategic Objective B-4, “Leverage shared resources to achieve population health improvements:”  
51           ○ Recognizes the extent of the challenge to improve health, particularly with the limited resources  
52           available to the Department

- 1       ○ Emphasizes using partnerships to leverage needed resources – including people, organizational
- 2       capabilities, and finances – in order to achieve the greatest impact on population health
- 3       improvements
- 4       ● Strategic Objective B-5, “Promote Health in All Policies (HiAP) across sectors:”
- 5       ○ Recognizes the critical role that policy plays in fostering health
- 6       ○ Focuses on fostering Health in All Policies in order to address the social determinants of health
- 7       and foster the health of individuals and communities
- 8       ○ Emphasizes working across sectors to build awareness of health impact of public policy and
- 9       promote positive approaches to population health improvement

10  
11 Strategic Priority C, “Strengthen Oklahoma’s health system infrastructure,” is supported by the following  
12 strategic objectives.

- 13       ● Strategic Objective C-1, “Reduce barriers to accessible care:”
- 14       ○ Recognizes the importance of ensuring that Oklahomans have access to high-quality, affordable
- 15       health care no matter where they live in the state or what their economic circumstance are
- 16       ○ Stresses increasing the close working relationship between public health and the health care
- 17       delivery system in order to carry out this objective
- 18       ● Strategic Objective C-2, “Champion health workforce transformation:”
- 19       ○ Focuses on the Department’s role in developing an adequate supply of competent health
- 20       professionals across Oklahoma to meet current and future needs
- 21       ○ Emphasizes the Department’s role in working with appropriate partners to recruit, develop,
- 22       support and retain that workforce
- 23       ● Strategic Objective C-3, “Align health system goals and incentives across the spectrum:”
- 24       ○ Emphasizes the Department’s role in working with public and private partners to align health
- 25       system goals across the state
- 26       ○ Includes efforts to align financial and other incentives to improve the effectiveness of
- 27       Oklahoma’s health system
- 28       ● Strategic Objective C-4, “Achieve compatible Health Information Exchange across public and
- 29       private sectors:”
- 30       ○ Focuses on the critical importance of Health Information Exchange in supporting systematic
- 31       approaches to improving population health
- 32       ○ Emphasizes the need for both compatible HIE infrastructure and the appropriate use of HIE by
- 33       public and private partners
- 34       ○ Stresses the Department’s leadership and convening role in aligning organizations to achieve
- 35       this objective
- 36       ● Strategic Objective C-5, “Evaluate and reduce regulatory barriers to health outcome improvement:”
- 37       ○ Recognizes that transformational change across the health system requires appropriate
- 38       regulatory requirements and compliance efforts to meet current and future needs
- 39       ○ Includes efforts to optimize regulatory policies and remove regulatory barriers in order to
- 40       strengthen Oklahoma’s health system infrastructure

41  
42 Strategic Priority D, “Strengthen the Department’s effectiveness and adaptability,” is supported by the  
43 following strategic objectives.

- 44       ● Strategic Objective D-1, “Cultivate a competent, adaptive, customer-oriented Oklahoma State
- 45       Department of Health workforce:”
- 46       ○ Focuses on the Department’s workforce as an essential resource for ensuring the effectiveness
- 47       and adaptability of the Department
- 48       ○ Emphasizes the Department’s efforts to recruit, develop, support and retain an outstanding
- 49       workforce within the Department
- 50       ○ Stresses the essential competencies of that workforce – including a strong customer orientation
- 51       and the ability to adapt to rapidly changing needs and emerging opportunities

- 1 ● Strategic Objective D-2, “Foster excellence through continuous quality improvement and  
2 accreditation:”
  - 3 ○ Builds on existing efforts to instill a continuous quality improvement mentality and culture  
4 throughout the Department
  - 5 ○ Focuses on continuing efforts to achieve excellence using continuous quality improvement  
6 methods and practices
  - 7 ○ Includes ongoing efforts to both secure accreditation for local health departments throughout the  
8 state and maintain the accreditation of those health departments that are already accredited
- 9 ● Strategic Objective D-3, “Evaluate and improve agency processes and communication:”
  - 10 ○ Focuses on ongoing internal efforts to ensure that the Department’s processes are effective and  
11 efficient
  - 12 ○ Emphasizes improving both internal and external communication – including the appropriate  
13 use of social media – to better link the Department internally, connect it with its public and  
14 private partners, and communicate with people throughout Oklahoma
- 15 ● Strategic Objective D-4, “Leverage technology solutions:”
  - 16 ○ Recognizes the gaps in the Department’s current technology and the effectiveness of that  
17 technology in linking the Department with its partner organizations
  - 18 ○ Focuses on investing in upgrading technology to provide appropriate solutions that will better  
19 serve both the internal needs of the Department and the requirements of its partner organizations  
20 throughout the state
- 21 ● Strategic Objective D-5, “Encourage a culture of innovation:”
  - 22 ○ Recognizes that the rapidly changing external environment requires the Department to foster a  
23 mindset and culture of innovation so that it can better meet current and future needs
  - 24 ○ Stresses the critical role of leadership in fostering an innovative mindset and culture
  - 25 ○ Links efforts to build that culture with the workforce development efforts outlined in Strategic  
26 Objective D-1 and the other strategic objectives supporting Strategic Priority D
- 27 ● Strategic Objective D-6, “Optimize resources by targeting high-value outcomes:”
  - 28 ○ Recognizes that the limitations of the Department’s resources require it to focus on the areas  
29 with the greatest impact
  - 30 ○ Prioritizes directing departmental resources on the areas that have the highest potential to  
31 improve population health and foster the health of all Oklahomans

32  
33 The meeting adjourned at 4:26 p.m.

34  
35 Sunday, August 16, 2015

36  
37 ROLL CALL

38  
39 Members in Attendance: Ronald Woodson, M.D., President; Martha A. Burger, M.B.A, Vice-President; Cris  
40 Hart-Wolfe, Secretary-Treasurer; Jenny Alexopoulos, D.O.; Terry R. Gerard, D.O.; Charles W. Grim, D.D.S.;  
41 R. Murali Krishna, M.D., Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.

42  
43 Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F.  
44 Hartsell, Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention  
45 and Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of  
46 General Counsel; Janice Hiner, Senior Advisor to the Commissioner; VaLauna Grissom, Secretary to the  
47 State Board of Health; Commissioner’s Office: Diane Hanley, Maria Souther.

48  
49 Visitors in attendance: See list

50  
51 Call to Order and Opening Remarks

52 Dr. Woodson called the meeting to order at 8:41 a.m.

**Approval of the Strategic Map**

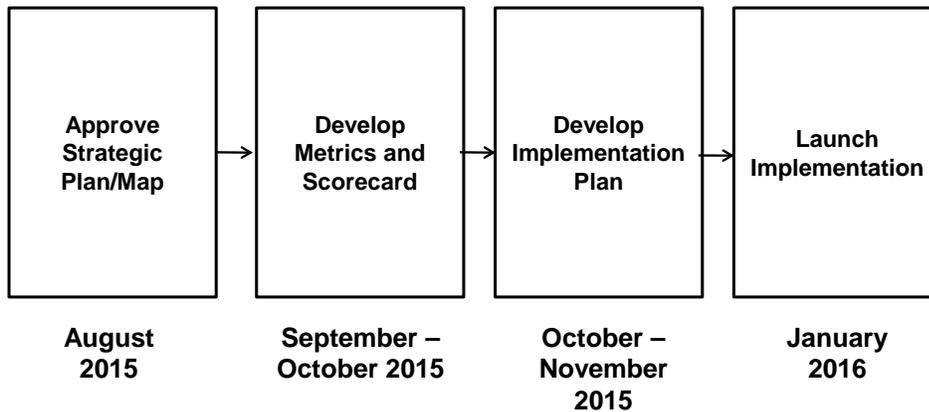
The Oklahoma Board of Health unanimously approved the Oklahoma State Department of Health Strategic Map: 2015-2020. It will guide the Department of Health for the next five years.

**Ms. Wolfe moved to approve the 2015-2020 Strategic map. Second Dr. Gerard. Motion carried.**

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

**Moving Forward with Implementation**

Tim Fallon concluded the strategic planning portion of the Board Retreat by outlining the following next steps in moving forward with implementation planning.



The Board agreed to develop an ad hoc work group to help Department leadership align its metrics and scorecard with the Oklahoma State Department of Health Strategic Map 2015-2020. Board members with an interest in serving on the work group should indicate their interest to Dr. Woodson for his consideration in appointing the work group. As indicated in the above graphic, the work group will have a short tenure – from after the retreat until no later than December 31, 2015.

**Board Development Session**

Tim Fallon provided members of the Board of Health with an Assessment of Board Best Practices. A copy of that assessment can be made available by request with the Office of the Board of Health.

Each member of the Board of Health completed the assessment. A summary of the results can be made available by request with the Office of the Board of Health.

Discussion of the assessment results included the following points.

- The assessment shows clear strengths in the following areas as demonstrated by the high scores for those items.
  - Endorse the Oklahoma State Department of Health’s strategic plan and regularly reviewing process on its implementation (4.78 out of 5.0)
  - Support the Oklahoma State Department of Health’s efforts to secure and maintain accreditation, including monitoring its efforts in that regard. (4.78 out of 5.0)
  - Participate in the development and implementation of the Oklahoma Health Improvement Plan. (4.22 out of 5.0)
- A lower score on the item, “Maintain and strengthen Oklahoma’s health infrastructure,” is due to the Board’s limited ability to influence the needed infrastructure improvements.
- Several items on advocacy were rated lower than other items.
  - Develop and implement an advocacy agenda with legislators. (3.22 out of 5.0)
  - Develop and implement an advocacy agenda with public and private partners. (3.33 out of 5.0)

- 1       ○ Develop and implement an advocacy agenda with the general public. (3.22 out of 5.0)
- 2 ● Advocacy efforts with the Office of The Governor have been significant, primarily as a result of Dr.
- 3 Cline’s efforts.
- 4 ● The Board needs to consider whether it wants to take action to improve its advocacy efforts.
- 5 ● Although the Board has done a good job in participating in the development of the Oklahoma Health
- 6 Improvement Plan, it has been less effective in being engaged in its implementation.
- 7 ● One possibility the Board may want to consider is establishing a Performance Improvement
- 8 Committee.
- 9 ● The Board agreed to have the Retreat Planning Committee include Board development in its
- 10 responsibilities. This approach will ensure appropriate consideration of ongoing Board development
- 11 without establishing a separate committee for that purpose.
- 12

13 VaLauna Grissom provided Board members with a sample packet of resources for ongoing Board  
14 development. She also updated the Board on:

- 15 ● Efforts to create an online portal that will provide a paperless way for the Board to manage its
- 16 materials, including online resources and tools for Board development
- 17 ● Plans to work with BoardSource and BoardMax to continue to provide appropriate resources for the
- 18 development of the Board and its individual members
- 19

20 The Board’s discussion of possibilities for next year’s Board Retreat included the following points.

- 21 ● The presentation by the Federal Reserve Bank was very helpful. Future meetings should continue to
- 22 provide this kind of input – either from third parties or partner organizations that are carrying out
- 23 significant health improvement initiatives.
- 24 ● Participants expressed appreciation of the current venue indicating that it provided an ideal
- 25 environment for the Board Retreat.
- 26 ● In considering future meeting sites, consideration should be given to:
- 27     ○ Meeting in different locations throughout the state
- 28     ○ Considering the possibility of negotiating a two-year contract with the site in order to ease the
- 29       burden of logistical arrangements with each site and to attempt to negotiate more favorable rates
- 30 ● Further consideration needs to be given to how to optimize the effectiveness of the “meet-and-greet”
- 31 on the first evening of the Retreat.
- 32 ● Although Board members differ on whether the retreat should be held on a weekend, most prefer
- 33 scheduling it to so that it doesn’t interfere with providers’ ability to see patients.
- 34     ○ One scheduling option to consider is beginning the retreat on Friday afternoon and concluding it
- 35       on Saturday evening.
- 36     ○ Another option is holding the retreat in a family-friendly environment so that spouses and
- 37       families can attend the event.
- 38

39 The Board concluded the Board Retreat by noting:

- 40 ● The retreat accomplished all of its intended objectives.
- 41 ● It was highly effective, particularly because it allowed for more interaction among the Board
- 42 members.
- 43 ● Board members agreed that this year’s retreat provides a good foundation to build on in planning
- 44 future retreats.

45 **Next Steps**

46 At the conclusion of the retreat, participants identified the following next steps.

47 TSI’s Next Steps

48 TSI will provide the following documents to VaLauna Grissom for distribution to session participants.

- 49 ● The Oklahoma State Department of Health Strategic Map: 2015-2020
- 50 ● A “presentation” version of the strategic map
- 51 ● A protocol for conducting a communications session to present the strategic map to key stakeholders
- 52 ● A comprehensive meeting summary of the Board Retreat

Reviewing Progress on Implementation and Making Adjustments

Tim Fallon outlined the following as possible elements of a “review and adjust process” for the Board of Health to use in building its strategic effectiveness.

- Use regular Board meetings for:
  - Implementation updates
  - Resolution of implementation issues/problems
- Conduct periodic review and adjust sessions once or twice during the year to:
  - Review of progress with implementation, including:
    - Accomplishments
    - Issues and problems
    - Lessons learned
    - Next steps
  - Make any needed adjustments to the strategic map and implementation plans
- Complete an annual strategy update session – which is typically a two or three-hour session – to:
  - Review progress on implementation.
  - Update the strategic map based on:
    - What was learned from implementation
    - What’s working and what isn’t
    - How the environment has changed
  - Set implementation priorities for the next 12 months.
  - Align financial and human resources with implementation priorities.

Other Next Steps

The following next steps are summarized earlier in this meeting summary. They are repeated here for convenience.

- The Board of Health agreed to develop an ad hoc work group to help Department leadership align its metrics and scorecard with the Oklahoma State Department of Health Strategic Map 2015-2020.
- Board members with an interest in serving on the work group should indicate their interest to Dr. Woodson for his consideration in appointing the work group. The work group will complete its work by December 31, 2015.
- The Retreat Planning Committee will include Board development in its responsibilities. This approach will ensure appropriate consideration of ongoing Board development without establishing a separate committee for that purpose.

PROPOSED EXECUTIVE SESSION

**Dr. Krishna moved Board approval to move into Executive Session at 10:45 a.m.** 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.

- Presentation concerning possible litigation regarding last legislative session.

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

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

**Dr. Stewart moved Board approval to come out of Executive Session at 11:37 a.m. and open regular meeting. Second Dr. Gerard. Motion carried.**

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

1 No action taken as a result of Executive Session

2

3 ADJOURNMENT

4 **Dr. Krishna moved to adjourn. Second Dr. Stewart. Motion carried.**

5

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

7

8

9 The meeting adjourned at 10:42a.m.

10

11 Approved

12

13

14

15 \_\_\_\_\_  
Ronald Woodson, M.D.

16 President, Oklahoma State Board of Health

17 October 6, 2015

# HEALTHY COMMUNITIES

Oklahoma State Board of Health  
Meeting

August 14, 2015

Steven Shepelwich  
Senior Advisor  
Community Development  
Federal Reserve Bank of  
Kansas City



# The Federal Reserve System



Ensure a strong economy through monetary policy and supervision of the banking and payment systems.

# Community Development at the Fed

- Community Development supports the Federal Reserve System's mission by promoting:
  - Community development
  - Fair and impartial access to credit, and
  - Access to banking services by the underserved.
- Our Approach
  - Research
  - Relationship building
  - Resource development
- Stakeholders include financial institutions, community development organizations, community groups, small business support organizations and government leaders.

# Focus Areas in Oklahoma

- **Community Development Investments**  
Support efforts by lenders to reinvest in their communities
- **Financial Stability for the Underserved**  
Support financial security for individuals and families
- **Small Business Development and Sustainability**  
Support small business and micro-enterprise development
- **Workforce Development Initiatives**  
Support efforts that promote workforce development
- **Healthy Neighborhoods**  
Support housing solutions and sustainable neighborhoods

# HEALTHY COMMUNITIES

Oklahoma State Board of Health  
Meeting

August 14, 2015

**Elizabeth Sobel Blum**

Senior Advisor

Community Development

**Federal Reserve Bank of Dallas**

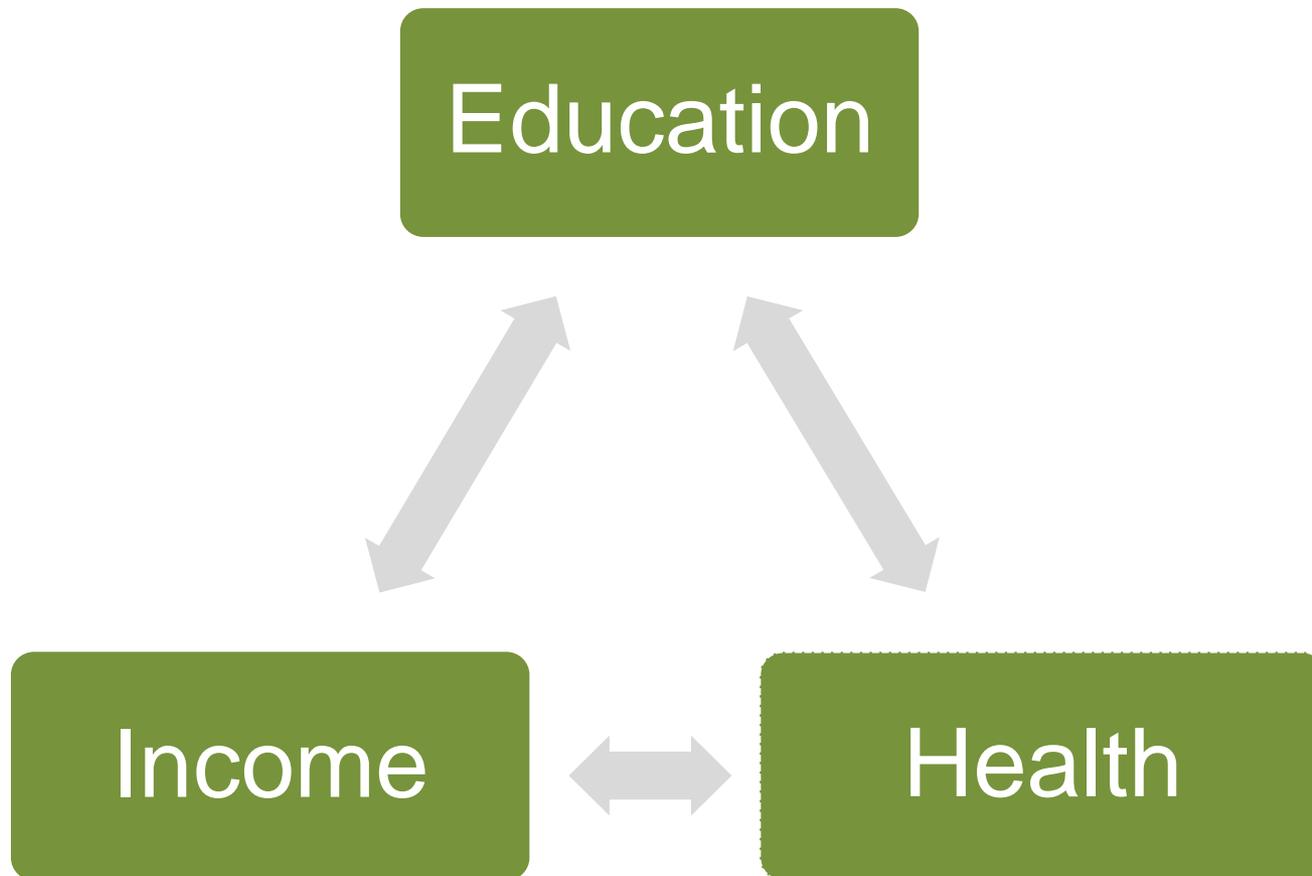


# Health of our Nation, Health of our Economy

## **Disclaimer:**

The views expressed here are the presenter's and not necessarily those of the Federal Reserve Bank of Dallas or the Federal Reserve System. Data and facts cited in this report are compiled from public and private sources deemed reliable at the time of presentation.

