I. CALL TO ORDER AND OPENING REMARKS

II. REVIEW OF MINUTES

   Approval of Minutes for October 4, 2016, Tri-Board Meeting

III. 2017/2018 BOARD OF HEALTH MEETING DATES

   Proposed 2017/2018 Board of Health Meeting Dates (second Tuesday of each month at 11:00 a.m., August 11-12, 2017, August 9-10, 2018, OSU/Stillwater), no meeting September or October of 2017/2018.

IV. APPOINTMENTS

A. Infant and Children's Health Advisory Council Appointment - Dr. Edd Rhoades

   Appointments: One Member
   Authority: 63 O.S., § 1-103a.1(E)
   Members: The Advisory Council shall consist of eight (8) members. Membership is defined in statute. Two members shall be appointed by the Governor, three members shall be appointed by the President Pro Tempore of the Senate, two members shall be appointed by the Speaker of the House, and one member shall be appointed by the State Board of Health. One position is being brought forth for appointment by the State Board of Health.

B. Oklahoma Food Service Advisory Council - Lynnette Jordan

   Appointments: Eight Members
   Authority: 63 O.S., § 1-106.3
   Members: The Advisory Council shall consist of fourteen (14) members. Membership is defined in statute. Nine (9) members shall be appointed by the Commissioner with the advice and consent of the State Board of Health, from a list of three names for each position provided by an association representing the majority of the restaurant owners in the state. One (1) representative from each of the following: Oklahoma School Nutrition Association; Independent Food Service Operator; General Public; Oklahoma Hotel & Motel Industry; Food Service Education; Food Processing Education; Oklahoma's Grocer's Association; Oklahoma Restaurant Association. Eight positions are being brought forth for advice and consent of the State Board of Health.

V. PROPOSED RULEMAKING ACTIONS

Discussion and possible action on the following:

A. CHAPTER 2. HUMANITY OF THE UNBORN CHILD ACT - Donald Maisch

   PROPOSED RULES:
   SUBCHAPTER 31. HUMANITY OF THE UNBORN CHILD ACT [NEW]
   310:2-31-1. Purpose. [NEW]
   310:2-31-2. Definitions. [NEW]
   310:2-31-3. Signage. [NEW]
   310:2-31-4. Language and web portal requirements. [NEW]

   AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. § 1-751 et seq.

   SUMMARY: These proposed regulations, if adopted, will implement the Department’s requirements contained in House Bill Number 2797, from the 2nd Session of the 55th Oklahoma Legislature (2016) known as “Humanity of the Unborn
Child Act" and codified at 63 O.S. § 1-751 et seq. The proposed regulations set forth the requirements to be used by facilities regulated by the Department to place signage in restrooms and other areas in compliance with the Act.

B. CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL - Donald Maisch

PROPOSED RULES:
Subchapter 1. Purpose and Definitions
310:15-1-2. Definitions. [AMENDED]
Subchapter 3. Physician Application and Reporting
310:15-3-1. Physician application. [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. §§ 2-801 through 2-805

SUMMARY: These proposed regulations, if adopted, will implement the agency's requirements from House Bill Number 2835, from the 2nd Session of the 55th Oklahoma Legislature (2016), codified at 63 O.S. §§ 2-801 through 2-805. The proposed regulations would remove the age limitation for clinical trials on the use of cannabidiol as required by the House Bill.

C. CHAPTER 233. BODY PIERCING AND TATTOOING - Dr. Henry F. Hartsell

PROPOSED RULES:
Subchapter 9. License Requirements
310:233-9-2. Artist license [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 21 O.S. Section 842.3

SUMMARY: The proposed amendments modify the proof of training and experience required before an applicant is approved to take the license examination. The proposal deletes the requirement for proof of two years' license from another state, and substitutes a requirement for documentation of two years' experience from another state. The proposal allows a licensure candidate to submit proof of completion of training that is substantially equivalent to the requirements for apprentice programs in Oklahoma. The effect of the change is to give candidates credit for experience or training in a state that does not license artists. The Oklahoma State Department of Health developed the foregoing amendments in response to a request for rulemaking filed by a facility operator and artist licensed in Oklahoma. Additionally, the amendments clarify the process for approving an applicant to take the license examination and issuing the permanent artist license.

D. CHAPTER 512. CHILDHOOD LEAD POISONING PREVENTION - Tina Johnson

PROPOSED RULES:
310:512-1-1 [AMENDED]
310:512-1-2 [AMENDED]
310:512-1-3 [AMENDED]
310:512-1-4 [AMENDED]
Subchapter 3. Specimen Risk Assessment, Screening And Management
310:512-3-1 [AMENDED]
310:512-3-2 [REVOKED]
310:512-3-2.1 [NEW]
310:512-3-3 [AMENDED]
310:512-3-4 [REVOKED]
310:512-3-4.1 [NEW]
310:512-3-5 [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-114.1

SUMMARY: This rule change will add amendatory language for Childhood Lead Poisoning Prevention in order to reflect current practice and modify terminology and definitions to coincide with current language used in the Oklahoma Childhood Lead Poisoning Prevention Program (OCLPPP). In May 2012, the Centers for Disease Control changed the blood lead level at which point certain actions should be initiated from 10 g/dL to 5 g/dL. See CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in “Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention” (https://www.cdc.gov/nceh/lead/acclpp/cdc_response_lead_exposure_recs.pdf).

The OCLPPP informally adopted this change in June 2012 and began offering follow-up services to children at the new lower level. However, sections of the rules regarding blood lead levels were last updated in 1994 and contain the older
E. CHAPTER 515. COMMUNICABLE DISEASE AND INJURY REPORTING - Dr. Kristy Bradley
[PERMANENT]
PROPOSED RULES:
Subchapter 1. Disease and Injury Reporting Requirements
310:515-1-1.1. Definitions [AMENDED]
310:515-1-2. Diseases to be reported
310:515-1-3. Diseases to be reported immediately [AMENDED]
310:515-1-4. Additional diseases, conditions, and injuries to be reported [AMENDED]
310:515-1-6 Additional diseases may be designated [AMENDED]
310:515-1-7 Control of Communicable Diseases Manual [AMENDED]
310:515-1-8 Organisms/specimens to be sent to the Public Health Laboratory [AMENDED] AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. § 1-104; and Title 63 O.S., §§ 1-502 and 1-503
SUMMARY: The proposal updates the existing rules in accordance with recommendations from the Council of State and Territorial Epidemiologists (CSTE), the Centers for Disease Control and Prevention, and local health care partners pertaining to reportable diseases. The proposal amends the lists of reportable diseases, in order to clarify those conditions and diseases that are required to be reported to the Department. The proposal also adds conditions of public health importance that require investigation and implementation of prevention activities. These changes minimally increase the reporting burden placed upon clinicians, have no impact on the reporting burden placed upon laboratories, and do not adversely affect the public health disease control and prevention activities.

The proposal removes the reference to a “non-versioned/non-codified” document which could further specify requirements of reporting. This change will eliminate any possibility of requirements that are not stated in rule. The duplicative requirements at OAC 310:515-1-4(3) (relating to occupational or environmental diseases) are amended by removing the requirements listed here and adding a reference to the amended rules on reporting blood lead levels at OAC 310:512, Childhood Lead Poisoning Prevention Rules. This proposal changes the current reporting guidance for hepatitis C to include persons of all ages, and lowers the alanine aminotransferase (ALT) levels for reporting from 400 to 200. This modification is in accordance with the CSTE case definition for hepatitis C that was revised effective January 1, 2016. Lastly, the proposal will more clearly specify which syphilis tests are required for reporting to the Department.

F. CHAPTER 599. ZOONOTIC DISEASE CONTROL - Dr. Kristy Bradley
[PERMANENT]
PROPOSED RULES:
310:599-1-2. Definitions [AMENDED]
Subchapter 3. Rabies Control
310:599-3-1. Management of dogs, cats, or ferrets that bite a person [AMENDED]
310:599-3-2. Supervising veterinarian’s responsibility [AMENDED]
310:599-3-5. Vaccinated domestic animals exposed to a rabid animal [AMENDED]
310:599-3-6. Unvaccinated domestic animals exposed to a rabid animal [AMENDED]
310:599-3-9. Administration of rabies vaccine [AMENDED] AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. Section 1-508
SUMMARY: The proposal updates the existing rules in accordance with recommendations from the National Association of State Public Health Veterinarians, the Centers for Disease Control and Prevention, and the American Veterinary Medical Association pertaining to animal rabies prevention and control. The proposal will primarily update Subchapter 3, Rabies Control, to align with new scientific findings which indicate that dogs and cats with an out-of-date rabies vaccination status that are exposed to a rabid animal can be effectively managed by immediate vaccination booster and
observation for 45 days similar to the method currently in place for management of currently vaccinated dogs, cats and
terrets that are exposed to a rabid animal (JAVMA, Vol 246, No. 2, January 15, 2015). It has been fifteen years since
these rules were implemented; therefore, minor revisions to the regulations are also needed to update sections for
alignment with current national guidance on animal rabies control and changes in animal rabies vaccine products. With
these changes, the Oklahoma State Department of Health anticipates minor cost savings for animal control departments
and other persons who are charged with enforcement of the rules due to the reduced time period of observation and
degree of follow up needed for dogs and cats with an overdue rabies vaccination status that are exposed to a rabid
animal. Some Oklahoma pet owners will benefit from the proposal due to a reduction of emotional and financial costs
because fewer dogs and cats exposed to a rabid animal will be required to be euthanized or undergo a six (6) month
veterinary supervised quarantine.

VI. STRATEGIC MAP UPDATE PRESENTATION
Tina Johnson, M.P.H., R.N., Deputy Commissioner, Community and Family Health Services; Keith Reed, RN, MPH, CPH,
Regional Director County Health Departments

VII. REVIEW OF ETHICS COMMISSION REQUIREMENTS
Donald D. Maisch, J.D., General Counsel, Oklahoma State Department of Health

VIII. ZIKA VIRUS AND MUMPS BRIEFING
Kristy K. Bradley, DVM, MPH, State Epidemiologist

IX. CONSIDERATION OF STANDING COMMITTEES’ REPORTS AND ACTION
A. Executive Committee - Ms. Burger, Chair
Discussion and possible action on the following: Update

B. Finance Committee - Ms. Hart-Wolfe, Chair
Discussion and possible action on the following: Update

C. Accountability, Ethics, & Audit Committee - Dr. Grim, Chair
Discussion and possible action on the following:
Update;
2017 Audit Plan

D. Public Health Policy Committee - Dr. Stewart, Chair
Discussion and possible action on the following: Update

X. PRESIDENT’S REPORT
Discussion and possible action

XI. COMMISSIONER’S REPORT
Discussion and possible action

XII. NEW BUSINESS
Not reasonably anticipated 24 hours in advance of meeting.

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

* Annual performance evaluation for the Office of Accountability Systems Director & Internal Audit Unit Director, and Board of
Health Secretary
Possible action taken as a result of Executive Session.

XIV. ADJOURNMENT
OKLAHOMA STATE BOARD OF HEALTH  
DECEMBER 13, 2016

OCTOBER 6, 2016 TRI-BOARD MEETING MINUTES

2017 / 2018 BOARD OF HEALTH MEETING DATES AND BOARD WORK CALENDAR

APPOINTMENTS

INFANT AND CHILDREN’S HEALTH ADVISORY COUNCIL APPOINTMENT
OKLAHOMA FOOD SERVICE ADVISORY COUNCIL APPOINTMENT

PROPOSED RULEMAKING

CHAPTER 2. HUMANITY OF THE UNBORN CHILD ACT [NEW]
CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL [AMENDED]
CHAPTER 233. BODY PIERCING AND TATTOOING [AMENDED]
CHAPTER 512. CHILDHOOD LEAD POISONING PREVENTION [AMENDED]
CHAPTER 515. COMMUNICABLE DISEASE AND INJURY REPORTING [AMENDED]
CHAPTER 599. ZOONOTIC DISEASE CONTROL [AMENDED]

STRATEGIC MAP UPDATE PRESENTATION

REVIEW OF ETHICS COMMISSION REQUIREMENTS

ZIKA VIRUS AND MUMPS BRIEFING

FINANCE COMMITTEE REPORT

QUARTERLY PERFORMANCE AND OPERATIONAL DASHBOARD

2017 AUDIT PLAN

COMMISSIONER’S REPORT
CALL TO ORDER AND OPENING REMARKS

REVIEW OF MINUTES
Approval of Minutes for October 4, 2016, Tri-Board Meeting

2017/2018 BOARD OF HEALTH MEETING DATES
Proposed 2017/2018 Board of Health Meeting Dates (second Tuesday of each month at 11:00 a.m., August 11-12, 2017, August 9-10, 2018, OSU/Stillwater), no meeting September or October of 2017/2018.

APPOINTMENTS
A. Infant and Children's Health Advisory Council Appointment - Dr. Edd Rhoades
   Appointments: One Member
   Authority: 63 O.S., § 1-103a.1(E)
   Members: The Advisory Council shall consist of eight (8) members. Membership is defined in statute. Two members shall be appointed by the Governor, three members shall be appointed by the President Pro Tempore of the Senate, two members shall be appointed by the Speaker of the House, and one member shall be appointed by the State Board of Health. One position is being brought forth for appointment by the State Board of Health.

B. Oklahoma Food Service Advisory Council - Lynnette Jordan
   Appointments: Eight Members
   Authority: 63 O.S., § 1-106.3
   Members: The Advisory Council shall consist of fourteen (14) members. Membership is defined in statute. Nine (9) members shall be appointed by the Commissioner with the advice and consent of the State Board of Health, from a list of three names for each position provided by an association representing the majority of the restaurant owners in the state. One (1) representative from each of the following: Oklahoma School Nutrition Association; Independent Food Service Operator; General Public; Oklahoma Hotel & Motel Industry; Food Service Education; Food Processing Education; Oklahoma's Grocer's Association; Oklahoma Restaurant Association. Eight positions are being brought forth for advice and consent of the State Board of Health.

PROPOSED RULEMAKING ACTIONS
Discussion and possible action on the following:

A. CHAPTER 2. HUMANITY OF THE UNBORN CHILD ACT - Donald Maisch
   [PERMANENT]
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   SUBCHAPTER 31. HUMANITY OF THE UNBORN CHILD ACT [NEW]
   310:2-31-1. Purpose. [NEW]
   310:2-31-2. Definitions. [NEW]
   310:2-31-3. Signage. [NEW]
   310:2-31-4. Language and web portal requirements. [NEW]
   AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. § 1-751 et seq.

   SUMMARY: These proposed regulations, if adopted, will implement the Department's requirements contained in House Bill Number 2797, from the 2nd Session of the 55th Oklahoma Legislature (2016) known as “Humanity of the Unborn
Child Act" and codified at 63 O.S. § 1-751 et seq. The proposed regulations set forth the requirements to be used by facilities regulated by the Department to place signage in restrooms and other areas in compliance with the Act.

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AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. §§ 2-801 through 2-805
SUMMARY: These proposed regulations, if adopted, will implement the agency’s requirements from House Bill Number 2835, from the 2nd Session of the 55th Oklahoma Legislature (2016), codified at 63 O.S. §§ 2-801 through 2-805. The proposed regulations would remove the age limitation for clinical trials on the use of cannabidiol as required by the House Bill.

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310:512-1-1 [AMENDED]
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310:512-1-4 [AMENDED]
Subchapter 3. Specimen Risk Assessment, Screening And Management
310:512-3-1 [AMENDED]
310:512-3-2 [REVOKED]
310:512-3-2.1 [NEW]
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310:512-3-4 [REVOKED]
310:512-3-4.1 [NEW]
310:512-3-5 [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-114.1
SUMMARY: This rule change will add amendatory language for Childhood Lead Poisoning Prevention in order to reflect current practice and modify terminology and definitions to coincide with current language used in the Oklahoma Childhood Lead Poisoning Prevention Program (OCLPPP). In May 2012, the Centers for Disease Control changed the blood lead level at which point certain actions should be initiated from 10 g/dL to 5 g/dL. See CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in “Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention” (https://www.cdc.gov/nceh/lead/acclpp/cdc_response_lead_exposure_recs.pdf).

The OCLPPP informally adopted this change in June 2012 and began offering follow-up services to children at the new lower level. However, sections of the rules regarding blood lead levels were last updated in 1994 and contain the older...
reference level. The current rules also have ambiguous language and outdated procedures and terms such as "environmental assessments" versus "environmental investigations."

The most significant changes will be to update the definitions of elevated blood lead levels and to further clarify the role of the laboratories and providers in reporting lead results. Lead results are reportable pursuant to Title 63 O.S. Sections 1-114.1 and § 1-503 and the Reportable Disease Rules, OAC 310-515.

The changes re-structure the order of some items to put them into more logical categories. This is part of OCLPPP’s overall effort to make the rules more accessible, understandable, and usable without altering their sense, meaning, or effect. Some sections have been reclassified and rearranged in a more logical order, removing language that is invalid, repealed or duplicative to improve the draftsmanship of the rule. New technologies (Point-of-Care devices, electronic reporting capabilities) are incorporated to make screening and reporting easier.

E. CHAPTER 515. COMMUNICABLE DISEASE AND INJURY REPORTING - Dr. Kristy Bradley

[PERMANENT]

PROPOSED RULES:

Subchapter 1. Disease and Injury Reporting Requirements
310:515-1-1. Definitions [AMENDED]
310:515-1-2. Diseases to be reported
310:515-1-3. Diseases to be reported immediately [AMENDED]
310:515-1-4. Additional diseases, conditions, and injuries to be reported [AMENDED]
310:515-1-6 Additional diseases may be designated [AMENDED]
310:515-1-7 Control of Communicable Diseases Manual [AMENDED]
310:515-1-8 Organisms/specimens to be sent to the Public Health Laboratory [AMENDED] AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. § 1-104; and Title 63 O.S., §§ 1-502 and 1-503

SUMMARY: The proposal updates the existing rules in accordance with recommendations from the Council of State and Territorial Epidemiologists (CSTE), the Centers for Disease Control and Prevention, and local health care partners pertaining to reportable diseases. The proposal amends the lists of reportable diseases, in order to clarify those conditions and diseases that are required to be reported to the Department. The proposal also adds conditions of public health importance that require investigation and implementation of prevention activities. These changes minimally increase the reporting burden placed upon clinicians, have no impact on the reporting burden placed upon laboratories, and do not adversely affect the public health disease control and prevention activities.

The proposal removes the reference to a “non-versioned/non-codified” document which could further specify requirements of reporting. This change will eliminate any possibility of requirements that are not stated in rule. The duplicative requirements at OAC 310:515-1-4(3) (relating to occupational or environmental diseases) are amended by removing the requirements listed here and adding a reference to the amended rules on reporting blood lead levels at OAC 310:512, Childhood Lead Poisoning Prevention Rules. This proposal changes the current reporting guidance for hepatitis C to include persons of all ages, and lowers the alanine aminotransferase (ALT) levels for reporting from 400 to 200. This modification is in accordance with the CSTE case definition for hepatitis C that was revised effective January 1, 2016. Lastly, the proposal will more clearly specify which syphilis tests are required for reporting to the Department.

F. CHAPTER 599. ZOONOTIC DISEASE CONTROL - Dr. Kristy Bradley

[PERMANENT]

PROPOSED RULES:

310:599-1-2. Definitions [AMENDED]
Subchapter 3. Rabies Control
310:599-3-1. Management of dogs, cats, or ferrets that bite a person [AMENDED]
310:599-3-2. Supervising veterinarian’s responsibility [AMENDED]
310:599-3-5. Vaccinated domestic animals exposed to a rabid animal [AMENDED]
310:599-3-6. Unvaccinated domestic animals exposed to a rabid animal [AMENDED]
310:599-3-9. Administration of rabies vaccine [AMENDED]

AUTHORITY: Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. Section 1-508

SUMMARY: The proposal updates the existing rules in accordance with recommendations from the National Association of State Public Health Veterinarians, the Centers for Disease Control and Prevention, and the American Veterinary Medical Association pertaining to animal rabies prevention and control. The proposal will primarily update Subchapter 3, Rabies Control, to align with new scientific findings which indicate that dogs and cats with an out-of-date rabies vaccination status that are exposed to a rabid animal can be effectively managed by immediate vaccination booster and
observation for 45 days similar to the method currently in place for management of currently vaccinated dogs, cats and ferrets that are exposed to a rabid animal (JAVMA, Vol 246, No. 2, January 15, 2015). It has been fifteen years since these rules were implemented; therefore, minor revisions to the regulations are also needed to update sections for alignment with current national guidance on animal rabies control and changes in animal rabies vaccine products. With these changes, the Oklahoma State Department of Health anticipates minor cost savings for animal control departments and other persons who are charged with enforcement of the rules due to the reduced time period of observation and degree of follow up needed for dogs and cats with an overdue rabies vaccination status that are exposed to a rabid animal. Some Oklahoma pet owners will benefit from the proposal due to a reduction of emotional and financial costs because fewer dogs and cats exposed to a rabid animal will be required to be euthanized or undergo a six (6) month veterinary supervised quarantine.

VI. STRATEGIC MAP UPDATE PRESENTATION
Tina Johnson, M.P.H., R.N., Deputy Commissioner, Community and Family Health Services; Keith Reed, RN, MPH, CPH, Regional Director County Health Departments

VII. REVIEW OF ETHICS COMMISSION REQUIREMENTS
Donald D. Maisch, J.D., General Counsel, Oklahoma State Department of Health

VIII. ZIKA VIRUS AND MUMPS BRIEFING
Kristy K. Bradley, DVM, MPH, State Epidemiologist

IX. CONSIDERATION OF STANDING COMMITTEES’ REPORTS AND ACTION
A. Executive Committee - Ms. Burger, Chair
   Discussion and possible action on the following: Update

B. Finance Committee - Ms. Hart-Wolfe, Chair
   Discussion and possible action on the following: Update

C. Accountability, Ethics, & Audit Committee - Dr. Grim, Chair
   Discussion and possible action on the following:
   Update:
   2017 Audit Plan

D. Public Health Policy Committee - Dr. Stewart, Chair
   Discussion and possible action on the following: Update

X. PRESIDENT’S REPORT
Discussion and possible action

XI. COMMISSIONER’S REPORT
Discussion and possible action

XII. NEW BUSINESS
Not reasonably anticipated 24 hours in advance of meeting.

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

* Annual performance evaluation for the Office of Accountability Systems Director & Internal Audit Unit Director, and Board of Health Secretary
   Possible action taken as a result of Executive Session.

XIV. ADJOURNMENT
CALL TO ORDER
Dr. Stephen Cagle, Oklahoma City-County Board of Health Chair, called the Tri-Board meeting to order on Tuesday, October 4, 2016 at 1:03 p.m. The final agenda was posted on October 3, 2016 on respective Board websites as well the building entrance on October 3, 2016 at 1:00 p.m.

OCCBH BOARD MEMBERS PRESENT: Dr. Stephen Cagle, Dr. Gary Raskob, Dr. Timothy Hill, Erika Lucas and Dr. Courtney Gray arrived at 1:08 pm.

OCCHD STAFF PRESENT: Gary Cox, Bob Jamison, Myron Coleman, Tony Miller, Jackie Shawnee, Shannon Welch, Laura Holmes, Phil Maytubby, Dave Cox, John Gogets and Patrick McGough.

TCCBH MEMBERS PRESENT: Kian Kamas, Bill Schloss

THD STAFF PRESENT: Dr. Bruce Dart, Karla Benford, Terri Cooper, Priscilla Haynes, Pam Rask, Reggie Ivey, Scott Buffington, Elizabeth Nutt, Kelly Vanbuskirk, Kaitlin Snider

OSBH MEMBERS PRESENT: Martha Burger, M.B.A., President; Cris Hart-Wolfe, Vice-President; Robert S. Stewart, M.D. Secretary-Treasurer, Charles W. Grim, D.D.S.; R. Murali Krishna, M.D.,(absent at 1:43 pm)

OSBH MEMBERS ABSENT: Jenny Alexopulos, D.O.; Terry Gerard, D.O.; Timothy E. Starkey, M.B.A.; Ronald Woodson, M.D.

OSDH STAFF PRESENT: Terry Cline, Commissioner; Henry F. Hartsell, Deputy Commissioner Protective Health Services; Carter Kimble, Director of Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director of Internal Audit and Office of Accountability Systems; Tony Sellars, Office of Communications; Deborah Nichols, Chief Operating Officer; VaLauna Grissom, Secretary to the State Board of Health.

Visitors in attendance: (see sign in sheet)

OPENING REMARKS, INTRODUCTIONS
Dr. Cagle thanked the Oklahoma State Department of Health and department leads and the Tulsa Health Department and their department leads for coming. Ms. Kamas, Vice-Chair for the Tulsa City-County Board of Health, welcomed each and thanked the OCCHD for hosting as well. Martha Burger, President of the OSBH, on behalf of the entire Board and Department, thanked the OCCBH for hosing the annual Tri-Board meeting.
OKLAHOMA STATE BOARD OF HEALTH MINUTES                              October 4, 2016

REVIEW OF MINUTES – OCCBH
Dr. Stephen Cagle entertained a motion to approve the September 20, 2016 meeting minutes. A motion was made by Dr. Timothy Hill. Dr. Gary Raskob seconded this motion. Vote taken: Dr. Stephen Cagle, Dr. Gary Raskob, Dr. Courtney Gray, Dr. Timothy Hill and Erika Lucas. Motion carried.

REVIEW OF TCCBH
Review and approval of minutes for September 21, 2016 were tabled due to a lack of quorum.

REVIEW OF MINUTES – OSBH
Martha Burger directed attention toward approval of the Minutes for August 12-13, 2016. Dr. Grim moved Board approval of the August 12-13, 2016 meeting minutes as presented. Second Dr. Krishna. Motion Carried.

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

HEALTH DEPARTMENT UPDATES
Gary Cox, J.D. (OCCHD), Bruce Dart, Ph.D. (THD), Terry Cline, Ph.D. (OSDH)
Gary Cox, presented OCCHD 2016: A Year in Review.
• Expanded social media reach with Spanish page to make citizens more aware of activities and resources available in OKC and to better connect with partners.
• Grew the Wellness Now Coalition membership to better engage the faith community.
• Highlighted Unity Conference with the faith community, where 150 individuals from multiple sectors (elected officials past & present, faith, police) joined the conversation on how to unify all races and prevent violence in our community.
• Highlighted the launch of the Mobile Market that will serve food desert areas of the community.
• Highlighted the successful Family Fun Day at the NE Regional Health and Wellness Campus sports fields with over 500 community members enjoying activities of various types among some of those were with the Energy soccer players.
• Highlighted the Open Streets Spring event that had over 40,000 community members being active in closed down streets, and the already scheduled Fall Open Streets event being held on October 23rd in South Oklahoma City.
• Highlighted them of the Grand Opening of Blue Cross Blue Shield of Oklahoma community sports fields located at the NE Regional Health and Wellness Campus.
• South OKC increased poor health outcomes.
• Importance of partnerships: S Oaks campus includes OCCHD, City of OKC, OCCC, UCO, primary care & behavioral health providers.
• Adjacent to Parmalee Elementary, emphasizing the importance of whole child, whole school, whole community model.
• Highlighted importance of engaging Hispanic community and getting resources to those families in need.
• Conducted open house with trusted partners in South OKC to promote the resources available to residents with over 300 in attendance.
• Education partnerships are a strong focus of OCCHD; higher graduation rates leads to a healthier community.
• Further integrated our work with OKCPS to include training of nurses to operate like Nurse Case Managers instead of tasks like handing out bandages.
• Use of Community Health Workers to divert frequent users of the Emergency Department to more appropriate areas of accessing services to meet their needs has proven very successful and a huge cost savings for the hospital system.

See Attachment A

Bruce Dart, Ph.D. presented on “Community Health Improvement Planning (‘CHIP’) and Leveraging the Social Determinants of Health”

• Review of multi-step approach including CHNA, focus groups, stakeholder meetings.
• Review of the recently completed CHNA; quantitative data overview (79-question survey to 2400 residents in 8 regions).
• Review of the focus groups: participants were recruited by a third party vendor and a mixed demographic.
• Review of focus group’s top health concerns (access, obesity, maternal health services) and top barriers (access to care related to ACA, lack of easily accessible walking/biking trails).
• Review of CHNA top health concern compared to focus group concerns.
• CHIP: Aim to improve the health and well-being of Tulsa residents, development of the CHIP, steering committee and task force members, community partners followed by putting the process in front of the community to get their feedback and buy-in; Components: local and current data, objective and measurable indicators that are reported annually.
• Deliberate focus on what the SDOH really means and how they are included in improving the community's health status (poverty, education, housing).
• Addressing SDOH by thinking 'upstream' before they become downstream.
• Narrowing 15 health concerns to 5 (burden and preventability exercise): lack of education; poor diet/inactivity; access to healthy foods/grocery stores; access to healthcare; teen pregnancy.
• Ability to change top 5 concerns to 2 main priorities: lack of education and access to health resources.
• What is the ability to change versus what is the health impact?
• What does health impact and community health really mean?
• Breaking priorities down into task forces: lack of education (health literacy; nutrition, physical activity, health education) and access to health resources (decrease sidewalk "gap" and increase the number of grocery stores in underserved areas).
• Next steps: task force meetings; research and gather information on priority; develop measurable goals; implement the CHIP.

See Attachment B

Dr. Cline provided an overview of budget priorities for SFY 2018. He began with a summary of core public health services outlining top priorities in Community and Family Health Services, Protective Health Services, Health Improvement Services and within the Office of the State Epidemiologist. Dr. Cline walked through a history of state appropriations to the OSDH over time, reductions to state appropriations over time and the impacts of those reductions. Additionally, Dr. Cline walked through reductions in federal funding to the OSDH over time further exacerbating the impacts of state reductions. Finally, Dr. Cline highlighted the priorities of the SFY 2018 Budget Request.

See Attachment C

All three Boards provided unanimous support for the SFY 2018 Budget Request.
LEGISLATIVE PRIORITIES PRESENTATION
Carter Kimble, Director, Office of State and Local Policy, Oklahoma State Department of Health
See Attachment D

OSBH Board members provided unanimous support and consent for the legislative agenda as presented. Board members provided unanimous support for updated language to the previously adopted Cigarette Tax Resolution.

Dr. Stephen Cagle asked for a motion from the Oklahoma City County Board of Health to adopt the policy agenda priorities as presented. Dr. Timothy Hill made the first motion and Mary Mélon seconded this motions. Roll call: Dr. Stephen Cagle, Dr. Courtney Gray, Dr. Timothy Hill, Mary Mélon, Dr. William Mills, Dr. Gary Raskob. Scott Mitchell nay, Dr. Lois Salmeron and Dr. J. Don Harris were absent for vote. Motion Carried.

Dr. Bruce Dart indicated the Tulsa Board of Health would consider the adoption of the policy agenda priorities as presented at the next Board meeting.

CHAIRMAN’S REPORT - OCCBH
Dr. Stephen Cagle spoke of the continued efforts between OCCHD and the Latino Community Development Agency (LCDA) in South OKC. He informed everyone that the Mobile Market truck will be ready to launch in the spring of 2017 and is available to view outside. The NERHW Campus video with Mayor Cornett and the Wellness Now Coalition Video were shown.

CHAIRMAN’S REPORT- TCCBH
Ms. Kamas deferred her report to the next Board meeting.

PRESIDENT’S REPORT – OSBH
Ms. Burger provided a brief update of the State Board of Health retreat. She thanked all the partners who contributed to a very productive retreat. The Board spent a considerable amount of time in review of budget cuts and the impact to Department services. The result was a reprioritization of strategic map efforts for the upcoming year. Proposed 2017 meeting dates tabled due to lack of quorum and will be considered at upcoming meeting.

NEW BUSINESS
No new business.

ADJOURNMENT
OCCBH
Dr. Stephen Cagle thanked the Oklahoma State Health Department and the Tulsa County Health Department for attending and asked for a vote to adjourn. Vote taken: Dr. Stephen Cagle, Dr. Gary Raskob, Dr. Courtney Gray, Dr. Timothy Hill and Erika Lucas. Motion carried.

TCCBH
Ms. Kian Kamas thanked both Board and Departments for participation and looks forward to TCCBH hosting in 2017 in Tulsa.

OSBH
Dr. Stewart moved board approval to adjourn. Second Dr. Grim. Motion Carried
AYE: Burger, Grim, Stewart, Wolfe
ABSENT: Alexopulos, Gerard, Krishna (absent for adjournment) Starkey, Woodson

The meeting adjourned by unanimous consent at 2:52 p.m.

