Regular Meeting of the Oklahoma State Board of Health
March 13, 2018, 11:00 AM
Posted at www.health.ok.gov
Oklahoma State Department of Health,
1000 NE 10th Street, 11th Floor, Room 1102
Oklahoma City, Oklahoma 73117

AGENDA

I. Call to Order, Roll Call, and confirmation of a Quorum.

II. Review, discussion and approval of Minutes for:
a) February 13, 2018 Regular Meeting

III. Joint Commission on Public Health Presentation – Gary Cox, JD, Executive Director, Oklahoma City-County Health Department
Consideration, possible action and vote on recommendations and final report.

IV. Consideration, possible action and vote on changes to the 2018 Board of Health Meeting Locations. Proposed changes:
April 10, 2018 – Logan County Health Department (Guthrie)
June 12, 2018 – McClain County Health Department (Blanchard)
December 11, 2018 – Canadian County Health Department (El Reno)

V. Consideration, possible action and vote on appointing Administrative Rule Attestation and Liaison Officers.

VI. Consideration of Standing Committees' Reports and Action:
Executive Committee – Ms. Burger, Chair
Discussion and possible action on the following:
b) Update

Finance Committee – Ms. Wolfe, Chair
Discussion and possible action on the following:
c) Update

Accountability, Ethics, & Audit Committee – Dr. Grim, Chair
Discussion and possible action on the following:
d) Update

Public Health Policy Committee – Dr. Stewart, Chair
Discussion and possible action on the following:
e) Update

VII. Report of the Acting Commissioner

VIII. Consideration of a motion and vote to adjourn into Executive Session pursuant to 25 O.S. § 307(B)(1) to discuss:
a) the employment, hiring, or appointment of the Interim Commissioner of Health.

IX. Executive Session pursuant to 25 O.S. § 307(B)(1) relating to:
a) the employment, hiring, or appointment of the Interim Commissioner of Health.

X. Consideration of a motion and vote to return to Open Session.

XI. Consideration, possible action and vote on matters discussed in Executive Session.

XII. New Business.

XIII. Adjournment.

STATE BOARD OF HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH
1000 N.E. 10th Street, Room 1102
Oklahoma City, Oklahoma 73117-1299

February 13, 2018

CALL TO ORDER, ROLL CALL, AND CONFIRMATION OF A QUORUM

Martha Burger, President of the Oklahoma State Board of Health, called the meeting of the Oklahoma State Board of Health to order on Tuesday, February 13 at 11:06 a.m. Charles W. Grim, D.D.S. and Jenny Alexopulos, D.O. joined the meeting at 11:09 a.m. The final agenda was posted at 9:35 a.m. on the OSDH website on February 12, 2018, and at 9:20 a.m. at the building entrance on February 12, 2018.

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

Central Staff Present: Preston Doerflinger, Interim Commissioner of Health; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Tina Johnson, Deputy Commissioner, Community & Family Health Services; Gunnar McFadden, Assistant Deputy Commissioner, Community & Family Health Services; Julie Ezell, General Counsel, Office of General Counsel; Tony Sellars, Director, Office of Communications; Brian Downs, Office of State and Federal Policy; Kristy Bradley, State Epidemiologist, Office of State Epidemiologist; Jan Fox, Director, HIV/STD Services; Beth Martin, Interim Director, Family Support & Prevention Services; Adrienne Rollins, Interim Director, Center for Health Innovation & Effectiveness; Margot Barnes, Director, Human Resources; Sara Cowden, Commissioner's Office; Leigh Newby, Revenue Officer, Financial Services; Sharon Butler, Informatics; Don Smalling, Interim Director, Office of Accountability Systems; Diane Hanley, Executive Assistant, Commissioner's Office; and Kim Bailey, Chief Operating Officer.

Visitors in attendance: Gary Cox, Executive Director, Oklahoma City-County Health Department; Bruce Dart, Executive Director, Tulsa City-County Health Department; Tom Gruber, Senior Deputy Attorney General; Kim Heaton, Office of the Attorney General; David Dude, American Cancer Society; Cara Gluck, OSDH Regional Director; Mendy Spohn, OSDH Regional Director; Matt Photos, KOKH-TV & KOCO-TV; Paul Monies, Oklahoma Watch; Dylan GoForth, Frontier; Brianna Bailey, Frontier; Meg Wingerter, Oklahoman; and Ian Smith, KFOR.

REVIEW, DISCUSSION AND APPROVAL OF MINUTES

Ms. Burger directed attention toward approval of the Minutes for the January 9, 2018 regular meeting. **Dr. Legako moved Board approval of the January 9th meeting minutes as presented. Second Mr. Starkey. Motion Carried.**

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart, Wolfe
ABSENT: Gerard

STATE OF THE STATE'S HEALTH STATUS UPDATE

Mr. Derek Pate, Director, Center for Health Statistics, and his staff are working to finalize the State of the State's Health (SOSH) website. Webinars will be held for the board members to provide a closer look at the website and also to share any insight or feedback before the website is published. Mr. Pate provided some historical context for the State of the State's Health Report and how it has evolved over time. As updates to the report were needed once again, several listening sessions were conducted in late 2016 and early 2017, with a wide variety of community stakeholders, to get feedback on how to improve the report. Based on the feedback received from those sessions, the State of the State's Health website was developed. Since that time additional website enhancements have been made and moving forward the SOSH website will be routinely updated on an ongoing basis.