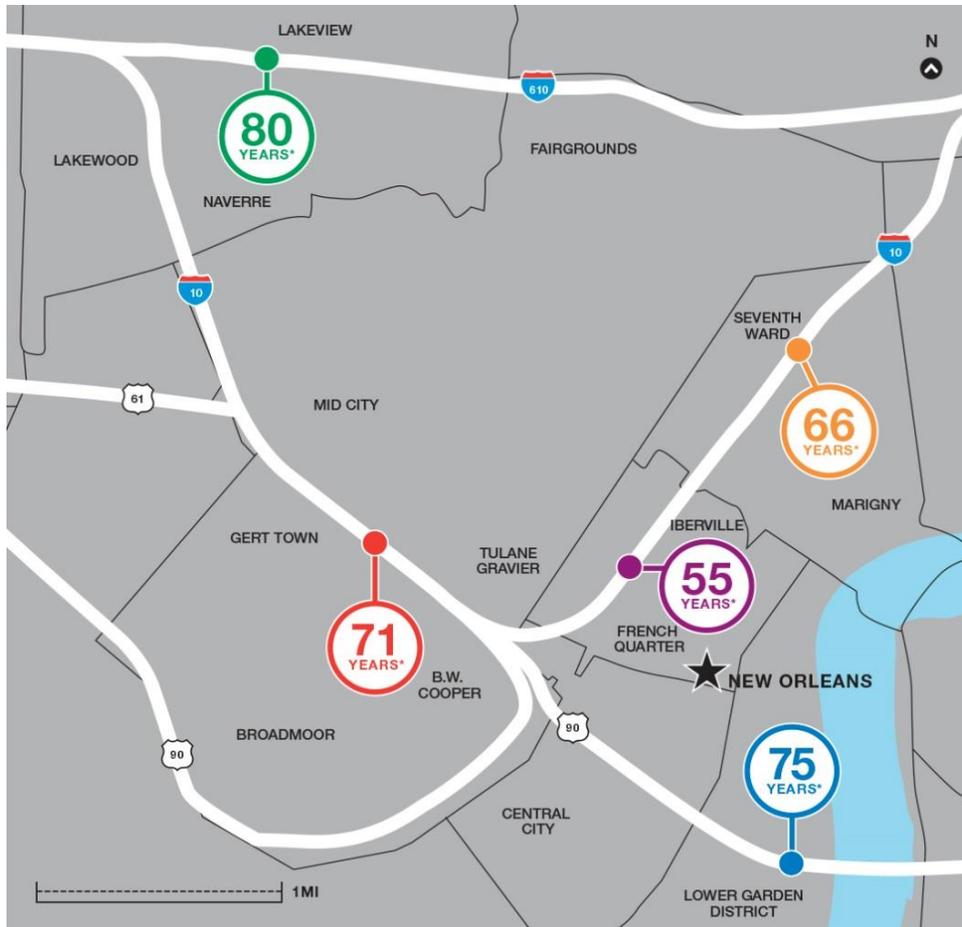
# Health is an Asset



# Community Reinvestment Act (CRA)

- Enacted to prevent redlining and encourage financial institutions to help meet the credit needs of all segments of their communities
- Each bank is evaluated on how well it serves its “assessment area”
- Community development activities (loans, investments and services)
  1. Affordable housing
  2. Community services targeting low- and moderate-income (LMI) individuals
  3. Economic development
  4. Revitalize or stabilize

# ZIP Code Matters



“Across America, babies born just a few miles apart have dramatic differences in life expectancy.

To improve health we need to improve people’s opportunities to make healthy choices— in the places where they live, learn, work and play.”

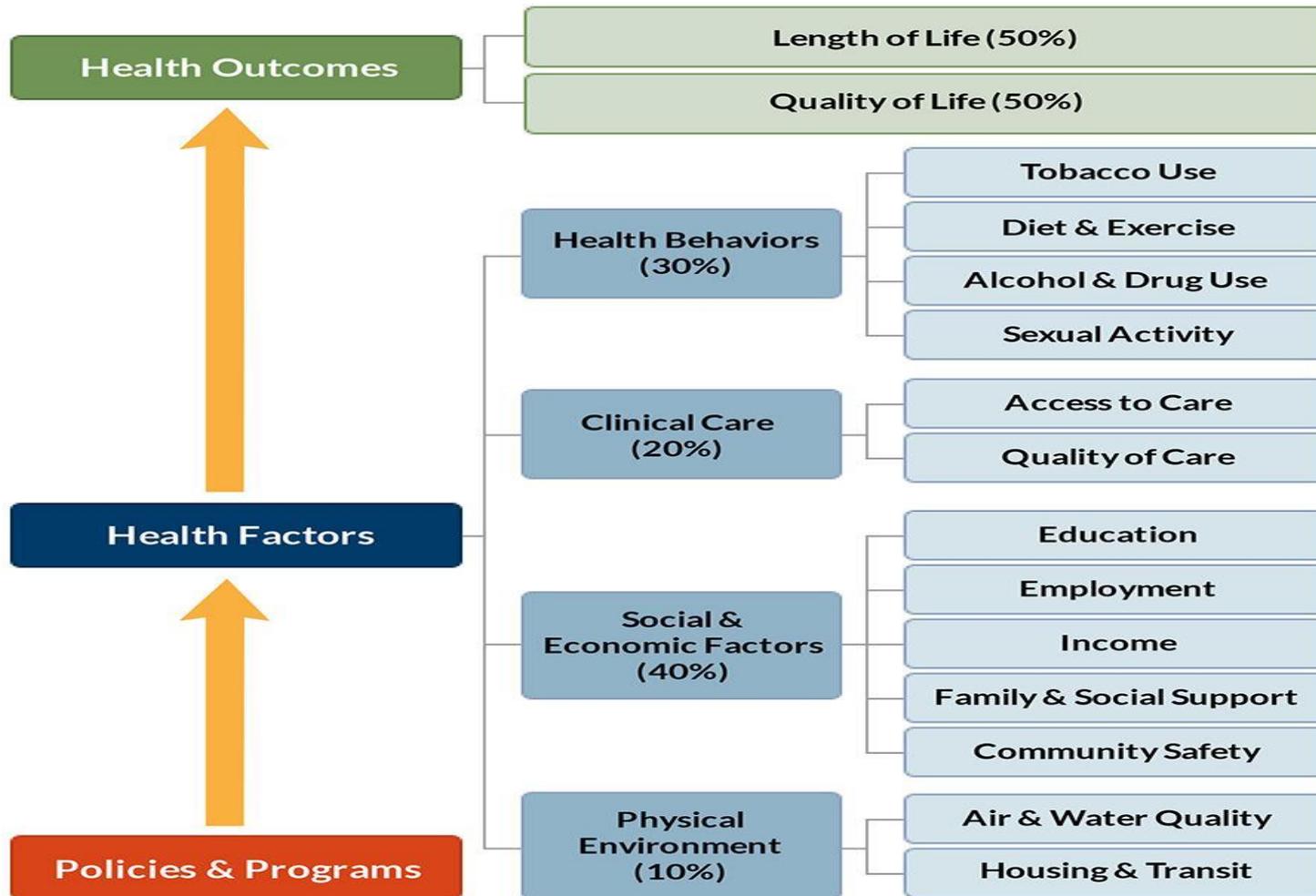


# The ZIP Code Improvement Business

## The Community and Economic Development Industries:

- Build high-quality, service-enriched **affordable housing**
- Support **small businesses and entrepreneurship**
- Finance **community facilities** (e.g., health clinics, child care centers, charter schools, grocery stores, shelters, community centers)
- Helping individuals build and repair their credit and access **quality financial products and services**

# Health & CED Industries' Common Interests: SOCIAL DETERMINANTS OF HEALTH



County Health Rankings model © 2014 UWPHI

# PRACTICAL APPLICATION: Public Health Accreditation Standards

## The Essential Public Health Services and Core Functions

1. Monitor Health
2. Diagnose & Investigate
3. Inform, Educate, Empower
4. Mobilize Community Partnerships
5. Develop Policies
6. Enforce Laws
7. Link to/Provide Care
8. Assure Competent Workforce
9. Evaluate

# PRACTICAL APPLICATION: Public Health Accreditation Standards

**Standard 1.1:** Participate in or Lead a Collaborative Process Resulting in a **Comprehensive Community Health Assessment**

**Standard 1.3:** Analyze Public Health Data to Identify Trends in...**Social and Economic Factors That Affect the Public's Health**

**Standard 3.1:** Provide Health Education and Health Promotion Policies, Programs, Processes, and Interventions to **Support Prevention and Wellness**

**Standard 4.1:** **Engage with...the Community in Identifying and Addressing Health Problems through Collaborative Processes**

**Standard 5.2:** **Conduct a Comprehensive Planning Process** Resulting in a Tribal/State/Community Health Improvement Plan

**Standard 6.1:** **Review Existing Laws** and Work with Governing Entities and Elected/Appointed Officials to **Update as Needed**

**Standard 8.1:** Encourage the Development of a Sufficient Number of **Qualified Public Health Workers**

# WHO TO ENGAGE: *Banking, Community & Economic Development Industries*



# Identifying Opportunities

## *Healthy Communities Checklist*

- Access to Healthy Food
- Access to Medical Care
- Aesthetics: Landscaping, Art, Culture
- Air, Soil and Water Quality
- Building Financial Capacity
- Built Environment
- Early Childhood Development
- Education
- Employment
- Entrepreneurship
- Personal/Public Safety
- Physical Activity
- Public Transportation
- Senior Needs: Accommodation, Care, Services
- Social Networks/  
Social Environment
- Social Services

**These components are integral to healthy, vibrant, resilient communities.**

# Appendix: List of Experts

## *Example: NeighborWorks*

- **The NeighborWorks Network**
- **Training and Certification**
- **Foreclosure Resources**
- **National Programs, including:**
  - **NW Community Building & Organizing Programs**
  - **NW Financial Capability Program**
  - **NW in Rural America**
  - **Success Measures**
  - **Green Organization Program**

### ***Healthy Communities Checklist:***

- ☑ Air, Soil and Water Quality
- ☑ Building Financial Capacity
- ☑ Built Environment
- ☑ Employment
- ☑ Physical Activity
- ☑ Social Environment/  
Community Engagement

# HEALTHY COMMUNITIES

“Healthy Communities: A Framework for Meeting CRA Obligations” is available online at [www.dallasfed.org/cd/healthy/index.cfm](http://www.dallasfed.org/cd/healthy/index.cfm). Select the “CRA” tab for the full report, appendix and checklist.



**Elizabeth Sobel Blum**

214.922.5252

[elizabeth.sobel-blum@dal.frb.org](mailto:elizabeth.sobel-blum@dal.frb.org)

**Federal Reserve Bank of Dallas  
Community Development**

[DallasFedComDev.org](http://DallasFedComDev.org)

[@DallasFedComDev](https://twitter.com/DallasFedComDev)

# Oklahoma City Branch Contact



**Steven Shepelwich**

405.270.8675

[steven.shepelwich@kc.frb.org](mailto:steven.shepelwich@kc.frb.org)

**Federal Reserve Bank of Kansas City  
Community Development**

[KansasCityFed.org/community](http://KansasCityFed.org/community)

## SECTION 4

# OKLAHOMA STATE DEPARTMENT OF HEALTH UPDATE PRESENTATION



HEALTHY OKLAHOMA

OKLAHOMA HEALTH IMPROVEMENT PLAN

[OHIP2020.com](http://OHIP2020.com)

# ORGANIZATIONAL UPDATE

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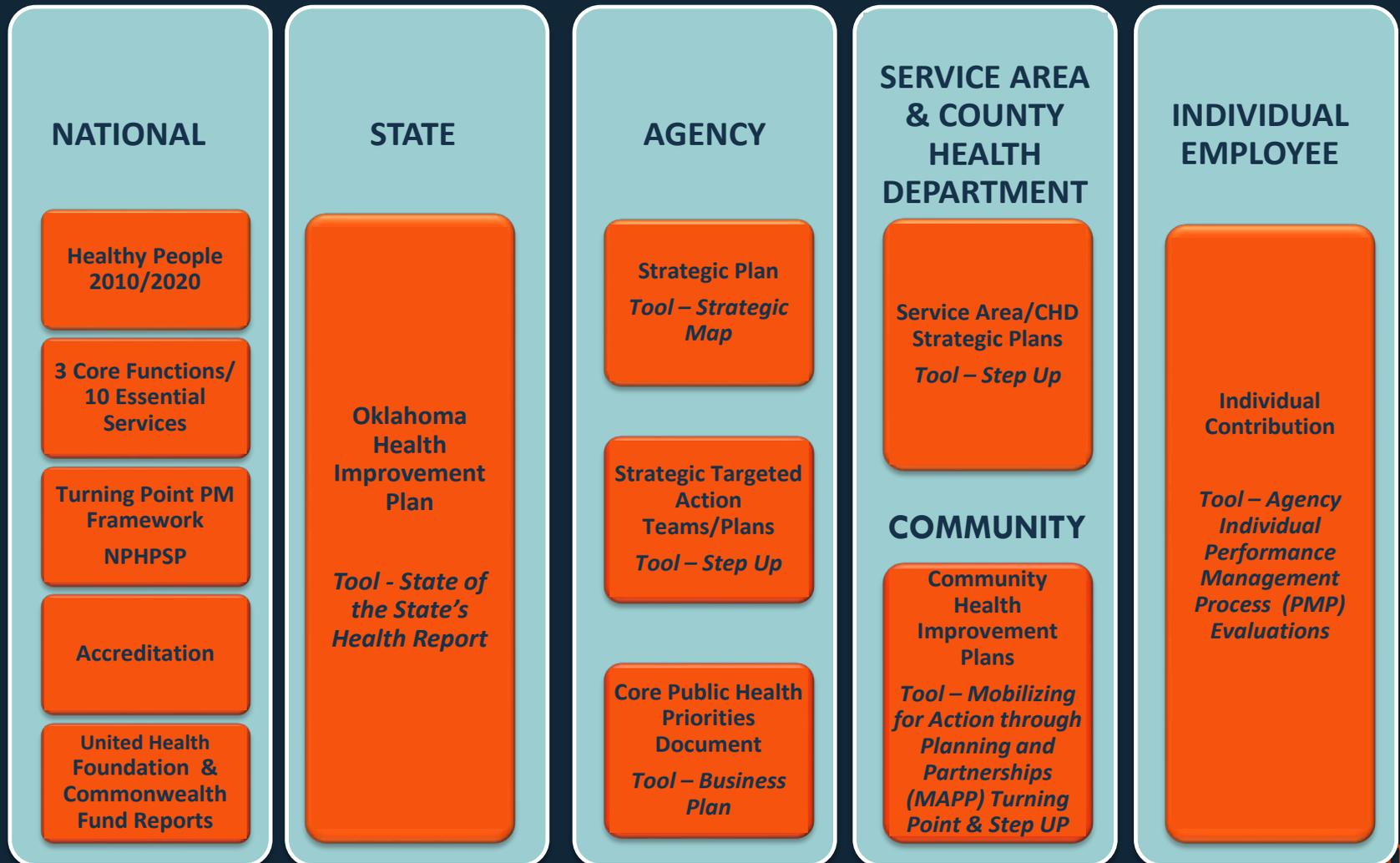
- Launched Oklahoma Health Improvement Plan (OHIP) 2020 (March 2015)
- Finalized OSDH agency strategic plan (August 2015)
- Continue with the Collaborative Improvement and Innovation Networks (COIIN) to reduce infant mortality
- Tobacco
  - 24/7 tobacco free schools
  - Adult smoking prevalence
- Obesity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