Approved

____________________
Martha Burger
President, Oklahoma State Board of Health
December 13, 2016
OCCHD Year in Review:
Importance of Partners

OCCHD Year in Review:
Community Engagement

OCCHD Year in Review:
South OKC

OCCHD Year in Review:
Hospital Pilot

Cohort 1:
- 42 Clients Enrolled
- 30% reduction in emergency room utilization and tobacco use

75% reduction in client direct costs
Total Client Cost Savings: $614,839.37
Average financial outcome: $5,716.59 cost savings per client
“If you want to go fast, go alone. If you want to go far, go together”

-African Proverb
Community Health Improvement Planning and Leveraging the Social Determinants of Health

The Tulsa County CHIP

Bruce Dart, Ph.D.
October 4, 2016

CHIP Process

Multi-step Approach
- CHNA
- Focus Groups
- Stakeholder Meetings
- Task Force Meetings
- CHIP Development and Implementation

Quantitative Data Overview
- 79 question survey to over 2,400 residents conducted by OSU in summer 2015
  - Health status
  - Healthy behaviors
  - Health perceptions
- Data analyzed by region based on zip codes and commonly recognized communities
  - Downtown
  - East Tulsa
  - Jenks/Bixby/Glenpool/Tulsa Hills
  - Midtown
  - Tulsa North
  - Owasso/Sperry/Skiatook/Collinsville
  - Sand Springs/west Tulsa
  - South Tulsa/Broken Arrow

Focus Groups
- Sixteen (16) 1 ½ hour focus group sessions were conducted between April 11-28, 2016.
- Two focus group sessions were conducted for each of the eight (8) CHNA regions.
- Respondents were recruited by a third party vendor via telephone and e-mail by zip code.
- For each group, 8 respondents were recruited in planning for 6-8 to attend each session.
- Respondent requirements included a mix of gender, age, race and ethnicity and household income levels.
- Each participant was provided a $100 Visa gift card

Focus Groups

Top Health Concerns
1. Affordability and access to quality healthcare
2. Obesity and link to chronic diseases
3. Mental health services
4. Elderly care
5. Lack of health education

Barriers
1. Access to care issues related to ACA
2. Life style stressors
3. Lack of easily accessible walking/biking paths and nutritious foods
4. High level of poverty
5. Oklahoma budget crisis
Community Concerns Snapshot

**CHNA Top 5 Concerns**
1. Poor Diet / Inactivity
2. Chronic Diseases
3. Alcohol / Drug Abuse
4. Access to Healthcare
5. Tobacco Use

**Focus Group Top 5 Concerns**
1. Affordability and access to quality healthcare
2. Obesity and link to chronic diseases
3. Mental health services
4. Elderly care
5. Lack of health education

CHIP – Community Health Improvement Plan

- **AIM**: Improve the health and well-being of Tulsa residents
- Development: Core Team, THD facilitators and project managers
- Steering Committee and Task Force Members: Partners representing the communities they serve
  - Commitment Letters Signed

CHIP Components

- Local and current data driven
  - Quantitative & Qualitative
  - On-going
- Objective measurable indicators that are reported annually
- Overriding circumstances: Health Equity/Social Economics

Using the CHIP to Impact Social Determinants of Health

Using the CHIP to Impact Social Determinants of Health – Think ‘Upstream’

Narrowing the Health Concerns: 15 Concerns to 5 Concerns

**Burden / Preventability Exercise**
- Individual sticker exercise
- Metrics assigned to each quadrant and axis
- Scores calculated for each dot
- Aggregate scores → Top 5 Focus Areas
Burden / Preventability Results

1. Lack of Education
2. Poor diet / Inactivity
3. Access to Healthy Foods / Groceries
4. Access to Healthcare
5. Teen Pregnancy

Preventability

Burden

Ability to Change/Health Impact:

From 5 concerns to 2 priorities

- Instead of “Burden / Preventability,” we now consider “Ability to Change / Health Impact”
- Ability to Change: To what degree is it feasible that the partners in our community have the control and influence to make the changes necessary to see improvement in this focus area?
- Health Impact: If improved, to what degree would this focus area improve overall community health?

Priority Health Topics Exercise

CHIP Priorities

- Access to Clinical Healthcare
- Access to Healthy Foods and Environments
- Reduction of access barriers

Set goals that are achievable and measured annually

- Decrease the sidewalk “gap” by 10% each year over 3 years.
- Increase the number of grocery stores in underserved areas by 2
Vision Statement

The Tulsa County CHIP is a collaborative effort among numerous partner organizations and individuals. Its mission is to improve the health of all Tulsa County residents, through collaboration to solve complex public health issues that cannot be solved by any single organization. The Tulsa County CHIP envisions a community that provides ample opportunities for good health for all residents, regardless of their race, ethnicity, income level, or the neighborhood in which they live.

Next Steps...

- Task Force meetings
- Research, gather information on priority
- Develop goals/activities to measure the CHIP annually
- Implement the CHIP

Questions?
Budget Priorities

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

Public Health Core Services

- Community and Family Health Services
- Office of the State Epidemiologist
- Protective Health Services
- Health Improvement Services

- County Health Departments
- Early Childhood Programs
- Maternal and Child Health
- Dental Health
- Long-Term Care
- Medical Facilities
- Community Health Services
- Injury Prevention Services
- Injury Prevention

- Tobacco Use Prevention & Cessation
- Obesity Reduction & Prevention
- Primary Care and Rural Health Development
- Health Care Information

OSDH SFY 2017 Total Budget by Revenue Source

State $312,383,093
Local $1,73,848
Federal $76,582
State Infrastructure $1,242,691
Fed. Qualified Health Centers (FQHC) $89,384
Uncompensated Care $741,051
Cord Blood Bank $500,000
Strategic Planning (STEP-UP) Software $220,000
Dental Health Education Services $220,000
Colorectal Cancer Screening $200,000
Ryan White Part B $786,000
Oklahoma Athletic Commission $14,000
Total $4,243,273

OSDH SFY 2017 State Appropriation by Program

Administration $312,383,093
Community & Family Health Services $1,242,691
Health Improvement Services $89,384
Office of the State Epidemiologist $741,051
Protective Health Services $500,000
Athletic Commission $14,000

Total $4,243,273

OSDH State Appropriation History

SFY 2009 – SFY 2017

SFY 16 Revenue Failure – 7%
OSDH Infrastructure ($52,364,854)
Federally Qualified Health Centers (FQHC) $237,160
Maternal & Child Health Programs (MCH) $220,000
Uncompensated Care $216,525

SFY 17 Appropriation Reduction – 2.5%
OSDH Infrastructure ($52,364,854)
Federally Qualified Health Centers (FQHC) $213,763
Maternal & Child Health Programs (MCH) $216,525
Uncompensated Care $204,894

SFY 2016, 2017 & Potential 2018 State Reductions

<table>
<thead>
<tr>
<th>Program</th>
<th>SFY 2016 Reduction</th>
<th>SFY 2017 Reduction</th>
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<tbody>
<tr>
<td>Federally Qualified Health Centers (FQHC)</td>
<td>$220,000</td>
<td>$220,000</td>
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<tr>
<td>Maternal &amp; Child Health Programs (MCH)</td>
<td>$220,000</td>
<td>$220,000</td>
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<tr>
<td>Uncompensated Care</td>
<td>$216,525</td>
<td>$204,894</td>
</tr>
<tr>
<td>Oklahoma Athletic Commission</td>
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<td>$3,016</td>
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<tr>
<td>Rural Native Health Program</td>
<td>$796,000</td>
<td>$796,000</td>
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<tr>
<td>Colorectal Cancer Screening (Reduction)</td>
<td>$216,525</td>
<td>$204,894</td>
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<tr>
<td>Total SFY ’16</td>
<td>$1,400,000</td>
<td>$1,213,010</td>
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<tr>
<td>Potential Reduction Beginning SFY ’18</td>
<td>$1,319,010</td>
<td>$1,126,010</td>
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* SFY 16 Revenue Failure = 7% of 2016 General Appropriations
* SFY 17 Appropriation Reduction = 2.5% of 2017 General Appropriations
* SFY 18 Potential Reduction = 3.0% of 2018 General Appropriations

Oklahoma State Department of Health – Creating a State of Health – www.health.ok.gov

Prepared for Valauna Grissom 12/9/2016 12:17:43 PM
Federal Funding Reductions SFY 2011 - SFY 2017

<table>
<thead>
<tr>
<th>Program</th>
<th>Federal Funding</th>
<th>% Reduced</th>
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</thead>
<tbody>
<tr>
<td>Hospital Preparedness</td>
<td>$2,877,398</td>
<td>44%</td>
</tr>
<tr>
<td>Public Health Emergency Preparedness</td>
<td>$372,324</td>
<td>13%</td>
</tr>
<tr>
<td>MIECHV</td>
<td>$689,803</td>
<td>32%</td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
<td>31%</td>
</tr>
<tr>
<td>Comprehensive Cancer</td>
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<td>13%</td>
</tr>
<tr>
<td>Tobacco</td>
<td></td>
<td>34%</td>
</tr>
<tr>
<td>Tuberculosis Elimination</td>
<td></td>
<td>18%</td>
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Services Rendered SFY 2016

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<thead>
<tr>
<th>County Health Departments</th>
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<tr>
<td>County Health Department Services</td>
<td>$2,877,398</td>
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<tr>
<td>County Health Department Clients</td>
<td>$372,324</td>
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<tr>
<td>County Health Department Visits</td>
<td>$689,803</td>
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<table>
<thead>
<tr>
<th>Inspections</th>
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<tbody>
<tr>
<td>Health Inspections</td>
<td>$28,489</td>
</tr>
<tr>
<td>Birth and Death Certificates Issued</td>
<td>$175,386</td>
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<tr>
<td>Death Certificates</td>
<td>$215,190</td>
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Infectious Disease

| Infectious Disease Reports | $10,856              |
| OSDH Hours of Infectious Disease Investigations | $17,517      |

Public Health Laboratory

Test Volumes for 2015

<table>
<thead>
<tr>
<th>Total Specimens</th>
<th>Total Tests</th>
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<tbody>
<tr>
<td>177,555</td>
<td>709,840</td>
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SFY 2018 Budget Request

<table>
<thead>
<tr>
<th>Program</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Public Health Lab</td>
<td>$7,587,146 (60.07%)</td>
</tr>
<tr>
<td>Immunization</td>
<td>$1,537,296 (12.17%)</td>
</tr>
<tr>
<td>FMAP Reductions</td>
<td>$1,281,368 (10.14%)</td>
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<tr>
<td>Restore One Time Funding</td>
<td>$1,275,108 (10.10%)</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>$602,642 (4.77%)</td>
</tr>
<tr>
<td>Childhood Lead Exposure</td>
<td>$12,630,310</td>
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OSDH Budget Request SFY 2018

<table>
<thead>
<tr>
<th>Program</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Adult Day Care/Residential Care/ Nursing Health Facility Plan Review</td>
<td>Per bed up to program cost</td>
</tr>
<tr>
<td>Sanitarians and Environmental Specialist</td>
<td>Per program cost up to program cost</td>
</tr>
<tr>
<td>State Fees</td>
<td></td>
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<tr>
<td></td>
<td>Amount</td>
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Public Health Collaborative Budget Request

Consumer Protection Fees

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<tr>
<th>Program</th>
<th>Fees</th>
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<tbody>
<tr>
<td>Food Licensure</td>
<td>Simplified, risk based fee structure</td>
</tr>
<tr>
<td>Temporary License</td>
<td>Eliminate plan review fee</td>
</tr>
<tr>
<td>Re-inspection fee</td>
<td>Per room block up to program cost</td>
</tr>
<tr>
<td>Hotel/Motel</td>
<td>Per pool/spa up to program cost</td>
</tr>
<tr>
<td>Swimming Pools/Public Bathing Places</td>
<td></td>
</tr>
</tbody>
</table>
Questions
2017 LEGISLATIVE PRIORITY
Oklahoma Tri-Boards of Health
OCTOBER 2016

Carter Kimble, MPH
Director of State and Federal Policy
Oklahoma State Department of Health

Legislative Priority

Recommendation to the Tri-Board is to adopt the resolution supporting a $1.50/pack increase in the state’s excise tax and that the revenue generated will be appropriated to fund activities supporting OHIP 2020 priorities.

Where we have been

• HJR1058- $1.50/pack increase in excise tax
  – Revenue was directed off the top (66% teacher pay, 32% Insure Oklahoma, 2% pediatric cancer)
  – Was laid over and never considered in House committee

Lessons learned
• Bill wasn’t heard because “cigarette tax was part of the budget negotiation”
• Advocacy effort was initially disjointed and disorganized
• Message of tax as a health policy was not resonating
• Education advocates were not engaged in HJR1058

Where we have been

• HB3210- $1.50/pack increase in excise tax
  – Revenue was directed to “Health revolving fund” to be appropriated by the legislature for any Medicaid compensable activity
  – Passed in House committee (13-7) and Senate committee
  – Failed on House floor (40-59)

Lessons learned
• Important component was ability for legislature to appropriate instead of the appearance of “off-the-top” revenue
• Democrats voted in a block to oppose
• Democrats held cigarette tax hostage in exchange for Medicaid Rebalancing
• Believed that Medicaid funding would be held harmless without passage of cigarette tax

Coalition building

• Large coalition gelled around cigarette tax proposal for health
  – Healthcare providers and payers
  – Patient advocates and associations
  – Developmentally Disabled advocates
  – Home and Community based service providers
  – Behavioral Health
  – Law enforcement
  – Municipalities
Where we are going

• Maintain the established health argument of cigarette tax as a stand alone policy
• Conversations with legislative leaders earlier in the game
• Simplifying messaging moving forward
  – Access to care
    • behavioral health and substance abuse
    • Medicaid provider rates
  – Cigarette tax as a multi-year funding solution

What else

• Shop this resolution around
  – Especially outside the traditional health partners
    • School boards, local chambers, county commissioners
• Engage your networks
• Keep pressure on legislators
  – “How are you going to ensure passage of the cigarette tax?”

Contacts

Carter Kimble, OSDH
carterk@health.ok.gov

Tammie Kilpatrick, OCCHD
tammie@fkconsulting.com

Scott Adkins, THD
scottadkinsconsulting@valornet.com
2017 MEETING DATES
(Location is OSDH unless otherwise indicated)

First Quarter
January 10, 2017 (11:00 a.m.)
February 14, 2017 (11:00 a.m.)
March 14, 2017 (11:00 a.m.) Comanche County Health Department

Second Quarter
April 11, 2017 (11:00 a.m.)
May 9, 2017 (11:00 a.m.)
June 13, 2017 (11:00 a.m.) Kay County Health Department

Third Quarter
July 11, 2017 (11:00 a.m.)
August 11-12, 2017 (Atherton, OSU Stillwater)

Fourth Quarter
October 3, 2017 (1:00 p.m. Tulsa)
December 12, 2017 (11:00 a.m.)

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2018 MEETING DATES
(Locations to be determined)

First Quarter
January 9, 2018 (11:00 a.m.)
February 13, 2018 (11:00 a.m.)
March 13, 2018 (11:00 a.m.)

Second Quarter
April 10, 2018 (11:00 a.m.)
May 8, 2018 (11:00 a.m.)
June 12, 2018 (11:00 a.m.)

Third Quarter
July 10, 2018 (11:00 a.m.)
August 10-11, 2018 (Atherton, OSU Stillwater)

Fourth Quarter
October 2, 2018 (1:00 p.m.)
December 11, 2018 (11:00 a.m.)
A Board Work Calendar will be developed on a regular basis by the Executive Committee and approved by the Board. The content should include the following.

- Regular Board meetings
- Summer working retreat
- A timetable regarding:
  - Finance reports due to the Committee and its report due to the Board
  - Audit reports due to the Committee and its report due to the Board
  - The content outline of the year’s State of the State’s Health (SOSH) Report due to the Board, the target date for when the draft of report is to be presented to Board and the target dates for approval, publication, release and distribution.

<table>
<thead>
<tr>
<th>EXECUTIVE COMMITTEE</th>
<th>Burger, Hart-Wolfe, Stewart, Woodson</th>
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<tbody>
<tr>
<td>Board Operations / Bylaw revisions</td>
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<tr>
<td>Appoint Officer Nomination Committee</td>
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<tr>
<td>Appoint Annual Committee Membership</td>
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<td>Review Annual Rules Submission</td>
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<tr>
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<th>Burger, Starkey, Krishna</th>
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<td>Monthly Finance Dashboard</td>
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<tr>
<td>Quarterly Operational &amp; Performance Dashboard</td>
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<th>Stewart, Woodson, Gerard</th>
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<tr>
<td>Monthly Policy Report</td>
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<td>SOSH Report (Joint with Exec. Committee)</td>
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<tr>
<td>Annual Audit Plan/Risk Analysis</td>
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<td>Complaint Coordinating Council</td>
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<table>
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<tr>
<th>2015-2020 STRATEGIC PLAN METRICS AD HOC COMMITTEE</th>
<th>Alexopulos, Stewart, Grim, Starkey</th>
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<tr>
<td>2015-2020 Strategic Plan proxy dashboard (merged w/ operational dashboard upon completion)</td>
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<tr>
<td>MEETING</td>
<td>LOCATION</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------</td>
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<tr>
<td>January 10, 2017</td>
<td>OSDH</td>
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<tr>
<td>February 14, 2017</td>
<td>OSDH</td>
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<tr>
<td>March 14, 2017</td>
<td>Comanche County HD</td>
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<tr>
<td>April 11, 2017</td>
<td>OSDH</td>
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<td>May 9, 2017</td>
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<td>June 13, 2017</td>
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<td>August 11-12, 2017</td>
<td>Atherton, OSU Stillwater</td>
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<td>October 3, 2017</td>
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<tr>
<td>December 12, 2017</td>
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MEMORANDUM

October 6, 2016

TO:            State Board of Health Members

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

SUBJECT: Infant and Children’s Health Advisory Council Appointment

This requests re-appointment of one member to the Infant and Children’s Health Advisory Council by the State Board of Health. The proposed appointee is as follows:

One member who is a physician licensed by the state who specializes in the diagnosis and treatment of childhood injuries in a trauma setting

- Dr. Amanda L. Bogie, M.D

The State Health Department’s staff conducted a check of the history of the proposed appointee using public information, including the Oklahoma Department of Corrections Offerder Lookup, the Oklahoma State Court Networks Court Dockets, and the Oklahoma Board of Medical Licensure and Supervision. The staff identified no offenses or adverse actions that would impair the ability of this individual to perform the responsibilities of the advisory council.

This nominee meets the qualifications of the position for which she is nominated. Dr. Edd D. Rhoades, M.D., Medical Director, Community and Family Health Services, has personally contacted the nominee and confirmed her willingness to serve and attend public meetings of the advisory council.

Additional information for the advisory council is as follows:

Statutory Citation
The Infant and Children’s Health Advisory Council is authorized in Title 63 O.S. Section 1-103a.1 (E).

Appointing Authority
Appointment shall be made by the State Board of Health.
Membership
The Infant and Children’s Health Advisory Council has eight members. The appointing authorities and membership categories are:

- Two members shall be appointed by the Governor:
  1) One member who works for the state or a political subdivision on child abuse issues, and
  2) One member who is knowledgeable about childhood immunizations.

- Three members shall be appointed by the President Pro Tempore of the Senate:
  1) One member who is knowledgeable about newborn screening issues,
  2) One member who is licensed by the state as an optometrist who has knowledge of vision screening for children, and
  3) One member who is licensed by the state who is an ophthalmologist with the knowledge of treating vision deficiencies in children.

- Two members shall be appointed by the Speaker of the House of Representatives:
  1) One member who is licensed by the state as a physician and works as a pediatrician, and
  2) One member who is a licensed by the state as a genetics counselor.

- One member shall be appointed by the State Board of Health who is a physician licensed by the state who specializes in the diagnosis and treatment of childhood injuries in a trauma setting.

The one new member will continue to serve with the current Infant and Children’s Health Advisory Council members, who are:

Governor Appointees:
- Dr. Stanley Grogg, D.O., Current Term Expires 10/31/2019

President Pro Tempore of the Senate Appointees:
- Dr. Lynn Cyert, Ph.D. Current Term Expires 06/05/2017
- Dr. Jeff Elliott, O.D, Current Term Expires 12/31/2017
- Dr. R. Michael Siatkowski, M.D., Current Term Expires 9/30/2018

Speaker of the House Appointees:
- Dr. Paul M. Darden, M.D., Current Term Expires 11/01/2017
- Dr. Susan J. Hassed, Ph.D., Current Term Expires 11/01/2017

Advisory Council Duties/Responsibilities
The jurisdictional areas of the Infant and Children’s Health Advisory Council shall include all issues that arise in the area of health care for infants and children and such other areas as designated by the State Board of Health. In addition to other powers and duties assigned to each Public Health Advisory Council, each Advisory Council, within its jurisdictional area, shall:

1) Have authority to recommend to the State Board of Health rules on behalf of the State Department of Health. The State Department of Health shall not have standing to recommend to the State Board of Health permanent rules or changes to such rules within the jurisdiction of an
Advisory Council which have not been submitted previously to the appropriate Advisory Council for action;

2) Before recommending any permanent rules to the State Board of Health, give public notice, offer an opportunity for public comment and conduct a public rulemaking hearing when required by the Administrative Procedures Act;

3) Have the authority to make nonbinding written recommendations to the State Board of Health and/or to the State Department of Health which have been concurred upon by at least a majority of the membership of the Advisory Council;

4) Have the authority to provide a public forum for the discussion of issues it considers relevant to its area of jurisdiction, and to:
   a) pass nonbinding resolutions expressing the sense of the Advisory Council, and
   b) make recommendations to the State Board of Health or the State Department of Health concerning the need and the desirability of conducting meetings, workshops and seminars; and

5) Cooperate with each other Advisory Council, the public, the State Board of Health and the Commissioner of Health in order to coordinate the rules within their respective jurisdictional areas and to achieve maximum efficiency and effectiveness in furthering the objectives of the State Department of Health.

The Advisory Council shall not recommend rules for promulgation by the State Board of Health unless all applicable requirements of the Administrative Procedures Act have been followed, including but not limited to notice, rule-impact statement and rulemaking hearings.

**Advisory Council Meeting Frequency**

Each Advisory Council shall meet at least twice a year, but no more than four times a year.

**Appointment Process and Quorum**

Two members shall be appointed by the Governor, three members shall be appointed by the President Pro Tempore of the Senate, two members shall be appointed by the Speaker of the House of Representatives, and one member shall be appointed by the State Board of Health. Four members shall constitute quorum.

**Attachments**

- Dr. Amanda L. Bogie, M.D., Curriculum Vitae
November 15, 2016

MEMORANDUM

TO: State Board of Health Members

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

SUBJECT: Appointments to the Oklahoma Food Service Advisory Council

This request is for advice and consent by the Board of Health for a new appointment and seven re-appointments representing the Oklahoma Food Service Advisory Council.

Oklahoma School Nutrition Association -- NEW (SB 1357)
- Krista Neal, Nutrition Service Director Stillwater Public Schools, Stillwater

Independent Food Service Operator
- Bill Ricks, VP Retail Braum's, Edmond -- preferred re-appointment
  Request advice and consent for appointment of Mr. Ricks, January 1, 2017 thru December 31, 2019

General Public
- Harold Kelly, Retired OGE, Edmond -- preferred re-appointment
  Request advice and consent for appointment of Mr. Kelly, January 1, 2017 thru December 31, 2019

Oklahoma Hotel & Motel Industry
- Michael Farney, GM, Wyndham Garden Hotel, Oklahoma City
  Request advice and consent for appointment of Mr. Farney, January 1, 2017 thru December 31, 2019

Food Service Education
- Bill Ryan, Faculty OSU School of Hotel & Restaurant, Stillwater -- preferred re-appointment
  Request advice and consent for appointment of Mr. Ryan, January 1, 2017 thru December 31, 2019

Food Service Processing Education
- Roy Escouba, Director Robert M Kerr Food & Ag Products Center, Stillwater -- preferred re-appointment
  Request advice and consent for appointment of Mr. Escouba, January 1, 2017 thru December 31, 2019

Oklahoma Grocer's Association
- Park Ribble, Director HAC, Inc, Guthrie -- preferred re-appointment
  Request advice and consent for appointment of Mr. Ribble, February 1, 2017 thru January 31, 2020

Oklahoma Restaurant Association
- Jim Hopper, President/CEO Oklahoma Restaurant Association, Oklahoma City -- preferred re-appointment
  Request advice and consent for appointment of Mr. Hopper, February 1, 2017 thru January 31, 2020
November 1, 2016
Food Service Advisory Council Appointments

Oklahoma State Department of Health staff conducted a background check of all of the candidates using public information, including the Oklahoma Department of Corrections Offender Lookup, the Oklahoma State Court Network Court Dockets, and Oklahoma State Department of Health licensure records. The staff identified no offenses or adverse actions that would impair the ability of the nominees to perform the responsibilities of the advisory council.

Consumer Health Service staff contacted each applicable nominee for the new position and only preferred nominees for the re-appointments by telephone to confirm qualifications for the position for which they are nominated. Staff also confirmed those nominees understood the time commitment to prepare for and attend public meetings and ensured they are willing and able to serve.

Additional information for the advisory council is as follows:

Statutory Citation:
Title 63, Section 1-106.3 of the Oklahoma Statutes authorizes the Oklahoma Food Service Advisory Council within the State Department of Health. The purpose of the Oklahoma Food Service Advisory Council is to advise the State Board of Health, the Commissioner of Health, and the Department regarding food service establishments and recommend actions to improve sanitation and consumer protection.

Appointing Authority:
The Commissioner appoints eight members of the Advisory Board with the advice and consent of the Board. Members serve three-year terms.

Membership:
Advisory Board consists of fourteen (14) members. Nine (9) members are appointed by the Commissioner, with the advice and consent of the State Board of Health, from a list of three names for each position provided by an association representing the majority of the restaurant owners in the state.

One (1) represents Oklahoma Restaurant Association
One (1) represents Oklahoma Hotel and Motel Association
One (1) represents Oklahoma Grocers Association
One (1) represents Food Service Education
One (1) represents Food Processing Education
One (1) represents Independent Food Service Operator
One (1) represents Food Processor
One (1) represents the School Nutrition Association of Oklahoma
One (1) Citizen represents the Public, shall not be a food service operator or employee and shall not be a member of a Food Service governing board.

The remaining members consist of:
One (1), the Director of the Oklahoma – City County Health Department, or a designee
One (1), the Director of the Tulsa – City County Health Department, or a designee
Two (2) Directors from other county health departments in this state or designee, appointed by the Commissioner;
One (1), the Director of the State Department of Agriculture, or a designee

Advisory Council Duties/Responsibilities:
Duties include advising the State Board of Health, the State Commissioner of Health, and the Department regarding food service establishments. The Advisory Council has the following duties and responsibilities:

1. Recommends actions to improve sanitation and consumer protection.
2. Evaluates, reviews and makes recommendations regarding Department inspection activities; and
3. Recommends and approves quality indicators and data submission requirements for food service establishments which shall be used by the Department to monitor compliance with licensure requirements.
November 1, 2016
Food Service Advisory Council Appointments

Advisory Council Meeting Frequency:
The Advisory Council meets once a quarter (4 times a year).

Appointment Process:
(1) Résumés/applications are submitted to Oklahoma Restaurant Association (ORA).
(2) ORA reviews the applicants and forwards to Oklahoma State Department of Health.
(3) Oklahoma State Department of Health reviews, conducts background checks, contacts the nominee then forwards recommendations to the Commissioner.
(4) Commissioner gains advice and consent of the Board of Health.
(5) Commissioner appoints nominee.

Attachments:
Nominee Résumés/Curriculum Vitae
PROPOSED RULEMAKING ACTIONS
The attached rule and supporting documents are submitted for PERMANENT adoption of the rule at the Board of Health's December 2016 meeting.

We received public comment. The response is attached along with a revised Rule Impact Statement. There were no revisions to the previously reviewed rule.

Attachments:
- Rule Impact Statement
- Rule Text
- Rule Comment Summary
RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 2. PROCEDURES OF THE STATE DEPARTMENT OF HEALTH

SUBCHAPTER 31. HUMANITY OF THE UNBORN CHILD ACT [NEW]

1. DESCRIPTION: (a brief description of the purpose of the proposed rule [75 O.S. §303.D.2(a)])

These proposed regulations, if adopted, will implement the Department’s requirements contained in House Bill Number 2797, from the 2nd Session of the 55th Oklahoma Legislature (2016) known as "Humanity of the Unborn Child Act" and codified at 63 O.S. § 1-751 et seq. The proposed regulations set forth the requirements to be used by facilities regulated by the Department to place signage in restrooms and other areas in compliance with the Act.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE: (a description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the agency from any private or public entities [75 O.S. §303.D.2(b)])

The classes of persons potentially affected are all owners of facilities licensed or permitted by the Department. Additionally, pregnant women may be affected by proposed regulations.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES: (a description of the classes of persons who will benefit from the proposed rule [75 O.S. §303.D.2(c)])

The potential benefit will be to assist and inform women who are pregnant.

4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES: (a description of the probable economic impact of the proposed rule upon affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change [75 O.S. §303.D.2(d)])

Based on public comments received, the following are the potential economic impact on regulated entities:

**Oklahoma Hospital Association:** Information we have obtained reveals the cost of the production of such signage ranges from $45.00 to $150.00 per sign depending on the styling and framing of the sign. Also be aware that due to the stringent cleanliness requirements that a sign must be able to be disinfected regularly in restrooms in medical facilities. This cost must be multiplied by the number of bathrooms at each facility and does not include the cost of installation. A brief sampling of the large and small hospitals and systems is stated below (cost is estimated at $80.00 per sign):

- INTEGRIS Health System – 403 bathrooms -- $60,000.00 (cost estimate at $150.00 for a 3 foot by 2 foot sign, including installation)
- OU Medical System – 109 bathrooms -- $8,720.00
- Rural Hospital #1 – 10 bathrooms -- $800.00
• SSM Healthcare (St. Anthony Hospital, Bone and Joint, St. Anthony Shawnee) – 100
bathrooms -- $10,000.00

As demonstrated in the information above, the cost of compliance and economic impact will vary widely on OSDH licensees from $750.00 for a small rural hospital to $60,000.00 for a large acute care hospital in an urban center. When aggregated, the fiscal impact of the 114,687 state licenses of the OSDH is enormous and will be at least $2,000,000.00 conservatively based on two public bathrooms per facility. We also added into the calculation at least two public bathrooms at each of the 751 facilities that are federally certified by the OSDH and that cost is conservatively an additional $120,000.00 based on two bathrooms per facility. The economic impact the other licensees of the OSDH such as restaurants, nursing homes, hotels and motels, dialysis center, radiology centers and assisted living would also be significant and be at least $2,120,000.00 across the licensed industries. Most are considered small businesses and the impact of compliance is disparate for those businesses. With over 140 licensed hospitals in Oklahoma the cost just to the hospitals is estimated to be at a minimum of $225,000.00.

Oklahoma Residential Assisted Living Association: The cost and inconvenience of creating and posting signage in all of our bathrooms will be an unnecessary burden on our members who are operating on very narrow margins.

Oklahoma Restaurant Association: The Oklahoma Restaurant Association is made up of more than 1,200 members throughout the state of Oklahoma who collectively operate over 4000 licensed locations in our state. These members are small businesses who are constantly faced with ever increasing regulations with which they are forced to comply without the benefit of clear thinking about how these new mandates will affect their ability to operate profitably. Two Oklahoma Restaurant Association members, who are multi-operation facilities throughout the state of Oklahoma were contacted. Together, these two restaurant companies operate over 200 locations throughout the state. They were asked to estimate their costs for compliance with this proposed rule. To print, laminate, purchase a frame, attach it to the bathroom wall so that it cannot be easily removed, and the labor to accomplish all of this is estimated to cost these two companies over $20,000.00. The margins of profitability in the restaurant industry are not large, typically in the 4-7% range. So you can imagine how each unfunded mandate puts additional strain on restaurants to be profitable.

Oklahoma State Medical Association: The OSDH must consider the fiscal impact of these proposed rules. With the sheer number of regulated entities to which these rules could apply and the non-standard size of the proposed sign, these regulations will pose an undue economic burden on thousands of individual physician practices, hospitals and others regulated by OSDH. The rules are not limited to health practitioners who will be unduly burdened by this unfunded mandate.

Oklahoma Primary Care Association: The cost of implementing this policy is not limited to the cost of printing or materials, but also staff time necessary to produce and install these signs and any necessary deliver of postal charges. Given the large font size requirement would likely exceed the capability of many entities to print a sufficiently large sign within their facility, many would likely have to order such signs from outside their organization requiring production charges and shipping and delivery expenses. Some of these additional shipping and handling or delivery charges could be relatively high given that CHSs [community health centers] serve Medically Underserved Areas which are many times very rural, and the local communities might not have the ability to professionally produce a sign of that size in the area. Obtaining a price quote from a professional printer for paper only printing, costs could range between $50.00 to $100.00 per sign and a separate preparation fee of $25.00 per job. The following is a possible direct cost to CHCs:
• Preparation fees – 20 CHC Organizations x $25.00 -- $500.00
• Printing – 90 locations, 2 pairs of men’s and women’s restrooms per location, 360 copies, $100.00 per paper copy -- $36,000.00
• Staff time for printing services -- $15.00 per hour, 5 hours for CHC to retrieve template and obtain printing services -- $1,500.00
• Framing for Paper Copies -- $20.00 per frame for 360 copies -- $7,200.00
• Installation -- $15.00 per hour, one hour per location -- $1,350.00
• Total Cost -- $46,550.00.

A much smaller size sign that would fit on a single standard 8 ½” x 11” piece of paper would substantially reduce the cost of printing for affected entities.

Oral comments from Jim Hopper, President and CEO of the Oklahoma Restaurant Association and the Oklahoma Hotel and Lodging Association at the November 3, 2016 public hearing: Both organizations represent a lot of small and medium size businesses in the State of Oklahoma. The Oklahoma Restaurant Association has over 1,200 members operating in approximately 4,000 locations. Any sign produced to meet the requirements of the proposed rules will need to be created, laminated, placed in a tamper proof frame and permanently attached to the walls of the restrooms so the signs cannot be tampered with, torn down or removed. There are definitely costs involved with complying with this Act. I reached out to two of my 1,200 members who have multiple locations across the State of Oklahoma. Together those two entities operate approximately 200 locations. The estimated costs just for these two businesses to have the signs produced and displayed are $20,000.00 to comply with the proposed requirements. Profit margins for these businesses are not very large and any added costs and/or unfunded mandates are cause for concern for members of both organizations.

5. COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY: (the probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency [75 O.S. §303.D.2(e)]) The cost to implement the rule for the Oklahoma State Department of Health is unknown at the present time. If adopted the proposed rules would establish requirements for Department licensed or permitted facilities that choose to place signs, in compliance with the Act, in the restroom and potentially other places in their establishment.

The cost to the Department to implement the amendments will be approximately $[4,419.63] to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented by existing Department personnel and will have no anticipated effect on state revenues.