# OHIP & STRATEGIC PLAN

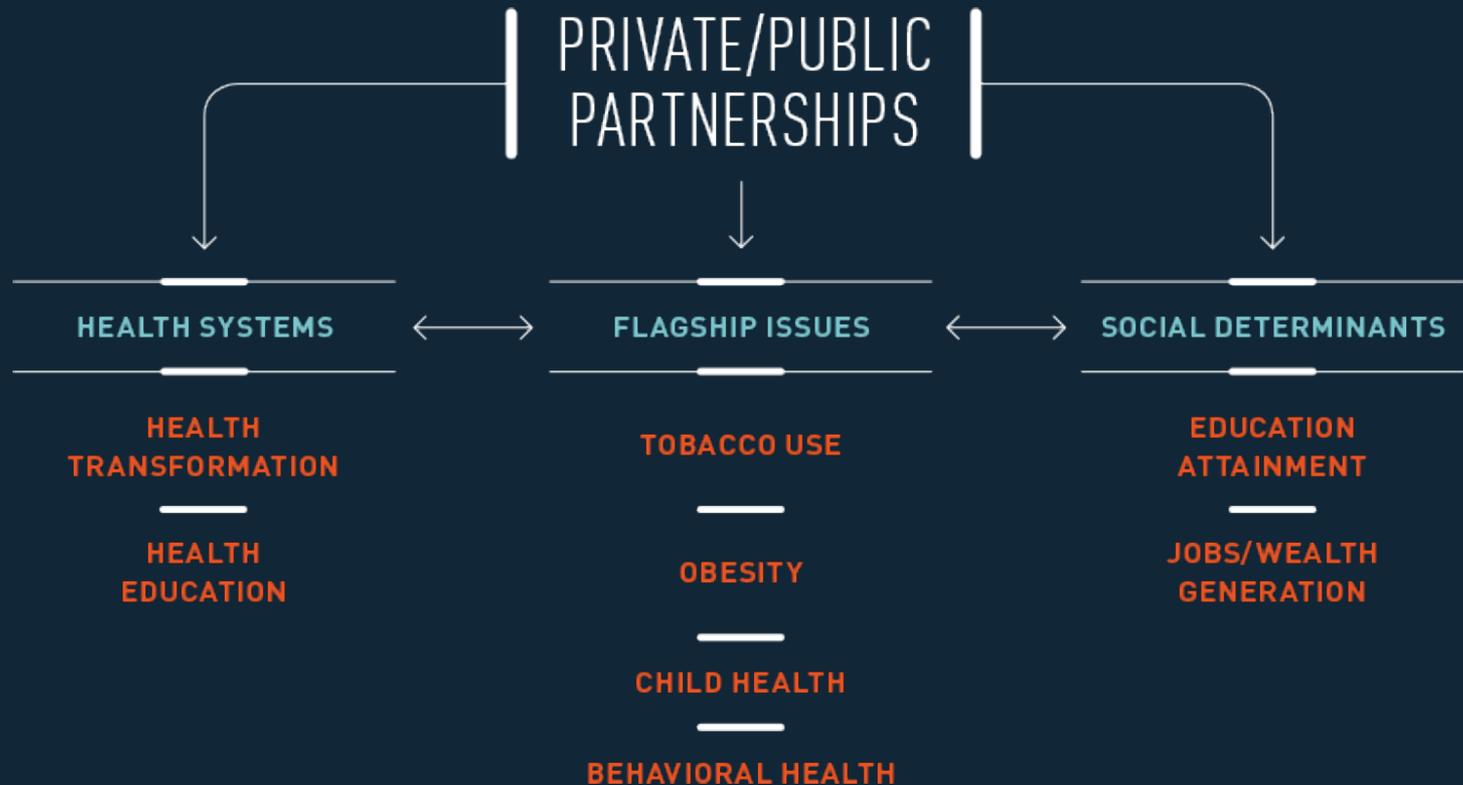
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# OKLAHOMA STATE DEPARTMENT OF HEALTH PERFORMANCE MANAGEMENT MODEL

← QUALITY IMPROVEMENT →



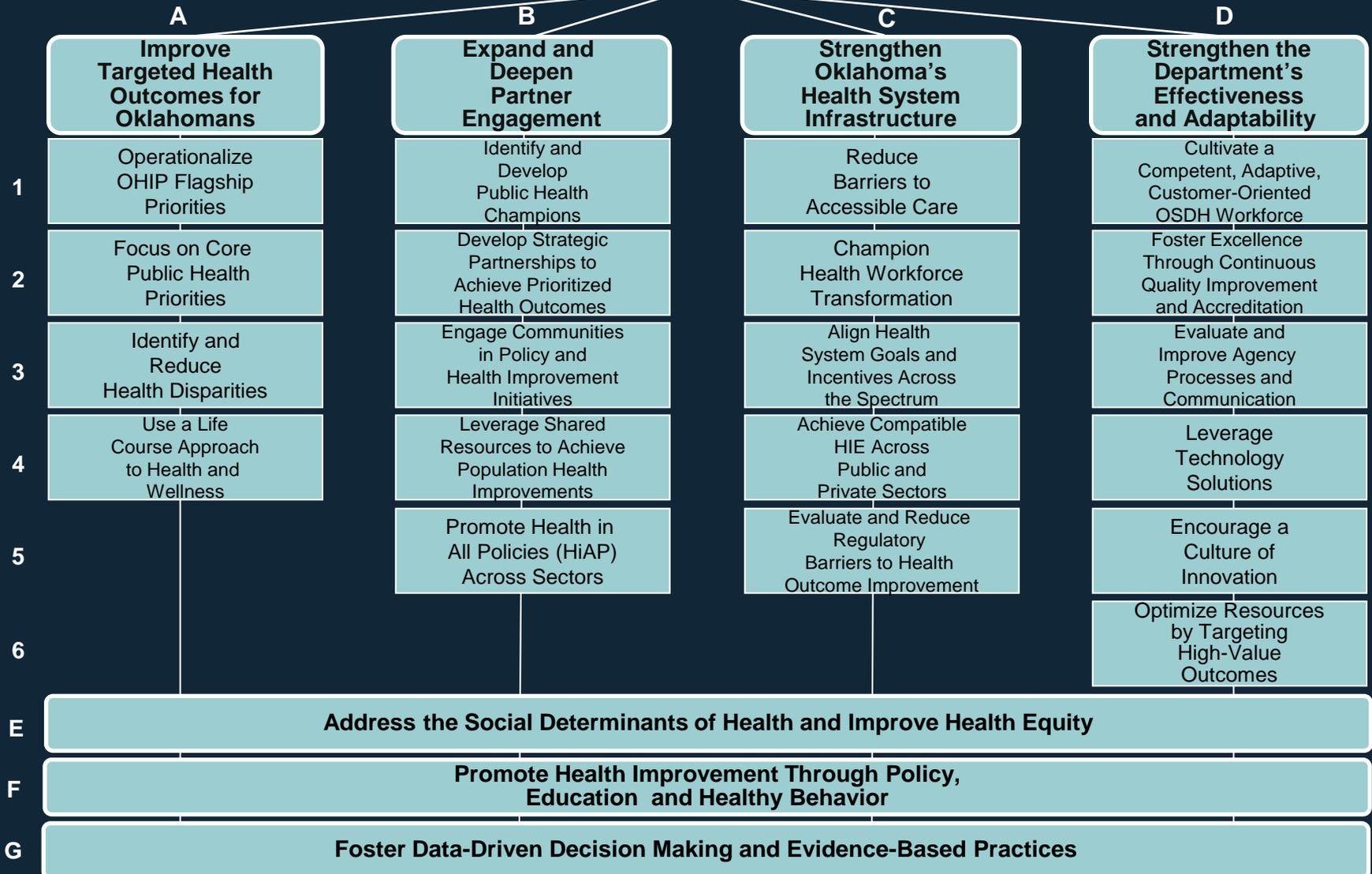
# OHIP FRAMEWORK



# Oklahoma State Department of Health Strategic Map: 2015-2020

Approved  
08/16/15

## Improve Population Health



PREPARING FOR A  
LIFETIME  
&  
EVERY WEEK COUNTS

---

# PREPARING FOR A LIFETIME

---

## Infant Mortality Collaborative Improvement and Innovation Networks (CoIINs)

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

## ASTHO Multi-State Learning Community

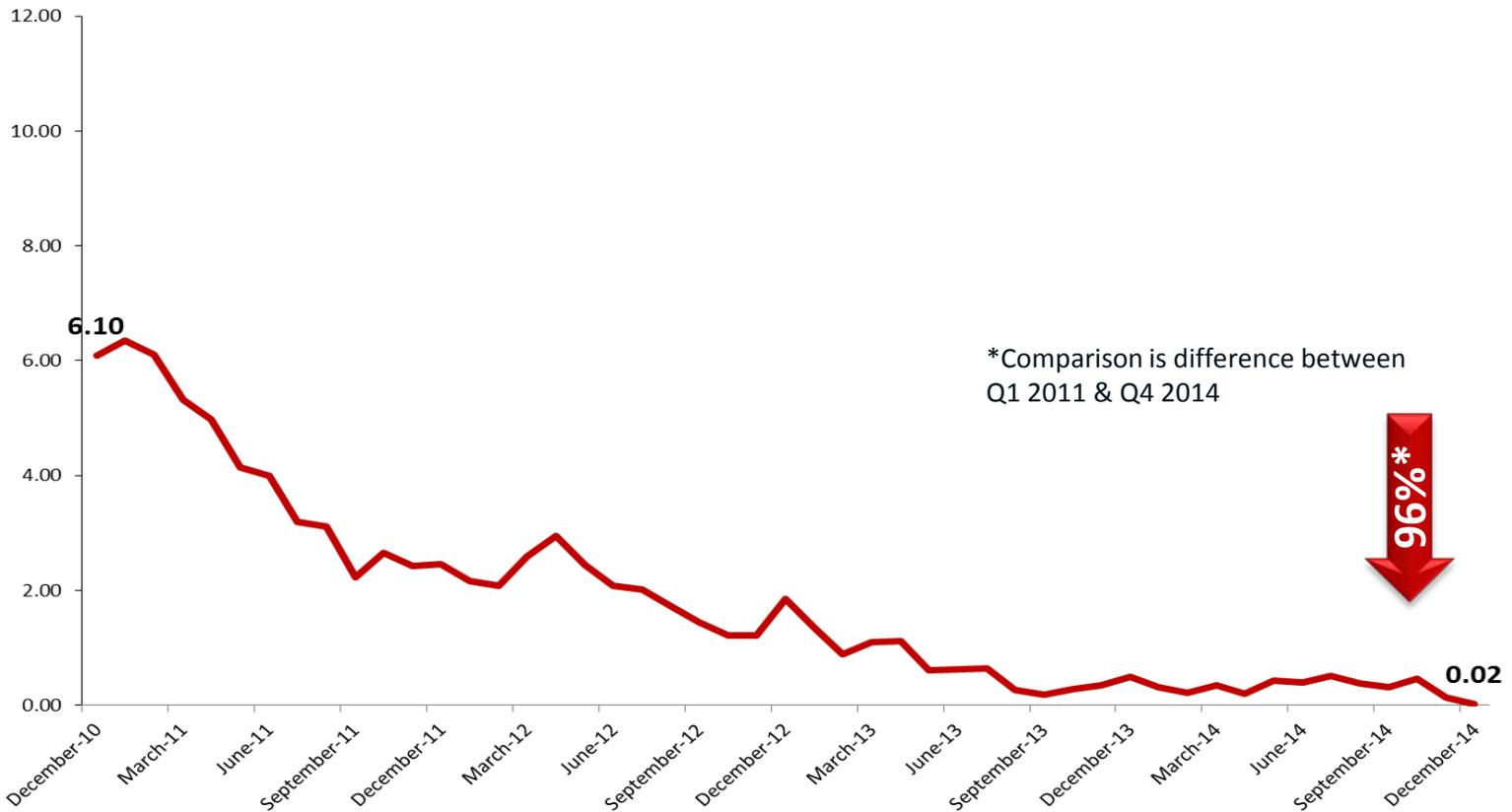
- Breastfeeding
- Long Acting Reversible Contraceptives (LARC)

## AMCHP/RWJF Improving Infant Outcomes

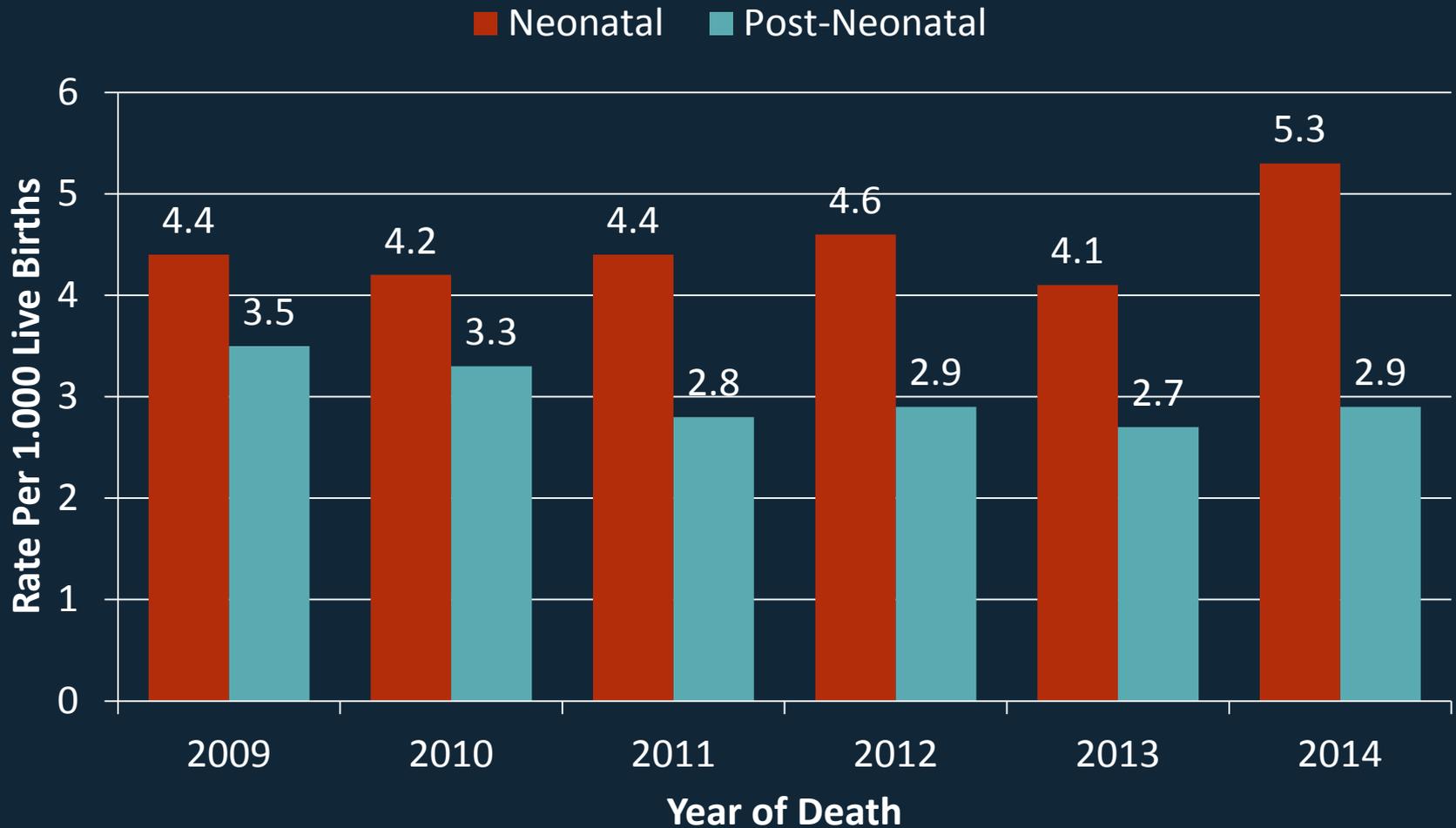
- Racial and Ethnic Disparities

# SUCCESSSES

**Scheduled C-Sections AND Inductions <39 Weeks  
WITHOUT a Documented Indication**  
- as percentage of Total Deliveries