6. IMPACT ON POLITICAL SUBDIVISIONS: (a determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule [75 O.S. §303.D.2(f)])

There is a potential economic impact any political subdivisions of the State of Oklahoma who receive licenses from the Oklahoma State Department of Health. Based on public comments, the following are the costs provided concerning one political subdivision of the State of Oklahoma:

Tulsa Campaign to Prevent Teen Pregnancy: The proposed regulations in HB 2797 will have a significant negative fiscal impact on already stressed state agencies. The regulations are completely
unnecessary and unwanted. This law imposes fiscal hardship on state agency budgets – most notably on the Oklahoma State Department of Health (OSDH) and the Oklahoma State Department of Education (ODSE) – in a time of financial crisis for our state. The May 2016 fiscal analysis of the bill states the negative financial impact of the bill: “Department of Education personnel anticipate that cost would include $10,000 to establish and maintain the information program, $145,000.00 - $150,000.00 for development of the program instructional training and materials for students and $10,000.00 per high school site for cost of instruction based on average teacher salary. There are 478 high schools sites. Additional costs cannot be estimated at this time.” The law established a dedicated revolving fund to be specifically used for promotion of material that is neither evidence-based nor part of any recognized quality sex education curricula. At a time when funding for education and public health is being slashed in our state, this law dilutes and confuses the great work that is already happening at the local level. Requiring OSDH to create and maintain a website of all programs across the state that claim to want to help pregnant women is an unfunded mandate that would require an exorbitant amount of staff time and resources. Oklahoma will continue to face a significant budget shortfall in 2017. It is time to be laser-focused on fiscal responsibility and real public health priorities that are actually impacting our communities.

7. ADVERSE EFFECT ON SMALL BUSINESS: (a determination of whether implementation of the proposed rule may have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act [75 O.S. §303.D.2(g)])

There is a potential economic impact to any and all small business in the State of Oklahoma who receive licenses from the Oklahoma State Department of Health and provide public restrooms. Many of the facilities from the information contained in #2 above are small businesses. Please see the information contained in #2 above for the economic adverse effect on small businesses. The following are additional adverse effects on small businesses received during the public comments on the proposed rules:

Oklahoma Association of Health Care Providers: There is no distinction between men’s and women’s restrooms with the requirement it (the sign) be posted in both places. This creates an unnecessary hardship and greater proportional negative impact on our small businesses because our facilities have many restrooms and the primary individuals utilizing those restrooms are seniors beyond reasonable child bearing age.

Oklahoma Residential Assisted Living Association: Our members and most long term care facilities are not necessarily open to the general public for the purposes of using a bathroom. Therefore, the majority of our residents and their visitors are likely not going to benefit from this information.

Oklahoma Assisted Living Association: This rule could have a negative emotional impact on our residents. I understand the purpose of House Bill 2797 is to educate those of child bearing age of option to terminating a pregnancy. However, our residents are obviously older and not of child bearing age. Is it necessary to inform them of options which are not applicable?

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1 75 O.S. § 502. As used in the Oklahoma Small Business Regulatory Flexibility Act:

4. “Small business” means a for-profit enterprise consisting of fifty or fewer full-time or part-time employees.

2 75 O.S. § 504(B). If the proposed rules may have an adverse economic effect upon small business, the agency shall submit a copy of the proposed rules and a rule impact statement to the Small Business Regulatory Review Committee for its review and comment pursuant to the review and comment provisions of paragraph 2 of subsection A and paragraph 6 of subsection B of Section 303 of this title.
Oklahoma Assisted Living Association: My other concern is that an assisted living center, while regulated by the Department of Health, is a limited public facility. They are homes of our residents. Some of these residents suffer from mental ailments. In some instances, these posters could cause further trauma to our residents. The public bathrooms are used mainly by the resident’s that live there. These posting could cause great confusion and undue stress to those that have dementia. In a worst case scenario they (the residents) could re-live a repressed memory of a personal experience causing emotional harm which would violate their rights.

8. EFFORTS TO MINIMIZE COSTS OF RULE: (an explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule [75 O.S. §303.D.2(h)])

All the requirements contained in the proposed regulations are required by the implementing statutory requirements.

9. EFFECT ON PUBLIC HEALTH AND SAFETY: (a determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk [75 O.S. §303.D.2(i)])

   • Explain how this rule supports core public health functions, ensures delivery of essential public health services, and contributes to strategic planning goals and objectives.
   • Hyperlinks to published articles on the internet supporting the statement of effects are acceptable.

The public health benefit is to assist and inform women who are pregnant.

10. DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION: (a determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented [75 O.S. §303.D.2(j)])

   It is unknown if there are any detrimental effects on public health and safety if these proposed rules are not adopted.

11. This rule impact statement was prepared on July 26, 2016. Modifications made subsequent to the publication of the Notice of Rulemaking Intent were made on: August 31, 2016, November 7, 2016 and November 22, 2016. (the date the rule impact statement was prepared and if modified, the date modified [75 O.S. §303.D.2(k)])
310:2-31-1. Purpose. [NEW]
The rules in this Subchapter implement the authorities assigned to the Oklahoma State Department of Health as established in Enrolled House Bill Number 2797, from the 2nd Session of the 55th Oklahoma Legislature (2016) known as the "Humanity of the Unborn Child Act" and codified at 63 O.S. § 1-751 et seq.

310:2-31-2. Definitions. [NEW]
The following words and terms, when used in this Subchapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Department" means the Oklahoma State Department of Health.
"O.S." means Oklahoma Statute.
"Signage" means information provided by the Department that shall be used by a facility licensed or permitted by the Department to produce a sign meeting the requirements of the Humanity of the Unborn Child Act.

310:2-31-3. Signage. [NEW]
Any facility licensed or permitted by the Department shall create, produce and display a sign pursuant to the Humanity of the Unborn Child Act that meets the following requirements:

(1) The background of any signage shall be white;
(2) The lettering on any signage shall be in black;
(3) The lettering on any signage shall be reasonably legible;
(4) The signage shall contain the following statement: "There are many public and private agencies willing and able to help you carry your child to term and assist you and your child after your child is born, whether you choose to keep your child or to place him or her for adoption. The State of Oklahoma strongly urges you to contact them if you are pregnant."
(5) Additionally, the signage shall contain lettering, which is reasonably legible that says: "This sign is created, produced and displayed in compliance with the Humanity of the Unborn Child Act. For more information, please visit www.ok.gov/health";
(6) The signage shall be created, produced and displayed in English, additional signage may be created, produced and displayed in languages other than English at the discretion of the owner or operator of the licensed or permitted facility;
(7) Neither the Department logo nor any other Department identification, except for the information required in OAC 310:2-31-3 (5) shall appear on the sign;
(8) Any facility creating, producing and displaying signage in compliance with these requirements shall display said sign in any and all public restrooms at the facility; and
(9) Any facility creating, producing and displaying signage in compliance with the requirements of this subchapter shall create, produce and display said signage at the facility’s expense.
310:2-31-4. Language and web portal requirements. [NEW]

The Department shall create a web portal on the Department’s website for the purposes of housing and making available information to comply with the Humanity of the Unborn Child Act. The information contained on the web portal shall include, at a minimum:

(1) The requirements contained in this subchapter.
(2) The following language in a downloadable format for use on the signage: "There are many public and private agencies willing and able to help you carry your child to term and assist you and your child after your child is born, whether you choose to keep your child or to place him or her for adoption. The State of Oklahoma strongly urges you to contact them if you are pregnant."
(3) The Department shall publish on its website the address for the web portal to all facilities licensed by the Department.
(4) The Department shall inform the advisory committees and/or councils who advise the Oklahoma State Board of Health on issues related to Department licensed or permitted facilities about the web portal and the requirements of this subchapter.
The Summary of Comments is submitted to the Board of Health, and upon approval from the Board of Health submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant Title 75 of the Oklahoma Statutes, Section 303.1 (A). Pursuant to Title 75 of the Oklahoma Statutes, Section 303.1 (E) the report shall include: (9) A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules; (10) A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.

Notice of the proposed rulemaking was published in the Oklahoma Register. The public comment period ran from October 3, 2016 through November 3, 2016. A public hearing on the proposed rulemaking was held on November 3, 2016. The Oklahoma State Department of Health received written comments from nine (9) individuals or organizations [Oklahoma Residential Assisted Living Association, Oklahoma Assisted Living Association; Oklahoma Primary Care Association; Oklahoma State Medical Association; Oklahoma Restaurant Association; Oklahoma Hospital Association; Tulsa Campaign to Prevent Teen Pregnancy; Planned Parenthood Great Plains; and Oklahoma Association of Health Care Providers]. Additionally, the Oklahoma State Department of Health received oral comments from Tamya Cox of Planned Parenthood Great Plains and Jim Hopper of the Oklahoma Restaurant Association and of the Oklahoma Hotel and Lodging Association during the November 3, 2016 public hearing. For the purposes of this Rule Comment Summary and Response, like comments will be grouped together and one response provided.

Organization Name: Oklahoma Hospital Association; Oklahoma Residential Assisted Living Association; Oklahoma Restaurant Association; Oklahoma State Medical Association; Oklahoma Primary Care Association; Planned Parenthood Great Plains; Oklahoma Hotel and Lodging Association; Tulsa Campaign to Prevent Teen Pregnancy; and Oklahoma Association of Health Care Providers

Comment Topic: Economic Impact on Regulated Businesses

Comments: The OSDH received the following comments concerning the economic impact of the proposed rules on the regulated businesses.

Oklahoma Hospital Association: Information we have obtained reveals the cost of the production of such signage ranges from $45.00 to $150.00 per sign depending on the styling and framing of the sign. Also be aware that due to the stringent cleanliness requirements that a sign must be able to be disinfected regularly in restrooms in medical facilities. This cost must be multiplied by the number of bathrooms at each facility and does not include the cost of instillation. A brief sampling of the large and small hospitals and systems is stated below (cost is estimated at $80.00 per sign):

- INTEGRIS Health System – 403 bathrooms -- $60,000.00 (cost estimate at $150.00 for a 3 foot by 2 foot sign, including installation)
- OU Medical System – 109 bathrooms -- $8,720.00
- Rural Hospital #1 – 10 bathrooms -- $800.00
- SSM Healthcare (St. Anthony Hospital, Bone and Joint, St. Anthony Shawnee) – 100 bathrooms -- $10,000.00
As demonstrated in the information above, the cost of compliance and economic impact will vary widely on OSDH licensees from $750.00 for a small rural hospital to $60,000.00 for a large acute care hospital in an urban center. With over 140 licensed hospitals in Oklahoma the cost just to the hospitals is estimated to be at a minimum of $225,000.00. When aggregated, the fiscal impact of the 114,687 state licenses of the OSDH is enormous and will be at least $2,000,000.00 conservatively based on two public bathrooms per facility. We also added into the calculation at least two public bathrooms at each of the 751 facilities that are federally certified by the OSDH and that cost is conservatively an additional $120,000.00 based on two bathrooms per facility. The economic impact the other licensees of the OSDH such as restaurants, nursing homes, hotels and motels, dialysis center, radiology centers and assisted living would also be significant and be at least $2,120,000.00 across the licensed industries. Most are considered small businesses and the impact of compliance is disparate for those businesses.

**Oklahoma Residential Assisted Living Association:** The cost and inconvenience of creating and posting signage in all of our bathrooms will be an unnecessary burden on our members who are operating on very narrow margins.

**Oklahoma Restaurant Association:** The Oklahoma Restaurant Association is made up of more than 1,200 members throughout the state of Oklahoma who collectively operate over 4000 licensed locations in our state. These members are small businesses who are constantly faced with ever increasing regulations with which they are forced to comply without the benefit of clear thinking about how these new mandates will affect their ability to operate profitably. Two Oklahoma Restaurant Association members, who are multi-operation facilities throughout the state of Oklahoma were contacted. Together, these two restaurant companies operate over 200 locations throughout the state. They were asked to estimate their costs for compliance with this proposed rule. To print, laminate, purchase a frame, attach it to the bathroom wall so that it cannot be easily removed, and the labor to accomplish all of this is estimated to cost these two companies over $20,000.00. The margins of profitability in the restaurant industry are not large, typically in the 4-7% range. So you can imagine how each unfunded mandate puts additional strain on restaurants to be profitable.

**Oklahoma State Medical Association:** The OSDH must consider the fiscal impact of these proposed rules. With the sheer number of regulated entities to which these rules could apply and the non-standard size of the proposed sign, these regulations will pose an undue economic burden on thousands of individual physician practices, hospitals and others regulated by OSDH. The rules are not limited to health practitioners who will be unduly burdened by this unfunded mandate.

**Oklahoma Primary Care Association:** The cost of implementing this policy is not limited to the cost of printing or materials, but also staff time necessary to produce and install these signs and any necessary deliver of postal charges. Given the large font size requirement would likely exceed the capability of many entities to print a sufficiently large sign within their facility, many would likely have to order such signs from outside their organization requiring production charges and shipping and delivery expenses. Some of these additional shipping and handling or delivery charges could be relatively high given that CHSs [community health centers] serve Medically Underserved Areas which are many times very rural, and the local communities might not have the ability to professionally produce a sign of that size in the area. Obtaining a price quote from a professional printer for paper only printing, costs could range between $50.00 to $100.00 per sign and a separate preparation fee of $25.00 per job. The following is a possible direct cost to CHCs:

- Preparation fees – 20 CHC Organizations x $25.00 -- $500.00
- Printing – 90 locations, 2 pairs of men’s and women’s restrooms per location, 360 copies, $100.00 per paper copy -- $36,000.00
• Staff time for printing services -- $15.00 per hour, 5 hours for CHC to retrieve template and obtain printing services -- $1,500.00
• Framing for Paper Copies -- $20.00 per frame for 360 copies -- $7,200.00
• Installation -- $15.00 per hour, one hour per location -- $1,350.00
• Total Cost -- $46,550.00.

A much smaller size sign that would fit on a single standard 8 ½” x 11” piece of paper would substantially reduce the cost of printing for affected entities.

**Planned Parenthood Great Plains:** These proposed rules also place a financial burden on business owners that must be licensed from the State including small businesses. While again the actual cost may seem minimal, the rules and law are silent to the repercussions if business owners refuse to comply. It is important that any mandates or regulations placed upon business owners be reasonable and serve a public health good. The Humanity of the Unborn Act accomplishes neither of these goals.

**Oral comments from Tamya Cox representing Planned Parenthood Great Plains at the November 3, 2016 public hearing:** These rules create an unnecessary fiscal impact on business owners that are arbitrary to said business owners.

**Oral comments from Jim Hopper, President and CEO of the Oklahoma Restaurant Association and the Oklahoma Hotel and Lodging Association at the November 3, 2016 public hearing:** Both organizations represent a lot of small and medium size businesses in the State of Oklahoma. The Oklahoma Restaurant Association has over 1,200 members operating in approximately 4,000 locations. Any sign produced to meet the requirements of the proposed rules will need to be created, laminated, placed in a tamper proof frame and permanently attached to the walls of the restrooms so the signs cannot be tampered with, torn down or removed. There are definitely costs involved with complying with this Act. I reached out to two of my 1,200 members who have multiple locations across the State of Oklahoma. Together those two entities operate approximately 200 locations. The estimated costs just for these two businesses to have the signs produced and displayed are $20,000.00 to comply with the proposed requirements. Profit margins for these businesses are not very large and any added costs and/or unfunded mandates are cause for concern for members of both organizations.

**Tulsa Campaign to Prevent Teen Pregnancy:** This Law requires all facilities licensed or permitted by the OSDH to produce signage in every restroom that “meets the requirements of this act.” These measures are unlikely to achieve the desired results and place inappropriate and unfair burdens on businesses.

**Oklahoma Association of Health Care Providers:** Expressed concerns with the fiscal impact of the rulemaking in compliance with the Humanity of the Unborn Child Act and Public Restrooms (HB 2797 in 2016). This amounts to an unfunded mandated of unreasonable costs of up to $80.00 per sign that must be multiplied by the number of bathrooms at each facility as well as the labor costs of installation. More than 70 percent of all nursing home beds are funded by the state Medicaid program. Medicaid rates have been cut significantly the past 6 years. The addition of unfunded mandates as required with this rule and the compounding impact of the Medicaid cuts further diminishes our ability to invest in improving patient care. This creates an unnecessary hardship and greater proportional negative impact on our small businesses because our facilities have many restrooms and the primary individuals utilizing those restrooms are seniors beyond reasonable child bearing age.

**Response:** The Oklahoma State Department of Health understands the concerns of the fiscal impact the proposed regulations will have upon the businesses it licenses. The Oklahoma State Department of Health thanks each of the commenters who provided fiscal impact information concerning the proposed rulemaking. The fiscal impacts provided in these comments will be added to an amended Rule Impact
Statement that is provided to the Board of Health, the Governor, the Speaker of the House and the President Pro Tempore of the Senate. Unfortunately, HB 2797 requires that rulemaking occur concerning the signage issue and the web portal issue. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

Organization Name: Tulsa Campaign to Prevent Teen Pregnancy and Planned Parenthood Great Plains

Comment Topic: Economic Impact on State Agencies (including the OSDH)

Comments: The OSDH received the following comments concerning the economic impact of the proposed rules on Oklahoma State Agencies.

Tulsa Campaign to Prevent Teen Pregnancy: The proposed regulations in HB 2797 will have a significant negative fiscal impact on already stressed state agencies. The regulations are completely unnecessary and unwanted. This law imposes fiscal hardship on state agency budgets – most notably on the Oklahoma State Department of Health (OSDH) and the Oklahoma State Department of Education (ODSE) – in a time of financial crisis for our state. The May 2016 fiscal analysis of the bill state the negative financial impact of the bill: “Department of Education personnel anticipate that cost would include $10,000 to establish and maintain the information program, $145,000.00 - $150,000.00 for development of the program instructional training and materials for students and $10,000.00 per high school site for cost of instruction based on average teacher salary. There are 478 high schools sites. Additional costs cannot be estimated at this time.” The law established a dedicated revolving fund to be specifically used for promotion of material that is neither evidence-based nor part of any recognized quality sex education curricula. At a time when funding for education and public health is being slashed in our state, this law dilutes and confuses the great work that is already happening at the local level. Requiring OSDH to create and maintain a website of all program across the state that claim to want to help pregnant women is an unfunded mandate that would require an exorbitant amount of staff time and resources. Oklahoma will continue to face a significant budget shortfall in 2017. It is time to be laser-focused on fiscal responsibility and real public health priorities that are actually impacting our communities.

Planned Parenthood Great Plains: During the legislative session, many opponents argued that the cost to implement HB 2797 was too great especially at a time with the State was facing a huge budget deficit. The Act creates obstacles for teen pregnancy prevention efforts that have already realized dramatic results in helping reduce the teen pregnancy rate. Communities and tribes have secured over $5 million in federal dollars while the State has refused to contribute any funding toward prevention. The proposed rules create an unnecessary cost to the Department itself. There is a simple cost just associated with the rule drafting process as well as the cost of implementing. The law requires the state to create a web portal complying with its provision. However, no additional funding was allocated to the Department for implementation. Even if the actual costs are minimal to the Department, the funding will have to be diverted from another area.

Response: The Oklahoma State Department of Health understands the concerns of the fiscal impact the proposed regulations will have upon the OSDH and other state agencies. The Oklahoma State Department of Health thanks each of the commenters who provided fiscal impact information concerning the proposed rulemaking. The fiscal impacts provided in these comments will be added to an amended Rule Impact Statement that is provided to the Board of Health, the Governor, the Speaker of the House and the President Pro Tempore of the Senate. Unfortunately, HB 2797 requires that rulemaking occur concerning the signage issue and the web portal issue. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

Organization Name: Oklahoma Association of Health Care Providers; Oklahoma Restaurant
Comment Topic: The Act and proposed rules are required to be implemented in situations where the targeted population of the Act is not available.

Comments: The OSDH received the following comments concerning the Act and/or the proposed regulations being required in locations where the targeted audience for the signs (pregnant women or women who intend on becoming pregnant) will not view the signs and receive its message.

Oklahoma Association of Health Care Providers: There is no distinction between men’s and women’s restrooms with the requirement it (the sign) be posted in both places. This creates an unnecessary hardship and greater proportional negative impact on our small businesses because our facilities have many restrooms and the primary individuals utilizing those restrooms are seniors beyond reasonable child bearing age.

Oklahoma Restaurant Association: The new statute does not differentiate between which restrooms must have the signs posted, but mandates they be posted in every public restroom in facilities licensed by the Health Department. This just makes no sense for signs to be posted in men’s restrooms.

Oklahoma Residential Assisted Living Association: Our members and most long term care facilities are not necessarily open to the general public for the purposes of using a bathroom. Therefore, the majority of our residents and their visitors are likely not going to benefit from this information.

Oklahoma Assisted Living Association: This rule could have a negative emotional impact on our residents. I understand the purpose of House Bill 2797 is to educate those of child bearing age of option to terminating a pregnancy. However, our residents are obviously older and not of child bearing age. Is it necessary to inform them of options which are not applicable?

Oral comments from Jim Hopper, President and CEO of the Oklahoma Restaurant Association and the Oklahoma Hotel and Lodging Association at the November 3, 2016 public hearing: The Act says (and this is a paraphrase) the entities that are licensed by the State Health Department that have restrooms that are open to the public must post these signs. The Act does not differentiate between men’s and women’s restrooms and does not differentiate between the type of businesses regulated by the Department, whether a hospital, nursing home, tattoo parlor. This language is poorly drafted and not well thought out by the legislature. You would think that the legislature would have reached out to stakeholders about the requirements of the Act, and say here is what we want to do, help us reach this goal.

Response: The OSDH agrees that HB 2797 (2016) and these proposed rules (due to the language contained in the House Bill) do not differentiate between which bathrooms the signs must be posted or what types of businesses the signs must be posted. The language from HB 2797 requires the signs contemplated by the Bill to be posted in the restrooms available to the public for those facilities licensed by the OSDH. Since the House Bill that was passed and signed into law does not differentiate between the types of bathrooms where the signs shall be posted or differentiate between the types of facilities where the signs shall be posted, the OSDH and the Board of Health does not have the legislative authority to make such a differentiation. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

Organization Name: Oklahoma Assisted Living Association

Comment Topic: Impact of HB 2797 and/or the proposed rules to implement the Bill on certain
residents at certain facilities regulated by the OSDH.

**Comments:** The OSDH received the following comments concerning the Act and/or the proposed regulations and the potential impact of both on the residents of the facility

**Oklahoma Assisted Living Association:** My other concern is that an assisted living center, while regulated by the Department of Health, is a limited public facility. They are homes of our residents. Some of these residents suffer from mental ailments. In some instances, these posters could cause further trauma to our residents. The public bathrooms are used mainly by the resident’s that live there. These posting could cause great confusion and undue stress to those that have dementia. In a worst case scenario they (the residents) could re-live a repressed memory of a personal experience causing emotional harm which would violate their rights.

**Response:** The OSDH sympathizes with the commenters concerning the potential impact of the placement of the signs in the restroom of Assisted Living facilities. This same or similar impact could also occur with the placement of signs in Nursing Facilities, Residential Care Facilities, Hospitals and other Primary Care Facilities. The House Bill that was passed and signed into law does not differentiate between the types of facilities where the signs shall be posted. Since the House Bill does not make distinction concerning the types of facilities that are required to post the signs, the OSDH and the Board of Health does not have the legislative authority to make such a differentiation. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

**Organization Name:** Oklahoma State Medical Association; and Oklahoma Hospital Association

**Comment Topic:** HB 2797 only requires the Oklahoma State Department of Health to regulate in this area when funds are appropriated.

**Comments:** The OSDH received the following comments concerning the proposed regulations not being necessary at the present time since the Oklahoma Legislature has not appropriated funds for requirements contained in HB 2797.

**Oklahoma State Medical Association:** The law at Title 63 Okla. Stat. § 1-752 clearly states these rules should be promulgated and in the form made available “contingent on the availability of funds being appropriated by the Legislature specifically for this purpose.” Given that such funding has not been provided, we believe these proposed regulations are both unnecessary and premature.

**Oklahoma Hospital Association:** HB 2797 contains language that the required website, which will provide the information required by the legislation, is contingent. “Contingent on the availability of funds being appropriated by the Legislature specifically for this purpose, the State Department of Health shall develop, update annually and maintain an electronic format containing information…” Title 63 Okla. Stat. § 1-752. There is no evidence that funds were appropriated to the OSDH in 2016 for implementation of the law such as enforcement of licenses and to establish the website for the information for compliance with the Humanity of the Unborn Child Act. Therefore, the OSDH should not proceed with the rulemaking for requiring the posting of signs that by licensees of the OSDH.

**Response:** While most of the provisions contained in HB 2797 contain the language, “contingent on the availability of funds being appropriated by the Legislature specifically for this purpose,…” and would require the OSDH to receive funding before implementing the requirements of the Bill, there are three provisions in the Bill that does not contain said language. These provisions are Section 2, Paragraph (B); Section 2, Paragraph (C), and Section 2, Paragraph (D) of HB 2797. Section 2, Paragraph (B) requires the OSDH to set up a hyperlink on the OSDH website containing certain information. Section 2, Paragraph (C) requires the OSDH to make available signage to all facilities regulated by the OSDH by January 1,
2018. Section 2, Paragraph (D) requires the Board of Health to promulgate rules to implement the provisions of Section 2. If the “contingent on the availability of funds being appropriated by the Legislature specifically for this purpose,...” language were a part of these three provisions, this proposed rulemaking would not have been commenced by the OSDH. Since the language was not contained in these three provisions, this rulemaking was commenced. Additionally, the OSDH has been contacted by the primary House author for HB 2797 concerning the progress being made on this proposed rulemaking. This would appear to demonstrate legislative intent that would run counter to the interpretation provided by the commenters. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

**Organization Name:** Oklahoma Association of Health Care Providers; Oklahoma State Medical Association; Oklahoma Hospital Association; Planned Parenthood Great Plains

**Comment Topic:** Discretionary language concerning signs being posted at places other than bathrooms

**Comments:** The OSDH received the following comments concerning the proposed regulations allowing for the signs to be placed in locations other than bathrooms.

**Oklahoma Association of Health Care Providers:** We concur with our colleagues at the Oklahoma Hospital Association that “the Oklahoma State Department of Health has exceeded the authority of the legislation by adding language to the rulemaking beyond posting in bathrooms the signs may also be posed in ‘other portions of the facility as necessary.’” See 310:2-31-3 (8). The law does not provide for any additional places for posting beyond the phrase ‘all bathrooms open to the public.’"

**Oklahoma State Medical Association:** The proposed rules speak to the possibility of displaying the signage “at any other location at the facility.” This goes beyond the wording and the intent of HB 2797, which specifically refers to signage being placed in the restroom. As such, at a minimum we believe this provision should be removed from the proposed rules.

**Oklahoma Hospital Association:** The OSDH has exceeded the authority of the legislation by adding language to the rulemaking, beyond just posting in bathrooms that signs may also be posed in “other portions of the facility as necessary.” See 310:2-31-3 (8). The law does not provide for any additional places for posting beyond the phrase “all bathrooms open to the public.”

**Response:** The language referenced by the commenters is discretionary and does not place any additional burden on any facility licensed or permitted by the OSDH. The language allows any facility, at its discretion, to place such a sign in any additional location at the facility. The commenters are correct, that HB 2797 only states that signs are required to be placed in the restrooms of facilities licensed or permitted by the OSDH. There is no language in HB 2797 that requires the need for this discretionary language. Therefore, based on the comments and response, the OSDH will propose the following amendment to the proposed rule in OAC 310:2-31-3 (8) to remove the discretionary language as follows: “Any facility creating, producing and displaying signage in compliance with these requirement shall display said sign in any and all public restrooms at the facility and may display the signage at any other location at the facility; and”

**Organization Name:** Oklahoma Restaurant Association; Planned Parenthood Great Plains; Oklahoma Hotel and Lodging Association

**Comment Topic:** Oklahoma State Department of Health to provide the signs
Comments: The OSDH received the following comments concerning the proposed regulations requiring the facilities regulated by the OSDH to pay for and provide signs.

Oklahoma Restaurant Association: The final version of HB 2797 that became law when signed by the Governor contained this provision in Section 2, C:

C. On or before January 1, 2018, the Department shall make available to each facility in this state which is open to the public containing a restroom available to the public, and licensed by the State Department of Health, signage which is to be posted in its restroom containing the statement and the website address to obtain information provided by subsection A of this section.

As you can see, the new law clearly states the Health Department shall provide these signs. The Proposed rule before you would require restaurants, and other small businesses cover by this rule, to bear the costs for these signs.

Planned Parenthood Great Plains: The proposed rules are an overreach of state law. 63 O.S.§751 (c) (sic) states “the department shall make available (emphasis added) to each facility licensed by the Department of Health signage which is to be posed in its restroom containing specific language and a link to a website.” There is nothing in the law that compels business owners to place signs in their restrooms. However, these proposed rules require signs to not only be created by the facility but also the proposed rules require the signage to be displayed. The law clearly states that the Department will create the signs and make them available to business owners. The business owners should then be allowed to choose whether or not they want to post. The Department is requiring business owners to ascribe to the anti-abortion view that is the true intent of this new law and thus the proposed rules. There are no provisions that allow business owners to decline displaying the signs. The Department is compelling government speech on private business owners to strengthen its anti-abortion agenda. In no other areas has the Department demanded that business owner place signs in bathrooms. The proposed rules are compulsory and more restrictive that state law requires. Therefore, the proposed rules should be rescinded or at the very least amended to follow state law and make signs available to business owners and allow them to use their own discretion.

Oral comments from Tamya Cox representing Planned Parenthood Great Plains at the November 3, 2016 public hearing: The bill requires that the Department shall make available the signs that are to be posted in any facility that is licensed by the Department. Shall make available implies that the Department will create these signs and make available. It does not compel business owners to place these signs in restrooms. The language in the rule that requires licensed facilities to create, produce and display the signs to be compulsory on business owners. We believe business owners should have the discretion so at the very least we are asking that Section 3 (b) be amended so that the signs may be available so that business owners want to place them and display them that is at the business owner’s discretion.

Oral comments from Jim Hopper, President and CEO of the Oklahoma Restaurant Association and the Oklahoma Hotel and Lodging Association at the November 3, 2016 public hearing: The legislation passed by the legislature and signed by the Governor clearly requires that the OSDH will provide these signs to be posted in the public restrooms. The proposed rule requires the business entities to provide the signs. It is unclear how that changed from the legislation to the proposed rules. We have concerns about that.

Response: HB 2797 requires the OSDH to “make available… signage”. The OSDH disagrees with the commenters that this language requires the OSDH to produce the signs. This language does not require the OSDH to produce the signs themselves, but to make signage available. Signage is defined as, “graphic designs, as symbols, emblems, or words, used especially for identification or as a means of
The proposed rulemaking, through the requirements for font, font size, specific language and placement, is making signage available as the term “signage” is defined.  As stated in a previous response to comments, the Oklahoma Legislature chose not to add the funding requirements language to this provision.  The OSDH has taken a nearly 30% reduction in state appropriations since fiscal year 2009.  The only way the OSDH can meet the requirements of HB 2797 is by requiring the costs of the signs be absorbed by licensees of the OSDH that maintain public restrooms.

There is nothing in HB 2797 that would give business owners the discretion whether to post the sign.  Specifically, Section 2, Paragraph (C) of HB 2797 states, “…signage which is to be posted in its restroom....”  This is mandatory language that the signs are required to be posted.  There is no discretion afforded in the language from Section 2, Paragraph (C).  The OSDH and/or the Board of Health has no agenda concerning abortion issues.  The only agenda for the OSDH and/or Board of Health is to implement those requirements within its jurisdiction from the authority granted by the legislature.  In this case the legislature mandated that signs be posted in restrooms that contain a specific message.  Additionally, the legislature mandates that a hyperlink to certain information be provided on the OSDH webpage and requires the Board to adopt rules.  That is all this proposed rulemaking provides.  This rulemaking goes no further than what is required by HB 2797.

Therefore, there will be no changes made to the proposed rulemaking based on these comments.

**Organization Name:**  Oklahoma Primary Care Association; Oklahoma State Medical Association; Oklahoma Assisted Living Association and Oklahoma Hospital Association

**Comment Topic:**  The requirements concerning the font size and language to be contained on the signs.

**Comments:** The OSDH received the following comments concerning the font, font size and language requirements for the signs contained in the proposed regulations.

**Oklahoma Primary Care Association:**  HB 2797 specified that OSDH is to make signage available to every facility licensed by OSDH in the state.  The signage is to include a specified statement explicitly provided in the legislation and the statement along with corresponding information is to be made available via the OSDH website.  The law does not specify the format of the sign with which the statement would be made.  Requiring a sign to include 1” tall font size for the prescribed statement and ½” tall compliance statement would require a physical printed sign to be extremely large – which may equate to more than seven full standard 8 ½” x 11” sheets of paper.  Including the requirement for a sign to be of such a large creates unnecessary additional expense to hose entities which must comply with this policy and goes beyond what is necessary to satisfy the statute.

**Oklahoma State Medical Association:** The proposed rules require lettering on any signage to “be at least one inch (1”) in height and be in a times new roman or courier font.”  With that size requirement, the required notice will take up several pages, making compliance overly burdensome and costly.

**Oklahoma Assisted Living Association:**  The sign requirements identified in 310:2-31-3, Section 3 and Section 5, the Department of Health requires that the lettering be “at least one inch (1”) in height” and “at least one-half inch (1/2”) in height.”  Section 2C of House Bill 2797 does not address the height requirements of the sign or provide any requirement that the signage or letters be of a certain size.  To that end, could you please provide the statutory authority requiring that the letter on the sign be of a minimum height?

**Oklahoma Hospital Association:**  The specific language which must be produced in 1” type, in Times
New Roman or Courier font in black typeface and on a white background is:

“There are many public and private agencies willing and able to help you carry your child to term and assist you and your child after your child is born, whether you choose to keep your child or to place him or her for adoption. The State of Oklahoma strongly urges you to contact them if you are pregnant.”

Additionally, the sign shall also contain in at least ½ inch height: “This sign is created, produced and displayed in compliance with the Humanity of the Unborn Child Act.”

The signage will **not fit onto one letter sized** (8 ½ x 11) **piece of paper** or a standard adhesive transparency. One inch type in either the Times New Roman or Courier font means the font size in a Word document is 110-point and will fit onto approximately seven (7) sheets of letter sized paper with a ½ inch margin on all four sides. The sign is a non-standard size to be produced in-house or framed in restrooms.

**Response:** Based on the comments received and the potential excessive cost the one inch and one-half inch lettering may cause, the Oklahoma State Department of Health proposes the following changes to the proposed rules:

310:2-31-3 (3): The lettering on any signage shall be at least one inch (1") in height and be in a times new roman or courier font reasonably legible.

310:2-31-3 (5): Additionally, the signage shall contain lettering, at least one-half inch (1/2") in height which is reasonably legible, that says: "This sign is created, produced and displayed in compliance with the Humanity of the Unborn Child Act.";

**Organization Name:** Tulsa Campaign to Prevent Teen Pregnancy and Planned Parenthood Great Plains

**Comment Topic:** Humanity of the Unborn Child Act (Act) and/or proposed regulations not in line with the mission of the OSDH

**Comments:** The OSDH received the following comments concerning the Act or the proposed regulations not being in line with the mission of the OSDH.

**Tulsa Campaign to Prevent Teen Pregnancy:** This law violates the mission of the OK Board of Health and OSDH, namely “to protect and promote the health of its citizens, prevent disease and injury, and cultivate conditions by which Oklahomans can be healthy.” No Oklahoman’s health is protected when pregnant women are encouraged to go to organizations, programs and/or services that, despite indicating an inclination to help pregnant women, OSDH knows nothing about, are not subject to OSDH oversight, and are not accountable to generally accepted medical standards.

**Planned Parenthood Great Plains:** The proposed rules are oppositional to the mission and value statement of the Department. The mission statement highlights “the importance to protect and promote health.” The proposed rules mandated by the so called Humanity of the Unborn Child Act neither protect nor promote health in Oklahoma. In fact, the law does the opposite – restricting access to safe, legal abortion or even information on comprehensive family planning options, which only harms Oklahomans seeking all available options. Even if the signs and web content required under the proposed rules contain comprehensive information about options for unintended pregnancies and family planning, the passive nature of displaying signs and web content means they are unlikely to significantly change behavior. The resources dedicated to the proposed rules would be better and more effectively spent on delivering comprehensive, medically accurate services directly to Oklahomans. The Department is without a way to reliably measure the impact of signs and web
materials on unintended pregnancy or abortion rates; by contrast, the delivery of direct services has a substantive, individually measured impact. In the service of protecting and promoting public health, the Department should prioritize initiatives that can measurably contribute to its mission.

**Response:** Whether the requirements contained in HB 2797 or the proposed rules violates the mission of the OSDH or the Board of Health is not within the purview of this rulemaking process. The proposed rulemaking was undertaken due to the requirements contained in Section 2, Paragraph (B); Section 2, Paragraph (C), and Section 2, Paragraph (D) of HB 2797. The proposed rulemaking was undertaken with the intent to “be in aid of and not in derogation of the legislative purpose” for the proposed rules, see Attorney General Opinion 84-194. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

**Organization Name:** Oklahoma Restaurant Association; Oklahoma Hotel and Lodging Association

**Comment Topic:** Future changes to the language in HB 2797

**Comments:** Contact has been made to an author of HB 2797 and changes to the bill may be forthcoming.

**Oral comments from Jim Hopper, President and CEO of the Oklahoma Restaurant Association and the Oklahoma Hotel and Lodging Association at the November 3, 2016 public hearing:** The Board of Health can take this as they want to, but we are already in conversations with the author in the legislature of this legislation to express our concerns and tell the author and the people at the legislature that we want to work with them to either change this law or repeal this law before it goes into effect because it does not make good common sense. There has to be a better way to get this message out to pregnant women about their options about their pregnancy.

**Response:** The OSDH appreciates the concerns expressed in these comments and the communication to members of the Oklahoma Legislature. As the bill is currently constructed, these provisions go into effect on January 1, 2018. To have rules in place by January 1, 2018, the OSDH must go through the current rulemaking process. These rules, as proposed, if adopted by the Board of Health and either (1) approved by the legislature; or (2) approved by the Governor, would not be finalized until sometime in September of 2017. If the Board of Health waited for any potential action to occur by the Oklahoma Legislature in the upcoming session, then there would be no rules in effect on January 1, 2018 as required by HB 2797. As stated previously, the OSDH has already received communications from the primary House author concerning the status of rulemaking. The Oklahoma Legislature or the Governor will not act on this proposed rulemaking, if passed by the Board of Health, until the end of the 2017 legislative session. If changes to HB 2797 are passed during the upcoming legislative session to change the necessity of these proposed rules, then the legislature and/or the Governor can deny the proposed rules. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

**Organization Name:** Planned Parenthood Great Plains

**Comment Topic:** Humanity of the Unborn Child Act (Act) is unconstitutional

**Comments:** The OSDH received the following comments concerning the Act being unconstitutional.

**Planned Parenthood Great Plains:** In 2015 (sic), the Oklahoma Legislature passed the so called Humanity of the Unborn Act despite the vocal opposition highlighting the numerous problems with such a measure. While the law appears in certain areas to attempt to expand access to resources for pregnant women, the true intent is to restrict safe, legal abortion access as evidenced by the numerous accounts from the author of the bill. The law plainly states the “purpose of achieving an abortion-free
society” [see, Enrolled HB 2797, Section 3 (2)] and demands educational material be created that “clearly and consistently teach that abortion kills a human being” [see, Enrolled HB 2797, Section 3 (2)]. It is important to continue to highlight the true intent of the Act. The United States Supreme Court recently affirmed long established precedence that the State may not create unnecessary and arbitrary barriers to abortion access [see, Whole Woman v. Hellerstedt, 579 US ______, 136 S.Ct. 2292]. The Humanity of the Unborn Act runs afoul of this decision. By creating an anti-abortion curriculum and requiring biased signs to be posted, the State is interfering in Oklahomans’ constitutionally protected right to an abortion. The State is emphasizing its anti-abortion agenda by requiring taxpayers to fund these unnecessary provisions. While the Act may not restrict the practice of abortion, its clear purpose is to advance an anti-abortion agenda—ever perceived obstacles create an impermissible undue burden. Because the Act itself is unconstitutional, the proposed rules of the Department must be rescinded.

Oral comments from Tamya Cox representing Planned Parenthood Great Plains at the November 3, 2016 public hearing: The Act these proposed rules derive from, we believe the Act is unconstitutional. We have a recent Supreme Court decision in June saying that any unnecessary or arbitrary barriers to the access to abortion will be ruled and deemed unconstitutional. We believe the Humanity of the Unborn Act runs afoul of the Constitution. So for that reason alone because we believe the Act itself is unconstitutional, we are asking the Department to rescind these rules.

Response: While the Department is aware of the recent United States Supreme Court ruling in the case of Whole Woman’s Health v. Hellerstedt, 579 US ______, 136 S.Ct. 2292 (2016) as well as the 2014 5th Circuit decision in Jackson Women’s Health Organization v. Currier, 760 F.3d 448 (5th Cir. 2014, cert. denied 2016), Oklahoma law requires the Department to presume that an Act of the Oklahoma Legislature is constitutional, see generally, Dani v. Miller, 374 P.3d 779 (Okla. 2016) and Reynolds v. Fallin, 374 P.3d 799 (Okla. 2016). It is the purview of the Oklahoma Courts, not an Oklahoma State Agency whether the Act as passed by the Oklahoma Legislature is unconstitutional, see generally, State v. Warren, 975 P.2d 900 (Okla. 1998). Therefore, it is not within the purview of the OSDH or the Board of Health to consider whether the Act is constitutional. The OSDH, as well as the Board of Health are required by law to presume the Act is constitutional, until a court says otherwise. Therefore, there will be no changes made to the proposed rulemaking based on these comments.

Organizations

Oklahoma Primary Care Association; Oklahoma Hospital Association

Comment Topic: OSDH web address on signs

Comments: That language for the signs does not contain the OSDH’s web address as required by HB 2797.

Oklahoma Primary Care Association: HB 2797 requires that the signs reference a website that includes information about unborn children and related services. The law requires that OSDH include this website on the Department’s website. However the proposed rule prohibits the signs from identifying OSDH. Therefore, the web address to be displayed on signs must not contain elements that would otherwise identify the agency.

Oklahoma Hospital Association: Additionally, the website address for the information required in the legislation is missing from the proposed rules on signage posting as required by 63 Okla. Stat. § 1-752.

Response: Section 2, Paragraph (C) does require the following:
On or before January 1, 2018, the Department shall make available to each facility in this state which is open to the public containing a restroom available to the public, and licensed by the State Department of Health, signage which is to be posted in its restroom containing the statement and the website address to obtain the information provided by subsection A of this section.

(Emphasis added). The OSDH inadvertently left off the web address to obtain information from the message. Therefore, based on these comments and this response, the following changes are being recommended to the proposed rulemaking (the underlined language is the language to be added):

- In OAC 310:2-31-3 (5) Additionally, the signage shall contain lettering, at least one half inch (1/2") in height which is reasonably legible, that says: "This sign is created, produced and displayed in compliance with the Humanity of the Unborn Child Act. For more information, please visit www.ok.gov/health";
- In OAC 310:2-31-3 (7) Neither the Department logo nor any other Department identification, except for the information required in OAC 310:2-31-3 (5), shall appear on the signage;

Agency Rule Contact:
Donald D. Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Room #206, Oklahoma City, Oklahoma 73117, (405) 271-60317 e-mail: DonM@health.ok.gov
To: Board of Health Secretary  
Through: Terry Cline, Ph.D.  
Commissioner  
Through: James Joslin  
Agency Rule Liaison  
From: Don Maisch  
General Counsel  
Date: November 10, 2016  
Subject: CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL

The attached rule and supporting documents are submitted for PERMANENT adoption of the rule at the Board of Health's December 2016 meeting.

We received no public comment. There were no revisions to the previously reviewed rule.

Attachments:
- Rule Impact Statement
- Rule Text
- Rule Comment Summary
RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 15. CLINICAL TRIALS ON THE USE OF CANNABIDIOL

1. DESCRIPTION: (a brief description of the purpose of the proposed rule [75 O.S. §303.D.2(a)])
These proposed regulations, if adopted, will implement the agency’s requirements from House Bill Number 2835, from the 2nd Session of the 55th Oklahoma Legislature (2016), codified at 63 O.S. §§ 2-801 through 2-805. The proposed regulations would remove the age limitation for clinical trials on the use of cannabidiol as required by the House Bill.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE: (a description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the agency from any private or public entities [75 O.S. §303.D.2(b)]) Those classes of persons potentially affected are physicians and patients that will be wanting to develop clinical trials for the use of Cannabidiol, as well as the educational facilities where the trials will occur. The costs of compliance of these rules will be to the physicians and the hospitals where the trials will occur. Since there is no fee associated with the filing for the approval, the only cost to the physician and the hospital will be the time needed to fill out and collect the appropriate paperwork.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES: (a description of the classes of persons who will benefit from the proposed rule [75 O.S. §303.D.2(c)]) The potential benefit will be to the physicians, patients and hospitals in determining whether Cannabidiol treatment is effective concerning certain seizure events, spasticity due to multiple sclerosis or due to paraplegia; intractable nausea and vomiting; or appetite stimulation with chronic wasting diseases. The Department will track and determine potential benefits through the receipt of reports from any of the approved trials.

4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES: (a description of the probable economic impact of the proposed rule upon affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change [75 O.S. §303.D.2(d)])

While the cost to the physicians or hospitals is unknown at the present time, it is assumed that there will be minimal costs to the physician or hospital if the proposed rules are adopted. Necessary time and equipment will need to be obtained to fill out the forms necessary to obtain approval and to conduct the needed clinical trial.

5. COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY: (the probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency [75 O.S. §303.D.2(e)])

The cost to implement the rule for the Oklahoma State Department of Health is unknown at the present time. If adopted the proposed rules would modify the requirements for physicians and hospitals wanting to conduct clinical trials on the use of Cannabidiol as a treatment for certain type of seizures, expanding the individuals who may participate in a clinical trial to anyone at any age. These new requirements
would increase the cost to the Oklahoma State Department of Health in receiving applications, reviewing applications and issuing approvals for the use of Cannabidiol in clinical trials.

The cost to the Department to implement the amendments will be approximately $4,419.60 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. IMPACT ON POLITICAL SUBDIVISIONS: (a determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule [75 O.S. §303.D.2(f)])

It is unknown if there will be any economic impact on any political subdivisions.

7. ADVERSE EFFECT ON SMALL BUSINESS: (a determination of whether implementation of the proposed rule may have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act [75 O.S. §303.D.2(g)])

Since all trials must occur at a research hospital, there will be no impact on small business.

8. EFFORTS TO MINIMIZE COSTS OF RULE: (an explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule [75 O.S. §303.D.2(h)])

There have been no effort to minimize compliance costs, as all the requirements contained in the proposed regulations are required by the implementing statutory requirements.

9. EFFECT ON PUBLIC HEALTH AND SAFETY: (a determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk [75 O.S. §303.D.2(i)])

- Explain how this rule supports core public health functions, ensures delivery of essential public health services, and contributes to strategic planning goals and objectives.
- Hyperlinks to published articles on the internet supporting the statement of effects are acceptable.

10. DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION: (a determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented [75 O.S. §303.D.2(j)])

It is unknown if there are any detrimental effects on public health and safety if these proposed rules are not adopted.

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1 75 O.S. § 502. As used in the Oklahoma Small Business Regulatory Flexibility Act:

4. "Small business" means a for-profit enterprise consisting of fifty or fewer full-time or part-time employees.

2 75 O.S. § 504(B). If the proposed rules may have an adverse economic effect upon small business, the agency shall submit a copy of the proposed rules and a rule impact statement to the Small Business Regulatory Review Committee for its review and comment pursuant to the review and comment provisions of paragraph 2 of subsection A and paragraph 6 of subsection B of Section 303 of this title.
11. This rule impact statement was prepared on July 1, 2016. Modifications made subsequent to the publication of the Notice of Rulemaking Intent were made on: November 22, 2016. (the date the rule impact statement was prepared and if modified, the date modified [75 O.S. §303.D.2(k)])
SUBCHAPTER 1. PURPOSE AND DEFINITIONS


The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise.

"Clinical Trial" means a trial at an academic medical center of the use of cannabidiol at an academic medical center on patients eighteen (18) years of age or younger pursuant to the requirements of Katie and Cayman's Law, codified at 63 O.S. §§ 2-801 through 2-805.

"O.S." means Oklahoma Statute.

"Severe forms of epilepsy" means refractory epilepsy that is not adequately treated by traditional medical therapies, including Lennox-Gastaut Syndrome and Dravet Syndrome, also known as Severe Myoclonic Epilepsy of Infancy.

SUBCHAPTER 3. PHYSICIAN APPLICATION AND REPORTING

310:15-3-1. Physician application.

Any physician, who has been designated a principal investigator of a clinical trial concerning Lennox-Gastaut Syndrome, also known as Severe Myoclonic Epilepsy of Infancy; any other severe form of epilepsy not adequately treated by traditional medical therapies (63 O.S. § 2-101 (23)), or any other form of refractory epilepsy that is not adequately treated by traditional medical therapies, spasticity due to multiple sclerosis or due to paraplegia; intractable nausea and vomiting; or appetite stimulation with chronic wasting diseases (63 O.S. § 2-801 (5)) on individuals eighteen (18) years of age or younger, and who requests approval from the Commissioner of Health, or designee shall:

(1) Submit an application on a form provided by the Commissioner of Health, which shall include the name, address and other contact information for the principal investigator;
(2) Submit a statement from either the Oklahoma State Board of Medical Licensure or the Oklahoma State Board of Osteopathic Examiners that the physician is licensed and in good standing with said licensure board;
(3) Submit a copy of the documents from the United States Food and Drug Administration naming the physician as the principal investigator;
(4) Submit a copy of the license obtained by the United States Drug Enforcement Administration;
(5) Submit and maintain a current Oklahoma State Bureau of Narcotics and Dangerous Drugs Control registration;
(6) Demonstrate registration with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control;
(7) Submit the names, addresses and other contact information of any subinvestigators who will be assisting the principal investigator and include with the submission:

(A) A copy of the license obtained by the United States Drug Enforcement Administration; and
(B) Information demonstrating registration of the subinvestigator with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control;

(8) Submit the following information concerning the clinical trial to be performed:
(A) Name, address and contact information of the academic medical center where the clinical trial will occur;
(B) Statement from Institutional Review Board (IRB) of the academic medical center where the clinical trial will occur, concurring with the requirements for said clinical trial;
(C) Statement from the United States Food and Drug Administration allowing cannabidiol to be used as a investigaion new drug on qualified patients with severe forms of epilepsy;
(D) Name, address and other contact information of the source of the cannabidiol to be used for the study. The submission of the information of the source of the cannabidiol shall include:
   (i) Information that the cannabidiol was manufactured at a facility in the United States or in a foreign country that was approved by the United States Food and Drug Administration; and
   (ii) Information that the cannabidiol has been tested on animals to:
       (I) demonstrate preliminary effectiveness; and
       (II) ensure the cannabidiol is safe to administer to humans;
(E) Submit a statement that the clinical trial will be performed at the highest standards of clinical research; and
(F) Submit a statement that the clinical trial will conclude no later than December 31, 2017;

(9) Submit a statement that the principal investigator and all subinvestigators shall adhere to the rules and regulations established by the relevant Institutional Review Board for the clinical trial; and
(10) Submit an attestation by the principal investigator as to the accuracy and completeness of the information provided in the application.
Title 310. Oklahoma State Department of Health
Chapter 15. Clinical Trials on the Use of Cannabidiol

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant to 75:303.1(A) of the Administrative Procedures Act, shall include:

9) A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules; (10) A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.[75:303.1(E)(9)&(10)]

Name: Kimble Carter

Comments: The proposed changes do not cover all the changes passed by the Oklahoma Legislature in House Bill 2835. The changes in House Bill 2835 added the following conditions for a clinical study on the effectiveness of cannabidiol: spasticity due to multiple sclerosis or due to paraplegia; intractable nausea and vomiting; or appetite stimulation with chronic wasting diseases.

Response: The Oklahoma State Department of Health agrees with the comment and proposes to make the following changes to the proposed modifications to Oklahoma Administrative Code 310:15-3-1:

Any physician, who has been designated a principal investigator of a clinical trial concerning Lennox-Gastaut Syndrome, also known as Severe Myoclonic Epilepsy of Infancy; any other severe form of epilepsy not adequately treated by traditional medical therapies (63 O.S. § 2-101 (23)), or any other form of refractory epilepsy that is not adequately treated by traditional medical therapies, spasticity due to multiple sclerosis or due to paraplegia; intractable nausea and vomiting; or appetite stimulation with chronic wasting diseases (63 O.S. § 2-801 (5)) on individuals eighteen (18) years of age or younger, and who requests approval from the Commissioner of Health, or designee shall:

1) Submit an application on a form provided by the Commissioner of Health, which shall include the name, address and other contact information for the principal investigator;
2) Submit a statement from either the Oklahoma State Board of Medical Licensure or the Oklahoma State Board of Osteopathic Examiners that the physician is licensed and in good standing with said licensure board;
3) Submit a copy of the documents from the United States Food and Drug Administration naming the physician as the principal investigator;
4) Submit a copy of the license obtained by the United States Drug Enforcement Administration;
5) Submit and maintain a current Oklahoma State Bureau of Narcotics and Dangerous Drugs Control registration;
6) Demonstrate registration with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control;
7) Submit the names, addresses and other contact information of any subinvestigators who will be assisting the principal investigator and include with the submission:
   A copy of the license obtained by the United States Drug Enforcement Administration; and
(B) Information demonstrating registration of the subinvestigator with the Oklahoma State Bureau of Narcotics and Dangerous Drugs Control;

(8) Submit the following information concerning the clinical trial to be performed:
(A) Name, address and contact information of the academic medical center where the clinical trial will occur;
(B) Statement from Institutional Review Board (IRB) of the academic medical center where the clinical trial will occur, concurring with the requirements for said clinical trial;
(C) Statement from the United States Food and Drug Administration allowing cannabidiol to be used as an investigational new drug on qualified patients with severe forms of epilepsy;
(D) Name, address and other contact information of the source of the cannabidiol to be used for the study. The submission of the information of the source of the cannabidiol shall include:
   (i) Information that the cannabidiol was manufactured at a facility in the United States or in a foreign country that was approved by the United States Food and Drug Administration; and
   (ii) Information that the cannabidiol has been tested on animals to:
      (I) demonstrate preliminary effectiveness; and
      (II) ensure the cannabidiol is safe to administer to humans;
(E) Submit a statement that the clinical trial will be performed at the highest standards of clinical research; and
(F) Submit a statement that the clinical trial will conclude no later than December 31, 2017;

(9) Submit a statement that the principal investigator and all subinvestigators shall adhere to the rules and regulations established by the relevant Institutional Review Board for the clinical trial; and
(10) Submit an attestation by the principal investigator as to the accuracy and completeness of the information provided in the application.

Agency Rule Contact:
Donald D. Maisch, General Counsel, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6017, e-mail: donm@health.ok.gov.
To: Board of Health Secretary

Through: Terry Cline, Ph.D.
Commissioner

Through: James Joslin
Agency Rule Liaison

e-approved
11/18/16

Through: Don Maisch
General Counsel

e-approved
11/18/16

From: Hank Hartsell
Deputy Commissioner
Protective Health Services

e-approved
11/18/16

From: Lynnette Jordan
Service Director
Consumer Health Service

e-approved
11/18/16

Date: November 18, 2016

Subject: CHAPTER 233. BODY PIERCING AND TATTOOING

The attached rule and supporting documents are submitted for PERMANENT adoption of the rule at the Board of Health's December 2016 meeting.

We received no public comment. There were no revisions to the previously reviewed rule.

Attachments:
- Rule Impact Statement
- Rule Text
- Rule Comment Summary
1. DESCRIPTION:
The proposed amendments modify the proof of training and experience required before an applicant is approved to take the license examination. The proposal deletes the requirement for proof of two years' license from another state, and substitutes a requirement for documentation of two years' experience from another state. The proposal allows a licensure candidate to submit proof of completion of training that is substantially equivalent to the requirements for apprentice programs in Oklahoma. The effect of the change is to give candidates credit for experience or training in a state that does not license artists. The Oklahoma State Department of Health (OSDH) developed the foregoing amendments in response to a request for rulemaking filed by a facility operator and artist licensed in Oklahoma. Additionally, the amendments clarify the process for approving an applicant to take the license examination and issuing the permanent artist license.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:
The classes of persons affected are applicants for artist licensure, and operators of establishments. Under the proposed amendments, applicants for licensure as body piercing or tattoo artists may be given credit for experience or training in states that do not issue licenses to artists. The change may reduce the applicants' costs to obtain a license in Oklahoma by reducing the time required to complete training. Facility operators will be affected by having access to additional qualified artists to appropriately staff their businesses. The OSDH requested in the notice of rulemaking intent information from businesses on cost impacts. No comments were received.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:
Persons benefiting will be applicants from states that do not have regulatory authority over licensing of individual artists. Additionally, facility operators may benefit from having access to additional qualified artists. Oklahoma-licensed artists may benefit by not having to compete against unlicensed individuals who do not comply with Oklahoma law or OAC 310:233. The public may benefit from having access to additional experienced and properly trained artists licensed by the OSDH. The number of complaints received by the OSDH on unlicensed artists rose 50% from 2014 to 2015, increasing from approximately 60 complaints in 2014, to 90 in 2015.

4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:
Facility operators may benefit economically from an increased supply of qualified and licensed artists to staff their businesses. Individual artists may benefit by being able to work legally as artists in Oklahoma. The level of the economic benefit is not known at this time. The rule involves no fee increases.
5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:**
   The cost to the Department to implement the amendments will be approximately $3,252.32 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues. Revenues to be used for implementation are the license fees for artists and facilities. Revenues from license fees may increase if more out-of-state artists request licensure, but the volume of such increase is unknown at this time. The benefit may be a reduction in unlicensed artists working in Oklahoma. No impacts on other agencies are anticipated.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**
   There is no anticipated impact on political subdivisions.

7. **ADVERSE EFFECT ON SMALL BUSINESS:**
   There is no anticipated adverse effect on small business. No comments were received in the public comment period.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:**
   The proposed changes add flexibility to the application of the rule by allowing for variation in the documentation submitted for proof of experience and training. Variation exists across states and not all states issue artist licenses – some states regulate only establishments, and some local jurisdictions issue licenses and permits. The proposed changes focus on the subject of the request for rulemaking action submitted by a facility operator and artist and do not add requirements or costs.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**
   This change will allow each out-of-state artist with acceptable experience and training to obtain an Oklahoma artist license without being required to demonstrate an additional 1,500 hours of training in apprentice status in Oklahoma. This may result in a decreased number of complaints about unlicensed artists practicing outside of licensed establishments.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**
    If this change is not made, Oklahoma will continue to have an experience and training requirement placing at a disadvantage those individuals who have worked in states with other types of regulatory frameworks. Some states such as Texas do not require state-issued licenses for individual artists and others such as Florida relatively recently have implemented individual licenses. The rule will treat license applicants with equivalent experience and training equitably, regardless of the state where they lawfully gained that experience and training. This change has the potential to decrease alleged incidents of unlicensed artists practicing in Oklahoma, and increase the numbers of licensed artists.

11. This rule impact statement was prepared on September 19, 2016, and revised November 17, 2016, and November 22, 2016.
TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 233. BODY PIERCING AND TATTOOING

SUBCHAPTER 9. LICENSE REQUIREMENTS

310:233-9-2. Artist license
(a) The artist must be a minimum of eighteen (18) years of age to be eligible for a license.
(b) No person shall practice body piercing or tattooing procedures without first obtaining an artist license from the Department.
(c) The artist license shall be valid from the date of issuance and shall automatically expire one (1) year from the date of issuance unless revoked or suspended by the Department. The artist shall have a current bloodborne pathogen certificate, CPR certificate and current first aid certification for license or renewal of license.
(d) The application for an artist license shall include:
   (1) Name;
   (2) Date of birth;
   (3) Sex;
   (4) Residence address;
   (5) Mailing address;
   (6) Telephone number;
   (7) Place(s) and licensed license number of employment as an artist;
   (8) Proof of training and experience which shall include one of the following;
       (A) Two (2) years' experience acquired in another state in compliance with applicable requirements of that state. Documentation may include copies of licenses, statements from the state's regulatory authority, statements from the facility operator where the applicant worked, membership in an entity for which practice as an artist is a requisite, or government forms such as tax returns filed by the artist showing employment as an artist; or
       (B) Proof of completion of an Oklahoma apprentice program that has been accepted by the Department complies with 310:233-9-5, 310:233-9-6 and 310:233-9-7, or documentation from another state showing completion of training that is substantially equivalent to an Oklahoma apprentice program and sponsorship per 310:233-9-5, 310:233-9-6 and 310:233-9-7;
   (9) Current bloodborne pathogen certification recognized from a nationally accredited program compliant with 310:233-9-2(m); and
   (10) Current first aid certification compliant with 310:233-9-2(n); and
(e) Each artist license shall be conditioned upon continued compliance with the provisions of this section as well as all applicable provisions of OAC 310:233.
(f) Each artist license shall be posted in a prominent and conspicuous area where it may be readily observed by clients.
(g) License fees shall be as follows:
   (1) $250.00 for an initial license;
   (2) $250.00 for a renewal license;
(3) $350.00 for late renewal when the license is not renewed within thirty (30) days after expiration; and
(4) $50.00 temporary artist license, not to exceed 7 days.

(h) A person who has acceptable proof of experience or training as stated required in 310:233-9-2(d)(8)(A and B) in performing tattooing may be deemed to have met the Department approved preparedness requirements status as per 310:233-9-2(d)(8)(A and B) approved by the Department to take the test specified in 310:233-9-2(i). A candidate shall have a minimum passing score of 70% on the written examination that will include:

(1) Knowledge of Anatomy, Physiology, and Disease;
(2) Theory and application of ink;
(3) Safety and Aseptic Technique;
(4) Professionalism; and
(5) Client Consultation Services.

(i) A candidate who does not meet this score can retest up to two (2) times. A candidate who does not pass the written examination must wait at least seven (7) days before retesting. Any candidate who is unable to attain competency after three attempts shall be required to enroll or re-enroll in an apprentice program. To apply, the candidate shall submit an application that requires the following:

(1) Notarized copy of the applicant's certificate of birth;
(2) Notarized copy of the applicant's driver's license or other similar photo identification;
(3) Notarized copy of his/her credentials and professional resume of satisfactory completion of any programs they have completed for proof of experience; and

(j) The Department shall accept the test administered by the Oklahoma Department of Career Technology with results to be evidenced by a completed testing verification provided to the Department by the Oklahoma Department of Career Technology.

(k) Within 30 days after receipt of a completed application, the Department shall notify the applicant in writing of its decision to approve or disapprove the applicant to take the examination. An applicant who is eligible for the testing process must present a letter of notification from the Department to administer the test given by Oklahoma Department of Career and Technology Education.

(l) Upon successful completion of the testing process, the applicant is eligible to apply for issuance of a permanent artist license. In order to apply for issuance of a license, the candidate applicant must submit the following to the Department:

(1) Completed Any changes in the application previously submitted as specified required in 310:233-9-2(i)(1-4),
(2) Completed Testing Verification Form provided by the Department which includes:
   (A) Skills evaluation information; and
   (B) Written certification examination records.

(m) Bloodborne training certification shall contain at a minimum the following elements:

(1) A general explanation of the epidemiology and symptoms of bloodborne diseases;
(2) An explanation of the modes of transmission of bloodborne pathogens;
(3) An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;
(4) An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

(5) An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices, and personal protective equipment;

(6) Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

(7) An explanation of the basis for selection of personal protective equipment;

(8) Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated;

(9) Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

(10) An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

(11) Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident; and

(12) An explanation of the signs and labels and/or color coding required.

(n) First aid certification shall include instruction in:

(1) Injury and acute illness as a health problem;

(2) Interactions with the local emergency medical services system;

(3) Responsibility for maintaining a current list of emergency telephone numbers (police, fire, ambulance, poison control) easily accessible to all employees;

(4) Instruction in the principles and performance of bandaging of the head, chest, shoulder, arm, leg, wrist, elbow, foot, ankle, fingers, toes, and knee; and

(5) Apprentices shall be provided with adequate instruction on the need for and use of universal precautions that should include:

(A) The meaning of universal precautions;

(B) Which body fluids are considered potentially infectious, and which are regarded as hazardous;

(C) The value of universal precautions for infectious diseases;

(D) The necessity for keeping gloves and other protective equipment readily available and the appropriate use of them; and

(E) The appropriate tagging and disposal of any sharp item or instrument requiring special disposal measures such as blood soaked material, and the appropriate management of blood spills.

(o) CPR training certification shall include instruction in:

(1) Performing a primary survey of each victim including airway, breathing, and circulation assessments;

(2) The presence of any bleeding, establishing and maintaining adult airway patency;

(3) Performing adult breathing resuscitation; and

(4) Performing choking assessments and appropriate first aid intervention.
RULE COMMENT SUMMARY AND RESPONSE
TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 233. BODY PIERCING AND TATTOOING

The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules; (10) A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.[75:303.1(E)(9)&(10)]

Name & Organization: Jonathan Cagle, Classic Tattoo & Body Piercing

Mr. Cagle provided comments concerning rule amendments that were considered in earlier proposed drafts but not addressed in the proposed changes to section 310:233-9-2, Artist license. This section is the only proposed section for amendment as announced in the Notice of Proposed Permanent Rulemaking. Amendments outside of the announced section are prohibited under the Administrative Procedures Act (75 O.S. § 250 et. seq.) and Rules on Rulemaking (OAC 655:10). As such, the comments will be reviewed and evaluated for possible future updates to Chapter 233.

Name & Organization: Tulsa Tattoo Co.

Tulsa Tattoo Co. provided comments concerning rule amendments that were considered in earlier proposed drafts but not addressed in the proposed changes to section 310:233-9-2, Artist license. This section is the only proposed section for amendment as announced in the Notice of Proposed Permanent Rulemaking. Amendments outside of the announced section are prohibited under the Administrative Procedures Act (75 O.S. § 250 et. seq.) and Rules on Rulemaking (OAC 655:10). As such, the comments will be reviewed and evaluated for possible future updates to Chapter 233.

Response: Based on the comments received, no changes to the proposed rules are warranted.
To: Board of Health Secretary

Through: Terry Cline, Ph.D.
Commissioner

Through: James Joslin
Agency Rule Liaison

Through: Don Maisch
General Counsel

Through: Tina Johnson
Deputy Commissioner

From: Susan Quigley
Childhood Lead Poisoning Prevention Program

Date: November 18, 2016

Subject: CHAPTER 512. CHILDHOOD LEAD POISONING PREVENTION RULES

The attached rule and supporting documents are submitted for PERMANENT adoption of the rule at the Board of Health's December 2016 meeting.

We received no public comment. There were no revisions to the previously reviewed rule.

Attachments:
- Rule Impact Statement
- Rule Text
- Rule Comment Summary
1. DESCRIPTION:
   This rule change will add amendatory language for Childhood Lead Poisoning Prevention in order to reflect current practice and modify terminology and definitions to coincide with current language used in the Oklahoma Childhood Lead Poisoning Prevention Program (OCLPPP).