# ONGOING CHALLENGES

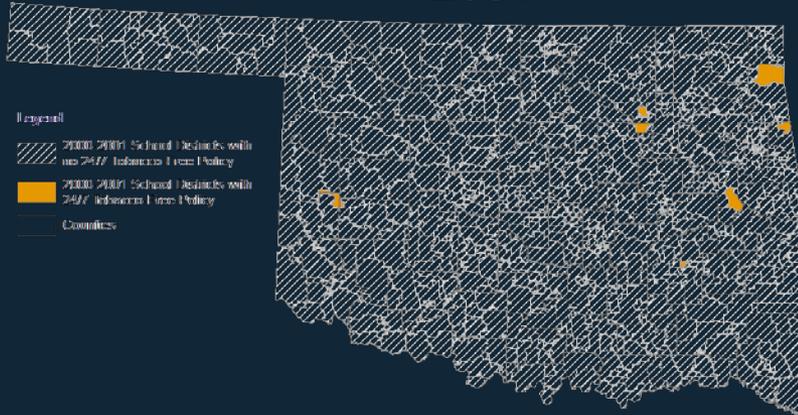


# TOBACCO

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

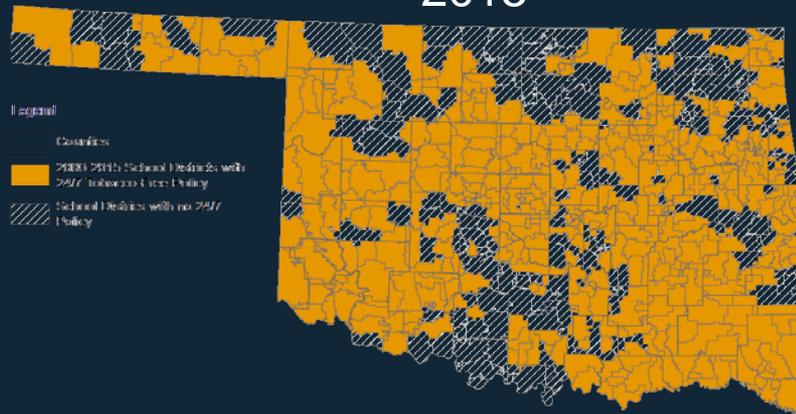
2001



2007



2015



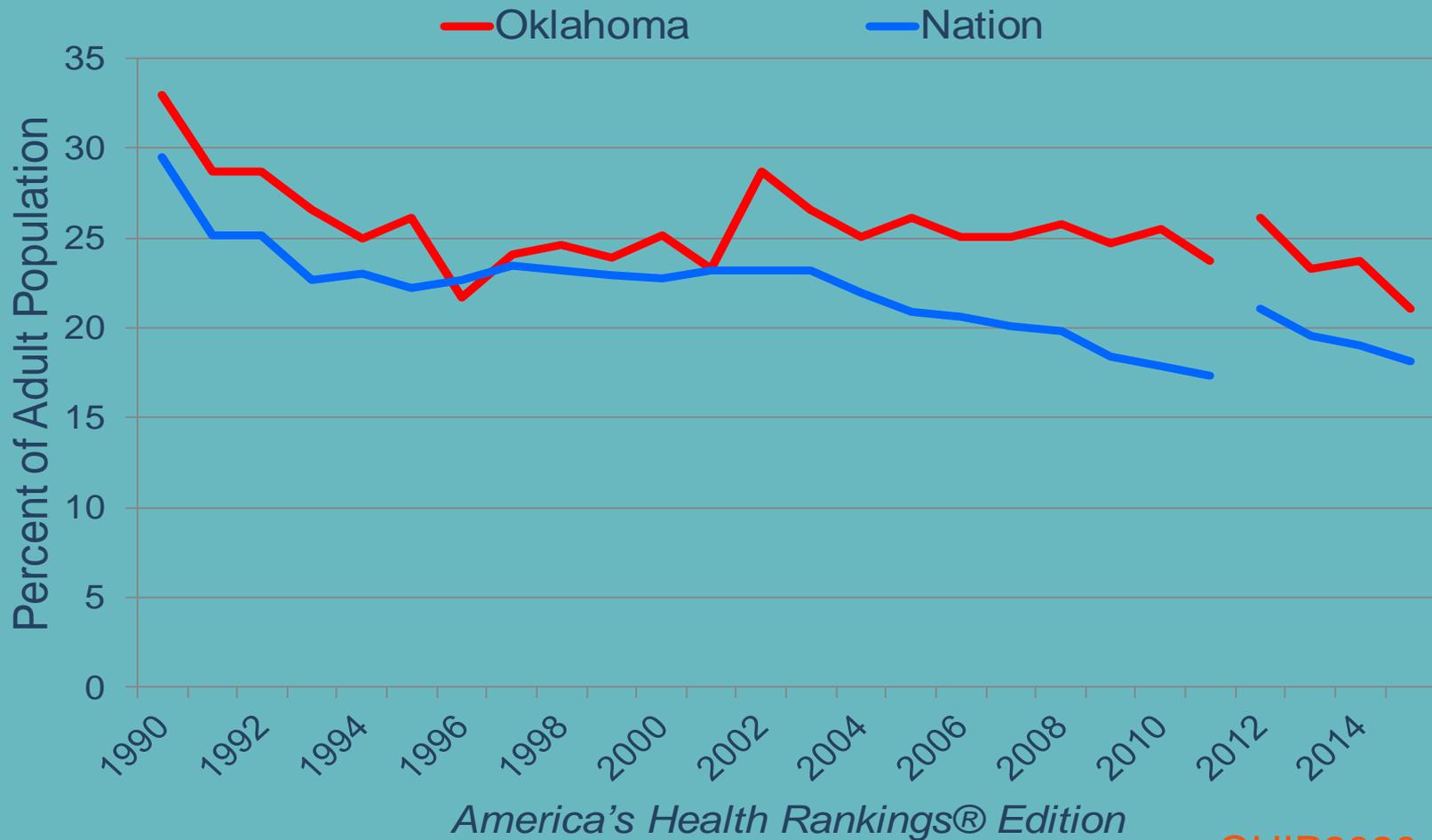
Current



[OHIP2020.com](http://OHIP2020.com)



# UHF SMOKING MEASURE OKLAHOMA AND THE NATION



# OBESITY

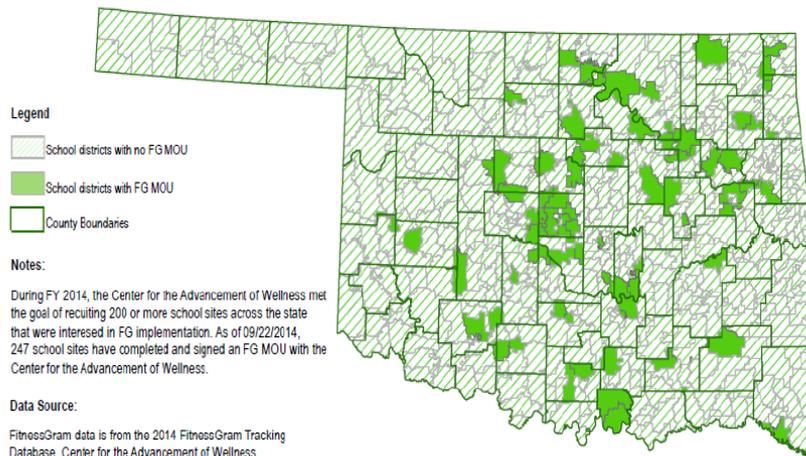
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# FITNESS GRAM

## Locations

## Results

Figure 3. School districts with Fitnessgram® memorandum of understanding



**Legend**

- School districts with no FG MOU
- School districts with FG MOU
- County Boundaries

**Notes:**

During FY 2014, the Center for the Advancement of Wellness met the goal of recruiting 200 or more school sites across the state that were interested in FG implementation. As of 09/22/2014, 247 school sites have completed and signed an FG MOU with the Center for the Advancement of Wellness.

**Data Source:**

FitnessGram data is from the 2014 FitnessGram Tracking Database, Center for the Advancement of Wellness, Oklahoma State Department of Health. The data is current through 09/22/2014.

Created: 10/03/2014 by Fahad Khan

Projection/Coordinate System: USGS Albers Equal Area Conic



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



Center for the Advancement of Wellness  
Oklahoma State Department of Health

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

\*Not a representative sample



OHIP2020.com

# HEALTH IN ALL POLICIES

---

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

# HEALTH TRANSFORMATION

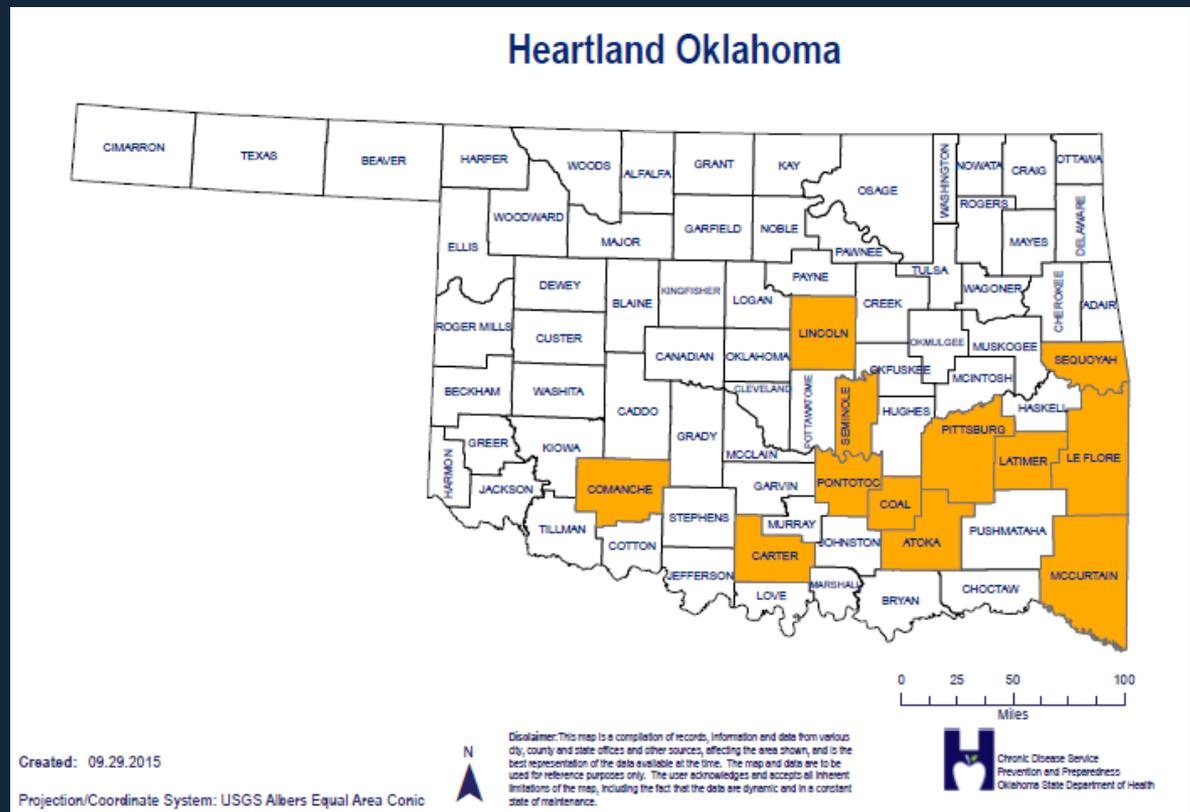
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# HEARTLAND OKLAHOMA

## Pilot Success

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

## Heartland OK Expanded to 12 Counties



# NGA POLICY WORKFORCE ACADEMY



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

# OKLAHOMA STATE INNOVATION MODEL (OSIM)

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



# EBOLA

---

# EBOLA

---

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



## SECTION 5

# OKLAHOMA CITY-COUNTY HEALTH DEPARTMENT UPDATE PRESENTATION



**WELLNESS NOW**

# **OCCHD UPDATE TRI-BOARD 2015**

Gary Cox, J.D.

Executive Director

Oklahoma City-County Health Department



# INNOVATION IN ACTION

## WELLNESS NOW

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





# INNOVATION IN ACTION

## WELLNESS NOW

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



**WELLNESS NOW**

# EXECUTIVE SUMMARY

## TOTAL WELLNESS

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



# INNOVATION IN ACTION

WELLNESS NOW

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



Susan Sarah Smith 2/2/1985 5 Schedule X

West

James St. Clair - OCCHD Nurse

## New Client

New Client

General Health

Safety

Tobacco and Alcohol use

Family Planning/STDs

Save

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

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

Food pantry assistance needed?  Yes  No

Concerned about weight  Yes  No

Regular exercise  Yes  No

Exercise frequency

Has client been tested for tuberculosis?

Are all vaccinations current?

If client is over 60, have they received a Shingles vaccine?

Has client had a flu shot this year?

### Safety

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

Physical or sexual abuse  Yes  No

Do you feel safe at home  Yes  No



West

James St. Clair - OCCHD Nurse

Program Forms - All Forms -

- Family Planning New Client History Test Form
- Pregnancy Screening Record
- Clinical Services BCD

### Completed Forms

Name	VisitType	Start Time
	FP/N	10:30:00



Susan Sarah Smith 2/2/1985 5 Schedule ✕

West v

James St. Clair - OCCHD Nurse

SSN	111223333	<a href="#" style="background-color: #e67e22; color: white; padding: 5px 10px; border-radius: 3px;">Edit</a>
Household Size	4	
Address	1234 S Columbia Ave Tulsa 36 74112	
Housing		<input type="checkbox"/> Reg Start
Phone	9185555555	<input type="checkbox"/> Reg Complete
Receives WIC	No	<input type="checkbox"/> Transport Time
E-mail	susan.smith@demo.net	<input type="checkbox"/> Check Out
Special Needs	No	<input type="checkbox"/> Provider Documentation
Language		
Employment		
Race	Hispanic or Latino	
Ethnicity		
Income	24000	
Education		
Last Modified By	Jason Roberts	

### Completed Forms

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



Susan Sarah Smith 2/2/1985 5 Schedule X

West

James St. Clair - OCCHD Nurse

Program Forms - All Forms -

### Scheduled Appointments

First Name	Last Name	VisitType	Start Time
Susan	Smith	FP/A	11:00:00

### Completed Forms

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



# CREATING SYSTEMS OF CARE

WELLNESS NOW

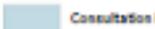
- Integration of Health Services
  - Public Health
  - Mental Health
  - Pharmacy
  - Clinical Care
  - Dental
- CHW Hospital Pilot

# INTEGRATED HEALTH SERVICES MODEL



Northeast Regional Health and Wellness Campus  
 Partner Building - First Floor  
 2700 NE 63 Street  
 Oklahoma City, OK 73111

**LEGEND**

 Exam Room	 Check-In	 Client Activity
 Consultation Room		 Client Flow



**WELLNESS NOW**

# ENGAGING NON-TRADITIONAL PARTNERSHIPS

## Examples of Engagement

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

PROPOSED  
INTEGRATED  
SCHOOL AND  
COMMUNITY  
HEALTH MODEL:  
SOUTH OKC





# CEO FORUM

WELLNESS NOW





# OPEN STREETS

WELLNESS NOW





WELLNESS NOW

# CREATING A CULTURE OF QUALITY

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



**WELLNESS NOW**

# CREATING RELATIONSHIPS

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



# WHEN IS CHANGE NECESSARY?

WELLNESS NOW

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



# CHIEF HEALTH STRATEGIST

WELLNESS NOW

The Local Health Department as Chief Health Strategist:

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



# THOUGHT PROVOKERS

## WELLNESS NOW

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

## SECTION 6

# TULSA HEALTH DEPARTMENT UPDATE PRESENTATION

## SECTION 7

# OKLAHOMA STATE INNOVATION MODEL UPDATE PRESENTATION

# Oklahoma State Department of Health

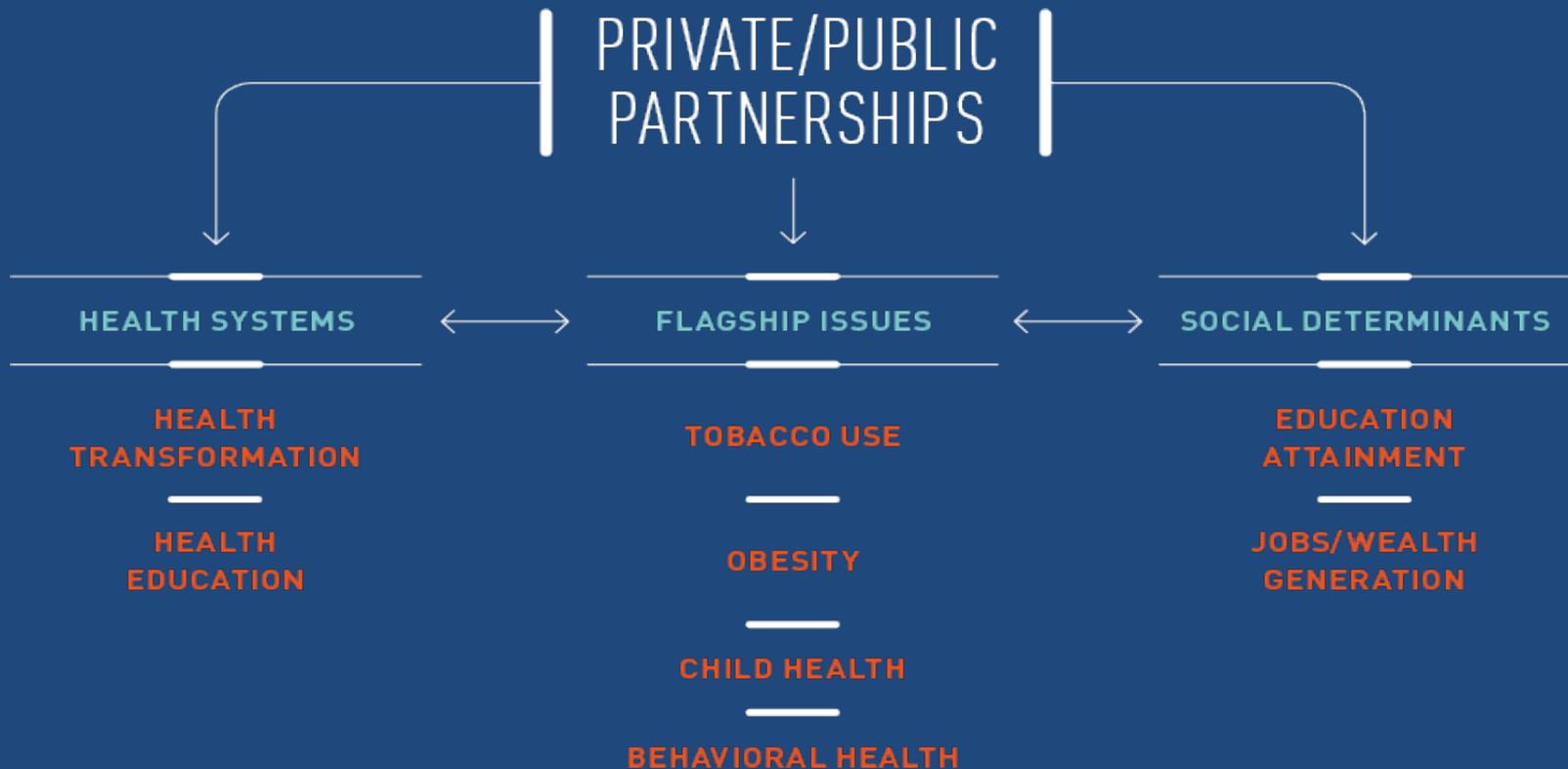


Oklahoma State Innovation Model (OSIM)  
Update

Tri-Board Meeting  
October 6, 2015

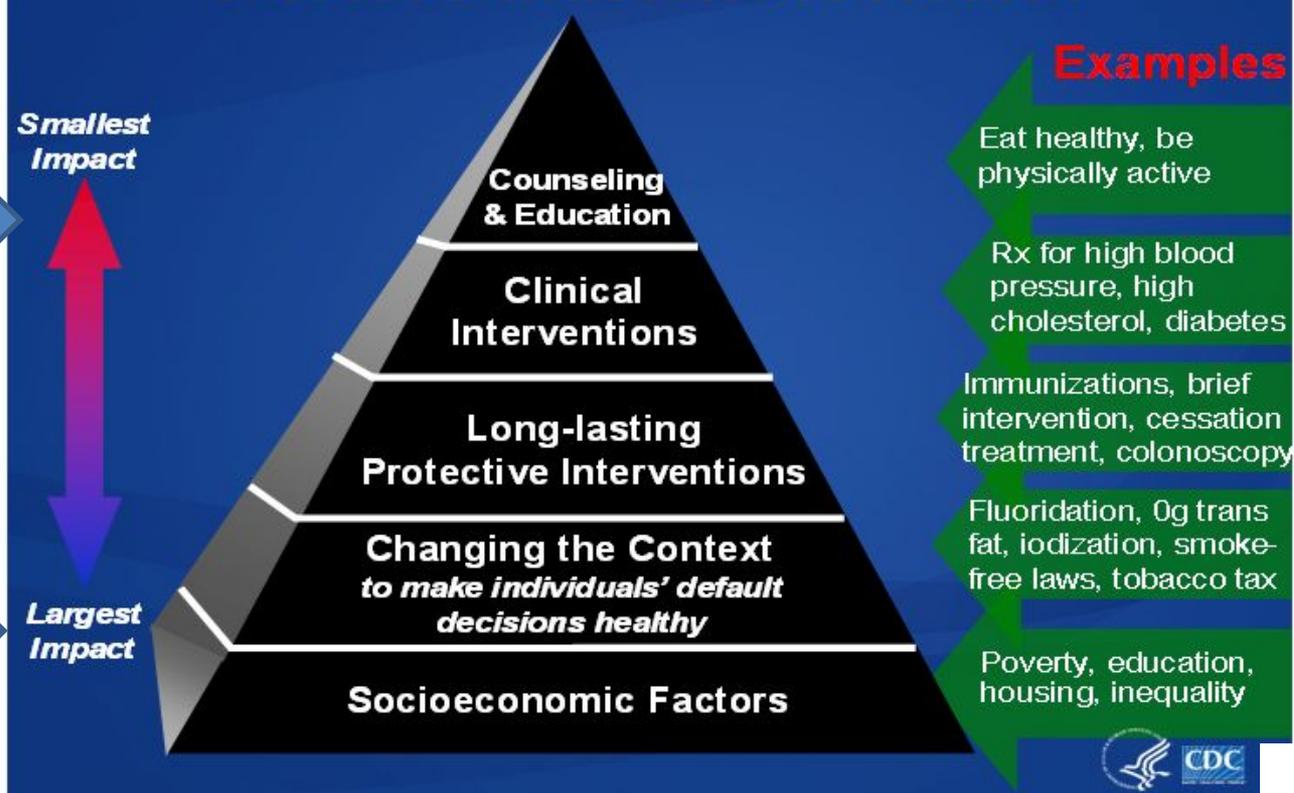


# OHIP 2020 FRAMEWORK



# Health Impact Pyramid

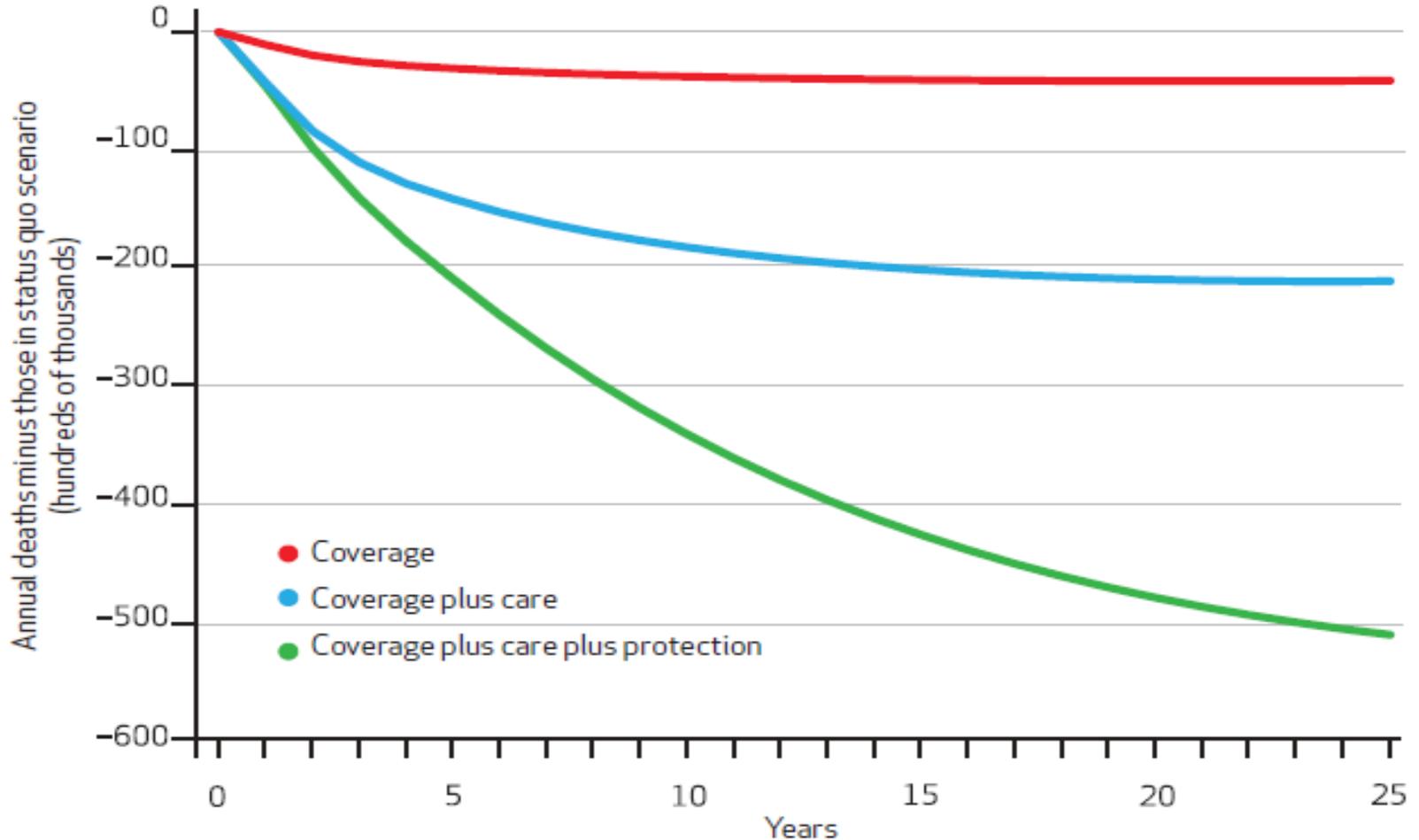
## Factors that Affect Health



Source: Frieden, Thomas R. A Framework for Public Health Action: The Health Impact Pyramid. *American Journal of Public Health*. April 2010, Vol. 100, no. 4., pp. 590-595.

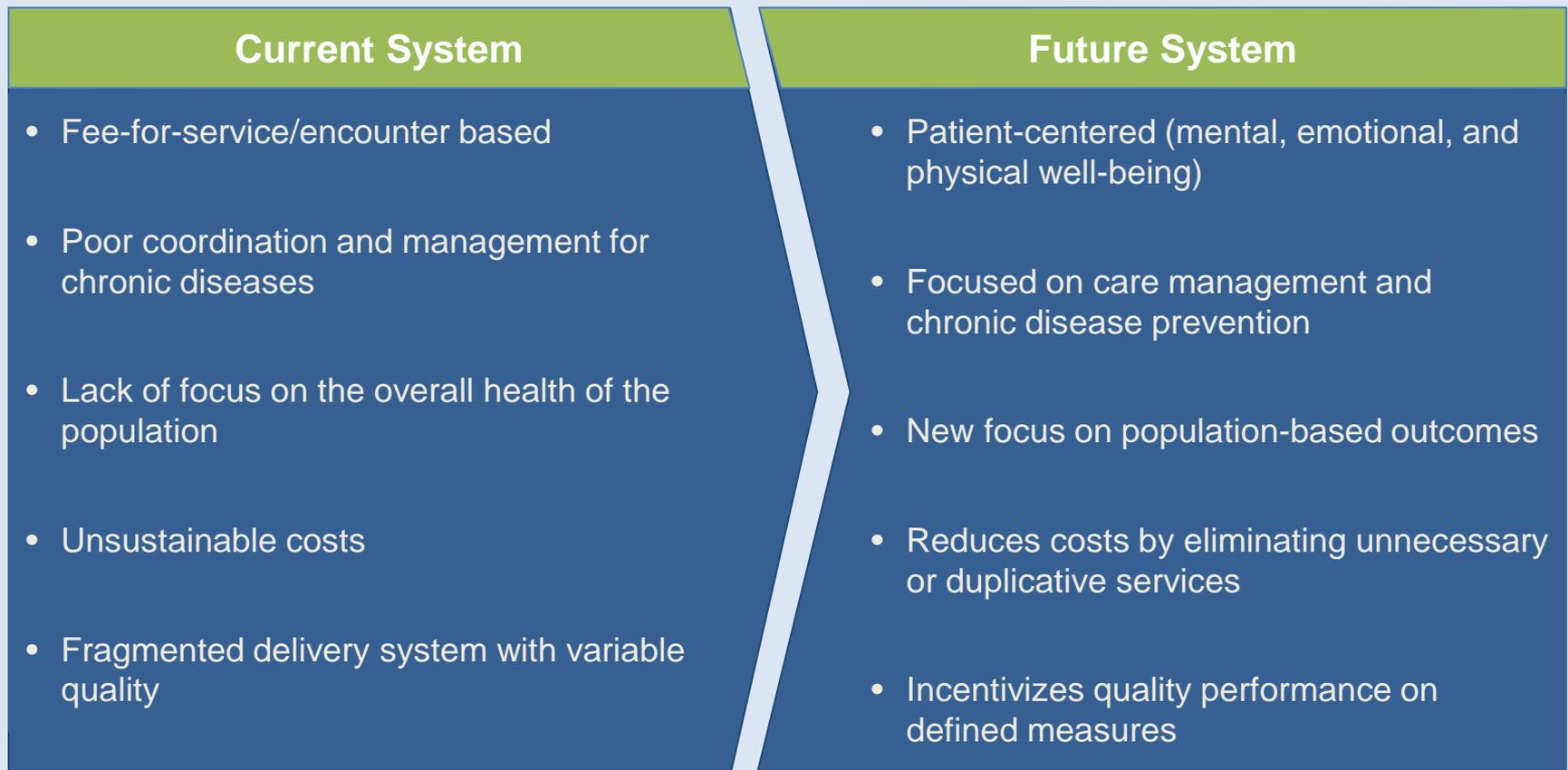
# The Importance of Population Health & Healthcare Integration

Annual Deaths, Three Layered Intervention Scenarios, Year 0 To Year 25



# OVERVIEW OF THE STATE INNOVATION MODEL PROJECT

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



# OSIM DELIVERABLES

The SHSIP is the primary deliverable from the OSIM initiative



# OSIM MEASURE ALIGNMENT

## OSIM Population Health Goals

### Tobacco Use

- Four level smoking status
- Percent with a quit attempt in the last year

### Obesity

- Adult BMI
- Youth BMI
- Physical Activity Guidelines
- Adult Fruit and Vegetable Consumption
- Food Desert/Food Availability

### Adult Hypertension

- Taking medicine for high blood pressure control among adults age  $\geq 18$  years

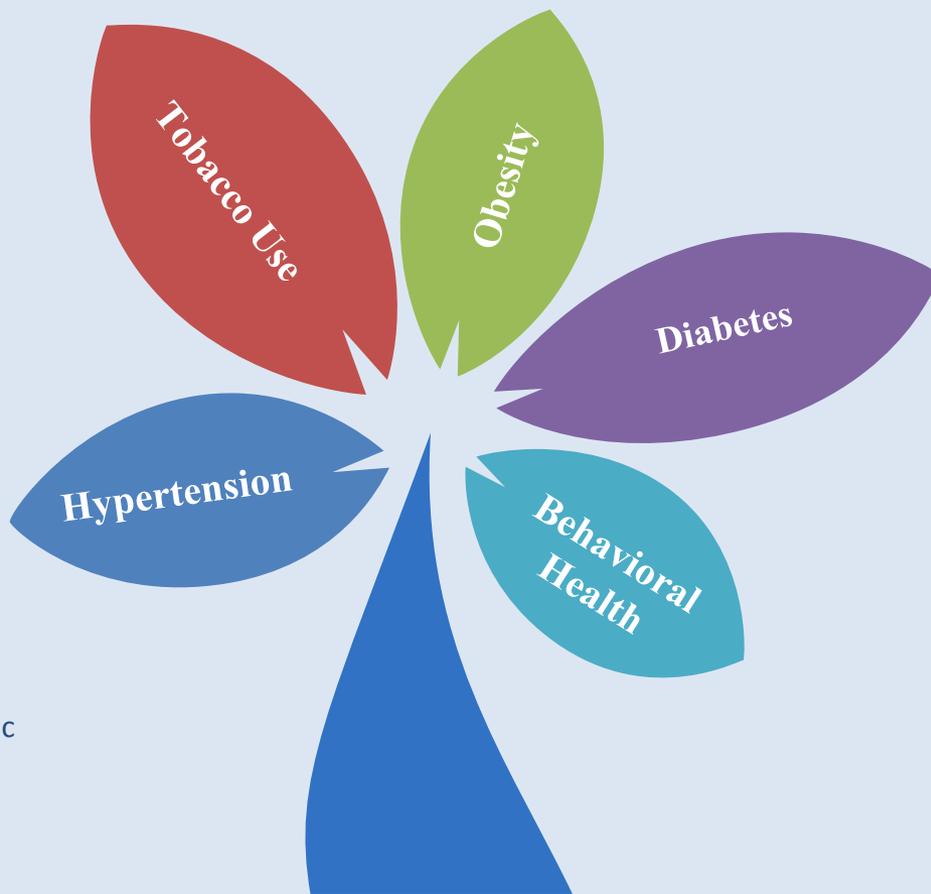
### Adult Diabetes

- Percentage of Adults with Diabetes having two or more A1c tests in the last year

### Behavioral Health

- TBD

## OSIM Clinical Population Health Goals



# OSIM WORKGROUP UPDATE: HEALTH EFFICIENCY & EFFECTIVENESS

## Health Efficiency & Effectiveness



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

## Key Findings

### Population Health Needs Assessment

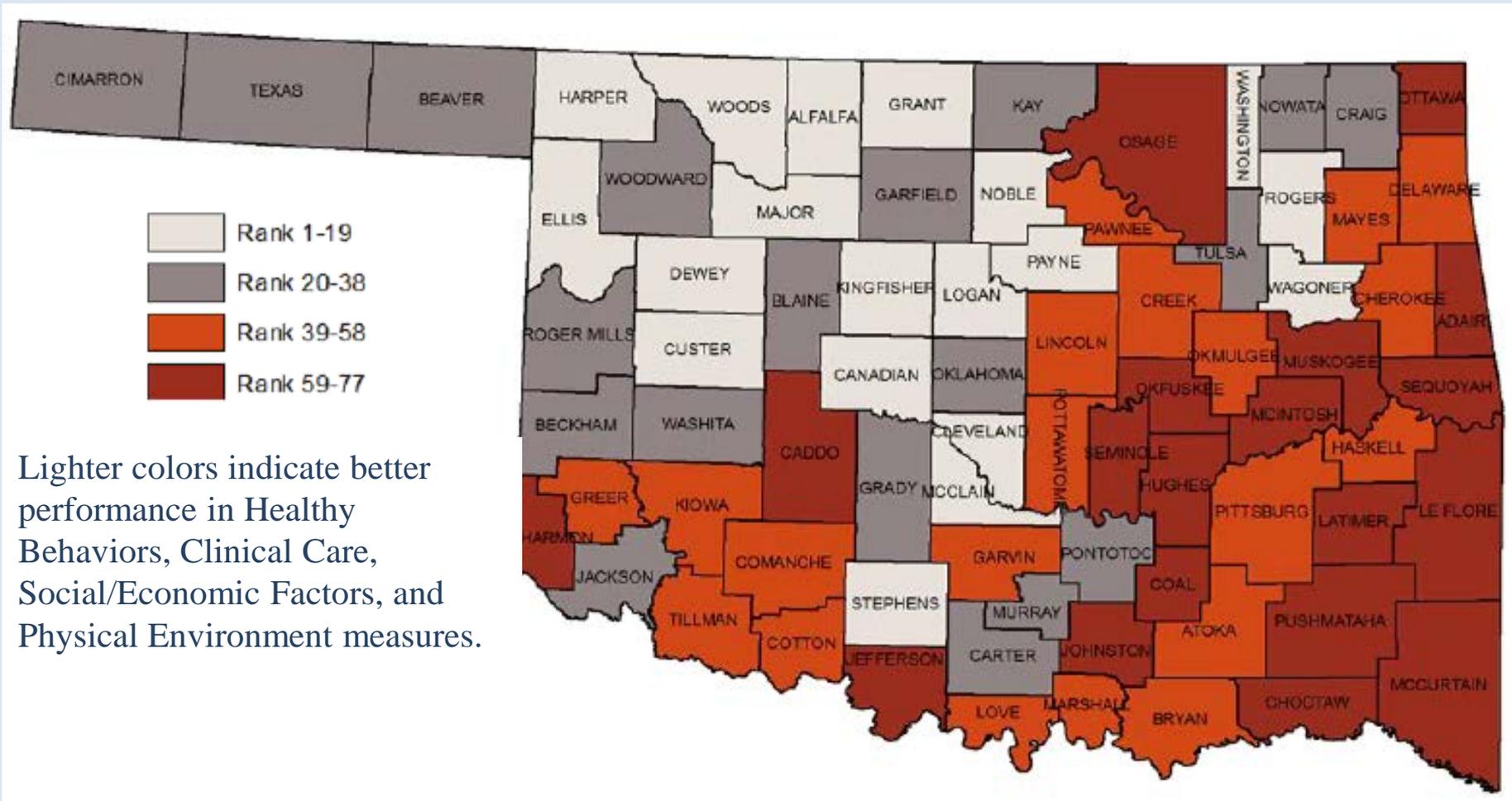
- Chronic disease affects all populations within the state, albeit at somewhat varying degrees
- 37.5% of adults in Oklahoma have hypertension, the 9<sup>th</sup> highest rate nationally
- Oklahoma is the 6<sup>th</sup> most obese state in the nation
- Diabetes, hypertension, obesity, physical activity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