   • In May 2012, the Centers for Disease Control changed the blood lead level at which point certain actions should be initiated from 10 µg/dL to 5 µg/dL. See CDC Response to Advisory Committee on Childhood Lead Poisoning Prevention Recommendations in “Low Level Lead Exposure Harms Children: A Renewed Call of Primary Prevention” (https://www.cdc.gov/nceh/lead/acclpp/cdc_response_lead_exposure_recs.pdf).

   • The OCLPPP informally adopted this change in June 2012 and began offering follow-up services to children at the new lower level. However, sections of the rules regarding blood lead levels were last updated in 1994 and contain the older reference level. The current rules also have ambiguous language and outdated procedures and terms such as "environmental assessments" versus "environmental investigations."

   • The most significant changes will be to update the definitions of elevated blood lead levels and to further clarify the role of the laboratories and providers in reporting lead results. Lead results are reportable pursuant to Title 63 O.S. Sections 1-114.1 and § 1-503 and the Reportable Disease Rules, OAC 310-515.

   • The changes re-structure the order of some items to put them into more logical categories. This is part of OCLPPP’s overall effort to make the rules more accessible, understandable, and usable without altering their sense, meaning, or effect. Some sections have been reclassified and rearranged in a more logical order, removing language that is invalid, repealed or duplicative to improve the draftsmanship of the rule. New technologies (Point-of-Care devices, electronic reporting capabilities) are incorporated to make screening and reporting easier.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:

   • All children in Oklahoma should be screened for lead in the blood at the ages of 12 months and 24 months as part of universal screening for lead in children up to 72 months of age. Many providers in Oklahoma and all Oklahoma County Health Departments are currently following the updated guidelines which have led to increased follow-up testing for children who would previously not have been considered at an elevated lead level.

   • Because most providers in the state have already begun to use the new action level for follow-up as recommended by the American Academy of Pediatrics who publicly, and in writing, commended the CDC for recognizing that there is no safe level of lead exposure and that the level should be lowered to avoid lasting damage to children.

• It is expected that cost impacts are greatest in the savings to society in avoidance loss of IQ points, behavioral problems, and damage to the nervous system and kidneys of children.
• Public comment was sought to identify any unanticipated cost impacts. No comments were received.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:
• The class of persons who will benefit from the proposed rule include all children in the state of Oklahoma under the age of 72 months, their parents, as well as pediatricians and clinics who perform blood lead testing.
• Children with levels of 5 or more micrograms per deciliter will receive follow-up testing and verification of capillary blood screens based on the lowered criteria for rescreens and follow-up.
• Children who have already received a verified test result will receive follow-up at or above 5 micrograms per deciliter. This follow-up includes educational information, assistance in determining the source of lead exposure, and monitoring of continued follow-up testing until the levels are below 5 micrograms per deciliter.
• Earlier intervention will reduce the likelihood of lasting damage caused by lead exposure. Damage includes loss of IQ points, behavioral problems, and damage to the nervous system and kidneys.
• Conservative estimates based on information from 2009 show that for every $1 spent on lead poisoning prevention, $17 to $221 dollars are returned as health benefits, in the form of increased IQ, higher lifetime earnings, increased taxable earnings and tax revenue, reduced spending on special education, and reduced criminal activity.

The Oklahoma State Department of Health’s Childhood Lead Poisoning Prevention Program intends to verify the benefit of the rule through both:

• Performance measures that include an increase in the amount of children receiving follow-up testing following a level of 5 micrograms per deciliter or above.
• Outcome measures that include a decrease in the overall rate of elevated blood lead levels in the state of Oklahoma.
• It should be noted that these impacts have already been seen in an increase of children receiving follow-up testing. On average, 200 additional children per year have received follow-up testing since OCLPPP implemented this change in practice as a recommendation in June 2012.
• In 2015, 367 children with blood lead levels in the range of 5 to 9 micrograms per deciliter and their parents received educational materials on the health hazards of elevated blood lead levels and methods of reducing lead exposures in the child’s environment as well as recommendations for follow-up testing. Among these children, 130 follow-up cases were closed out successfully after these children received at least two follow-up blood lead tests with blood lead levels below acceptable minimums. The average time from intake to successful close-out was 246 days for children at blood lead levels of 5 to 9 micrograms per deciliter. An additional 73 child cases were closed out after achieving one follow-up blood lead test with blood lead levels below acceptable minimums.
4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:

- It is estimated that approximately 700 more cases of screening tests at the level of action have been followed up with repeat screenings since implementing the recommended level to 5 micrograms per deciliter.
- OCLPPP spends approximately $1,200 per month at the cost of $10 per test to pay for testing for children not covered by Medicaid or private health insurance.
- OCLPPP has estimated the effect of compliance and economic impact and has compared the amount spent for lead testing in 2011 (prior to our change in practice regarding the new level of reference). In 2011, OCLPPP spent $14,500 on blood lead testing. After implementation of the new level of concern, OCLPPP spent $10,300 in 2013. This reduction is based mainly on a greater number of children who are at risk for blood lead testing being covered by Medicaid (and thus their testing is paid for by Medicaid and not OSDH), and more children and families now eligible for the other health insurance. This represents a decrease in program costs of nearly 33%.

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

The cost to the Department to implement the amendments will be approximately $4,409.89 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. IMPACT ON POLITICAL SUBDIVISIONS:

The proposed rules will have no anticipated effect or impact on political subdivisions.

7. ADVERSE EFFECT ON SMALL BUSINESS:

The implementation of the proposed rule should have no adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act. Public comment was sought to identify any unanticipated cost impacts. No comments were received.

8. EFFORTS TO MINIMIZE COSTS OF RULE:

The costs of the rule have been kept to a minimum. Less costly alternatives do not exist and a rule change is required to ensure that all providers in the State of Oklahoma are aware of the changes in elevated lead levels for Oklahoma children and have easier to understand guidelines for follow-up testing.

9. EFFECT ON PUBLIC HEALTH AND SAFETY:

- As discussed above, early identification and intervention for children with elevated lead levels is a positive contribution to child health and will improve the core public health services for children in Oklahoma.
• High lead levels or even ‘low’ levels for an extended period of time can cause irreparable damage to health and behavior.
• These rule changes will clarify the change from a level once considered a ‘reference level’ of 10 or more micrograms per deciliter to an ‘action level’ of 5 micrograms per deciliter or above.

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

• In 2015, 367 children with blood lead levels in the range of 5 to 9 micrograms per deciliter and their parents received educational materials on the health hazards of elevated blood lead levels and methods of reducing lead exposures in the child’s environment as well as recommendations for follow-up testing. Without a change in the "action level" to 5 micrograms per deciliter, children may not be identified for treatment and follow-up.
• The largest percentage of children with elevated lead levels fall in the category of lead levels from 5-9 micrograms per deciliter; (approximately 81% of all children with blood lead levels of 5 micrograms per deciliter or higher).
• Without adopting this change, funding opportunities based on need as well as the ability to offer follow-up and education to a greater amount of children at risk for lasting effects from lead exposure are greatly diminished.
• Official adoption of the Centers for Disease Control and Prevention’s recommended elevated level of 5 micrograms per deciliter will ensure that Oklahoma is following the national recommended action level and offering services to more children and reducing their risk of lasting damage through intervention, prevention, and educational efforts.

11. This rule impact statement was prepared on January 26, 2016 and updated on September 16, 2016. Modifications made subsequent to the publication of the Notice of Rulemaking Intent were made on: November 18, 2016.
**310:512-1-1. Purpose**

Under 63 O.S. 1991, Sections 114.1, the following rules are established concerning the screening of all Oklahoma children, ages 6 months to 72 months of age, for lead poisoning, designated by the Oklahoma State Board of Health.

The rules in this Chapter establish procedures and standards for childhood lead screening, assessment, poison prevention, and reporting as authorized under the provisions of Title 63 O.S. Section 114.1.

**310:512-1-2. Criteria**

(a) The Oklahoma State Board of Health shall establish procedures for blood lead screening which shall include risk assessment, laboratory assays, sample collection, reporting, follow-up, and parent education. The Infant and Children’s Health Advisory Council shall advise the Oklahoma State Board of Health on the establishment of rules for the prevention of childhood lead poisoning which shall include risk assessment, blood lead screening, laboratory assays, sample collection, reporting, lead hazard control, and rules related to the role of the provider such as: follow-up, diagnosis and treatment, developmental screening, referral for environmental assessments and lead hazard control, and parent education.

(b) All health care providers shall comply with the following procedures for blood lead screening established by the Oklahoma State Board of Health.

(c) After sufficient statewide data collection and documented incidence of low lead exposure, the Commissioner of Health may exempt a community or county from universal lead screening.

**310:512-1-3. Lead poisoning prevention program**

(a) The Department shall establish maintain a lead poisoning prevention program. This program shall be responsible for establishing and coordinating activities to prevent lead poisoning and to minimize risk of exposure to lead.

(b) The Department shall promulgate and enforce rules for screening children for lead poisoning, and for follow-up of children who have elevated blood lead levels.

(c) The Department may enter into interagency agreements to coordinate lead poisoning prevention, exposure reduction, identification and treatment activities and lead reduction activities with other federal, state and local agencies and programs.

(d) The Department shall establish maintain a statewide registry surveillance system of children with elevated lead levels, all Oklahoma children’s blood lead levels, provided such information is monitored as confidential except for disclosure for medical treatment purposes or disclosure of non-identifying epidemiological data.

(e) The Department shall develop and implement public education and community outreach programs on lead exposure, detection and risk reduction.

**310:512-1-4. Definitions**

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Advisory Council" means the advisory council on lead poisoning prevention Infant and Children’s Health Advisory Council.

"Anticipatory guidance" means providing parents or guardians of children under the age of six with information regarding the major causes of lead poisoning and means of preventing lead exposure. Such guidance shall be pertinent to the environment of the child.

"Blood lead screening" refers to measuring lead concentration by capillary or venous blood collection to identify elevated blood lead levels.

"Case Management" refers to providing a collaborative process to assess, educate, coordinate, monitor, or evaluate options and services required to meet the child’s environmental health and human service needs.

"CLIA ’88" "CLIA" means the Clinical Laboratory Improvement Amendments. These amendments apply to the Federal Law that governs laboratories who examine human specimens for the diagnosis, prevention, or treatment of any disease or impairment, or the assessment of the health of human beings.

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**NOTE:**

The text above is a natural representation of the document content as described in the image. It has been formatted to ensure clarity and readability, maintaining the structure and key points of the original text.
"Clinical Management Guidelines" means voluntary guidelines produced by the Department for clinical management and treatment decisions based on the initial or confirmed blood lead level.

"Confirmatory testing" refers to a blood lead concentration measured on venous blood the collection of a venous blood sample to confirm an initial elevated capillary blood lead screening result. The collection of a capillary sample within 12 weeks to confirm an initial elevated capillary blood lead screening result may be used if the initial capillary level is less than 10 µg/dL.

"Confirmed elevated blood lead level" refers to a concentration of lead in the blood taken from a venous sample which is above the reference level. It may also refer to a second capillary test as described in "confirmatory testing".

"Department" refers to the Oklahoma State Department of Health.

"Dwelling" refers to a building or structure thereof, including the property occupied by and appurtenant to such dwelling, which is occupied in whole or in part as the home, residence or sleeping place of one or more human beings and shall without limiting the foregoing, include child care facilities for children under six years of age, schools and nursery schools.

"Elevated blood lead level" means a confirmed concentration of lead of 10 micrograms (µg) per deciliter (dL) or greater-in blood at or above the current reference level as defined by the Centers for Disease Control.

"Environmental management investigation" refers to on-site dwelling environmental investigation and exposure assessment, sampling for lead, environmental testing and reporting, notice of conditions conducive to lead poisoning. Environmental intervention means an on-site dwelling investigation to determine the existence, nature, severity, and location of lead or lead-based paint hazards, completed by a person licensed as a certified risk assessor by the Oklahoma Department of Environmental Quality.

"Follow-up" refers to actions by local health departments and health care providers which, depending on the blood level and exposure history of the child, shall include as appropriate: risk reduction education, follow-up testing, confirmatory testing, medical evaluation, medical management, environmental management investigation, and case management, in accordance with generally accepted medical standards and public health guidelines.

"Follow-up testing" refers to repeat blood lead testing by venous blood draw for any child with a previously confirmed elevated blood lead level.

"Health care provider" means any health professional or facility authorized to conduct blood lead screening. Health care provider includes, but is not limited to, physicians, physician assistants, advance practice registered nurses, city-county health departments, county health departments, medical clinics, medical offices, hospitals, and Head Start programs.

"High risk lead exposure" refers to any positive response on the LERAQ or other suitable risk assessment questionnaire.

"Laboratory" refers to the Oklahoma State Department of Health Laboratory or a laboratory approved by the Oklahoma State Department of Health to conduct blood lead measurement any in-state CLIA approved laboratory or out-of-state CLIA approved laboratory providing blood lead testing for residents of Oklahoma. Laboratory may also refer to any entity using a point of care instrument for the purpose of blood lead testing of Oklahoma residents.

"LERAQ" refers to the Lead Exposure Risk Assessment Questionnaire which consists of a model set of questions developed by the Department to assess a child’s risk of exposure to lead and includes information regarding areas of the state with higher than average risks for lead exposure.

"Low risk lead exposure" refers to negative responses to all questions on the LERAQ or other suitable risk assessment questionnaire.

"Person" means any natural person.

"Point-of-Care Instrument" refers to a blood lead testing device designed for the quantitative measurement of lead in fresh whole blood.

"Primary Health Care Provider" refers to any person or government entity that provides well child health care services, such as annual examinations and immunizations, to children under six years of age. Primary health care provider includes, but is not limited to, physicians, physician assistants, advance practice registered nurse, local health departments, medical clinics, medical offices, and hospital outpatient clinics.

"Program" refers to the Oklahoma Childhood Lead Poisoning Prevention Program (OCLPPP) lead poisoning prevention program in of the Department.

"Reference Level" means a level of lead in the blood measured in micrograms per deciliter used to identify children with lead levels that are much higher that most children’s lead levels. This level is based on the U.S. population of children ages 1-5 years who are in the highest 2.5% of children when tested for lead in their blood based on the 97.5 percentile of the National Health and Nutrition Examination Survey (NHANES) for the two most recent surveys. The reference level currently in use is 5 micrograms per deciliter.
"Risk Assessment Questionnaire" means a set of questions designed to determine an individual’s risk for lead exposure and lead poisoning, as approved by the Department and based on recommendations from the CDC.

"Satisfactory specimen" means a specimen collected using an appropriate procedure which is suitable in both blood quantity and quality to perform screening for Blood Lead measurement. Federal CLIA '88 regulations require that the laboratory requisitions contain sufficient patient data that must include patient's name, date of birth, date of collection, test(s) to be performed, and name and address of person requesting the test.

"Submitter" any health care provider (primary and non-primary), hospital, physician, laboratory, or other facility that submits blood specimens for blood lead measurements.

"Target population" refers to any infant or child, 6 months to 72 months of age.

"Unsatisfactory specimen" means a blood specimen which is not suitable in quality or quantity to perform blood lead measurements.

SUBCHAPTER 3. SPECIMEN RISK ASSESSMENT, SCREENING AND MANAGEMENT

310:512-3-1. Screening Parameters Risk assessment and screening criteria
(a) All children in Oklahoma, 6 months to 72 months of age shall be assessed for blood lead exposure utilizing the risk assessment questionnaire as defined in paragraph (c) and should have access to service which will assess the exposure to lead in their environment as part of each periodic health care visit occurring at age 6, 12, and 24 months and age 3 years, 4 years and 5 years. An initial capillary or venous sample should be done at 12 months and 24 months of age, anytime the child has not had a baseline before the age of 72 months, or with any change in the child’s assessment.
(b) A parent or guardian who refuses blood lead testing screening of their child shall also indicate in writing this refusal in the child’s record. All children in Oklahoma shall have a blood lead screening test as part of each periodic health care visit occurring at age 12 and 24 months of age or at any age after age 24 months up to age 72 months, if not previously tested for blood lead.
(c) A risk assessment questionnaire is based on recommendations from the CDC and shall be approved by the Department prior to implementation. The questionnaire should include questions related to the following:
(1) Does the child live in or frequently visit a home built before 1978?
(2) Does the child have a sibling or playmate with an elevated blood lead level?
(3) Is the child eligible for Medicaid, WIC, or Head Start?
(4) Does the child live with someone who has a job or hobby that may involve lead (example: jewelry making, building renovation or repair, working with automobile batteries, lead solder, or battery recycling)?
(5) Does the child eat or mouth trinkets or items that contain lead?
(6) Does the child live in an area identified as a high risk target area by the Program?
(d) A "Yes" or "Don't know" answer to the questions in paragraph (c) is considered a positive answer and requires the child to have a blood lead test.
(e) The Department publishes current high risk target areas on its website located at: http:lpp.health.ok.gov.
(f) The Department publishes the LERAQ as an approved risk assessment questionnaire on its website.

310:512-3-2. Screening criteria [REVOKED]
(a) For children at low risk for lead exposure, according to risk assessment questions, the health care provider should perform an initial blood lead test at 12 months of age, or when initially assessed if older.
(1) If the result is <10 μg/dL, the child should be retested at 24 months of age.
(2) If the result is between 10–19 μg/dL, the child should be retested every 3–4 months until two consecutive measurements are <10 μg/dL or three consecutive measurements are <15 μg/dL. At this point, the child should be retested in one year.
(3) If the result is ≥20 μg/dL, retest every 3–4 months and individual case management should be provided.
(b) For children at high risk for lead exposure, according to risk assessment questions, the health care provider should perform an initial blood lead test at 6 months of age, or when initially assessed if older.
(1) If the result is <10 μg/dL, the child should be retested every 6 months until two consecutive measurements are <10 μg/dL or three consecutive measurements are <15 μg/dL. At this point, the test repeated yearly, if the child remains at high risk for lead exposure.
(2) If the result is between 10–19 μg/dL, the child shall be retested every 3–4 months until two consecutive measurements are <10 μg/dL or three consecutive measurements are <15 μg/dL. At this point, restested yearly, if the child remains at high risk for lead exposure.
(3) If the result is ≥20 μg/Dl, the child should be retested every 3–4 months and individual case management shall be provided.

310:512-3-2.1 Primary health care provider responsibilities for risk assessment and screening
(a) Every primary health care provider who provides a periodic health care visit to a child at age 6, 12, and 24 months and age 3, age 4 and 5 years shall assess the child for risk of lead exposure using the LERAQ, or suitable risk assessment questionnaire approved by the Department.
(b) For children at high risk for lead exposure according to the LERAQ, or suitable risk assessment questionnaire, the primary health care provider shall perform a blood lead test beginning at 6 months of age, or when initially assessed, if older.
(c) Every primary health care provider who provides a periodic health care visit to a child shall order an initial capillary or venous blood lead screening test at age 12 and 24 months, or at any age after age 24 months up to age 72 months if never tested.
(d) Every primary health care provider who provides a periodic health care visit to a child at age 6, 12, and 24 months and age 3, age 4, and 5 years shall:
   (1) Give oral or written anticipatory guidance to a parent or guardian on prevention of childhood lead poisoning, including, at minimum, the information that children can be harmed by exposure to lead, especially deteriorating or disturbed lead-based paint and the dust from it, and are particularly at risk of lead poisoning from the time the child begins to crawl until 72 months of age; and
   (2) Discuss the child’s blood lead test results with the child’s family and any necessary follow up.
(e) Any health care provider who performs blood lead screening of a child who is six months of age to six years of age and who is not the child's ongoing primary health care provider shall forward the blood lead test result, if elevated at or above the reference level, to the child’s primary health care provider.
(f) If a parent or guardian refuses blood lead testing screening of their child, the health care provider shall have the parent or guardian indicate in writing this refusal in the child’s medical record and provide a copy via mail or by fax to the Oklahoma Childhood Lead Poisoning Prevention Program.

310:512-3-3. Blood collection—lead screening tests
(a) Capillary sample for blood lead testing. Capillary blood specimens are acceptable for initial blood lead screening if appropriate collection procedures are followed, to minimize the risk of environmental lead contamination. A capillary blood lead sample may be obtained for confirmation of an elevated blood lead level less than 10 μg/dL when a venous sample is not obtainable.
(b) Venous sample for blood lead testing. Venous blood is the preferred specimen for blood lead analysis and should be used for lead measurement whenever practical. A venous sample is required for confirmation of blood lead concentration equal to or greater than 10 μg/dL and preferred for confirmation of an elevated blood lead level less than 10 μg/dL.
(c) Point-of-Care instruments. Point-of-Care instruments shall not be used to confirm elevated blood lead levels even if the sample is collected by venipuncture.

310:512-3-4. Providers screening and follow-up [REVOKED]
(a) Primary provider screening and follow-up.
   (1) At each routine well child visit or at least annually if a child has not had routine well child visits, primary health care providers should assess each child who is at least six months of age but under six years of age for high dose lead exposure using a risk assessment tool based on currently accepted public health guidelines. Each child at high risk for lead exposure should be tested.
   (2) Primary health care providers should provide the parent or guardian of each child under six years of age anticipatory guidance on lead poisoning prevention as part of routine care.
   (3) Primary health care providers should screen each child for lead exposure starting at 6 months of age, as part of routine well child care.
   (4) Each primary health care provider who screens a child for an elevated blood lead level should explain the blood lead test results and any necessary follow up.
   (5) Primary health care providers should provide or make reasonable efforts to ensure the provision of follow up testing for each child with an elevated blood lead level ≥10 μg/Dl.
   (6) Primary health care providers should confirm blood lead levels ≥10 μg/Dl of blood obtained on a capillary fingerstick specimen from a child using a venous blood sample.
(7) For each child who has a confirmed blood lead level of ≥20 μg/Dl (micrograms per deciliter), the primary health care providers should provide or make reasonable efforts to ensure the provision of medical evaluation, or referral for medical evaluation, medical treatment if necessary, and referral to the appropriate local or state health department for environmental management. Medical evaluation should include at a minimum: a detailed lead exposure assessment, a nutritional assessment, including iron status, and a developmental screening.

(b) Non-Primary provider screening and follow-up.

(1) A health care provider who provides services to a child who is at least six months of age but under six years of age and who is not the child's ongoing primary care provider, (such as a hospital inpatient facility, an emergency service if the child's condition permits, or another facility or practitioner which provides services to the child on a one-time or walk-in basis), should inquire if the child has been appropriately screened for lead exposure.

(2) If the child, under 72 months of age, has not received such appropriate lead assessment and screening, the health care provider should screen the child for a blood lead level.

(3) If screening is performed, the blood lead test result should be sent to the child's primary care provider or, if not available, to the local health department for appropriate follow-up.

310:512-3-4.1. Health care provider responsibilities for follow-up after screening

(a) Health care providers shall provide or make reasonable efforts to ensure the provision of confirmation and follow-up testing for each child with an elevated blood lead level above the reference level.

(b) If the initial blood lead test result is below the reference level on either a venous or capillary sample, the health care provider shall retest the child annually if answers on the LERAQ or suitable risk assessment questionnaire indicate continuing high risk for lead exposure.

(c) For each child who has an elevated blood lead level at or above the reference level, the health care provider shall take those actions that are reasonably and medically necessary and appropriate based upon the child’s blood lead level to reduce, to the extent possible, the child’s blood lead level below the reference level. Such actions may include the following:

1. Education of a parent or guardian on lead hazards and lead poisoning;
2. Clinical evaluation for complication of lead poisoning;
3. Follow-up blood lead analyses as indicated based on level of elevation and period of time;
4. Developmental screening;
5. Referral to the Department for an environmental investigation for a single venous blood lead test result equal to or greater than 20 μg/dL; and
6. Chelation therapy should be considered and, when possible, a medical toxicologist, provider experienced in chelation therapy, or pediatric environmental health specialist should be consulted for a child with a blood lead test greater than 45 μg/dL.

(d) If the initial capillary blood lead test result is elevated, the health care provider shall obtain a venous confirmation test in accordance with the Clinical Management Guidelines as established by the Department.

(e) If the initial venous blood lead test result or the confirmation test is elevated, the health care provider shall obtain venous follow-up testing in accordance with the Clinical Management Guidelines as set forth by the Department.

310:512-3-5. Reporting requirements

(a) Laboratory.

(1) Laboratories shall report the results of all blood lead tests performed on children 6 months to 72 months of age persons that who are residents of Oklahoma to the Childhood Lead Poisoning Prevention Program. These reports shall be confidential and may be utilized only for the purpose of assuring service delivery, program administration, data analysis, and evaluation.

(2) Federal CLIA regulations at Title 42, of the Code of Federal Regulations, Section 493.1241 (relating to standards for test requests), require that laboratory requisitions contain sufficient patient data that must include patient's name, sex, date of birth, date of collection, test(s) to be performed, the source of the specimen, name and address of person requesting the test, as well as "Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.") Laboratories shall report the following information to the Childhood Lead Poisoning Prevention Program by mail, telephone, facsimile, or electronic data transmission: name, date of birth, sex, address, county of residence, type of sample (venous or capillary), blood lead level, health care provider ordering the test, laboratory identifiers, date the sample was collected, and the date of analysis, and additional information.
already available such as race, ethnicity, Medicaid status and/or Medicaid Number. The laboratory receiving the sample from the health care provider taking the sample shall assure that the laboratory requisition slip is fully completed and includes the information required pursuant to the Subsection. In the event electronic submission is not available, lab reports must be submitted by a method and format approved by the Oklahoma Childhood Lead Poisoning Prevention Program.

(3) Time limits for reporting test results to the Childhood Lead Poisoning Prevention Program shall be as follows:

(A) Results of all blood lead levels <10 μg/dL less than the reference level at a minimum of a monthly basis.

(B) Results of all blood lead levels equal to or >10 μg/dL greater than the reference level at a minimum of a weekly basis and if possible daily.

(4) All clinical laboratories shall notify the health care provider ordering the blood lead test by telephone or fax, when the results of any analysis in a child up to 72 months of age is ≥ equal to or greater than 20 μg/dL within 24 hours of the date of the analysis.

(5) Nothing in this Subsection shall be construed to relieve any laboratory from reporting results of any blood lead analysis to the physician, or other health care provider that ordered the test or to any other entity as required by State, Federal or local statutes or regulations or in accordance with accepted standard of practice.

(b) Health care providers.

(1) All health care providers should ensure that all of the information as specified in 310:512-3-5(b) (relating to standards for test requests), is completed for all blood lead analyses ordered by health care providers and that this information accompanies the sample to the testing laboratory.

(2) On written or verbal notification of an elevated capillary lead level, ≥10 mg/dL equal to or greater than the reference level, the child's health care provider will obtain a confirmatory test by venous sample confirmatory testing.

(3) All health care providers shall notify the Childhood Lead Poisoning and Prevention Program of any blood lead level in a child up to 72 months of age equal to or >10 μg/dL equal to or greater than the reference level within 1 week and equal to or greater than >20 μg/dL within 24 hours of having been notified of this result by the testing laboratory, the following information shall be provided when reporting: name, date of birth, sex, address, county of residence, type of sample (venous or capillary), blood lead level, health care provider ordering the test, laboratory identifiers, date the sample was collected and the date of analysis.

(4) Upon notification of a blood lead level ≥20 μg/dL, an environmental investigation and public health followup will be carried out by the Oklahoma State Department of Health. Any health care provider utilizing a point-of-care instrument to test blood lead samples is required to report all such results, regardless of the level, to the Childhood Lead Poisoning Prevention Program, and follow the guidelines for reporting as stated in 310:512-3-5(a) (relating to laboratory reporting).

(5) On written notification of unsatisfactory specimens, the child's health care provider will obtain a repeat specimen.

(6) These reports shall be confidential and may be utilized only for the purpose of assuring service delivery, program administration, data analysis, and evaluation.
The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules; (10) A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing. [75:303.1(E)(9)&(10)]

None received.

Agency Rule Contact:
Susan Quigley, Administrative Programs Manager, Childhood Lead Poisoning Prevention Program, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-6711, e-mail susanq@health.ok.gov.
Blood lead concentrations have decreased dramatically in US children over the past 4 decades, but too many children still live in housing with deteriorated lead-based paint and are at risk for lead exposure with resulting lead-associated cognitive impairment and behavioral problems. Evidence continues to accrue that commonly encountered blood lead concentrations, even those below 5 μg/dL (50 ppb), impair cognition; there is no identified threshold or safe level of lead in blood. From 2007 to 2010, approximately 2.6% of preschool children in the United States had a blood lead concentration ≥5 μg/dL (≥50 ppb), which represents about 535,000 US children 1 to 5 years of age. Evidence-based guidance is available for managing increased lead exposure in children, and reducing sources of lead in the environment, including lead in housing, soil, water, and consumer products, has been shown to be cost-beneficial. Primary prevention should be the focus of policy on childhood lead toxicity.

OVERVIEW AND INTRODUCTION

Primary prevention, reducing or eliminating the myriad sources of lead in the environment of children before exposure occurs, is the most reliable and cost-effective measure to protect children from lead toxicity. Very high blood lead concentrations (eg, >100 μg/dL) can cause significant overt symptoms, such as protracted vomiting and encephalopathy, and even death. Low-level lead exposure, even at blood lead concentrations below 5 μg/dL (50 ppb), is a causal risk factor for diminished intellectual and academic abilities, higher rates of neurobehavioral disorders such as hyperactivity and attention deficits, and lower birth weight in children. No effective treatments ameliorate the permanent developmental effects of lead toxicity. Reducing lead exposure from residential lead hazards, industrial sources, contaminated foods or water, and other consumer products is an effective way to prevent or control childhood lead exposure. Lead poisoning prevention education directed at hand-washing or dust control fails to reduce children’s blood lead concentrations. However, pediatricians and parents should be aware of measures to reduce the toxic effects of lead on children, including the promulgation of regulations to screen or test older housing units for lead hazards.
before occupancy and after major renovation and abatement; revision of federal standards to reduce allowable levels of lead in settled house dust, water, soil, cosmetics, and other consumer products; and enhanced protection for children who live in lead-contaminated communities or near lead-emitting industries.

SCOPE OF THE PROBLEM

Over the past 4 decades, blood lead concentrations among US children have declined dramatically since the elimination of lead from gasoline, paints, and other consumer products1 (Fig 1, Table 1). From 1976 to 1980, blood lead concentrations among US children declined more sharply than anticipated after the phase-out of leaded gasoline.2 In 1978, the US Consumer Product Safety Commission (CPSC) restricted the allowable content of lead in residential paint to 0.06% (600 ppm); in 2008, it was lowered to 0.009% (90 ppm).3, 4 There have also been significant reductions in tap water lead concentrations since the US Environmental Protection Agency (EPA) promulgated the Lead and Copper Rule.5, 6 Finally, use of lead solder in canned foods and other consumer products was banned. It is difficult to accurately apportion the decline in blood lead concentrations to specific sources, but the combined effect of these regulations clearly led to the dramatic reductions in children’s blood lead concentrations.1 The key to preventing lead toxicity in children is to reduce or eliminate persistent sources of lead exposure in their environment.

Prevention of low-level lead toxicity has historically focused on anticipatory guidance, screening children’s blood for lead after exposure, and iron or calcium supplementation to reduce lead absorption.7 Unfortunately, studies that evaluated the efficacy of parent education or provision of cleaning equipment to families failed to show significant reductions in children’s blood lead concentrations.8 Similarly, calcium and iron supplementation have not consistently been shown to be efficacious in reducing blood lead concentrations of children.9, 10 Collectively, these studies indicate that the focus of prevention should be on reducing the sources of childhood lead exposures rather than identifying children who have already been unduly exposed or attempting to ameliorate the toxic effects of lead exposure.

In 2005, the American Academy of Pediatrics (AAP) recognized that blood lead concentrations below 10 μg/dL (100 ppb) may impair cognition; no threshold for the
toxic effects of lead was identified. The AAP adopted a blood lead concentration >10 μg/dL (>100 ppb) as the "level of concern" recommended by the Centers for Disease Control and Prevention (CDC), which indicated the need for closer medical and public health management. Extensive and compelling evidence now indicates that lead-associated cognitive deficits and behavioral problems can occur at blood lead concentrations below 5 μg/dL (50 ppb). In 2012, the US National Toxicology Program of the National Institutes of Health reported that, after other risk factors are accounted for, blood lead concentrations <5 μg/dL (<50 ppb) are strongly associated with intellectual deficits, diminished academic abilities, attention deficits, and problem behaviors (Table 2). In that same year, the Advisory Committee on Childhood Lead Poisoning Prevention of the CDC concluded that there is no safe level of lead exposure and adopted the use of a reference value of ≥5 μg/dL (≥50 ppb) (based on the 97.5th percentile of lead concentrations from the National Health and Nutrition Examination Survey [NHANES]) to be used as a trigger to guide clinical and public health interventions.

Low-level elevations in children’s blood lead concentrations, even at concentrations below 5 μg/dL (50 ppb), can result in decrements in cognitive functions, as measured by IQ scores and academic performance. For a given level of exposure, lead-associated IQ decrements are proportionately greater at the lowest blood lead concentrations. The IQ decrement associated with an increase in blood lead concentration from <1 μg/dL (<10 ppb) to 30 μg/dL (300 ppb) was 9.2 IQ points, but the decrement associated with an increase in blood lead concentration from <1 μg/dL (<10 ppb) to 10 μg/dL (100 ppb) was 6.2 IQ points. The population impact of lead on intellectual abilities is substantial. Despite the dramatic reductions in blood lead levels, lead toxicity accounts for an estimated total loss of 23 million IQ points among a 6-year cohort of contemporary US children.