### Initiative Inventory

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

# POPULATION HEALTH NEEDS ASSESSMENT

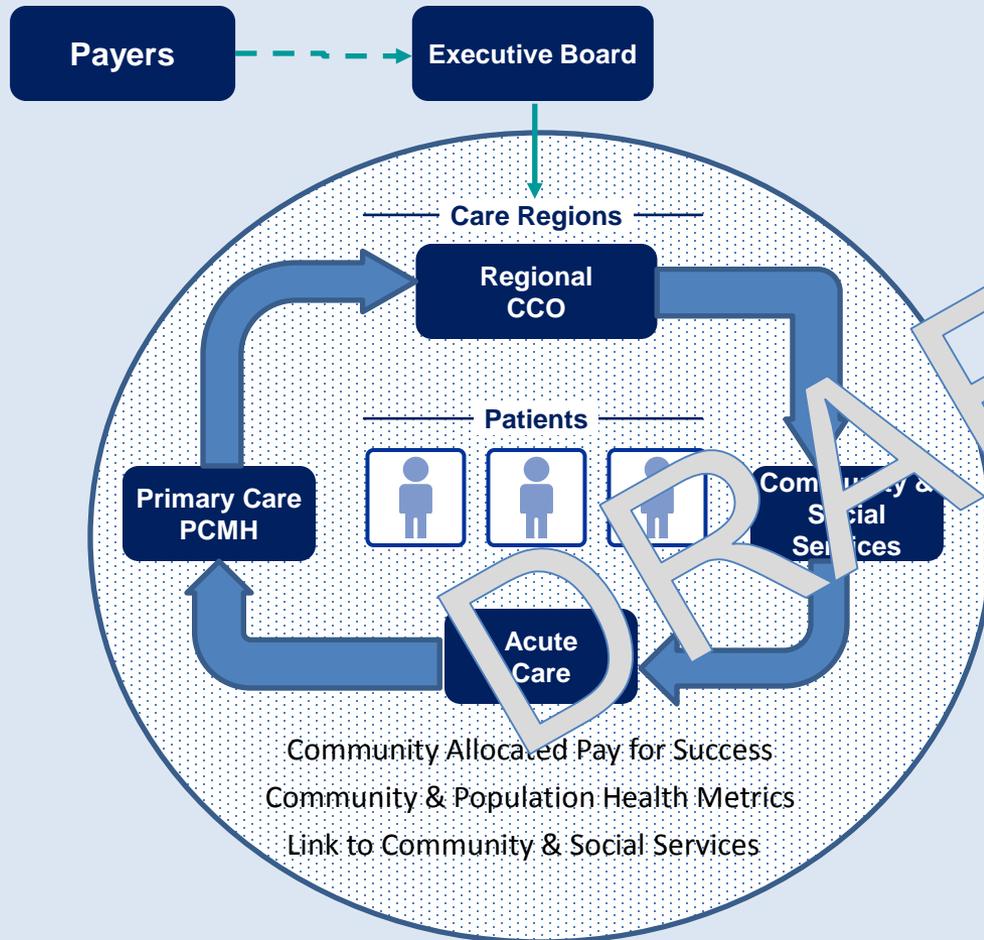
County Health Factors by Quartile Ranking, Oklahoma, 2015



# COMMUNITY COORDINATION ORGANIZATION (CCO MODEL)

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

# CARE COORDINATION ORGANIZATION



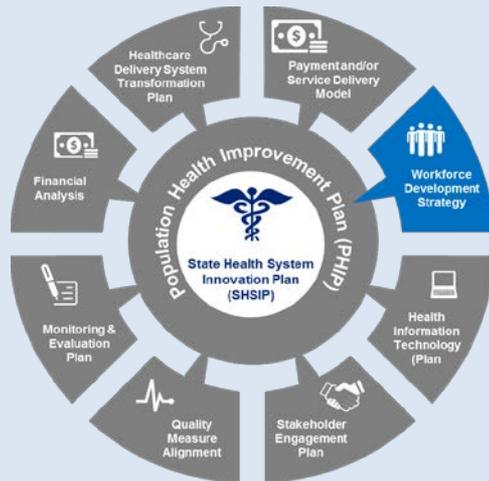
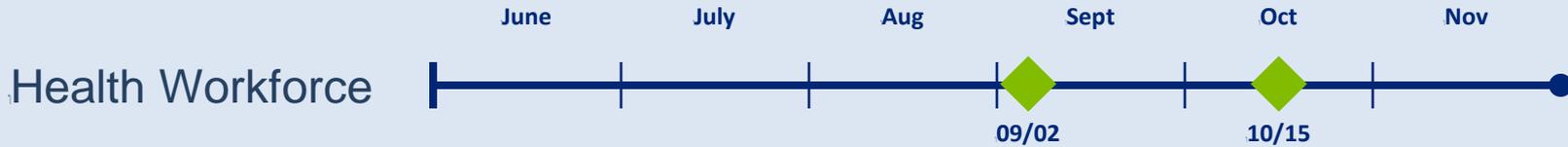
## Executive Board

- Support Regional CCO's from multi-payer pool
- HIT Infrastructure / resource
- Utilize public/private governance

## CCO

- Transitions of care
- Reports data/analytics to providers
- Social resource hub/ patient navigation
- Link to primary care and hospitals through reporting and support services
- Provide practice enhancement
- Provide care coordination
- Organization is responsive to **all** patients

# OSIM WORKGROUP UPDATE: HEALTH WORKFORCE



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

## Key Findings

### Provider Organizations and Provider Landscapes

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

### Workforce Gap Analysis

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

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

## High Quality Data

- Determined minimum data set, integrating into licensure renewal
- Centralizing and aggregating data – OSDH
- Expanded health workforce surveys - OSDH
- NEXT STEP – Linking to education (including GME)
- NEXT STEP – Linking to economic data
- NEXT STEP – Rational care delivery areas

## Coordination of Efforts

- Determined sustainable and inclusive mechanism for coordinating health workforce efforts
- Integrated health workforce coordination into economic development work and established health workforce subcommittee in statute
- NEXT STEP – Building comprehensive plan and recommendations for consideration of health workforce subcommittee and approval of the Governor's Council on Workforce and Economic Development
- NEXT STEP – Inclusion of health workforce planning locally in Oklahoma Works

## Workforce Redesign to Meet Transformed Health System

- Determined 25 most needed health professions in the next 5 – 10 years based on economic analysis
- Determined to 5 – 6 emerging professions based on assessment of evidence and stakeholder feedback
- NEXT STEP – Develop recommendations for training, retraining, academic detailing, and practice facilitation
- NEXT STEP – Linking to other existing efforts H2O

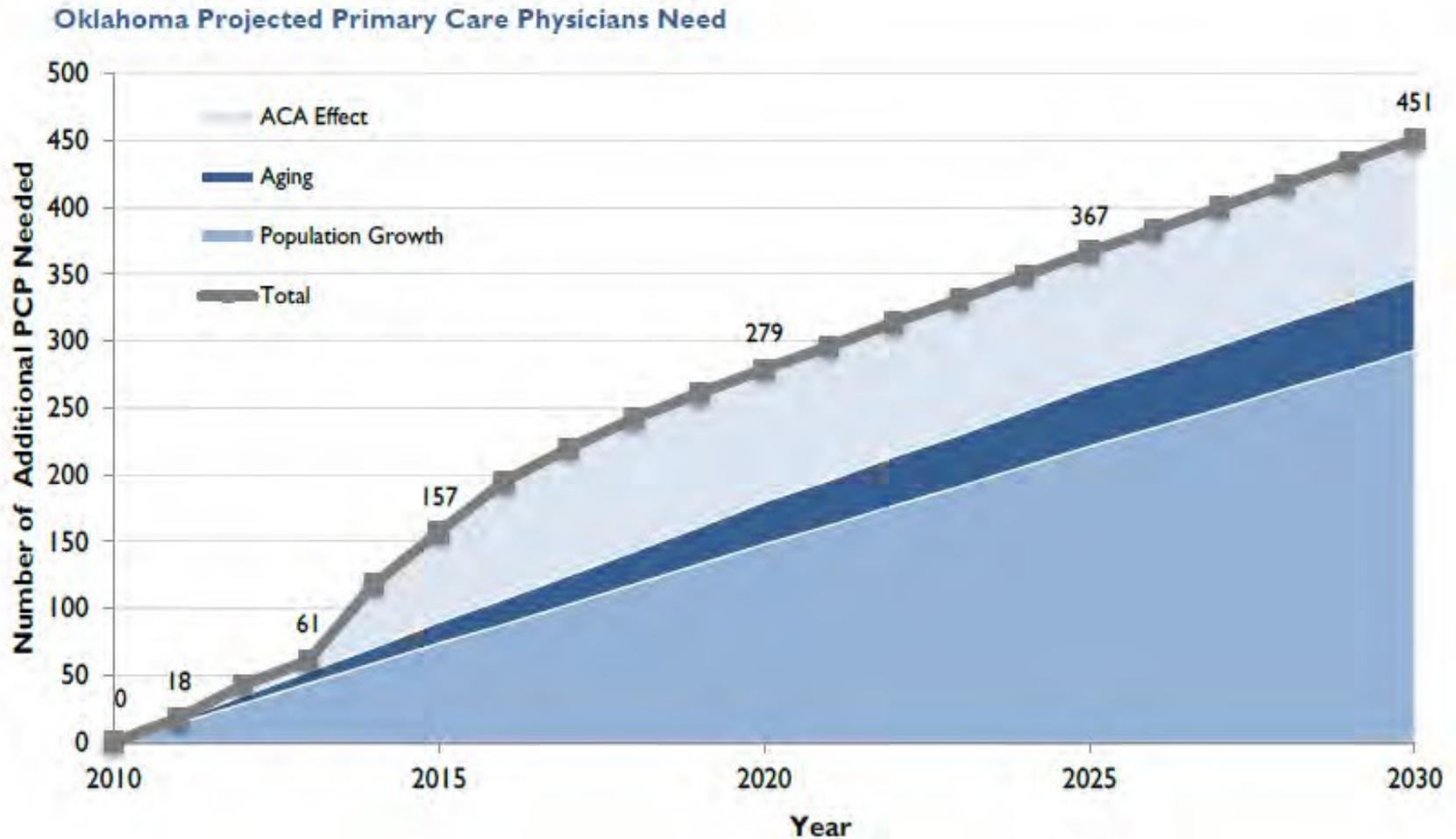
## Pipeline, Recruitment and Retention

- GME Subcommittee working on statewide data aggregation – graduates, residents, GME funding availability and type
- NEXT STEP – Building a longitudinal data system for better evaluation and analysis
- NEXT STEP - Integration and coordination of recruitment and retention programs PMTC, NHSC, J-1 Visa Waivers, etc.



# HEALTH WORKFORCE GAP ANALYSIS

## Oklahoma Project Primary Care Physicians Need



# HEALTHCARE PROFESSIONS NEEDED BY 2015

## Economic Projections

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

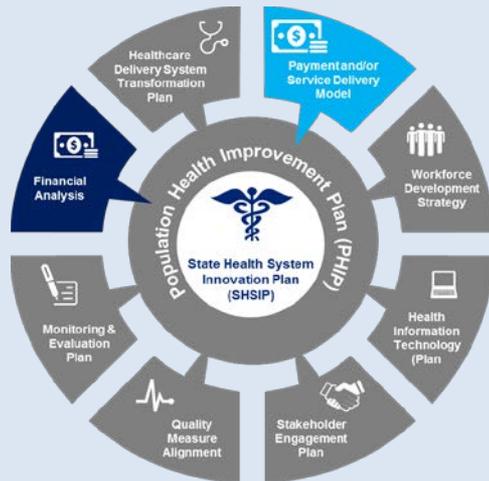
## Emerging Professions

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

# OSIM WORKGROUP UPDATE: HEALTH FINANCE

## Health Finance



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

## Key Findings

### Oklahoma Insurance Market Analysis

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

# Enrollment by Insurance Source

<b>Figure III-1</b> <b>State of Oklahoma</b> <b>Estimated Enrollment by Insurance Source</b> <b>Calendar Years 2013 through 2015</b>			
<b>Insurance Source</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
Uninsured	657,200	607,100	543,800
Individual	122,100	171,800	223,500
Small Group	189,000	182,800	177,300
Large Group	488,800	491,300	493,200
Self-Funded	840,400	849,400	854,500
EGID <sup>10</sup>	169,800	175,200	184,500
Medicaid/CHIP (with Duals)	792,500	805,800	826,700
Medicare (without Duals)	499,300	501,900	504,200
Other Public Programs	91,400	91,900	92,500
<b>Total</b>	<b>3,850,500</b>	<b>3,877,200</b>	<b>3,900,200</b>

Notes:

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

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

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

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

# RELATIVE COSTS FOR CHRONIC DISEASE FOR OKLAHOMA COMMERCIAL CARRIERS

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

# OSIM WORKGROUP UPDATE: HEALTH INFORMATION TECHNOLOGY

## Health Information Technology



Deliverable / Milestone	Status	Date
EHR / HIE Surveys	■ Complete	08/10
Value Based Analytics Roadmap	■ Preliminary deliverable received; undergoing internal review	08/25
HIT Plan: Internal Review	■ Outline of HIT plan and conceptual design complete and currently undergoing review	10/30
HIT Plan: CMS Submission	■ Pending completion of stakeholder review	11/30

## Key Findings

### Electronic Health Record / Health Information Exchange Surveys

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

# VBA CONCEPTUAL DESIGN PROPOSAL DISCUSSION

## Value-Based Analytic Roadmap

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- Three process phases:



### Design that Supports the Following:

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

# OSIM: Stakeholder Engagement

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

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

# QUESTIONS

## SECTION 8

# LEGISLATIVE PRIORITIES UPDATE PRESENTATION

# 2016 LEGISLATIVE PRIORITY

Oklahoma Tri-Boards of Health

· O C T O B E R 2 0 1 5



Tammie Kilpatrick - OCCHD

Scott Adkins - THD

Mark Newman - OSDH

# PROPOSED LEGISLATIVE PRIORITY



# Economic Research Confirms That Cigarette Tax Increases Reduce Smoking

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

Source: Campaign for Tobacco-Free Kids



# Economic Research Confirms That Cigarette Tax Increases Reduce Smoking Continued

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

Source: Campaign for Tobacco-Free Kids



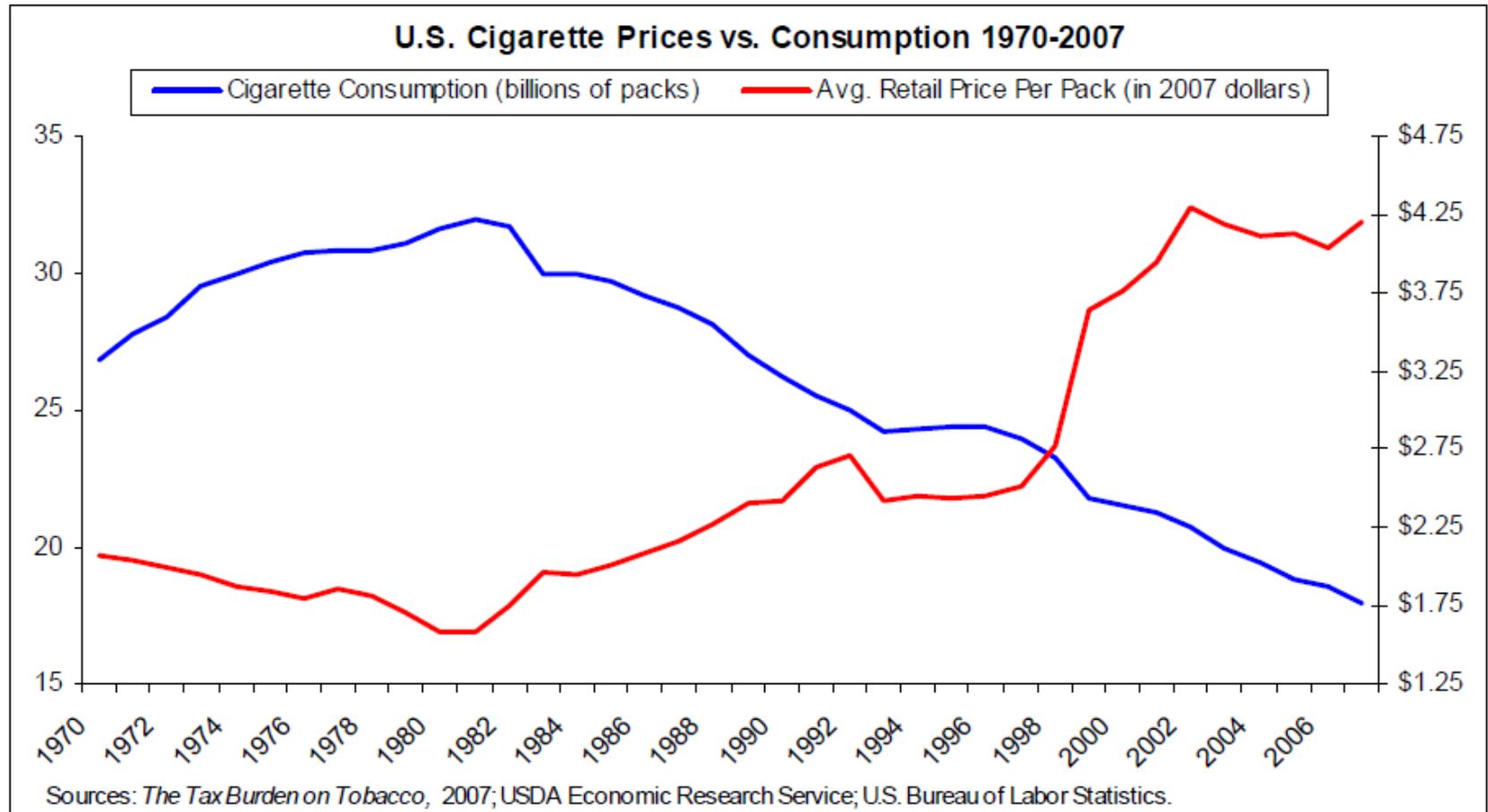
# Recent State Experiences

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

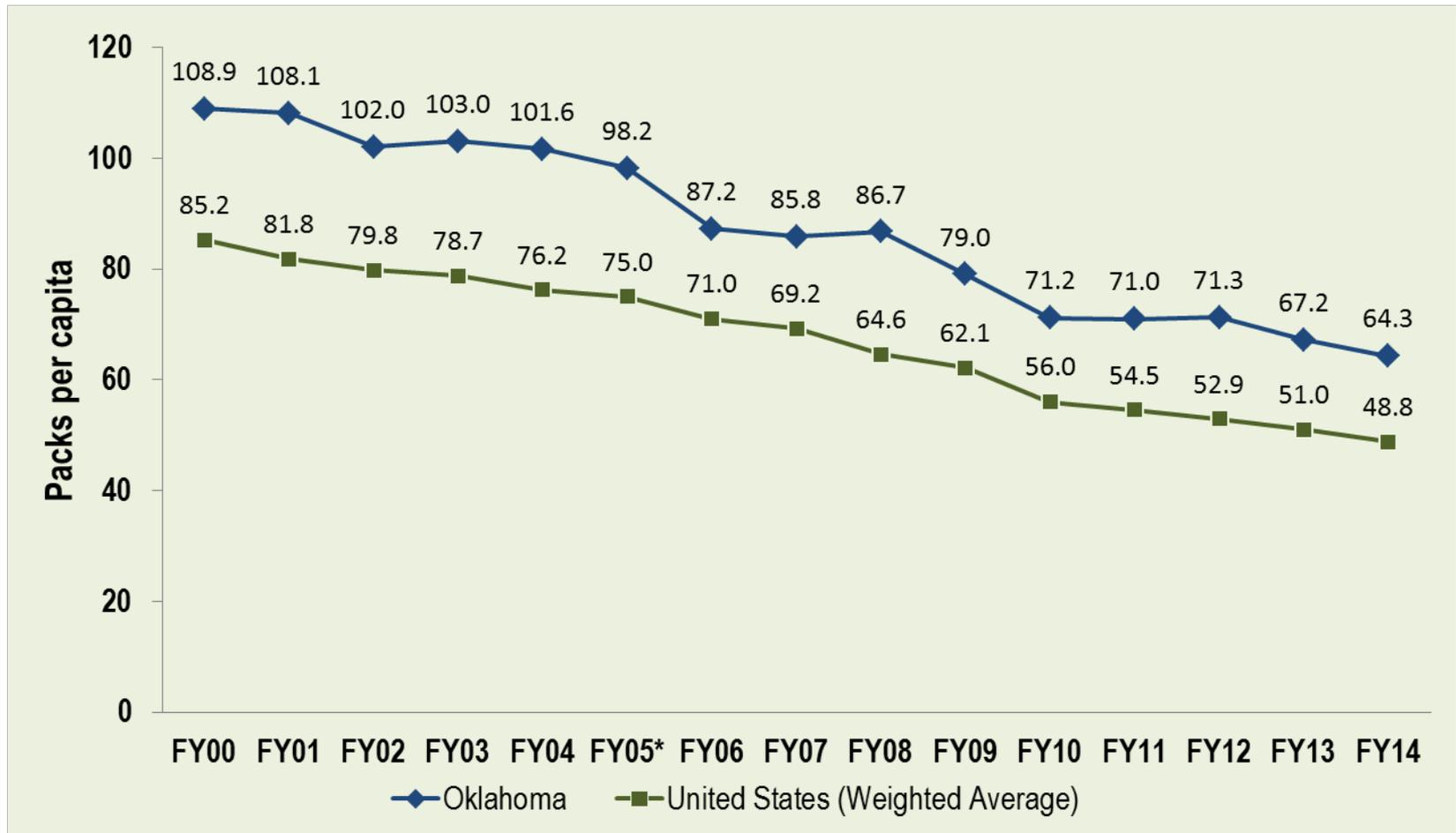
Source: Campaign for Tobacco-Free Kids



# Increasing U.S. Cigarette Prices and Declining Consumption



# Per Capita Cigarette Sales Oklahoma and United States

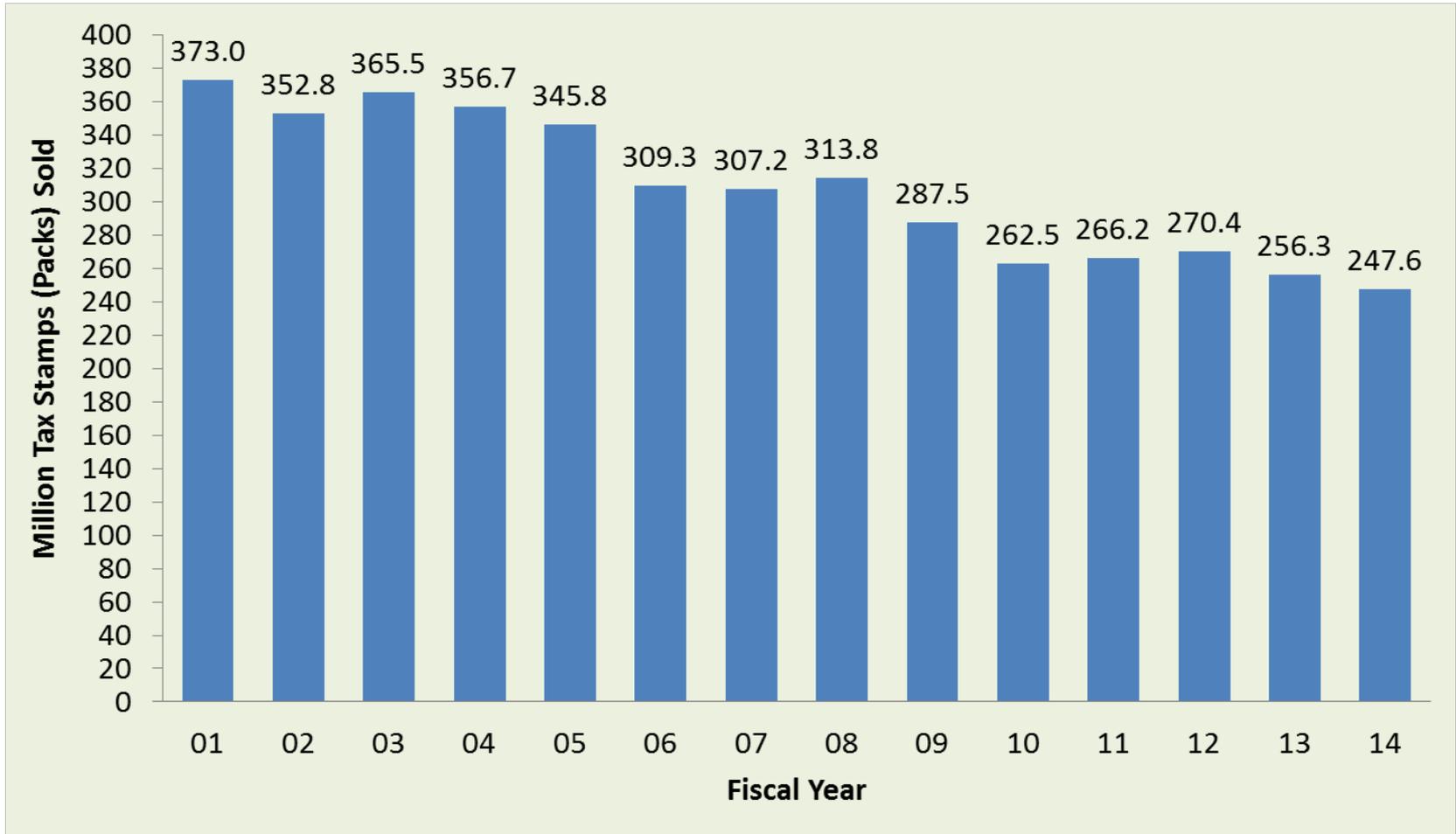


\* A voter-approved increase in Oklahoma's cigarette tax took effect on January 1, 2005, midway through fiscal year 2005

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



# Total Oklahoma Cigarette Sales Tribal & Non-Tribal Combined



Tax stamp sales provided by Oklahoma Tax Commission



# Projected New Annual Revenue from Increasing the Cigarette Tax Rate:

<b>\$1.50</b>	<b>\$1.00</b>
\$181.99 million	\$140.84 million

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

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



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

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

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



# For More Information

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# QUESTIONS



SECTION 9  
FINANCE COMMITTEE REPORT

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

**SFY 2016 BUDGET AND EXPENDITURE FORECAST: AS OF 9/22/2015**

<u>Division</u>	<u>Current Budget</u>	<u>Expenditures</u>	<u>Obligations</u>	<u>Forecasted Expenditures</u>	<u>Not Obligated or Forecasted</u>	<u>Performance Rate</u>
Public Health Infrastructure	\$ 16,733,160	\$ 202,189	\$ 5,052,479	\$ 10,923,037	\$ 555,454	96.68%
Protective Health Services	\$ 61,098,300	\$ 6,709,066	\$ 10,077,475	\$ 41,632,388	\$ 2,679,372	95.61%
Prevention & Preparedness Services	\$ 59,100,035	\$ 1,853,652	\$ 30,988,752	\$ 21,768,665	\$ 4,488,966	92.40%
Health Improvement Services	\$ 22,645,340	\$ 109,162	\$ 4,330,607	\$ 15,973,712	\$ 2,231,859	90.14%
Community & Family Health Services	\$ 233,214,025	\$ 12,295,222	\$ 35,923,219	\$ 178,991,276	\$ 6,004,308	97.43%
<b>Totals:</b>	<b>\$ 392,790,860</b>	<b>\$ 21,169,290</b>	<b>\$ 86,372,532</b>	<b>\$ 269,289,078</b>	<b>\$ 15,959,959</b>	<b>95.94%</b>
<b>&lt; 90%</b>	<b>90% - 95%</b>		<b>95% - 102.5%</b>		<b>102.5% - 105%</b>	<b>&gt;105%</b>

**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**

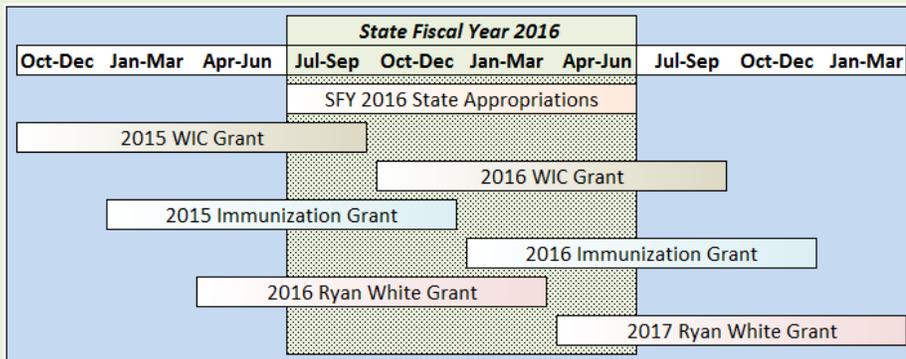
- The amounts reported as 'Not Obligated or Forecasted' are not an estimate of lapsing funds
- Two divisions, Prevention & Preparedness Services and Health Improvement Services, have a "yellow light" status as of September 22, 2015
- The amounts not obligated and not forecasted for these two divisions are due to supplies and equipment purchases budgeted but not yet acquired, contracts that are budgeted and in the process of being encumbered, and budgeted vacant positions that are in the process of being filled

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

**UNDERSTANDING THE BOARD OF HEALTH FINANCE REPORT**

**Variations in Budget Amounts Reported**

- The Oklahoma State Department of Health (OSDH) operates programs that follow various fiscal years
- Finance reports for the Board of Health span the state fiscal year (July – June)
- Most grant funded programs operate on non-state fiscal years
- Reporting on multiple overlapped fiscal years causes small fluctuations in budget amounts reported each month



- A program’s fiscal period is determined by its primary funding source
- The non-state fiscal year is partitioned by state fiscal year
- While the a grant’s budget typically stays static, the amount apportioned to each state fiscal year may be revised

**What is a Forecasted Expenditure?**

- Payroll costs for filled positions
- Estimates for vacant positions that are actively being filled
- Unobligated, but reasonably estimatable future costs
  - Travel reimbursements
  - WIC food instrument payments
  - Trauma fund distributions
  - FQHC reimbursements
- Budgeted amounts for non-state fiscal periods not yet active, example:
  - The 2017 Ryan White grant period begins 4/1/2016
  - Purchase Orders (obligations) for this time period (4/1/2016 – 6/30/2016) have not been processed and there is no method to reasonably estimate these future costs
  - To report this portion of the grant fiscal year budget (4/1/2016 – 6/30/2016) as available would inflate the available resources reported

**What is an Obligation?**

- An obligation is a cost for which there is a reserve on the budget
- This includes:
  - Encumbrances (the balance of a purchase order)
  - Credit card purchase requests
  - Other expenditure transactions in process

**Change in Reported Budget Amount for SFY 2016**

- Before state fiscal year 2016, the reported budget amounts included:
  - Budgeted internal transfers between funds
  - Budgeted program reimbursements for internal service funds
- These transactions are internal and do not represent actual costs
- These transactions represented a duplication of real costs incurred
- For the October 2016 Board Finance Report, the effect of this change is approximately \$23 million

## SECTION 10

# QUARTERLY PERFORMANCE AND OPERATIONAL DASHBOARD

The Oklahoma State Department of Health (OSDH), as part of its ongoing quality improvement efforts, has implemented new software to generate quarterly dashboard reports. The new software reduces manual processes improving the time it takes to create the dashboards and the opportunity for human and transposition errors. As a result you will notice changes to the format and layout of the dashboard report.

During the August strategic planning meeting the BOH decided to form an ad hoc committee to develop new metrics consistent with the revised OSDH strategic map. The Department anticipates some or all of those metrics will be displayed on an updated quarterly dashboard. Further, changes in format and layout are possible with this new software and expected as the ad hoc committee discusses appropriate metrics and desired reporting format.

A summary of the changes you will find on each of the three dashboard pages is listed below:

**Public Health Imperative: Regulatory Measures** – This dashboard contains the same four bar charts as the previous version with the following changes:

- The order in which the bar charts appear has been changed so that the immediate and non-immediate jeopardy complaint charts can be compared side-by-side.
- The scorecard indicator color for these charts was previously a small circle to the left of each chart. It is now a box in the top left corner of each chart with the letters “SC” (for scorecard). The color assignment criteria have **not** changed and are listed in the legend at the bottom of the page.
- Colors used for the bars on the charts has changed

**Public Health Infrastructure: County Health Department Visits** - This dashboard contains the same two line graphs and table as the previous version with the following changes:

- The color of the lines on the graphs has changed
- Numerical values on the Y axis have been abbreviated (i.e., 50k instead of 50,000)
- Year and quarter are listed together on the X axis

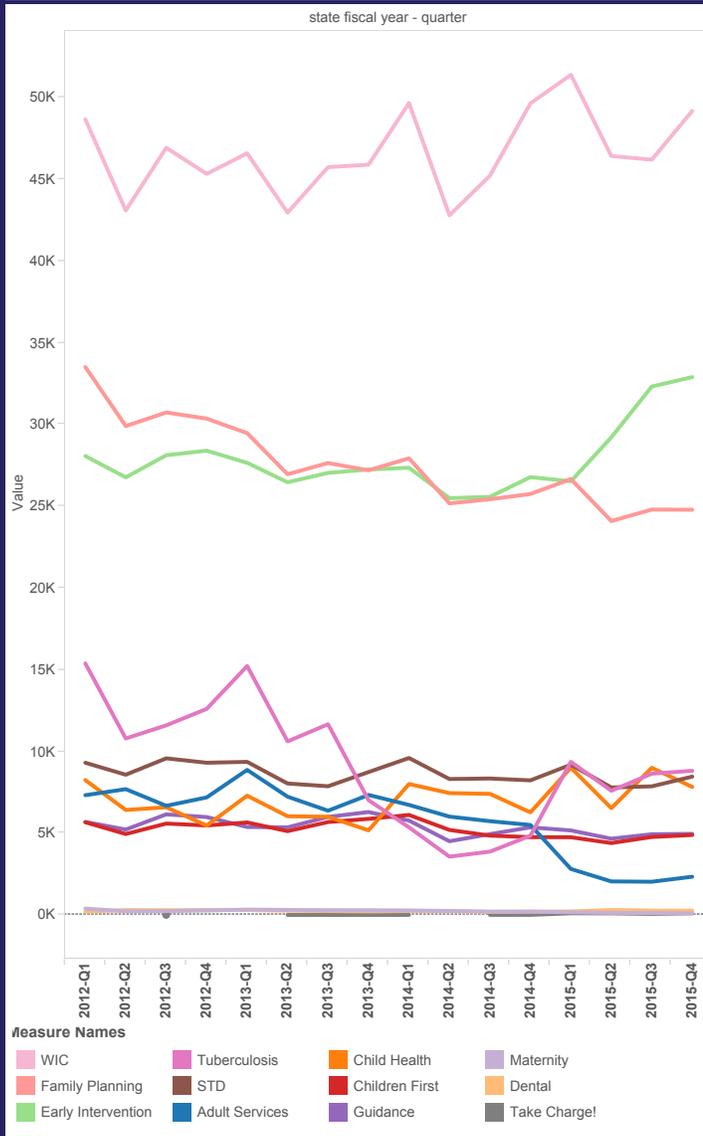
**Public Health Imperative: Infectious Disease Measures** – This dashboard contains the same two bar charts as the previous version with the following changes:

- Colors used for the bars on the charts has changed
- Enteric disease types are listed both below each bar as well as in a color-coded legend
- Number of reports and the estimated investigation time have been combined with the number of specimens into a single table

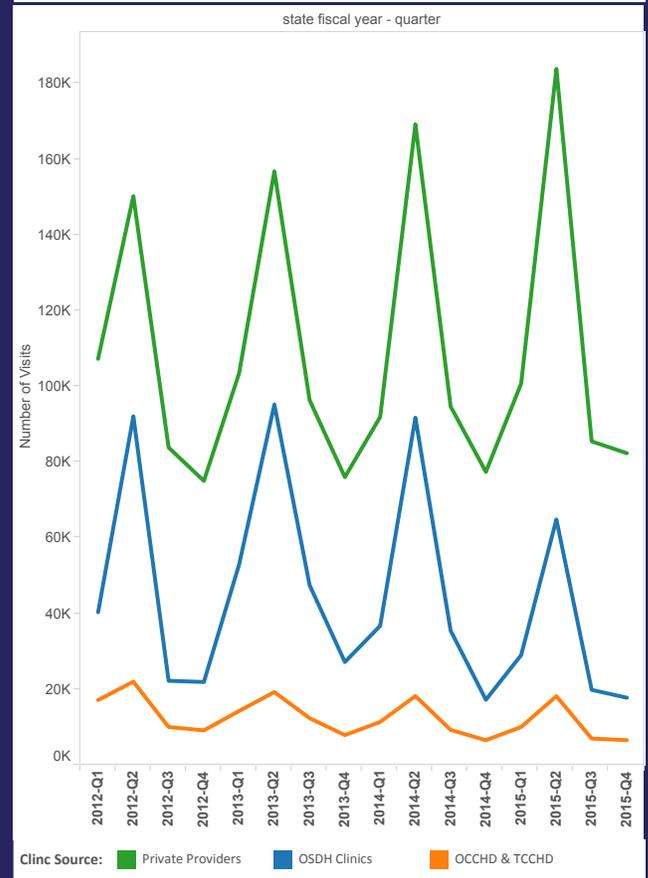
# Oklahoma State Board of Health Dashboard

## Public Health Infrastructure: County Health Department Visits

**Figure 1: Total Visits for OSDH 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 Clinic Services by Quarter**

Quarter	2012	2013	2014	2014-2013 %Change	2015	2015-2014 %Change
Q1	618,208	622,006	582,616	-6.33	563,781	-3.23
Q2	603,648	562,372	550,747	-2.07	541,329	-1.71
Q3	575,867	566,328	514,731	-9.11	492,126	-4.39
Q4	567,115	567,752	520,059	-8.40	486,557	-6.44
<b>Total</b>	<b>2,364,838</b>	<b>2,318,458</b>	<b>2,168,153</b>		<b>2,083,793</b>	

### Explanation of Dashboard

**Figure 1. Total Visits for OSDH Clinics by Quarter.** Notably, there has been an increase in number of client visits for the Early Intervention program. During the past year, they implemented a 10-day rule for their providers to turn in service notes for data entry. This has improved data entry time. Additionally, referrals have increased and some key vacancies have been filled across the state. All three factors have probably contributed to the increase in encounters being reported.

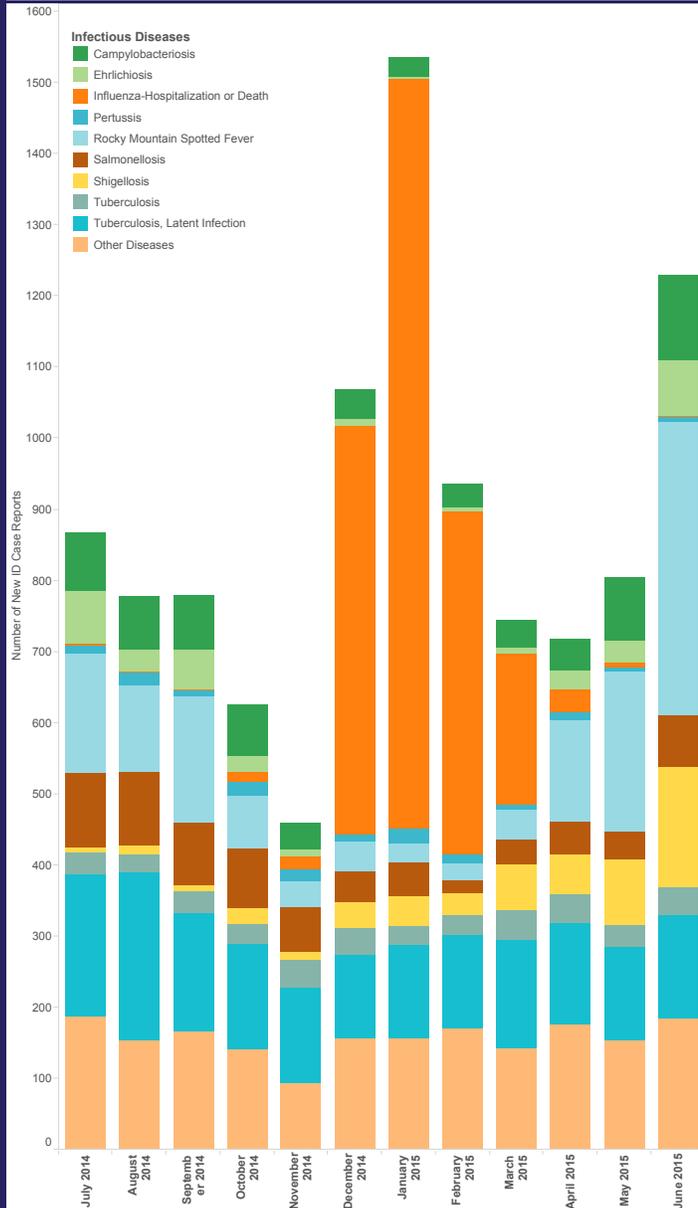
**Figure 2. Total Immunization Visits by Quarter.** The current data shows a decrease in immunizations for OSDH. However, immunizations at private provider clinics has increased, perhaps reflecting increased availability of flu shots at private clinics and drug stores. The strong cyclic data trend continues 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 Clinic Services by Quarter.** Services in county health department clinics have decreased in the 4th quarter of SFY2015 and are projected to slightly increase when final data from several programs have been fully entered for the 1st quarter of SFY 2016.

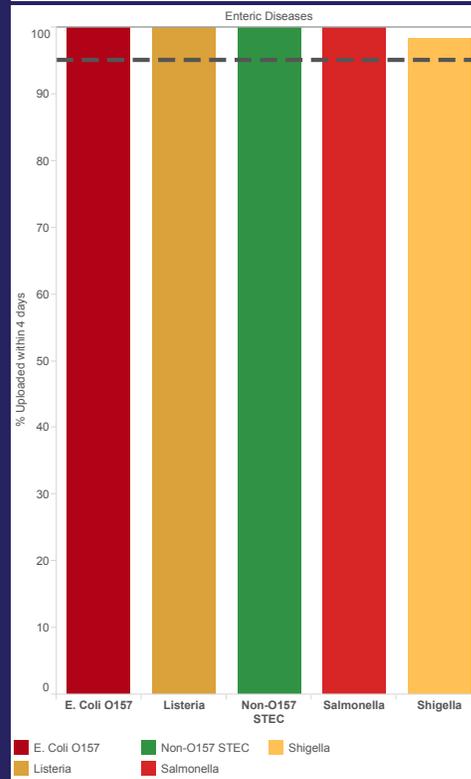
# Oklahoma State Board of Health Dashboard

## 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, July 2014 - June 2015  
Benchmark = 95%



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

Month of Month	# of Rep	Est. Hrs	# Specimens
July 2014	867	1,395	16,165
August 2014	777	1,409	15,919
September 2014	779	1,207	16,128
October 2014	625	1,190	15,976
November 2014	459	1,197	12,196
December 2014	1,069	1,627	14,039
January 2015	1,534	1,004	14,259
February 2015	935	1,010	13,063
March 2015	744	1,122	14,793
April 2015	717	1,190	15,234
May 2015	804	1,197	13,291
June 2015	1,229	1,627	15,310

### Explanation of Dashboard

'Number of New Infectious Disease (ID) Case Reports' shows the new cases of infectious disease received by the Acute Disease Service by month. The 'Number of New Infectious Disease Case Reports' reflect significant seasonal trends. Most notable is the increase of flu case in the winter months of December, January and February. Less dramatic is the increase of tickborne diseases Ehrlichiosis and Rocky Mountain Spotted Fever in the warmer months May - September where increased outdoor activity increases exposure to disease carrying ticks. The increase of the above and other infectious disease reports resulted in an increase in investigation time of ADS epidemiologists and county health department Communicable Disease and Tuberculosis nurses.

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

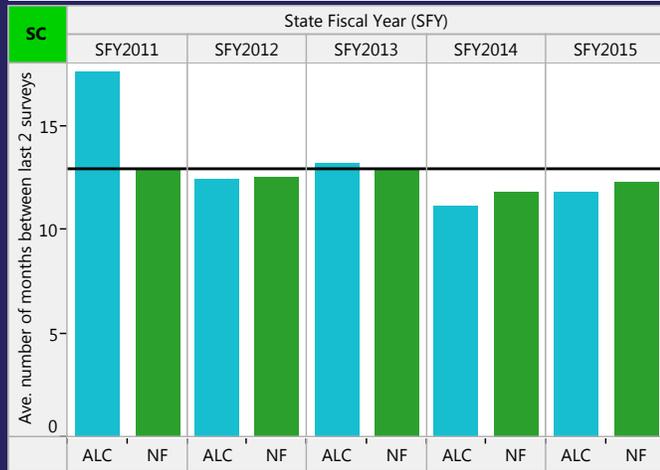
'Percentage of PH Lab Disease Uploaded to PulseNet within 4 Days' indicates that the benchmark of 95% has been met and exceeded for all factored enteric diseases. The overall rate is 99.95% for the uploading of PulseNet within 4 days for SFY 2015.

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

# Oklahoma State Board of Health Dashboard

## Public Health Imperative: Regulatory Measures

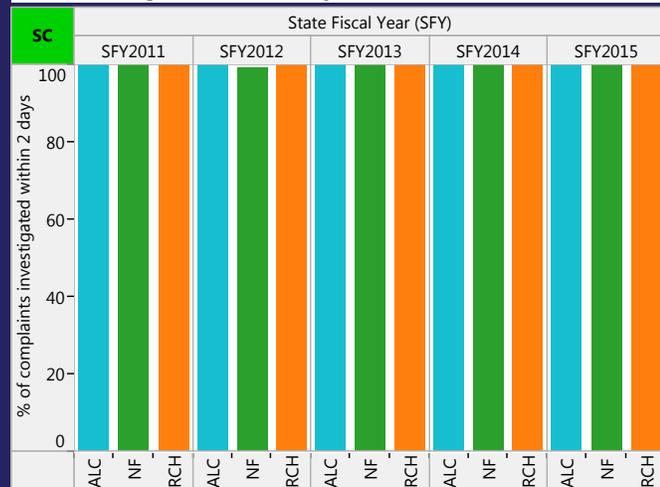
**A. Average Interval Between Inspections for ALCs and NFs is 12.9 months.** 160 Licensed Assisted Living Centers. 302 Licensed Nursing Facilities.



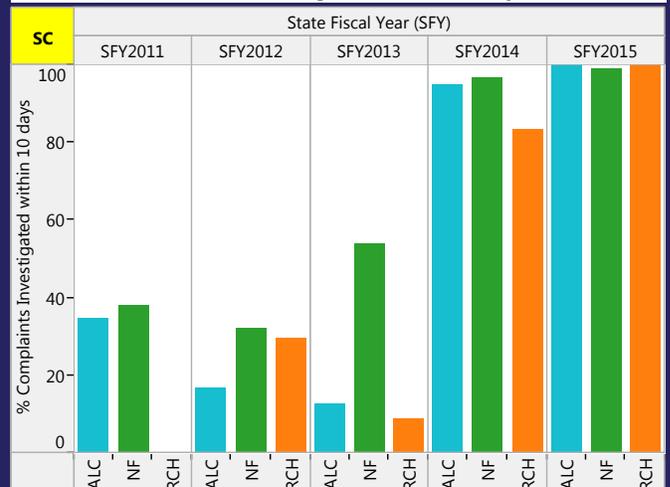
**B. Percentage of Food Service Establishments Inspected at Least Once Per Fiscal Year**



**C. Percent of Immediate Jeopardy Complaints for ALCs, NFs & RCHs Investigated Within 2 Days**



**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 2015 is from July 1, 2014 to June 30, 2015.

Protective Health Services has a "green light" for three of four performance measures by meeting the benchmarks for (a) average interval between inspections for ALCs and NFs, (b) percent of immediate jeopardy complaints for NFs, ALCs, and RCHs, (c) food service establishment inspections.

Non immediate jeopardy-high priority (NIJH) complaints indicate a "yellow light" because of the 100% compliance standard. For this state fiscal year, seven out of 331 nursing facility complaints were investigated in more than 10 days; 324 of 331 were investigated within the 10 day time frame. The average time it takes to initiate a NIJH complaint is currently 6.1 days. For all three facility types, the overall performance rate is 98.2%, with NFs met at 97.8%, ALCs met at 100% and RCHs met at 100%. Under federal contract standards, performance on nursing facility NIJH complaint investigations is considered acceptable at the 95% level.

*Assisted Living Centers (ALCs), Nursing Facilities (NFs), Residential Care Homes (RCHs)*

SC = Score card (upper left corner): Green = Measure is Satisfactory; Yellow = Two Quarters Not Met in Last Year; Red = Shortfall Has Occurred Three Consecu..

SECTION 11  
COMMISSIONER'S REPORT

**OKLAHOMA STATE BOARD OF HEALTH**  
**COMMISSIONER'S REPORT**  
Terry Cline, Ph.D., Commissioner  
October 6, 2015

**PUBLIC RELATIONS/COMMUNICATIONS**

50<sup>th</sup> Anniversary of Oklahoma Health Center Foundation –interview  
Choctaw Nation Regional Health Clinic Groundbreaking  
Jaclyn Cosgrove, Oklahoman – interview  
Fortune Club – speaker  
Governor's State Charitable Campaign Luncheon – attendee  
Oklahoma Immunization Advisory Committee – attendee  
OSU Medical Center Tulsa Community Forum – attendee  
Journal Record Innovation Luncheon – attendee  
College of Public Health New Student Welcome – speaker  
Choctaw Nation Formal MOU Signing – speaker  
Oklahoma Institute for Child Abuse Annual Conference - speaker  
Oklahoma State University Distinguished Alumni - recipient  
50 State Convening to Prevent Opioid Overdose & Addiction, US HHS - speaker

**SITE VISITS**

Bryan County Health Department  
Blaine County Health Department  
Major County Health Department  
Garfield County Health Department  
Logan County Health Department

**STATE/FEDERAL AGENCIES/OFFICIAL**

Governor Fallin's Cabinet Meeting  
No Wrong Door Director's Meeting  
ABD Care Coordination Inter-Agency Steering Group  
Tracey Strader, Exec Director, TSET  
Oklahoma Health Care Authority Strategic Planning Conference - speaker  
COPH Hudson Fellows Committee  
David Boren, President, OU, COPH  
Turning Point Annual Conference – speaker  
Oklahoma Health & Human Services Cabinet Meeting  
Tara Oakman, Robert Wood Johnson Foundation  
Bruce Dart, Exec Director, THD & Gary Cox, Exec Director, OCCHD

**OTHERS:**

Dee Porter, Exec. Director, Primary Care Association  
Terry Taylor, CEO, OK Health Center Foundation  
Oklahoma City County Health Department Board Meeting  
Tulsa County Health Department Board Meeting  
ACGME CLER Committee Meeting  
ASTHO State Health Leadership Institute Orientation  
ASPEN Institute Initiative Kick-off Meeting  
Tribal Public Health Advisory Committee  
OHIP Executive Committee  
OHIP Full Team Meeting  
Scott Mitchell & Stephen Cagle with Tracey Strader - Radio program  
Oklahoma Residential & Assistant Living Association Meeting  
Tulsa Cancer Center of America Tour  
Reforming States Group Steering Committee  
Craig Jones, Exec. Director, Oklahoma Hospital Association  
Junior League of Oklahoma City, Community Advisory Board  
PHAB Executive & Finance Meeting

SECTION 12

PROPOSED 2016 BOARD OF HEALTH MEETING DATES

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

**PROPOSED**

First Quarter

January 12, 2016 (11:00 a.m.)

February 9, 2016 (11:00 a.m.)

March 8, 2016 (11:00 a.m.) County Health Department TBD

Second Quarter

April 12, 2016 (11:00 a.m.)

May 10, 2016 (11:00 a.m.)

June 14, 2016 (11:00 a.m.) County Health Department TBD

Third Quarter

July 12, 2016 (11:00 a.m.)

August 12-14, 2016 (Location TBD)

Fourth Quarter

October 4, 2016 (1:00 p.m. Oklahoma County)

December 13, 2016 (11:00 a.m.)

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