### Table 1: Federal Lead Poisoning Prevention Policies

<table>
<thead>
<tr>
<th>Policy or Legislation</th>
<th>Year</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead Based Paint Poisoning Prevention Act</td>
<td>1971</td>
<td>First major lead-based paint legislation; addressed lead-based paint in federal housing.</td>
</tr>
<tr>
<td>Ban on Residential Paint</td>
<td>1978</td>
<td>CPSC banned lead paint in residential properties.</td>
</tr>
<tr>
<td>Housing and Community Development Act</td>
<td>1987</td>
<td>Highlighted the danger to children of lead-contaminated dust.</td>
</tr>
<tr>
<td>Lead Contamination Control Act</td>
<td>1988</td>
<td>Authorized CDC to make grants to state and local programs to screen children and to provide for education about lead poisoning.</td>
</tr>
<tr>
<td>Residential Lead-Based Paint Hazard Reduction Act, Title X</td>
<td>1992</td>
<td>Established primary prevention of lead poisoning as a national strategy.</td>
</tr>
<tr>
<td>Guidelines for the Evaluation and Control of Lead-Based Paint Hazards in Housing</td>
<td>1995</td>
<td>FDA amended food additive regulations to ban lead solder from food cans.</td>
</tr>
<tr>
<td>Ban Lead Solder in Food Cans</td>
<td>1995</td>
<td>Regulation issued by HUD setting forth new requirements for lead-based paint notification, evaluation, and remediation.</td>
</tr>
<tr>
<td>Lead Safe Housing Rule</td>
<td>1999</td>
<td>HUD established guidelines for evaluating and controlling residential lead-based paint hazards.</td>
</tr>
<tr>
<td>Hazard Standards for Lead in Paint, Dust and Soil</td>
<td>2001</td>
<td>US EPA established a definition of a lead-based paint hazard and standards for paint, dust, and soil in children's play areas.</td>
</tr>
<tr>
<td>Consumer Product Safety Improvement Act</td>
<td>2008</td>
<td>CPSC lowered the cap on lead in paint from 0.06% to 0.009% and incorporated the Lead-Free Toy Act, setting limit on lead content in toys.</td>
</tr>
<tr>
<td>Lead Renovation, Repair and Paint Rule</td>
<td>2010</td>
<td>US EPA required contractors working on homes built before 1978 to be certified and follow lead safe guidelines.</td>
</tr>
</tbody>
</table>

### Table 2: Effects of Low-Level Lead Exposure on Academic and Intellectual Abilities, Puberty, Kidney Function, Postnatal Growth, Hearing, and Other Health Endpoints

<table>
<thead>
<tr>
<th>Blood Lead Concentration</th>
<th>Evidence Level</th>
<th>Health Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5 μg/dL</td>
<td>Sufficient</td>
<td>Decreased academic achievement, Lower IQ scores, Attention-related behavior problems, Antisocial behaviors, Delayed puberty, Decreased kidney function in children ≥12 y of age, Decreased postnatal growth, Decreased hearing, Hypersensitivity by skin prick test, Asthma and eczema, Cardiovascular effects, Kidney function &lt;12 y of age</td>
</tr>
<tr>
<td>5 μg/dL</td>
<td>Inadequate</td>
<td>≥5 μg/dL (≥50 ppb) is efficient but will fail to preserve the majority of lost IQ points in US children. The prevention paradox refers to the concept that most disease or disability occurs in low- to moderate-risk groups. Children who have blood lead concentrations ≥5 μg/dL (≥50 ppb) will, on average, experience...</td>
</tr>
</tbody>
</table>

From the US Department of Health and Human Services, National Institute of Environmental Health Sciences, 2012.
Froehlich et al found that having a lead-associated IQ deficit of 6.1 points, an IQ deficit much larger than that of children who have lower blood lead concentrations (Fig 2). Still, if the focus is only on reducing exposures for children who have a blood lead concentration ≥5 μg/dL (≥50 ppb), we will fail to preserve more than 20 million (>80% of total) of the 23 million IQ points lost among US children with lower lead exposure because there are so many more children who have low to moderate blood lead concentrations (Fig 2). No therapeutic interventions currently exist for low blood lead concentrations; therefore, prevention of exposure is paramount. For these reasons, this statement focuses heavily on how pediatricians can help prevent lead exposure in children.

Elevated blood lead concentrations can result in the development of behavioral problems in children, including inattention, impulsivity, aggression, and hyperactivity. Needleman et al found that adolescents who had higher bone lead concentrations had higher scores for delinquency and aggression. In a meta-analysis of 16 studies, Marcus et al concluded that lead exposure, measured via blood lead or bone lead concentrations, was a risk factor for conduct disorder. In 2 prospective longitudinal studies, higher childhood blood lead or tooth lead concentrations resulted in higher rates of self-reported delinquent behaviors and arrests or convictions. Reyes concluded that the reduction in population mean blood lead concentrations was the major risk factor associated with the decline in severe violent behaviors over the past 3 decades. Limited evidence implicates lead exposure in diminished kidney function in adolescents at low levels of exposure. Using the NHANES, Fadrowski et al found that, among 769 adolescents with a median blood lead concentration of 1.5 μg/dL (15 ppb), a doubling of the concentration led to a significant reduction in the glomerular filtration rate. It is not clear whether chronic, low-level lead exposure in childhood or adolescence is sufficient to result in chronic renal failure or whether it is the cumulative effect of a variety of risk factors that ultimately results in the development of chronic renal failure. Still, this study is consistent with others linking lead exposure with chronic renal failure in adults.

Lead can cause spontaneous abortion, low birth weight, and reduced growth in children. In a case–control study of pregnant women in Mexico City with blood lead concentrations that ranged from 1.3 μg/dL (13 ppb) to 29 (290 ppb) μg/dL, the odds for spontaneous abortion increased by 1.8 for every 5-μg/dL (50-ppb) increase in maternal blood lead concentration. Early studies that examined the association of prenatal lead exposure and low birth weight or preterm birth, measured via either maternal or cord blood lead concentrations, found inconsistent results. However, in a large cohort involving more than 34 000 live births, investigators found that a 5-μg/dL (50-ppb) increase in blood lead concentrations was associated with a 61-g decrement in birth weight. The National Toxicology Program concluded that maternal blood lead concentrations <5 μg/dL (<50 ppb) are associated with lower birth weight.

**PREVENTING LEAD TOXICITY**

Despite historical reductions in children’s blood lead concentrations, preventing childhood lead toxicity remains a major public health priority in the United States. Many children who live in older, poorly maintained housing or older housing that undergoes renovation are at high risk for lead exposure. In the NHANES conducted from 2007 to 2010, approximately 2.6% of preschool children in the United States had a blood lead concentration ≥5 μg/dL (≥50 ppb), which represents about 356 000 US children 1 to 5 years of age. Children who live in older housing units experienced an increased risk...
for having a blood lead concentration in excess of 5 μg/dL (50 ppb); 15% of US children who lived in housing units built before 1950 had a blood lead concentration ≥5 μg/dL (≥50 ppb), whereas 4.2% of children who lived in housing built between 1950 and 1978 had a blood lead concentration ≥5 μg/dL (≥50 ppb), compared with 2.1% of children who lived in housing units built after 1978.27 No treatments have been shown to be effective in ameliorating the permanent developmental effects of lead toxicity.28 Finally, the economic costs of childhood lead toxicity are substantial. Despite the historical reductions in blood lead concentrations, it has been estimated that the annual cost of childhood lead exposure in the United States is $50 billion.29 For every $1 invested to reduce lead hazards in housing units, society would benefit by an estimated $17 to $221, a cost–benefit ratio that is comparable with the cost–benefit ratio for childhood vaccines.30

The key to preventing lead toxicity in children is identification and elimination of the major sources of lead exposure. Primary prevention of lead exposure is now widely recognized as the optimal strategy because of the irreversible effects of low-level lead toxicity.7,12 The primary prevention approach contrasts with practices and policies that too often have relied predominantly on detection of lead exposure only after children develop elevated blood lead concentrations.

**SOURCES AND VARIABILITY OF LEAD EXPOSURE**

Lead ingestion and absorption are dynamic during the first 2 years of life. Blood lead concentrations of children who live in lead-contaminated environments typically increase rapidly between 6 and 12 months of age, peak between 18 and 36 months of age, and then gradually decrease.31 The peak in children’s blood lead concentrations stems from the confluence of normal mouthing behaviors and increasing mobility.31 Younger children also absorb lead more efficiently than older children and adults.32 Iron deficiency can also increase the absorption of lead.33 A large number of housing units in the United States contain lead-based paint. In a national survey of housing conducted in 2011, it was estimated that 37 million (35%) of 106 million housing units contain lead-based paint.34 Lead-based paint is the most common, highly concentrated source of lead exposure for children who live in older housing.35 Paint that was used on both the interior and exterior of houses through the 1950s contained higher concentrations of lead than that of houses built in later years.34,35 The lead concentration in paint and other media can be measured by using a hand-held instrument called the x-ray fluorescence (XRF) spectrum analyzer or by chemically analyzing paint chips.

The US Department of Housing and Urban Development (HUD) defines lead-based paint as an XRF reading ≥1 μg/cm² or 5000 ppm of lead in a paint chip.36 The presence of lead-based paint is not as predictive of childhood lead exposure as a lead paint hazard. A lead paint hazard is defined by the EPA as “any condition that causes exposure to lead from contaminated dust, lead-contaminated soil, or lead-contaminated paint that is deteriorated, or the presence of accessible (or chewable) surfaces, friction surfaces or impact surfaces that would result in adverse human health effects.”37

Age of the housing is a major determinant of lead paint hazards. For housing built from 1978 to 1998, 2.7% contained one or more lead paint hazards, whereas the prevalence of residential hazards increased to 11.4% of housing built from 1960 to 1977, 39% of housing built from 1940 to 1959, and 67% of housing units built before 1940.34 Federal regulations for defining a lead paint hazard in house dust are obsolete. Federal agencies have set environmental lead standards to protect children from having a blood lead concentration ≥10 μg/dL (≥100 ppb), but it is now recognized that there is no safe level of lead exposure. Therefore, because the current standards for lead in house dust, water, and soil remain too high to protect children,31,38 the percentage of housing that contains one or more lead paint hazards described above is an underestimate.

Lead-based paint is the major source of lead, but ingestions of lead-contaminated house dust and residential soil are the major pathways for exposure (Fig 3).35–42 House dust, which can be contaminated by small particles of lead-based paint or track-in of lead-contaminated soil, is a major pathway of lead exposure for children who live in older, poorly maintained housing.40 Ingestions of lead-contaminated house dust and soil are also the primary pathways of exposure for children who live in homes that were recently abated or renovated.43–45

Sampling house dust for lead hazards involves using a special wipe to sample a specified area, such as the floor, which is readily accessible to a child, or a window sill or window trough.36 Windows are often more heavily contaminated than floors because exterior paints often contained higher concentrations of lead, and window troughs can act as reservoirs. Sampling house dust for lead is used to screen older housing units that may contain lead hazards at the time of purchase or rental and before occupancy; to conduct a full risk assessment that involves extensive sampling of settled dust in housing units that failed a lead hazard screen or where there is a high probability of a lead hazard;
and to conduct clearance testing after repair or renovation of painted surfaces and after lead abatement, to verify that the housing unit is safe for occupancy (Table 3).38

Lead-contaminated soil is an important source of lead intake for children.40,41 Lead-contaminated soil can directly contribute to children’s blood lead concentrations via soil ingestion and indirectly from soil tracked indoors on shoes, which then contaminates house dust (Fig 3). Former mine and smelter communities present a particular risk to children for the ingestion of lead-contaminated soil, but lead in urban soil also is often heavily contaminated from the past use of leaded gasoline and paints. Other sources of lead in soil include weathering of lead-based exterior paint and nearby renovation or demolition activity. Soil testing is usually performed in areas where children play and the foundation perimeter. The EPA standards are 400 μg of lead per gram of soil for play areas and 1200 μg/g for the foundation perimeter.37 Children’s blood lead concentrations increase by approximately 3.8 μg/dL (38 ppb) for every 1000-ppm increase in soil lead concentration.40

Water is an important but often overlooked source of exposure for children, especially for infants who are formula fed.5,46,47 Water typically contributes to approximately 20% of a child’s blood lead concentrations if the water lead concentration exceeds 5 ppb (Fig 3).31 The contribution of lead from water can be much higher for some children, especially for infants who ingest large quantities of tap water.5,46,47 Children who reside in communities with lead service lines and inadequate anticorrosion control are also at increased risk for elevated blood lead concentrations.48

Phasing out leaded gasoline and creating stricter national air lead standards led to large reductions in the contribution of airborne lead to children’s blood lead concentrations. Still, in some communities, such as those surrounding regional airports, airborne lead is an important source of lead exposure. Airborne lead is ingested primarily after it settles in house dust and soil where children play. Current sources of airborne lead include lead battery recycling operations, piston engine aircraft, and incinerators.49 The contributions of airborne lead to children’s blood lead concentrations are proportionately greater at the lower levels of exposure than at higher levels.49

Other sources of lead intake for children have been identified, such as nutritional supplements and folk medicines, ceramic dishware, and cosmetics50–52 (Table 3).
Lead brought into the home from a worksite by a parent can also be a major source of exposure for some children. Consumer products such as children’s toys, lunch boxes, crayons, and lipstick that are contaminated with lead have received a great deal of attention. These products constitute a small source of lead intake for most children, but they can be the major source for an individual child. Moreover, because lead exposure is cumulative and there is no apparent threshold for the adverse effects of lead exposure, all sources of lead exposure should be eliminated. It is the responsibility of the relevant federal agencies, such as the CPSC and the Food and Drug Administration (FDA), to promulgate and enforce standards that will protect children from lead-contaminated consumer products.

**RESIDENTIAL STANDARDS FOR LEAD IN PAINT, DUST, AND WATER**

**Lead in Paint and Dust**

Under section 403 of Title X, the US Congress mandated the EPA to promulgate residential health-based lead standards that are designed to protect children from lead toxicity. Standards are necessary to identify lead hazards before a child is unduly exposed and to identify the source of lead exposure for children who have blood lead concentrations ≥5 μg/dL (≥50 ppb). Unless performed carefully, attempts to reduce lead exposure, such as abatement, repair, or renovation, can result in increased contamination and elevation in a child’s blood lead concentration. Dust clearance tests, which involve collecting dust from floors or windows of a home by using a lead-free material that resembles a baby wipe, should be conducted after extensive repair, renovation, or abatement of older housing units to determine whether the housing intervention was sufficient to protect children from lead hazards, especially in housing units built before 1960. Property owners are required to disclose possible presence of lead-based paint in properties built before 1978 and are required to provide the blue pamphlet from the EPA, HUD, and Consumer Product Safety Commission titled “Protect Your Family From Lead in Your Home” at the time of rental or sale.

Most existing lead standards fail to protect children (Table 4). In 1978, the CPSC set the maximum paint lead concentration at 0.06% (600 ppm), because there was evidence that paint could be manufactured with this lower level of contamination. Similarly, the EPA’s action level of 15 ppb of lead in water, which is used to regulate water systems in the United States, is routinely (but erroneously) used as a health-based standard; it was not intended as a health-based standard, nor does it adequately protect children or pregnant women from adverse effects of lead exposure. In 1988, the HUD established a postabatement floor dust standard of 200 μg/ft² because there was evidence that it was feasible to attain, not because it was demonstrated to be safe or protective. In 2001, the EPA promulgated residential lead standards of 40 μg/ft² for floors and 250 μg/ft² for window sills. Unfortunately, these standards, which failed to protect children from having a blood lead concentration ≥10 μg/dL (≥100 ppb) when they were first promulgated, dictate the levels of lead contamination considered “normal” or “low,” and they provide an illusion of safety.

At a floor standard of 40 μg/ft², the current EPA standard for floors, 50% of children were estimated to have a blood lead concentration ≥5 μg/dL (≥50 ppb); 5% of children have a blood lead concentration ≥5 μg/dL (≥50 ppb) at a median floor dust lead level of 1.5 μg/ft² (Fig 4). Scraping, sanding, or construction during painting, repair, renovation, or abatement of older housing can result in lead contamination of a child’s environment.

### TABLE 4 Federal Standards for Lead in House Paint, House Dust, Soil, Water, Air, and Candy

<table>
<thead>
<tr>
<th>Source Standard</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lead-based paint (XRF)</td>
<td>1 μg/cm²</td>
</tr>
<tr>
<td>2. Paint containing lead applied after August 14, 2009</td>
<td>90 ppm by wt</td>
</tr>
<tr>
<td>3. Testing (full risk assessment) for dust lead hazards (by wipe sampling)</td>
<td></td>
</tr>
<tr>
<td>a. Floors</td>
<td>40 μg/ft²</td>
</tr>
<tr>
<td>b. Interior window sills</td>
<td>200 μg/ft²</td>
</tr>
<tr>
<td>4. Screening test for dust levels (by wipe sampling) to determine whether a full risk assessment is indicated</td>
<td></td>
</tr>
<tr>
<td>a. Floors</td>
<td>25 μg/ft²</td>
</tr>
<tr>
<td>b. Interior window sills</td>
<td>125 μg/ft²</td>
</tr>
<tr>
<td>5. Dust lead clearance levels after abatement (by wipe sampling)</td>
<td></td>
</tr>
<tr>
<td>a. Floors</td>
<td>40 μg/ft²</td>
</tr>
<tr>
<td>b. Interior window sills</td>
<td>250 μg/ft²</td>
</tr>
<tr>
<td>6. Bare residential soil</td>
<td></td>
</tr>
<tr>
<td>a. Children’s playground area</td>
<td>400 μg/g</td>
</tr>
<tr>
<td>b. Yard other than play area</td>
<td>1200 μg/g</td>
</tr>
<tr>
<td>7. Drinking water systems</td>
<td></td>
</tr>
<tr>
<td>Exceeded if lead is above this concentration in &gt;10% of a drinking water system’s tap water samples</td>
<td>15 ppb (0.015 mg/L)</td>
</tr>
<tr>
<td>8. Candy likely to be consumed by small children</td>
<td>0.1 ppb</td>
</tr>
<tr>
<td>9. National Ambient Air Quality Standards: <a href="http://www.epa.gov/ttn/naaqs/standards/">http://www.epa.gov/ttn/naaqs/standards/</a></td>
<td>0.15 μg/m³</td>
</tr>
</tbody>
</table>

Other state or local standards may vary, and the most protective standard applies. FDA has not set a standard for lead in cosmetics.

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1–7, adapted from HUD. 8, from FDA Guidance for Industry, November 2006.
<22 μg/dL (<220 ppb), Aschengrau et al reported a 6.5-μg/dL (65-ppb) increase in blood lead concentrations for children whose homes had undergone paint abatement. Clark et al reported that 6-month-old infants were 11 times more likely to have a ≥5 μg/dL (≥50 ppb) increase in blood lead concentrations after abatement compared with older children. Spanier et al reported that routine renovation of older housing was associated with a 12% higher mean blood lead concentration. These studies indicate that the levels of lead-contaminated dust generated by lead hazard control work or housing renovations can result in excessive lead exposure and absorption for children unless there is sufficient cleanup and clearance testing after the work is completed. The HUD has published technical guidelines and regulations for workers involved in lead-based paint abatement or remediation of housing.

In 1992, the US Congress mandated the EPA to promulgate regulations to protect children from lead exposure resulting from housing repairs and renovation. In 2011, the EPA finalized recommendations for the Lead Renovation, Repair and Painting Rule. Unfortunately, the EPA failed to recommend the validated wipe-sampling method for clearance testing. Instead, it used an unvalidated cloth test, which should not be confused with the validated wipe sampling test. The white cloth test assumes that if dust is visible on a white cloth (ie, the “white glove test”), it contains a lead hazard; conversely, if there is no visible dust, it does not contain a lead hazard. Although it would be valuable to have a quick test to identify the presence of a lead hazard, the white cloth test is not a validated tool and is not a reliable way to quantify the presence of a lead hazard.

Lead hazard control work can result in sizable reductions in the magnitude of dust lead loading when proper procedures are followed and cleanup and postwork clearance testing are performed. In 1 study, dust lead levels (measured as micrograms of lead per area) immediately after professional abatement were 8.5 μg/ft², 8.0 μg/ft², and 21 μg/ft² for floors, interior window sills, and window troughs, respectively, representing reductions of more than 80% compared with preabatement levels. In another study of more than 2600 housing units, postabatement dust lead levels were 12 μg/ft², 31 μg/ft², and 32 μg/ft² for floors, window sills and window troughs, respectively. These levels were achieved with dust clearance testing set at 100 μg/ft² or higher, but floor dust lead levels below 5 μg/ft² can be achieved by following a specific protocol. In 1 unpublished study of more than 160 housing units built before 1978, 1 group found that it is possible to routinely meet floor lead levels below 5 μg/ft² after housing renovations costing an average of $5600 (B. Lanphear, MD, MPH, Simon Fraser University, unpublished data).

**Lead in Water**

The primary sources of lead in water, which can be dissolved or particulate, consist of lead service lines, lead solder, and brass fittings that contain high concentrations of lead. Plumbing installed before 1986, the year a federal ban was issued on using lead pipe and lead solder and a maximum lead content of 8% by weight for brass plumbing was established, is more likely to contain higher concentrations of lead. Lead services lines that are being replaced, are undergoing maintenance, or are damaged can release particles of lead that can be ingested. Partial service line replacement, which is sometimes performed to minimize the cost of service line repair by water authorities, fails to reduce lead exposure. Proper maintenance and ultimately full replacement of water service lines will be necessary to eliminate lead intake from water, but it must be performed with proper precautions. In the interim,
water filters that are certified by the National Sanitation Foundation for lead removal can effectively reduce water lead concentrations. The EPA recommends running the cold water of residential units for up to 2 minutes to flush the lead leached from pipes out of the plumbing system, but flushing is useful only in housing units without lead service lines.\textsuperscript{58–61} In housing units without lead service lines, and where the primary source is brass fittings or lead-soldered joints, a 1-minute flush may be sufficient, depending on the length of plumbing; for housing units with lead service lines, flushing may increase lead exposure, again depending on the length of the lead service lines.\textsuperscript{58–61}

Drinking fountains in older schools can be an important source of lead exposure.\textsuperscript{5} Unfortunately, there are no regulations for evaluating lead contamination of school drinking fountains in most states.

Implementation of the Lead and Copper Rule has significantly reduced tap water lead levels. In 1991, the US EPA set an action level for lead in water of 15 μg/L or (15 ppb).\textsuperscript{6} Communities in which >10% of water samples taken from various taps throughout the system exceed 15 ppb are considered to be out of compliance and are required by the EPA to take action to reduce lead levels using corrosion control methods or replacement of lead service lines. The action level is used as an administrative tool to evaluate community-level exposure; it is not a health-based standard. The maximum contaminant level goal, the value the EPA deems acceptable for health, is 0.

**Testing Asymptomatic Children for Elevated Blood Lead Concentrations**

In the primary care office, primary prevention begins with education and counseling. Ideally, environmental assessments, such as screening older housing units, occurs before a child is born so that parents can identify and hire trained workers to abate environmental lead exposure hazards.\textsuperscript{12} It is especially important to conduct an environmental assessment for lead if a family resides in a housing unit built before 1960 that has undergone recent renovation, repair, or painting or if it is poorly maintained.

Screening questionnaires frequently used in the primary care setting fail to identify children who have elevated blood lead concentrations,\textsuperscript{5,6} but they may be useful as a tool to identify lead hazards in children who have a blood lead concentration ≥5 μg/dL (≥50 ppb). In addition, public health agencies often use other methods of targeting children who should be screened with a blood lead test on the basis of community and residential characteristics, such as older housing. Blood lead surveillance data can be used to identify cities, communities, or housing units at higher than typical risk for lead poisoning. Technologies using geographic information system–based analyses and surveillance from electronic medical records are important tools to identify at-risk children who should have their blood lead concentration measured.

In 1991, the CDC recommended universal blood lead testing for all children.\textsuperscript{6,3} In 2005, the AAP recommended that states and cities formulate their own lead screening recommendations on the basis of local data because of the wide variation in lead exposure.\textsuperscript{7} The AAP, consistent with the CDC, recommended universal screening of children’s blood for lead if they lived in communities with more than 27% of housing built before 1950 or a prevalence of blood lead concentrations ≥10 μg/dL in children 12 to 36 months old of 12% or greater.\textsuperscript{7,12,63,64} Screening is not efficient after 36 months of age unless specific high-risk factors are identified; the likelihood of a child having a blood lead concentration >10 μg/dL after 36 months of age is low.\textsuperscript{65} These recommendations now need to be updated to conform to with our new understanding of lead toxicity.\textsuperscript{11,12}

A detailed evaluation and follow-up of children who have blood lead concentrations <10 μg/dL (<100 ppb) is now indicated. Current federal regulations for clinical laboratory testing through the Clinical Laboratory Improvement Amendments of 1988\textsuperscript{66} permit an allowable laboratory error in blood lead proficiency testing programs of ±4 μg/dL (±40 ppb) for blood lead concentrations ≤20 μg/dL (≤200 ppb). This range of error can result in children being misclassified and cause additional anxiety or false comfort when blood lead concentrations within the margin of error erroneously are interpreted as going up or down. The majority of laboratories analyzing blood lead reference materials routinely achieved laboratory error of ±2 μg/dL (±20 ppb) at blood lead concentrations ≤20 μg/dL (≤200 ppb).\textsuperscript{67} Changing the allowable laboratory error to tighter performance requirements, such as ±2 μg/dL (±20 ppb), could decrease misclassification of children and lead to better allocation of health care resources.

**Case Management of Children With a Blood Lead Concentration at or Above Reference Value**

The AAP is adopting the current reference value of ≥5 μg/dL (≥50 ppb) for case management.\textsuperscript{12} The CDC recommended that the 97.5th percentile of blood lead concentrations derived from the combination of the 2 most recent cycles of NHANES data be used to identify children who have unacceptably high exposure and to set public health goals.\textsuperscript{12} The CDC will reconsider the reference value for children’s blood lead concentrations every 4 years.\textsuperscript{12}

After confirmatory testing, it is important to monitor children who have blood lead concentrations.
The AAP recognizes that environmental investigations will typically be conducted by local or state health or environmental departments to identify sources of lead exposure for a child who has a blood lead concentration ≥5 μg/dL (≥50 ppb). In many cases, however, the pediatrician can provide clues about possible sources of lead intake by taking a careful history.

Case management involves a thorough investigation of potential sources of lead poisoning in a child’s environment, including paint, house dust, water, and soil. Case management also includes a questionnaire and visual inspection for other potential sources of lead exposure, including antique furniture, toys, ethnic folk remedies, and consumer products such as imported food, cosmetics, and ceramics. It can include testing deteriorated paint on furniture, such as...

### TABLE 5 AAP Recommendations on Management of Childhood Lead Exposure and Poisoning

<table>
<thead>
<tr>
<th>Lead Level</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5 μg/dL (&lt;50 ppb)</td>
<td>1. Review laboratory results with family. For reference, the geometric mean blood lead concentration for US children 1–5 y old is &lt;2 μg/dL (&lt;20 ppb). 2.5% have a blood lead concentration ≥5 μg/dL (≥50 ppb). 2. Repeat the blood lead concentration in 6–12 mo if the child is at high risk for lead exposure or if risk profile increases. Follow all local and state lead screening recommendations. 3. For children initially screened before 12 mo of age, consider retesting in 3–6 mo for children at high risk; lead exposure may increase as mobility increases. 4. Perform routine assessment of nutrition and physical and mental development and assess risk factors for iron deficiency. 5. Provide anticipatory guidance about common sources of environmental lead exposure: paint in homes or child care facilities built before 1980, soil near roadways, take-home exposures related to adult occupations, and imported spices, cosmetics, folk remedies, and cookware.</td>
</tr>
<tr>
<td>5–14 μg/dL (50–140 ppb)</td>
<td>1. Perform steps as described above for blood lead concentrations &lt;5 μg/dL (&lt;50 ppb). 2. Retest venous blood lead concentration within 1–3 mo to verify that the lead concentration is not rising. If it is stable or decreasing, retest the blood lead concentration in 3 mo. Refer patient to local health authorities if such resources are available. Most states require elevated blood lead concentrations be reported to the state health department. Contact the CDC at 800-CDC-INFO (800-232-4636) or <a href="http://www.cdc.gov/ncceh/lead">www.cdc.gov/ncceh/lead</a> or the National Lead Information Center at 800-424-LEAD (5323) for resources regarding lead poisoning prevention and local childhood lead poisoning prevention programs. 3. Take a careful environmental history to identify potential sources of exposures (see #5 above) and provide preliminary advice about reducing or eliminating exposures. Take care to consider other children who may be exposed. 4. Provide nutritional counseling related to calcium and iron. Encourage the consumption of iron-enriched foods (eg, cereals, meats). Encourage families to sign up for the Special Supplemental Nutrition Program for Women, Infants, and Children, if eligible. 5. Screen for iron sufficiency with adequate laboratory testing (complete blood cell count, ferritin, C-reactive protein) and provide treatment per AAP guidelines. Consider starting a multivitamin with iron. 6. Perform structured developmental screening evaluations at child health maintenance visits, because lead’s effect on development may manifest over years.</td>
</tr>
<tr>
<td>15–44 μg/dL (150–440 ppb)</td>
<td>1. Perform steps as described above for blood lead concentrations 5–14 μg/dL (50–140 ppb). 2. Confirm the blood lead concentration with repeat venous sample within 1–4 wk. 3. Abdominal radiography should be considered for children who have a history of pica for paint chips or excessive mouthing behaviors. Gut decontamination may be considered if leaded foreign bodies are visualized on radiography. Any treatment of blood lead concentrations in this range should be provided in consultation with an expert. Contact local pediatric environmental health specialty unit (<a href="http://www.pehsu.net">www.pehsu.net</a> or 888-347-2632) or local or regional Poison Control Center (<a href="http://www.aapcc.org">www.aapcc.org</a> or 800-222-1222) for guidance.</td>
</tr>
<tr>
<td>&gt;44 μg/dL (&gt;440 ppb)</td>
<td>1. Follow guidance for blood lead level 15–44 μg/dL (150–440 ppb) as listed above. 2. Confirm the blood lead concentration with repeat venous lead level within 48 h. 3. Consider hospitalization or chelation therapy (managed with the assistance of an experienced provider). Safety of the home or child care facility with respect to lead hazards, isolation of the lead source, family social situation, and chronicity of the exposure are factors that may influence management. Contact your regional pediatric environmental health specialty unit or Poison Control Center or the CDC for assistance.</td>
</tr>
</tbody>
</table>

≥5 μg/dL (≥50 ppb). The pediatrician should inform the local or state health department and request an inspection of the child’s house to identify and remediate any lead hazards (Table 4). Screening children for iron deficiency and insufficient dietary calcium intake is also important. A detailed description of the diagnosis and treatment of significant lead toxicity (ie, ≥45 μg/dL [≥450 ppb]) is beyond the scope of this policy statement, but guidance is available in an earlier publication of the AAP and through the Pediatric Environmental Health Specialty Units Web site (www.pehsu.net) (Table 5). Children who have elevated blood lead concentrations need to be monitored until environmental investigations and remediation are complete and blood lead concentrations decline. The AAP recognizes that environmental investigations will typically be conducted by local or state health or environmental departments to identify sources of lead exposure for a child who has a blood lead concentration ≥5 μg/dL (≥50 ppb). In many cases, however, the pediatrician can provide clues about possible sources of lead intake by taking a careful history.

Case management involves a thorough investigation of potential sources of lead poisoning in a child’s environment, including paint, house dust, water, and soil. Case management also includes a questionnaire and visual inspection for other potential sources of lead exposure, including antique furniture, toys, ethnic folk remedies, and consumer products such as imported food, cosmetics, and ceramics. It can include testing deteriorated paint on furniture, such as...
a crib, taking dust samples from child care settings or a family member’s house, and taking soil samples from a child’s play area.

**SUMMARY AND RECOMMENDATIONS**

Lead toxicity results in substantial, population-level effects on children’s intellectual abilities, academic abilities, problem behaviors, and birth weight. Pediatricians may be well equipped to advocate for more stringent regulations to reduce sources of lead exposure and prevent childhood lead exposure. The AAP recognizes the importance of a variety of educational, enforcement, and environmental actions to reduce the number of children who are exposed to lead hazards and concur with recent detailed recommendations for prioritization of primary prevention of lead toxicity.7,12,68–70 The AAP offers the following recommendations for government as well as pediatricians, other health care providers, and public health officials.

**Recommendations for Government**

1. The federal government should expand the resources currently offered by the HUD to local and state governments for lead hazard control work.

2. The federal government should provide both financial and nonfinancial resources and technical guidance through the CDC, the EPA, and the HUD to state and local public health agencies as well as environmental and housing agencies engaged in childhood lead poisoning prevention efforts.

3. The US EPA and HUD should review their protocols for identifying and mitigating residential lead hazards (eg, lead-based paint, dust, and soil) and lead-contaminated water from lead service lines or lead solder and revise downward the allowable levels of lead in house dust, soil, paint, and water to conform with the recognition that there are no safe levels of lead.

4. The federal government should resume and expand its vital role in providing federal public health leadership in childhood lead poisoning prevention work through the CDC. Allocation of additional resources would be necessary to accomplish this goal.

5. The Centers for Medicare & Medicaid Services, which is responsible for regulating clinical laboratory testing through the Clinical Laboratory Improvement Amendments of 1988,49 should expeditiously revise current regulations for allowable laboratory error permitted in blood lead proficiency testing programs from ±4 μg/dL (±40 ppb) to ±2 μg/dL (±20 ppb) for blood lead concentrations ≤20 μg/dL (≤200 ppb).12 In the future, when feasible, allowable laboratory error permitted in blood lead proficiency testing programs should be reduced even more, to ±1 μg/dL (±10 ppb) for blood lead concentrations ≤20 μg/dL (≤200 ppb).

6. The federal government should continue to conduct the NHANES and provide national data on trends in blood lead concentrations. These newer data should be used by the CDC to periodically formulate a new reference value and guide clinical and public health interventions.

7. The federal government should continue to regularly survey children and adolescents in the NHANES for ADHD and conduct disorder by using validated diagnostic surveys from the

8. Local or state governments, in consultation with pediatricians, should develop policies and regulations requiring the remediation of lead-contaminated housing and child care facilities, including the elimination of lead hazards during transfer of rental units or renovation or demolition of older housing.

9. State and local governments should collect, analyze, and publish blood lead test results performed in their jurisdictions and should regularly publish reports of age of housing and other risk factors for children having blood lead concentrations ≥5 μg/dL (≥50 ppb). These reports should be readily available to pediatricians, health care providers, and the public.

10. Federal, state, and local governments should provide resources for environmental evaluations and case management of children who have blood lead concentrations ≥5 μg/dL (≥50 ppb), in conjunction with the child’s primary care provider.

11. State and local governments should take steps to ensure that water fountains in schools do not exceed water lead concentrations of 1 ppb.

**Recommendations for Pediatricians, Health Care Providers, and Public Health Officials**

1. Pediatricians are in a unique position to work with public health officials to conduct surveys of blood lead concentrations among a randomly selected,
representative sample of children in their states or communities at regular intervals to identify trends in blood lead concentrations. These periodic surveys are especially important for children who live in highly contaminated communities, such as smelter communities or regions with a historically high prevalence of lead exposure.

2. Pediatricians, health care providers, and public health officials should routinely recommend individual environmental assessments of older housing, particularly if a family resides in a housing unit built before 1960 that has undergone recent renovation, repair, or painting or that has been poorly maintained.

3. Pediatricians and public health officials should advocate for the promulgation and enforcement of strict legal standards based on empirical data that regulate allowable levels of lead in air, water, soil, house dust, and consumer products. These standards should address the major sources of lead exposure, including industrial emissions, lead paint in older housing, lead-contaminated soil, water service lines, and consumer products.

4. Pediatricians should be familiar with collection and interpretation of reports of lead hazards found in house dust, soil, paint, and water, or they should be able to refer families to a pediatrician, health care provider, or specialist who is familiar with these tools.

5. Pediatricians, women’s health care providers, and public health officials should be familiar with federal, state, local, and professional recommendations or requirements for screening children and pregnant women for lead poisoning.12,68,69

6. Pediatricians and other primary care providers should test asymptomatic children for elevated blood lead concentrations according to federal, local, and state requirements. Immigrant, refugee, and internationally adopted children also should be tested for blood lead concentrations when they arrive in the United States because of their increased risk.71,72 Blood lead tests do not need to be duplicated, but the pediatrician or other primary care provider should attempt to verify that screening was performed elsewhere and determine the result before testing is deferred during the office visit.

7. Pediatricians and other primary care health providers should conduct targeted screening of children for elevated blood lead concentrations if they are 12 to 24 months of age and live in communities or census block groups with ≥25% of housing built before 1960 or a prevalence of children’s blood lead concentrations ≥5 μg/dL (≥50 ppb) of ≥5%.

8. Pediatricians and other primary care providers should test children for elevated blood lead concentrations if they live in or visit a home or child care facility with an identified lead hazard or a home built before 1960 that is in poor repair or was renovated in the past 6 months.7,12

9. Pediatricians and primary care providers should work with their federal, state, and local governments to ensure that a comprehensive environmental inspection is conducted in the housing units of children who have blood lead concentrations ≥5 μg/dL (≥50 ppb) and that they receive appropriate case management.

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ABBREVIATIONS
AAP: American Academy of Pediatrics
ADHD: attention-deficit/hyperactivity disorder
CDC: Centers for Disease Control and Prevention
CPSC: Consumer Product Safety Commission
EPA: Environmental Protection Agency
FDA: US Food and Drug Administration
HUD: Department of Housing and Urban Development
NHANES: National Health and Nutrition Examination Survey
XRF: x-ray fluorescence
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68. Centers for Disease Control and Prevention. Guidelines for the Identification and Management of Lead Exposure in Pregnant and Lactating Women. Atlanta, GA: Centers for Disease Control and Prevention; 2010


70. Centers for Disease Control and Prevention. Preventing Lead Exposure in Young Children: A Housing-Based Approach to Primary Prevention of Lead Poisoning. Atlanta, GA: Centers for Disease Control and Prevention; 2004


## Prevention of Childhood Lead Toxicity

COUNCIL ON ENVIRONMENTAL HEALTH  
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To: Board of Health Secretary

Through: Terry Cline, Ph.D., Commissioner

From: James Joslin
Agency Rule Liaison

Date: November 10, 2016

Subject: CHAPTER 515. COMMUNICABLE DISEASE AND INJURY REPORTING

The attached rule and supporting documents are submitted for PERMANENT adoption of the rule at the Board of Health's December 2016 meeting.

We received no public comment. There were no revisions to the previously reviewed rule, and impact statement.

Attachments:
   - Rule Impact Statement
   - Rule Text
   - Rule Comment Summary

c. Kristy Bradley, State Epidemiologist
   Don Maisch, General Counsel
RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 515. COMMUNICABLE DISEASE AND INJURY REPORTING

1. DESCRIPTION: The proposal updates the existing rules in accordance with recommendations from the Council of State and Territorial Epidemiologists (CSTE), the Centers for Disease Control and Prevention, and local health care partners pertaining to reportable diseases. The proposal amends the lists of reportable diseases, in order to clarify those conditions and diseases that are required to be reported to the Department. The proposal also adds conditions of public health importance that require investigation and implementation of prevention activities. These changes minimally increase the reporting burden placed upon clinicians, have no impact on the reporting burden placed upon laboratories, and do not adversely affect the public health disease control and prevention activities.

The proposal removes the reference to a “non-versioned/non-codified” document which could further specify requirements of reporting. This change will eliminate any possibility of requirements that are not stated in rule. The duplicative requirements at OAC 310:515-1-4(3) (relating to occupational or environmental diseases) are amended by removing the requirements listed here and adding a reference to the amended rules on reporting blood lead levels at OAC 310:512, Childhood Lead Poisoning Prevention Rules. This proposal changes the current reporting guidance for hepatitis C to include persons of all ages, and lowers the alanine aminotransferase (ALT) levels for reporting from 400 to 200. This modification is in accordance with the CSTE case definition for hepatitis C that was revised effective January 1, 2016. Lastly, the proposal will more clearly specify which syphilis tests are required for reporting to the Department.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE: Affected persons will be health care providers that report diagnoses of listed diseases and laboratories that perform specific testing that identifies listed diseases.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES: The citizens of Oklahoma will benefit due to the increased ability of the Oklahoma State Department of Health to identify disease and epidemics and prevent additional cases.

4. ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES: There will be no significant economic impact to Oklahoma health care providers and laboratories. The Department does not charge or collect any fees associated with this rule.

5. COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY: The cost to the Department to implement the amendments is estimated to be $1,500.00 to publish, distribute, and educate health care provider and laboratory personnel on the amended lists of reportable diseases/organisms and the time frames for reporting. There will be no increased personnel costs.

6. IMPACT ON POLITICAL SUBDIVISIONS: There will be no impact on any political subdivision as a result of implementing or enforcing this rule.

7. ADVERSE EFFECT ON SMALL BUSINESS: Implementation of the proposed rule should have no adverse effect on small businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

8. EFFORTS TO MINIMIZE COSTS OF RULE: No less costly methods were identified.
9. **EFFECT ON PUBLIC HEALTH AND SAFETY:** Reports of infectious disease will be submitted to the Oklahoma State Department of Health. These reports will be investigated and will be used to monitor trends of diseases or conditions of public health importance and reduce the risk of disease transmission to the public.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:** It is critical that newly identified diseases that pose a risk to the public health be placed into the reportable disease rule, or that newly adopted national surveillance policies regarding these diseases be reflected in rule. The Department will assist the medical system in obtaining newly developed tests for certain diseases that are not available to clinicians in the private sector. The identification of cases will enable the Department to reduce the risk of transmission of these diseases to the public.

11. This rule impact statement was prepared on July 13, 2016 and revised on August 31, 2016 and November 23, 2016. No modifications made subsequent to the publication of the *Notice of Rulemaking Intent*. 

   *(the date the rule impact statement was prepared and if modified, the date modified [75 O.S. §303.D.2(k)])*
310:515-1-1. Definitions

When used in this Chapter, the following words or terms shall have the following meaning unless the context of the sentence requires another meaning:

"AIDS" means Acquired Immunodeficiency Syndrome.

"Anti-HAV-IgM+" means a positive test result for the hepatitis A virus immunoglobulin M antibody.

"Anti-HBc-IgM+" means a positive test result for the hepatitis B core immunoglobulin M antibody.

"CD4" means cluster of differentiation 4 glycoprotein that serves as a receptor for HIV on T helper cells.

"Department" or "OSDH" means the Oklahoma State Department of Health.

"E. coli" means Escherichia coli.

"EIA" means enzyme immunoassay.

"HBeAg+" means a positive test result for the hepatitis B "e" antigen.

"HBsAg+" means a positive test result for the hepatitis B surface antigen.

"HBV DNA+" means a positive test result for deoxyribonucleic acid of the hepatitis B virus.

"HIV" means Human Immunodeficiency Virus.

"PHIDDO" or "PHIDDO system" means Public Health Investigation and Disease Detection of Oklahoma system.

"NAT for HCV RNA+" means a nucleic acid amplification test with a positive test result for hepatitis C virus ribonucleic acid.

"Outbreak of disease" means two or more cases residing in different households that have a similar clinical syndrome of a potentially infectious disease, toxin, or agent of known or unknown etiology.

"RIBA" means recombinant immunoblot assay.

"S/co" means the signal-to-cut-off-ratio.

"Spp." is an abbreviation referring to the term "species," and is used to broaden the antecedent term in order to include all organisms that may be found or described within a given genus.

"Unusual disease or syndrome" means a case of an uncommon, possibly infectious disease of known or unknown etiology, even if laboratory testing may be pending or inconclusive, or if testing for common etiologies is negative. Such cases of disease may not normally be endemic to Oklahoma, may be an emerging or re-emerging disease, and/or represent diseases for which a public health intervention may be needed. Examples of such unusual diseases or syndromes include but are not limited to, unexplained adult respiratory distress syndrome, rash illness with atypical presentation, or an illness occurring along with an unusual pattern of illness or death among animals.

"VISA" means vancomycin intermediate Staphylococcus aureus.

"VRSA" means vancomycin resistant Staphylococcus aureus.

310:515-1-2. Diseases to be reported
The diseases listed in this Chapter must be reported, along with patient identifiers, demographics, and contact information, to the Department upon discovery as dictated in sections OAC 310:515-1-3 and OAC 310:515-1-4. The current "Oklahoma Disease Reporting Manual" shall serve as the standard for disease-specific diagnostic test results to be reported. Ancillary laboratory test results, signs, and symptoms must be reported upon request. The current edition of the "Oklahoma Disease Reporting Manual" may be accessed from the Acute Disease Service disease reporting and alerts web page of the OSDH web site at http://IDReportingAndAlerts.health.ok.gov. Laboratories having greater than 400 positive tests performed on-site per year for reportable diseases described in 310:515-1-3, 310:515-1-4(1) and 310:515-1-4(2), or as may be otherwise required to be reported by OSDH, shall begin electronic laboratory reporting no later than August 30, 2010 using secure electronic data transmission meaningful use standards.

310:515-1-3. Diseases to be reported immediately

The following diseases must be reported by any health practitioner or laboratory personnel to the OSDH electronically via the secure web-based Public Health Investigation and Disease Detection of Oklahoma system or by telephone (405-271-4060 or 800-234-5963) immediately upon suspicion, diagnosis, or testing as specified in the "Oklahoma Disease Reporting Manual".

1. Anthrax (Bacillus anthracis).
2. Bioterrorism - suspected disease.
3. Botulism (Clostridium botulinum).
4. Diphtheria (Corynebacterium diphtheriae).
5. Haemophilus influenzae invasive disease.
6. Hepatitis A (Anti HAV-IgM+).
7. Free-living amebae infections causing primary amebic meningoencephalitis (Naegleria fowleri).
8. Hepatitis B during pregnancy (HBsAg+).
9. Measles (Rubeola).
10. Meningococcal invasive disease (Neisseria meningitidis).
12. Novel influenza A.
13. Outbreaks of apparent infectious disease.
14. Plague (Yersinia pestis).
15. Poliomyelitis.
17. Tularemia (Francisella tularensis).
18. Typhoid fever (Salmonella Typhi).
19. Viral hemorrhagic fever.

310:515-1-4. Additional diseases, conditions, and injuries to be reported

The following diseases, conditions and injuries must be reported by physicians, laboratories, and hospitals (by infection control practitioners, medical records personnel, and other designees) to the OSDH as dictated in the following subsections:

1. Infectious diseases. Reports of infectious diseases and conditions listed in this subsection must be submitted electronically via the PHIDDO system, telephoned, or submitted via secure electronic data transmission to the OSDH within one (1) working day.
(Monday through Friday, state holidays excepted) of diagnosis or positive test as specified in the "Oklahoma Disease Reporting Manual".

(A) Acid Fast Bacillus (AFB) positive smear. Report only if no additional testing is performed or subsequent testing is indicative of *Mycobacterium tuberculosis* Complex.

(B) AIDS (Acquired Immunodeficiency Syndrome).

(C) *Anaplasma phagocytophilum* infection.

(C)(D) Arboviral infections (West Nile virus, St. Louis encephalitis virus, Eastern equine encephalitis virus, Western equine encephalitis virus, Powassan virus, California serogroup virus, chikungunya virus, Zika virus).

(D)(E) Brucellosis (*Brucella* spp.).

(E)(F) Campylobacteriosis (*Campylobacter* spp.).

(F)(G) Congenital rubella syndrome.

(G)(H) Cryptosporidiosis (*Cryptosporidium* spp.).

(H)(I) Dengue Fever.

(I)(J) *E. coli* O157, O157:H7, or a Shiga toxin producing *E. coli*.

(J)(K) Ehrlichiosis (*Ehrlichia* or *Anaplasma* spp.).

(L) *Haemophilus influenzae* invasive disease.

(M) Hantavirus infection, without pulmonary syndrome.

(N)(O) Hantavirus pulmonary syndrome.

(O)(P) Hemolytic uremic syndrome, postdiarrheal.

(P) Hepatitis A (Anti-HAV-IgM+).

(Q)(R) Hepatitis B. If HBsAg+, anti-HBc-IgM+, HBeAg+, or HBV DNA+ then report results of the entire hepatitis panel.

(R)(S) Hepatitis C in persons < or = 40 years or in persons having jaundice or ALT > or = 4000 regardless of age with laboratory confirmation. If hepatitis C EIA is confirmed by NAT for HCV RNA, or signal-to-cut-off (s/co) ratio or index is predictive of a true positive then report results of the entire hepatitis panel.

(S)(T) Human Immunodeficiency Virus (HIV) infection.

(T)(U) Influenza associated hospitalization or death.

(U)(V) Legionellosis (*Legionella* spp.).

(V)(W) Leptospirosis (*Leptospira interrogans*).

(W)(X) Listeriosis (*Listeria monocytogenes*).

(X)(Y) Lyme disease (*Borrelia burgdorferi*).

(Y)(Z) Malaria (*Plasmodium* spp.).

(Z)(AA) Mumps.

(AA)(BB) Pertussis (*Bordetella pertussis*).

(BB)(CC) Psittacosis (*Chlamydophila psittaci*).

(CC)(DD) Q Fever (*Coxiella burnetii*).

(DD) Rocky Mountain Spotted Fever (*Rickettsia rickettsii*).

(EE) Rubella.

(FF) Salmonellosis (*Salmonella* spp.).

(GG) Shigellosis (*Shigella* spp.).

(HH) *Staphylococcus aureus* with reduced susceptibility to vancomycin (VISA or VRSA).

(IH) Streptococcal disease, invasive, Group A (GAS) (*Streptococcus pyogenes*).
(EE)(II) Streptococcus pneumoniae invasive disease, in persons less than 5 years of age.

(EE)(JJ) Syphilis (Treponema pallidum). Nontreponemal and treponemal tests are reportable. If any syphilis test is positive, then all syphilis test results on the panel must be reported. For infants < or = 12 months, all syphilis tests ordered, regardless of test result, must be reported.

(GG)(KK) Tetanus (Clostridium tetani).

(HH)(LL) Trichinosis (Trichinella spiralis).

(II)(MM) Tuberculosis (Mycobacterium tuberculosis).

(JJ)(NN) Unusual disease or syndrome.

(KK)(OO) Vibriosis (Vibrionaceae family: Vibrio spp. (including cholera), Grimontia spp., Photobacterium spp., and other genera in the family).

(LL)(PP) Yellow Fever.

(2) Infectious diseases. Reports of infectious diseases and conditions listed in this subsection must be reported to the OSDH within one (1) month of diagnosis or test result as specified in the OSDH Disease Reporting Manual.

(A) CD4 cell count with corresponding CD4 cell count percentage of total (by laboratories only).

(B) Chlamydia infections (Chlamydia trachomatis).

(C) Creutzfeldt-Jakob disease.

(D) Gonorrhea (Neisseria gonorrhoeae).

(E) HIV viral load (by laboratories only).

(3) Occupational or Environmental diseases. Laboratories must report blood lead level results greater than 105 ug/dL within one (1) week and results less than 105 ug/dL within one (1) month. Health care providers must report blood lead level results pursuant to the requirements established in Title 310, Chapter 512, Childhood Lead Poisoning Prevention Rules 20 ug/dL or greater within twenty-four (24) hours and results 105-19 ug/dL within one (1) week.

(4) Injuries (hospitalized and fatal cases only).

(A) Burns.

(B) Drownings and Near Drownings.

(C) Traumatic Brain Injuries.

(D) Traumatic Spinal Cord Injuries.

310:515-1-6. Additional diseases may be designated

The Commissioner of Health may designate any disease or condition as reportable for a designated period of time for the purpose of enhanced public health surveillance or special investigation.


310:515-1-8. Organisms/specimens to be sent to the Public Health Laboratory
(a) Isolates or appropriate specimens of the following organisms shall be sent to the OSDH Public Health Laboratory for typing.

1. *Bacillus anthracis.*
2. *Brucella* spp.
3. Carbapenem-resistant *Enterobacteriaceae.*
4. *E. coli O157, O157:H7,* or a Shiga toxin producing *E. coli.*
5. *Francisella tularensis.*
12. *Staphylococcus aureus* that are VISA or VRSA.

(b) Following consultation with an OSDH epidemiologist, clinical specimens from suspected cases of Botulism must be sent to the OSDH Public Health Laboratory for referral and testing.
RULE COMMENT SUMMARY AND RESPONSE

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 515. COMMUNICABLE DISEASE AND INJURY REPORTING

The Summary of Comments is submitted to the Board of Health, and upon approval from the Board of Health submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant Title 75 of the Oklahoma Statutes, Section 303.1 (A). Pursuant to Title 75 of the Oklahoma Statutes, Section 303.1 (E) the report shall include: (9) A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules; (10) A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.

Notice of the proposed rulemaking was published in the Oklahoma Register. The public comment period ran from October 3, 2016 through November 3, 2016. A public hearing on the proposed rulemaking was held on November 3, 2016. The Oklahoma State Department of Health received no written or oral comments concerning the proposed rulemaking during the public comment period.

Agency Rule Contact:
Kristy Bradley, State Epidemiologist, Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1207; phone (405) 271-7637, e-mail KristyB@health.ok.gov
To: Board of Health Secretary

Through: Terry Cline, Ph.D.
Commissioner

Through: James Joslin
Agency Rule Liaison

Through: Don Maisch
General Counsel

From: Kristy Bradley
State Epidemiologist

Date: November 18, 2016

Subject: CHAPTER 599. ZOONOTIC DISEASE CONTROL

The attached rule and supporting documents are submitted for PERMANENT adoption of the rule at the Board of Health’s December 2016 meeting.

We received no public comment. There were no revisions to the previously reviewed rule.

Attachments:
- Rule Impact Statement
- Rule Text
- Rule Comment Summary
RULE IMPACT STATEMENT

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 599. ZOONOTIC DISEASE CONTROL [AMENDED]

1. DESCRIPTION: (a brief description of the purpose of the proposed rule [75 O.S. §303.D.2(a)]):

The proposal updates the existing rules in accordance with recommendations from the National Association of State Public Health Veterinarians, the Centers for Disease Control and Prevention, and the American Veterinary Medical Association pertaining to animal rabies prevention and control.

The proposal will primarily update Subchapter 3, Rabies Control, to align with new scientific findings which indicate that dogs and cats with an out-of-date rabies vaccination status that are exposed to a rabid animal can be effectively managed by immediate vaccination booster and observation for 45 days similar to the method currently in place for management of currently vaccinated dogs, cats and ferrets that are exposed to a rabid animal (JAVMA, Vol 246, No. 2, January 15, 2015). It has been fifteen years since these rules were implemented; therefore, minor revisions to the regulations are also needed to update sections for alignment with current national guidance on animal rabies control and changes in animal rabies vaccine products.

With these changes, the Oklahoma State Department of Health anticipates minor cost savings for animal control departments and other persons who are charged with enforcement of the rules due to the reduced time period of observation and degree of follow up needed for dogs and cats with an overdue rabies vaccination status that are exposed to a rabid animal. Some Oklahoma pet owners will benefit from the proposal due to a reduction of emotional and financial costs because fewer dogs and cats exposed to a rabid animal will be required to be euthanized or undergo a six (6) month veterinary supervised quarantine.

2. DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE; (a description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the costs of the proposed rule, and any information on cost impacts received by the agency from any private or public entities [75 O.S. §303.D.2(b)]):

Classes of persons affected by the proposed rule include pet owners, animal control officers, veterinarians, and public health employees charged with implementation and enforcement of the state’s rabies control regulations. No increased costs associated with the proposed rule changes are anticipated. The Oklahoma State Department of Health (Department) does not receive any revenues related to animal bite management or rabies control. The public was requested to report any unanticipated costs during the comment period. No comment was received.

3. DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES: (a description of the classes of persons who will benefit from the proposed rule [75 O.S. §303.D.2(c)]):

Some Oklahoma pet owners will benefit from the proposed changes to the rule due to a reduction of emotional and financial costs because fewer dogs and cats exposed to a rabid animal will be required to be euthanized or undergo a 6-month veterinary supervised quarantine. Minor cost savings are anticipated for those classes of persons who are charged with enforcement of the regulations due to the reduced time
period of observation and degree of follow up needed for dogs and cats with an overdue rabies vaccination status that are exposed to a rabid animal.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:** (a description of the probable economic impact of the proposed rule upon affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change [75 O.S. §303.D.2(d)]):

The economic impact, if any, resulting from the proposed rule revisions will be cost savings. The Department does not charge or collect any fees associated with zoonotic disease control. The public was requested to report any unanticipated costs during the comment period. No comment was received.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY:** (the probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency [75 O.S. §303.D.2(e)]):

The cost to the Department to implement the amendments will be approximately $4,419.63 to cover the costs of rule drafting, adoption, publication, distribution, and education. The proposed rules will be implemented and enforced by existing Department personnel and will have no anticipated effect on state revenues.

6. **IMPACT ON POLITICAL SUBDIVISIONS:** (a determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule [75 O.S. §303.D.2(f)]):

The Department anticipates no economic impact on any political subdivisions. The public was requested to report any unanticipated costs during the comment period. No comment was received.

7. **ADVERSE EFFECT ON SMALL BUSINESS:** (a determination of whether implementation of the proposed rule may have an adverse economic effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act [75 O.S. §303.D.2(g)])

The Department anticipates no economic impact on small businesses. The public was requested to report any unanticipated costs during the comment period. No comment was received.

8. **EFFORTS TO MINIMIZE COSTS OF RULE:** (an explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or nonregulatory methods or less intrusive methods for achieving the purpose of the proposed rule [75 O.S. §303.D.2(h)]):

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1 75 O.S. § 502. As used in the Oklahoma Small Business Regulatory Flexibility Act:

4. "Small business" means a for-profit enterprise consisting of fifty or fewer full-time or part-time employees.

2 75 O.S. § 504(B). If the proposed rules may have an adverse economic effect upon small business, the agency shall submit a copy of the proposed rules and a rule impact statement to the Small Business Regulatory Review Committee for its review and comment pursuant to the review and comment provisions of paragraph 2 of subsection A and paragraph 6 of subsection B of Section 303 of this title.
The proposed rule changes are anticipated to result in a decrease of compliance costs associated with management of a dog, cat, or ferret exposed to a rabid animal to prevent the further transmission of this zoonotic disease to other animals or people. These proposals are determined to be the least intrusive methods needed by the Department to assure the public is protected from rabies.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:** (a determination of the effect of the proposed rule on the public health, safety and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk [75 O.S. §303.D.2(i)]): There will be no change in the level of risk of rabies transmission to the public resulting from the adoption of the proposed rule.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:** (a determination of any detrimental effect on the public health, safety and environment if the proposed rule is not implemented [75 O.S. §303.D.2(j)]):

The Department will lose an opportunity to align its policies and procedures for rabies control by the least intrusive means necessary, and according to the most current scientific information available, if the proposed rule is not adopted and implemented.

11. This rule impact statement was prepared on January 5, 2016. Modifications made subsequent to the publication of the Notice of Rulemaking Intent were made on: November 18, 2016. (the date the rule impact statement was prepared and if modified, the date modified [75 O.S. §303.D.2(k)]).
310:599-1-2. Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Animal" means any warm-blooded mammal.

"Cat" means any Felis catus.

"Currently vaccinated" means properly immunized by or under the supervision of a licensed veterinarian with an antirabies vaccine licensed and approved by the United States Department of Agriculture for use in that animal species, or meeting conditions specified in OAC 310:599-3-8. Vaccine must have been given at appropriate time interval(s) for the age of the animal and type of vaccine administered. Within 28 days after initial vaccination, a peak rabies antibody titer is expected, and the animal is considered immunized. Regardless of the age of the animal at initial vaccination, a booster vaccination should be administered one year later, then at appropriate time intervals based on the type of vaccine administered.

"Department" means the Oklahoma State Department of Health.

"Department designee" means an employee of the Oklahoma State Department of Health, or a county health department, who is acting within their scope of rabies control authority designated through the Commissioner of Health.

"Dog" means any Canis familiaris, excluding hybrids.

"Domestic animal" means a companion animal including dogs, cats, and ferrets; an equine animal; or a livestock animal.

"Euthanize" means the humane killing of an animal generally performed by a veterinarian, or personnel at an animal control facility under the indirect supervision of a veterinarian.

"Exposure to rabies" means a bite or introduction of saliva or neural tissue into open cuts in skin, or onto mucous membranes through physical contact with the saliva or other potentially infectious tissues from an animal confirmed or suspected of being infected with rabies.

"Ferret" means any Mustela putorius furo.

"First party ownership" means a situation where the owner of a biting animal is directly related to the bite victim, that is parent-child, sibling-sibling, grandparent-child; or when the legal residence of the animal owner and the bite victim are the same.

"Home quarantine" means confinement and observation of an animal allowed at the animal owner's property for a specified time period, where one of the following acceptable methods of confinement for a dog are used: (a) complete indoor housing, (b) caging or kenneling in an enclosure with a securely latched door, or (c) yard confinement with perimeter fencing that the dog is unable to climb over or dig under. Acceptable methods of confinement for a cat or ferret are: (a) complete indoor housing, or (b) caging in an enclosure that prevents escape. The animal's needs for ambient temperature control, water, nutrition, elimination, and space to comfortably stand up and lie down must be adequately provided by the selected confinement method. Should the animal exhibit neurologic signs, die, or disappear during the specified period, an Oklahoma licensed veterinarian and the Department shall be immediately notified.

"Hybrid" means an offspring of wild animals crossbred to domestic dogs or cats; considered
to be wild animals in the enforcement of OAC 310:599.

"Quarantine" means physical confinement of an animal during a specified time period when the animal is monitored for the development of disease. During this time period, the animal is prevented from having contact with other animals, and human contact is limited to as few caretakers as possible.

"Rabies" means an acute disease of humans and warm-blooded mammals caused by the rabies virus (genus Lyssavirus) that affects the central nervous system and is almost always fatal.

"Recognized animal control facility" means any facility operating for the purpose of stray animal control and/or animal welfare that is under contract or letter of agreement which identifies a licensed veterinarian responsible for animal quarantines.

"Recognized zoological park" means any member of the American Association of Zoological Parks.

"Severe injury" means any physical injury that results in broken bones or lacerations requiring multiple sutures or cosmetic surgery. [4 O.S. Supp. 1991, § 44 (3)]

"Wild animal" means an animal considered as wildlife; any animal not normally adapted to live in intimate association with humans nor raised for consumption by humans.

"Zoonotic disease" means a disease that is transmissible from animals to humans under natural conditions.

SUBCHAPTER 3. RABIES CONTROL

310:599-3-1. Management of dogs, cats, or ferrets that bite a person

(a) Any person or entity owning, harboring, or keeping a dog, cat or ferret which in the preceding ten (10) days has bitten any person, shall upon receipt of written notice by the local animal control authority or Department designee, place such animal in quarantine under the supervision of a licensed veterinarian for a period of ten (10) days from the date the person was bitten. The impoundment and observation of the dog, cat, or ferret shall be conducted at the veterinarian's facility, or a recognized animal control facility. Unvaccinated animals shall be vaccinated against rabies on the final day of the ten (10) day observation period prior to discharge from the veterinarian's supervision.

(b) Exceptions to this rule include the following circumstances:

(1) Dogs, cats, or ferrets involved in a first party ownership may be allowed to be placed in a home quarantine for a ten (10) day period immediately following the bite.

(2) Dogs, cats, and ferrets meeting the criteria of currently vaccinated against rabies, and not inflicting a severe injury, shall be placed in a home quarantine until the end of a 10 day period from the bite. In some instances, a certification of animal health obtained after examination by a licensed veterinarian on the tenth day may be required by the Department or local animal control authority.

(3) Animals in service to the blind or hearing-impaired, and search and rescue dogs or other animals used for police enforcement duties shall be exempt from the quarantine when a bite exposure occurs and proper record of immunization against rabies is presented. A certification of animal health obtained after examination by a licensed veterinarian at the end of 10 days may be required by the Department.

(4) Stray or unwanted dogs, cats, or ferrets that have bitten any person may either be
quarantined for ten (10) days at a veterinary facility or a recognized animal control facility; or immediately euthanized and the brain tissue submitted to the Oklahoma State Department of Health Public Health Laboratory for rabies testing. Upon successful completion of the ten (10) day period, a stray animal may be placed for adoption at the discretion of the animal control authority.

(5) Dogs, cats, and ferrets that bite a veterinarian or staff member under their supervision during a routine examination or elective procedure may be considered eligible for home quarantine if the bite victim and owner agree the animal will be examined by a licensed veterinarian at the end of the ten (10) day period from the bite to confirm the animal’s health status.

(5) In rare instances, other good and valid health reasons of the owner or animal may be considered for justification to home quarantine (e.g., a bitch with a litter of very young puppies, an animal with a contagious disease, etc.). Approval for home quarantine will be determined by the Department or its designee.

310:599-3-2. Supervising veterinarian's responsibility

It shall be the duty of the veterinarian in whose supervision the dog, cat, or ferret is placed to keep the animal isolated and secured in a separate cage or kennel and under observation for any symptoms of rabies. The veterinarian shall report immediately to the Department designee any changes occurring in the condition of the dog, cat, or ferret. In the event the animal being observed dies, or develops rabies-like symptoms within the specified period of confinement, the head of the animal shall be removed immediately and packed in a shipping container in accordance with instructions published on the rabies laboratory form, ODH Form 460, and sent to the Oklahoma State Department of Health Public Health Laboratory, 1000 N.E. Tenth Street, Oklahoma City, Oklahoma 73117-1299, for rabies testing.

310:599-3-5. Vaccinated domestic animals exposed to a rabid animal

Any domestic animal which is currently vaccinated against rabies and is exposed to a rabid animal shall be re-vaccinated within three (3) days of notification and isolated, by leashing or confinement under the owner's supervision, for a period of at least forty-five (45) days from exposure date.

310:599-3-6. Unvaccinated domestic animals exposed to a rabid animal

(a) Any dog, cat, or ferret which is not currently vaccinated against rabies and is exposed to a rabid animal shall be:

(1) Euthanized immediately either by a veterinarian of the owner's choice, or the local animal control officer or his/her agent; or

(2) Placed in strict quarantine and observed for a period of four (4) months for dogs and cats or six (6) months for ferrets under the supervision of a licensed veterinarian, either at a veterinary facility or a recognized animal control facility. The exposed animal shall be immediately vaccinated against rabies upon entry into quarantine and then given booster vaccinations at the third and eighth week of the quarantine period. Animals less than 16 weeks of age at the time of entry into quarantine may be required to receive a booster vaccine in addition to the above protocol.

(b) Any dog or cat that is overdue for a booster vaccination, and has documentation of receiving
a USDA-licensed rabies vaccine at least once previously by or under the supervision of a licensed veterinarian, shall be re-vaccinated and isolated, by leashing or confinement under the owner's supervision, for a period of at least 45 days from exposure date. Ferrets that are overdue for rabies booster vaccination shall be evaluated on a case-by-case basis by the Department, taking into consideration factors such as the severity of exposure, time elapsed since last vaccination, number of previous vaccinations, and current health status to determine the need for euthanasia or immediate booster vaccination and isolation for a period of at least 45 days from exposure date.

(c) Any dog or cat that is overdue for a booster vaccination and without appropriate documentation of having received a USDA-licensed rabies vaccine at least once by or under the supervision of a licensed veterinarian shall:

(1) Treated as unvaccinated by the Department and either euthanized as described in (a) of this section; or
(2) Immediately given a booster vaccination and placed in strict quarantine for a period of four months under the supervision of a licensed veterinarian; or
(3) Prior to booster vaccination, the owner may work with the licensed veterinarian to conduct prospective serologic monitoring. Serologic monitoring shall include collecting paired blood samples to document prior vaccination by providing evidence of an anamnestic response to booster vaccination. If an adequate anamnestic response is documented, the animal can be considered to be overdue for booster vaccination as described in (b) of this section. If there is inadequate anamnestic response, the animal is considered to have never been vaccinated and managed as described in (a) of this section.

(d) Any livestock or equine animal which is not currently vaccinated and is exposed to a rabid animal will be managed according to the most current Compendium of Animal Rabies Control published by the National Association of State Public Health Veterinarians, Inc. and any State Department of Agriculture guidelines that may apply.

310:599-3-9. Administration of rabies vaccine [AMENDED]

(a) It is prohibited for anyone to administer rabies vaccine to any animal unless said vaccine is licensed for use in the particular animal species in question. Exceptions to this include:

(1) The vaccination of wolf-dog hybrids with a rabies vaccine approved for dogs; or(2) Use at recognized nonprofit zoological parks, or research institutions; or(3) Special approval by the Commissioner of Health permitting the vaccination in a particular species where the preponderance of scientific literature suggests vaccine efficacy, and vaccine usage is determined to protect public health and safety.

(b) Animals vaccinated per these exceptions will still be considered as a wild animal species if involved in a bite to a person, and will be handled according to OAC 310:599-3-4.

(c) Rabies vaccines presently licensed are listed in the most current Compendium of Animal Rabies Control published annually by the National Association of State Public Health Veterinarians. Copies shall be available from the Communicable Disease Division, Oklahoma State Department of Health, 1000 N.E. Tenth Street, Oklahoma City, Oklahoma 73117-1299.
The rule report submitted to the Governor, the Speaker of the House of Representatives and the President Pro Tempore of the Senate, pursuant 75:303.1(A) of the Administrative Procedures Act, shall include: (9) A summary of the comments and explanation of changes or lack of any change made in the adopted rules as a result of testimony received at all hearings or meetings held or sponsored by an agency for the purpose of providing the public an opportunity to comment on the rules or of any written comments received prior to the adoption of the rule. The summary shall include all comments received about the cost impact of the proposed rules; (10) A list of persons or organizations who appeared or registered for or against the adopted rule at any public hearing held by the agency or those who have commented in writing before or after the hearing.[75:303.1(E)(9)&(10)]

None received.

Agency Rule Contact:
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PRESENTATIONS
Community Engagement

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Community Engagement Defined

- **Community Engagement**
  The process of working collaboratively through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community, memers. It often involves partnerships and coalitions that help mobilize resources and influence systems, changing relationships among partners, and serving as catalysts for changing policies, programs, and practices. (CDC, 1997, p. 9)

Community Engagement Continuum

Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

**Outreach**
- Some Community Involvement
  - Communication flows from one to the other, to inform
  - Provides community with information.
  - Entities coexist.
- Outcomes: Optimally, establishes communication channels and channels for outreach.

**Consult**
- More Community Involvement
  - Communication flows to the community and then back, answer seeking
  - Gets information or feedback from the community.
  - Entities share information.
- Outcomes: Develops connections.

**Involve**
- Better Community Involvement
  - Communication flows both ways, participatory form of communication
  - Involves more participation with community on issues.
  - Entities cooperate with each other.
- Outcomes: Visibility of partnership established with increased cooperation.

**Collaborate**
- Community Involvement
  - Communication flow is bidirectional
  - Forms partnerships with community on each aspect of project from development to solution.
  - Entities form bidirectional communication channels.
- Outcomes: Partnership building, trust building.

**Shared Leadership**
- Strong Bidirectional Relationship
  - Final decision making is at community level.
  - Entities have formed strong partnership structures.
- Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.

Reference: Modified by the authors from the International Association for Public Participation.

Figure 1.1. Community Engagement Continuum

Key Points to Consider

• Community engagement is a valuable tool for public health, to the point of being an accreditation requirement.

• Current state regarding community engagement:
  – Often considered as just an implementation tool for policy or program change
  – Tends to just be a function of local and/or field staff

• Opportunities to enhance our community engagement:
  – Start early in the planning process, even in the contemplation phase
  – Practice more broadly throughout the agency in partnership with local/field staff

• Ultimately, we should focus on two areas:
  – Changing the mindset within the agency regarding community engagement
  – Ensuring support is in place for sustainable change and effective outcomes
Public Health Accreditation Board (PHAB)

• Focus on Community Engagement

  – Domain 3: Inform and Educate about Public Health Issues and Functions

  – Domain 4: Engage with the Community to Identify and Address Health Problems
Accreditation Requirements
Domain 3

• Standard 3.1.2: Health promotion strategies to mitigate preventable health conditions

  – We must demonstrate how we engage the community during the development and implementation of health promotion strategies.

  • Process must be evidence-based, rooted in sound theory, practice-based evidence, and/or a promising practice.

  • Process must include input, review, and feedback from the target audience.
Accreditation Requirements
Domain 4

• Standard 4.1: Engage with the public health system and the community in identifying and addressing health problems through collaborative processes.

  – Local health departments must document a current, ongoing comprehensive community partnership or coalition in which it is an active member.
  – The state health department must provide consultation, technical assistance, and/or information to Tribal and local health departments or to public health system partners on use of methods for collaborative community engagement.
• Standard 4.2: Promote the community’s understanding of and support for policies and strategies that will improve the public’s health.

  – The health department must document engagement with the specific population in the community that will be affected by a policy or strategy.
Accreditation Requirements

- Bottom line...It’s about the process....
  
  - Health departments must demonstrate that community engagement is a meaningful part of the entire process to improve population health.
Team Planning & Goal-Setting
Goal 1: Cultivate a community engagement culture in all public health policy and health improvement initiatives.

- Measurable Activity/Task 1:
  - Identify two evidence-based practices for creating culture change by June 30, 2016.
    - Examples:
      » Lewin’s 3 Step
      » Prosci’s ADKARS
      » Kotter’s 8 Step
Engage Communities in Policy and Health Improvement Initiatives

• Goal 1: Cultivate a community engagement culture in all public health policy and health improvement initiatives.
  – Measurable Activity/Task 2:
    • Launch an evidence-based model of culture change within two OSDH program service areas by December 31, 2016.
      – Examples:
        » Maternal & Child Health
        » Consumer Health
        » Center for the Advancement of Wellness
        » Family Support & Prevention
        » HIV/STD Service
        » Emergency Preparedness & Response
        » Center for Health Innovation & Effectiveness
Engage Communities in Policy and Health Improvement Initiatives

• Goal 1: Cultivate a community engagement culture in all public health policy and health improvement initiatives.

  – Measurable Activity/Task 3:
    • Evaluate the effectiveness of the culture change model by January 31, 2018.
• **Goal 2:** Enhance community engagement effectiveness throughout the health improvement process.
  
  – **Measurable Activity/Task 1:**
    • Create a hub of evidence-based community engagement resources, making those available to stakeholders by June 30, 2017.
      
      – Examples:
        » PRECEDE-PROCEED
        » Planned Approach to Community Health (PATCH)
        » Healthy Communities
        » Assessment Protocol for Excellence in Public Health (APEX PH)
        » Protocol for Assessing Community Excellence in Environmental Health (PACE EH)
        » Mobilizing for Action through Planning and Partnerships
Engage Communities in Policy and Health Improvement Initiatives

• Goal 2: Enhance community engagement effectiveness throughout the health improvement process.

  – Measurable Activity/Task 2:

    • Identify at least two sources of technical assistance to support community engagement.

      – Examples:

        » Office or Partner Engagement
        » Center for the Advancement of Wellness
Questions?
Review of Ethics Commission Requirements

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Review of Ethics Commission Requirements

• On January 1, 2015, the Ethics Commission repealed all of its requirements and promulgated new requirements.

• In some instances, the requirements remained substantially the same, while other requirements changed significantly.

• This presentation will review certain Ethics Commission Requirements that will have the highest probability of impacting members of the Board of Health.

• All the Ethics Commission requirements are in Title 74 of the Oklahoma Statutes, Chapter 62, Appendix I.
Lobbying vs. Education

Lobbying is defined in the Ethics Commission (Requirements) as:

- Any oral or written communication;
- With the Governor or with a member of the Legislature or with an employee of the Governor or the Legislature (Legislative Lobbying) or;
- With a state officer or employee of an agency (Executive Lobbying);
- On behalf of a lobbyist principal (which includes a state agency in its definition);
- With regard to the passage, defeat, formulation, modification, interpretation, amendment, adoption, approval or veto;
- Of any legislation, rule, regulation, executive order or any other program, policy or position of state government.
The Requirements have determined the following are not included in the definition of lobbying:

- Testimony given before, or submitted in writing to, a committee or subcommittee of the Legislature

- A speech, article, publication or other material that is widely distributed, published in newspapers, magazines or similar publications or broadcast on radio or television
Lobbying vs. Education

The Requirements specifically prohibit state employees and members of any board, council or commission:

• From being a lobbyist, which would include the activities of a lobbyist.

• The prohibition applies to both Executive Lobbyist activities and Legislative Lobbyist activities.
While there is nothing in Oklahoma law defining “Education” in the Lobbying v. Education setting or drawing a distinction between the two, generally providing education is viewed as:

- Providing basic factual information about a particular organization or issue.
- Education gives factual information about who is affected, number of people served, budget or proven impacts and accomplishments.
- Education does not provide value judgments or ask people to take a particular stance.
Lobbying vs. Education

Examples of each (and what is allowed and not allowed)

• (When speaking to a members of the legislature [or staff], the Governor [or staff] or state agency officials): Urge the elected officials to vote yes on a bill to raise the cigarette tax by $1.50 per pack which will reduce the number of people smoking in Oklahoma. Please vote yes for this bill.”

• This is lobbying, the request is asking an elected official to take a particular stance. This is prohibited.

• The exception would be if this was stated to a legislative committee, in a speech to the public or in a opinion newspaper, magazine, TV or radio piece.
Lobbying vs. Education

Examples of each (and what is allowed and not allowed)

• (When speaking to a members of the legislature [or staff], the Governor [or staff] or state agency officials):

• By increasing the cigarette tax by $1.50 per pack would:
  
  o Reduce the number of cigarette packs sold by 26 million in the first year;
  
  o Prevent 31,800 kids alive today from becoming smoking adults;
  
  o Approx. 29,600 adults would quit smoking in 1st yr.

• This is education; it is fact driven and impartial. It does not ask listeners to take a particular stance. This is allowed.
Conflict of Interest – Misuse of Authority, Misuse of Office and Requirement of Impartiality

The Requirements specifically prohibit a state officer from:

• Misusing his/her authority for the benefit of self, family members, or business associates

• Misusing his/her office for the benefit of self, family members, or business associates

• Not being impartial in dealing with third parties for the benefit of self, family members or business associates

• Exception -- to the extent otherwise permitted or authorized by the Constitution or statutes or by Ethics Commission Rules (Rules).
Political Activities Prohibitions

The Requirements do not allow:

- The use of public funds for political fundraising
- Political fundraising on State Property
- The use of public funds to influence elections
- The distribution of campaign materials on state property
- State employees or state officers to engage in activities that could influence the results of an election while wearing identification that identifies the person as a state officer or employee or while performing the duties of a state employee or state officer
- The use of state equipment for campaigns (including state questions) or to make a campaign contribution
The Requirements do allow for political contributions to a candidate, to a political party, to a PAC or to a state question.

Contribution limitations:

- $10,000.00 to a political party in a calendar year
- $2,600.00 to any candidate per each portion of an election cycle [election cycle is primary election, run-off election and general election]
- Unlimited concerning voting for or against a state question
Review of Ethics Commission
Requirements

QUESTIONS
Zika Virus Briefing Summary
Oklahoma State Board of Health
12/13/2016

Current National Statistics: As of November 16, 2016, the CDC reports a total of 4,255 cases of Zika virus disease or congenital infections reported by U.S. states; 139 Florida cases included in this total are due to local mosquito-borne transmission and 35 U.S. cases are sexually transmitted. The number of Zika disease cases reported by the U.S. territories has escalated to 32,068, primarily attributed to the epidemic in Puerto Rico.

The U.S. Zika Pregnancy Registry is tracking a total of 1,087 pregnant women with any laboratory evidence of Zika virus infection. Adverse pregnancy outcome data indicates 5 pregnancy losses with birth defects and 26 liveborn infants with birth defects (an increase of 3 infants over the last month).

Local Transmission in Florida: Two areas of active local mosquito-borne transmission continue in Miami-Dade County. On 8/19/16, the Florida DOH reported a small area of local transmission described as a < 1.5 square mile area in south Miami Beach, which was expanded to ~ 4.5 square miles on 9/19/16. In early October, a new area in North Miami Beach was classified as an active area of transmission. The ongoing local case clusters are not considered evidence of widespread transmission in Miami-Dade County.

Current State Statistics:

- Total number of calls to Acute Disease Service (ADS) Epi-on-Call since February 6, 2016: 1,321 (avg of 32 consultations per week); the number of Zika-related inquiries have declined to about 15 calls/week during November.
  - # Physician Consultations: 644
  - # of calls related to Florida travel - 31

- # Specimens approved for testing to date: 369 (some patients later declined testing)
  - 301 tested at OSDH Public Health Laboratory
  - Overall, 320 specimens tested negative; 21 unsatisfactory for testing; 30 positive tests (includes 1 asymptomatic infant)
  - 70% of specimens tested are among asymptomatic pregnant women (all negative), 25% are symptomatic non-pregnant persons, and 5% are symptomatic pregnant women
  - Unknown how many specimens have been sent by Oklahoma medical providers to commercial reference laboratories for Zika virus testing; 13 positive results to-date from testing at commercial labs

- Case count: 29 (recent cases associated with travel to Puerto Rico, Mexico, and Caribbean islands)
  - 18 females (1 pregnant woman who delivered a healthy baby); 11 males
  - All outpatient evaluations
  - Counties of residence: Canadian (4), Carter, Cleveland (3), Comanche, Creek, Garfield, Grady (3), Johnston, Lincoln, Oklahoma (5), Payne, Tulsa (4), Wagoner (2), Woodward
Program Updates
OSDH has processed three separate federal grant applications for supplemental Zika funding following congressional appropriations of $1.1 billion for Zika preparedness and response:

- Epidemiology & Laboratory Capacity cooperative agreement - $571,105 (19 month budget period)
- Public Health Preparedness & Response -- $149,965 (7 month budget period)
- Oklahoma Birth Defects Registry -- $108,262 (7 month budget period)

Emergency Preparedness & Response
A contract is being developed to help facilitate the logistics of five regional, one-day long Zika Preparedness workshops to be scheduled during Spring 2017. The purpose of the workshops will be to strengthen information sharing with community leaders and other local response partners. These workshops will offer partner agencies the most current information related to mosquito control and disease mitigation, and highlight Oklahoma’s multi-layer response system. The workshops will help to assure that response partners understand their role, and that the response efforts are coordinated across all levels of government including non-governmental partners and the healthcare system.

Screening & Special Services
Both women currently enrolled in the U.S. Pregnancy Zika Registry and being monitored by OSDH have consented to the 12-month follow up of their infant’s development.

Communications
Google Analytics software has been used to monitor the interest and usage of Zika-related resources displayed on the OSDH web site. Data obtained over the past 4 weeks shows a steady decline in the number of website hits on the OSDH Zika virus web page with less than 100 unique visitors this week compared to 400 - 450 website visitors per week previously.

OSDH continues to respond to requests for lectures and Zika virus updates at medical meetings across the state.
The Oklahoma State Department of Health and county health departments of Garfield and Kay counties continue to investigate and provide a public health response to an outbreak of mumps. State and local public health officials are working closely with schools and healthcare providers to rapidly identify suspected cases and exclude affected persons from childcare centers, schools or workplaces during the timeframe they are able to transmit mumps to other persons. Both cases in Tulsa and Osage counties are connected to outbreak activity in Garfield and Kay counties.

**Case Summary**

Number of outbreak-associated cases: 189

- **County of Residence**
  - Garfield County: 174 (92%)
  - Kay County: 10 (6%)
  - Osage County: 4 (2%)
  - Tulsa County: 1 (<1%)

- **Age range:** 6 months - 63 years (Median age: 15)
- **Number hospitalized due to mumps:** 0
- **Measles, Mumps, and Rubella (MMR) vaccination history**
  - Vaccinated: 134 (71%)
  - Not vaccinated / unknown: 54 (29%)
  - Under age for vaccination: 1 (<1%)

Number of additional reports under investigation: 77

For further information call or visit us on the World Wide Web:
http://ads.health.ok.gov
Phone (405) 271-4060
**Division** | **Current Budget** | **Expenditures** | **Obligations** | **Forecasted Expenditures** | **Not Obligated or Forecasted** | **Performance Rate**
---|---|---|---|---|---|---
Public Health Infrastructure | $21,875,730 | $5,406,660 | $7,048,848 | $8,744,106 | $676,116 | 96.91%
Protective Health Services | $63,233,250 | $18,669,362 | $7,938,985 | $34,839,258 | $1,785,645 | 97.18%
Office of State Epidemiologist | $54,673,057 | $13,328,973 | $23,033,248 | $12,119,446 | $6,191,390 | 88.68%
Health Improvement Services | $34,245,346 | $6,028,939 | $7,676,864 | $15,723,593 | $4,815,950 | 85.94%
Community & Family Health Services | $225,465,701 | $51,750,373 | $31,820,580 | $134,821,556 | $7,073,192 | 96.86%
**Totals:** | **$399,493,084** | **$95,184,307** | **$77,518,525** | **$206,247,959** | **$20,542,293** | **94.86%**

**Expenditure Forecast Assumptions**

- Payroll forecasted through June 30, 2017
- 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
  - Amounts budgeted for county millage
  - Amount budgeted to support rural EMS agencies
  - Budget amounts for fiscal periods other than state fiscal year not yet active

**Budget and Expenditure Explanation**

- The amounts reported as 'Not Obligated or Forecasted' are not an estimate of lapsing funds. This represents planned expenditures that OSDH is currently taking action to execute.
- Office of the State Epidemiologist is still in Red Light status due to Ryan White contracts not yet obligated. The new grant period begins April 1, 2017.
- Health Improvement Services is in Red Light status due to the Prevention and Control of Diabetes and Heart Disease, Obesity, Stroke and Associated Risk grant funds planned for contractual services and executed through an RFP. Cost projections can be completed once bids are received.
- Community and Family Health is lapsing WIC and MIECHV categorical funding which can not be used to support other programs in Community and Family Health.
- The agency has a current overall performance rating of 94.86%, a net change of 2.21% from October’s report.
Oklahoma State Department of Health
Board of Health – Finance Brief
December 13, 2016
Focus: OSDH – Protective Health Services fee increases proposed during the SFY 2017 Legislative Session

- OSDH has absorbed a 28.42% decrease in State Appropriated dollars since 2009
- Fee increases are being requested in the following fee based programs:
  - Assisted Living Centers
  - Food and Hotel/Motel
  - Adult Day Care
  - Residential Care Homes
  - Nursing Facilities
  - Public Bathing (Pools)
  - Radiation*
  - Drug Manufacturers*
- For FY16, fee dollars received in the programs listed equaled $5,427,694
- In FY16, fee based programs in Protective Health performed mandated inspections at a cost of $11,226,448
- State Appropriated dollars totaling $5,798,754 were used to supplement the costs above revenue in Protective Health Services fee based programs
- Fee increases in the programs listed would generate an additional $6,116,821

*Radiation and Drug Manufacturers is fee restructuring only

FY17 Protective Health Total Budget $62,769,744

- Protective Health Service Budget
- $4,527,763
  - 7%
  - Federal
- $16,739,891
  - 27%
  - State
- $41,502,090
  - 66%
  - Fees

Rulemaking Process
OSDH, working with advisory councils and stakeholders, drafts a fee change within limits set by law. OSDH files with the Governor and the Secretary of State a notice of intent to amend rules. The Secretary publishes the notice of intent in the Oklahoma Register and a 30 day public comment period starts. OSDH prepares a statement of impacts, costs and benefits. At the comment period's end, a public hearing is held. OSDH analyzes public input and may recommend adjustments to the proposed rule. OSDH may ask the advisory council for additional advice. OSDH Senior Leadership reviews the rule and analyses, and forwards those to the State Board of Health for adoption at a public meeting. If the Board approves, the rule goes to the Governor and Legislature. If the Governor approves and the Legislature does not disapprove, OSDH files the rule with the Secretary of State, who publishes notice of rule adoption. The final rule is effective 10 days after publication.

If a fee change rule is not adopted, or if the fee limits set in law do not allow an increase, a service reduction may be needed. In some programs (e.g. food establishment inspections) OSDH may have room to reduce services to mandated minimums. In other programs (e.g. residential care inspections) legislation may be needed to reduce mandated inspections or to raise fee limits.

FY17 OSDH Total Budget of $399,493,084

- OSDH Budget
  - $53,333,050
    - 13%
    - Federal
  - $68,485,486
    - 17%
    - State
  - $53,703,390
    - 14%
    - Fees
  - $223,971,158
    - 56%
    - Millage
QUARTERLY PERFORMANCE AND OPERATIONAL DASHBOARD
Explanatory Note

The State Fiscal Year (SFY) begins July 1st and ends June 30th. SFY 2017 is from July 1, 2016 to June 30, 2017.

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

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

**SC = Score Card:**
- Green = Measure is Satisfactory
- Yellow = Two Quarters Not Met in Last Year
- Red = Shortfall Has Occurred Three Consecutive Quarters
The 'Number of New Infectious Disease (ID) Case Reports' graph shows the new cases of infectious disease received by the Acute Disease Service (ADS) by month. It reflects significant seasonal trends such as the increase of influenza hospitalizations/deaths in the winter months and increase in enteric and tickborne diseases in the summer months.

Notable: The decline in the recent number of tickborne disease case reports and overall investigation time is due to prioritization of case investigations for which there is a public health intervention such as pertussis and the mumps outbreak in north central Oklahoma. There has also been a large decline in the number of shigellosis case reports.

Investigation of travel-associated Zika virus cases and consultation with Oklahomans who traveled to areas with local Zika transmission and their healthcare providers have continued to be intensive public health activities. TB cases have increased over the previous calendar year. In 2015 Oklahoma had 52 TB cases while there have been 61 TB cases through September 2016. Oklahoma has an increase in TB deaths as well from 13 to 19.

### Explanation of Dashboard

#### Number of New Infectious Disease Case Reports and Estimated Investigation Time (Hrs.):
**July 2015 - September 2016**

<table>
<thead>
<tr>
<th>Month of Year</th>
<th># of Rep</th>
<th>Est. Hrs</th>
<th># Specimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2015</td>
<td>862</td>
<td>1,217</td>
<td>13,523</td>
</tr>
<tr>
<td>December 2015</td>
<td>635</td>
<td>1,053</td>
<td>14,967</td>
</tr>
<tr>
<td>January 2016</td>
<td>632</td>
<td>1,146</td>
<td>15,180</td>
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<tr>
<td>July 2016</td>
<td>926</td>
<td>1,343</td>
<td>15,403</td>
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<tr>
<td>May 2016</td>
<td>960</td>
<td>1,454</td>
<td>15,607</td>
</tr>
<tr>
<td>October 2015</td>
<td>904</td>
<td>1,214</td>
<td>15,058</td>
</tr>
<tr>
<td>February 2016</td>
<td>731</td>
<td>1,236</td>
<td>15,005</td>
</tr>
<tr>
<td>September 2015</td>
<td>1,236</td>
<td>1,676</td>
<td>15,728</td>
</tr>
<tr>
<td>July 2015</td>
<td>1,241</td>
<td>1,626</td>
<td>15,715</td>
</tr>
<tr>
<td>April 2015</td>
<td>719</td>
<td>1,285</td>
<td>15,914</td>
</tr>
<tr>
<td>August 2015</td>
<td>1,269</td>
<td>1,915</td>
<td>15,952</td>
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<tr>
<td>June 2016</td>
<td>1,081</td>
<td>1,635</td>
<td>16,143</td>
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<tr>
<td>March 2016</td>
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<tr>
<td>September 2016</td>
<td>910</td>
<td>1,337</td>
<td>17,037</td>
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<tr>
<td>August 2016</td>
<td>1,105</td>
<td>1,780</td>
<td>17,715</td>
</tr>
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</table>

### Source:
Public Health Investigation and Disease Detection of Oklahoma (PHIDDO) System

Prepared for Valauna Grissom 12/9/2016 12:17:43 PM
Table 1: OSDH + OCCHD + THD Clinic Services by Quarter

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Q1</td>
<td>596,527</td>
<td>790,716</td>
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<tr>
<td>Q4</td>
<td>535,709</td>
<td>717,895</td>
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<td>693,875</td>
<td>-1.7</td>
<td>708,725</td>
<td>2.0</td>
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<td>2,520,251</td>
<td>2,814,136</td>
<td>20.6</td>
<td>2,677,776</td>
<td>-1.2</td>
<td>2,743,925</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Explanation of Dashboard

Figure 1. Total Visits for OSDH + OCCHD + THD Clinics by Quarter. The increase in Early Intervention (Sooner Start) visits is the result of increasing the number of contractors in order to increase services across the state. However, the apparent drop in Early Intervention visits in the last quarter is primarily due to a time lag in entering the data. Notably, there has been an increase followed by a decrease in the number of client visits for the Child Health program during SFY2016. This variability in recent Child Health visits is mostly due to changes in numbers from Tulsa. The number of Child Health visits at OSDH clinics has remained stable. WIC visits have decreased. This may be the result of eWIC implementation since participants taking on-line nutrition education will not have visit the clinics as often.

Figure 2. Total Immunization Visits by Quarter. The overall decrease in immunizations for OSDH is a reflection of the decrease in clients receiving their annual flu shots at public clinics. Large retail pharmacies receive vaccine shipments several weeks earlier than health departments. The strong cyclic data trend continues to be consistent for almost 4 years, with a decline in immunization services in the 3rd and 4th quarter across all public and private clinics. 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. The optimal time for flu shots is during October-December.

Table 1. OSDH + OCCHD + THD Clinic Services by Quarter. Services in county health department clinics were similar for each quarter of SFY 2016 compared to SFY 2015. Quarterly changes were less than 5%, the total number of visits between SFY 2016 and 2015 had about a 1% decrease.
2017 AUDIT PLAN
Oklahoma State Department of Health  
Annual Internal Audit Plan  
State Fiscal Year 2017

Introduction

The annual audit plan is used as a blueprint for maximizing audit coverage, optimally using audit resources and providing the greatest benefit to Agency Management and Oklahoma taxpayers. An annual audit plan is prepared at the beginning of each fiscal year and is based on input solicited from each of the deputy commissioners and their finance officers through a comprehensive complex risk assessment approach and concerns of the Accountability, Ethics and Audit Committee of the Board of Health and the Internal Audit Staff.

A risk assessment approach was used to identify and rank the importance of all Department major activities and programs. Based on the complexity of Department operations, geographical dispersion and the current understanding of functional areas, the audit plan for fiscal year 2017 has been developed using criteria to assess risk and prioritize audit projects. Among these criteria are:

- Concerns from the Board of Health, Commissioner of Health, State Auditor’s and Inspector’s Office, and Internal Audit Unit
- Audits requested by Division management
- Financial risk
- Federal compliance risk
- Miscellaneous (internal control environment, potential effect on state of health, performance measures, time since last audit, etc…)
- Availability of audit resources

The Internal Audit Unit anticipates changes to the plan may become necessary if issues of greater risk arise throughout the fiscal period.

The following brief narratives discuss areas that the Internal Audit Unit will review utilizing current resources.

County Health Department Audits

The Oklahoma State Department of Health maintains 82 county health department locations in 68 counties throughout the State, which provide a variety of health services to the public. Of the $403.5 million Agency budget for SFY-17, the county health departments are directly budgeted approximately $98 million, which consists of $47.3 million of State/Federal funds, $31.9 million of local millage funds (county payroll reimbursement) and $19 million of local millage funds (Local Operating Budgets). County health departments also utilize other budgets referred to as Shared Services. Historically, counties utilize approximately $53.4 million of Shared Services budgets. The budgeted expenditures equate to 38% (($98+$53.4)/$403.5) of the Agency’s total expenditures, indicating a significant need to continue to provide audit coverage to this area.

The Internal Audit Unit will continue striving to review county health department processes once every 3 years, with emphasis placed on compliance with Agency Policies, Federal Guidelines, Cash Receipts and Receivables, Pharmacy Inventory, (including Immunization Vaccines), Travel Reimbursement Processes, County Fixed Asset Inventory, Temporary Food License, Expenditures (LEP), Fixed Assets, Purchase Orders, Contracts and including Influenza Billing, Collection and Depositing Processes and Cell Phone testing when appropriate.
Federal Monitoring Requirements

Independent Audit Reports

The Internal Audit Staff plans to further enhance the Agency’s monitoring requirements as set forth in the Federal Office of Management and Budget (OMB) Circular A-133 by continuing to ensure local governments, non-profit organizations and institutions of higher education who are contracted to perform services on behalf of OSDH using Federal funds have an Independent Audit performed. Contractors are required by contractual language to submit the Independent Audit Reporting forms to the Federal Audit Clearing house on an annual basis, if Federal expenditure thresholds are met. These audit report forms are reviewed for any findings pertaining to OSDH awards. Any findings are resolved by the Internal Audit Unit or forwarded to the appropriate program area for resolution.

The Internal Audit Unit will continue to monitor subrecipients of State and/or Federal awards as required by OMB Circular A-133.

Invoice Validation

Additionally, the Internal Audit Unit will review supporting documentation of vendor invoices as part of the overall Agency contract monitoring process. Based on a contractor risk analysis performed by the OSDH Procurement Unit, the Internal Audit Unit will request supporting documentation of paid vendor invoices for review of proper supporting documentation.

Internal Agency and Contract Audits

The Internal Audit Unit anticipates reviewing procedures, internal controls, proper use of funds and supporting documentation, compliance with Federal regulations and state statutes, proper supporting documentation for matching funds and safeguarding of assets, as applicable, for the following areas of concern:

- Grant Reporting – Financial
- Payables
- Internal Controls – Fixed Assets
- Grant Reporting – Programmatic
- Cash Receipts, Accounts Receivable & Refunds
- Terrorism Preparedness and Response
- Pharmaceutical Inventory & Credit – Central Office only
- Long Term Care Services
- Oklahoma – Actions to Prevent Obesity, Diabetes, Heart Disease and Stroke

The Internal Audit Unit will review the items above as audit staff time will permit.
COMMISSIONER'S REPORT
PUBLIC RELATIONS/COMMUNICATIONS

Oklahoma Public Health Association – keynote speaker
Champions of Health Gala (Blue Cross and Blue Shields of Oklahoma) – speaker
Patients, Physicians and Society Course Lecture (Psychiatry and Behavioral Sciences Education Office-OU Health Sciences Center)
GE Global Research Oil & Gas Technology Center Grand Opening
Jaclyn Cosgrove, Oklahoman – interview
Oklahoma Nurses Association Annual Convention – panelist
Oklahoma Psychological Annual Conference – keynote speaker
NorthCare Building Dedication – speaker
KIDS COUNT Conference – panelist
Leadership OKC Class – presenter
Leadership Norman Class- presenter
National Association of Attorneys General-Bridging the Gaps: Reducing Prescription Drug & Opioid Abuse and Misuse Summit - panelist

STATE/FEDERAL AGENCIES/OFFICIAL

Michael Botticelli, Director, National Drug Control Policy
Dr. Karen DeSalvo, Acting Assistant Secretary for Health
Kana Enomoto, Principal Deputy Administrator, Substance Abuse and Mental Health Services Administration
Preston Doerflinger, Secretary of Finance, Administration, and Information Technology
Dr. Jason Sanders, OU Health Sciences Center Senior Vice President and Provost
Dean Gandy, Executive Director, University Hospitals Authority & Trust
Secretary Chris Benge, Governor’s Office, Chief of Staff
State Innovation Waiver Interagency Workgroup
Representative Leslie Osborn
Mark Tygret, Director and Nicole McPhetridge, Deputy Director of House Fiscal Division
Michael Teague, Secretary of Energy & Environment, Scott Thompson, Executive Director and Jimmy Givens, Deputy Executive Director for Dept. of Environmental Quality
Governor’s Cabinet Meeting
Denise Northrup, Office of Management and Enterprise Services
Health & Human Services Cabinet Meeting
Randy Dowell, Senate Chief Operating Officer and Anthony Sammons, Assistant Director of Fiscal Staff

SITE VISITS

Blaine County Health Department
Craig County Health Department
McIntosh County Health Department, Checotah
McIntosh County Health Department, Eufaula
Ottawa County Health Department
Rogers County Health Department
Woodward County Health Department
OTHERS:

ASTHO Board Meeting, Policy Summit, & Annual Business Meeting
Reforming States Group Executive Leadership Program - speaker
1332 Task Force Meeting
Zarrow Mental Health Symposium
Tri-Board Health Departments Meeting
Arcadia Trails/Integris – OKC & Ardmore
Public Health 3.0 - George Washington University/HHS – panelist
Oklahoma Commission on Children and Youth Meeting
Accreditation Council for Graduate Medical Education, CLER Committee Meeting
Reforming States Group (Milbank Memorial Fund) Executive Steering Committee
Greater Oklahoma City Chamber Forum Luncheon
CDC Prevent Block Grant Meeting
OSDH Champion Soccer Game – finals!
Hudson Fellowship Selection Committee
CORE Accreditation Team Meeting
OHIP Executive Committee (by phone)
Contingency Review Board Meeting (HCA/SSM)
Advisory Board Meeting-OU College of Public Health
PHAB Accreditation Committee
Oklahoma Cancer Policy Forum
OHIP Full Team Meeting