CONSIDERATION OF STANDING COMMITTEES REPORTS AND ACTION

Executive Committee

Ms. Burger reported that the committee discussed public health issues currently in the news, namely the flu and measles. Other topics of discussion included changes in the finance area and the Board of Health meetings possibly visiting some county health departments.

Finance Committee

Ms.Wolfe introduced Kim Bailey, Chief Operating Officer. She came to the health department from the Oklahoma Workers' Compensation Commission (WCC) where she served as Executive Director and General Counsel. She has a degree from Georgetown University and a Juris Doctorate degree from the University of Oklahoma. She is taking on additional duties and will be the Acting Chief Financial Officer. Ms. Wolfe also thanked the staff of financial services who continue to work diligently toward an efficient resolution.

Accountability, Ethics, & Audit Committee

Dr. Grim indicated there were no known significant audit issues to report at this time.

Public Health Policy Committee

Dr. Stewart reminded everyone that the legislature is now back in session. There was a lot of interest at the Capitol on the proposed revenue package. One of the health department's legislative priorities is the cigarette tax which was included in this revenue package. Although this revenue package failed to make it through the legislature, smoking cessation is one of the most important things one can do as advocates of public health. It will remain a priority for OSDH.

Dr. Stewart also shared that policy staff have been working to identify bills they think will have a public health impact. Those bills are divided into categories and then distributed to Senior Leadership for further monitoring. Three broad areas are emerging in this legislative session around immunizations, medical marijuana, and governance. Dr. Stewart reminded the Board that State Question 788, Medical Marijuana Legalization, will be on the ballot for June 26th, 2018 and if the bill passes, some of the implementation will belong to the Oklahoma State Department of Health. Dr. Stewart mentioned that it will be important to provide leadership on governance so it remains a strong advocate for public health. The Board will continue to receive regular updates on the bills OSDH is tracking.

REPORT OF THE INTERIM COMMISSIONER

Mr. Doerflinger shared that the agency continues moving forward in finances. Many folks are doing great work and have continued to identify operational areas of concern that will contribute to the overall financial health of the agency. Mr. Doerflinger also mentioned that recommendations have come from the Joint Commission on Public Health and the Board will need to see those recommendations. Last, Mr. Doerflinger asked Dr. Kristy Bradley, State Epidemiologist, to provide an update on influenza and a measles case her team has been working on.

Dr. Bradley reported that this has been a severe flu season. Immunization Service, Acute Disease Service, Public Health Laboratory and the county health departments have been on the front lines of this flu response. Early on Oklahoma was having more of the Type A flu and then shifted to H3N2, the strain of flu that is most associated with severe illness, hospitalization and death. The flu season epidemic peaked the third week of January and there is now a decline in hospitalizations and less patience visits for flu like illness. Currently, the public health lab has seen Type B flu and H1N1 emerge over the last week. Dr. Bradley shared that it is possible to get the flu more than once in a season due to the different strains of the flu. Dr. Legako noted it is still important to get a flu vaccine. On the OSDH website, there is a weekly viral disease surveillance report, *Flu View*, and it is updated every Thursday at 10 a.m.

Mr. Gary Cox, Executive Director, Oklahoma City-County Health Department shared that their facility held a free drive-through clinic on a Saturday morning for four hours. The event went very well and they were able to give 430 flu shots to those who were appreciative and who otherwise may not have received a flu shot.

Dr. Bradley provided an update on a recently reported measles case. A team of epidemiologists met with staff at the Cleveland County Health Department to identify where the contagious person had been and to determine who might have been at risk. A press release was put out identifying locations of possible exposure. Everyone was cooperative through the process and OSDH staff was able to provide information on symptom follow-up and guidance on appropriate infection control practices that could be followed in healthcare facilities to minimize future exposures or spread. Measles is one of the most contagious viral diseases. This measles case is very rare for Oklahoma and occurred because of international travel.

Mr. Tom Gruber, Senior Deputy Attorney General, advised the Board to go into Executive Session concerning pending claims because he has determined that disclosure will seriously impair the ability of the Board to conduct a pending proceeding in the public interest.

CONSIDERATION OF A MOTION AND VOTE TO ADJOURN INTO EXECUTIVE SESSION PURSUANT TO 25 O.S. Section 307(B)(4) for confidential communications between the Board and its attorney concerning pending investigations, claims, or actions, if the Board, with the advice of its attorney, determines that the disclosure will seriously impair the ability of the Board to conduct a pending proceeding in the public interest.

Dr. Krishna moved Board approval to go into Executive Session at 11:42 AM. Second Dr. Grim. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart, Wolfe
ABSENT: Gerard

CONSIDERATION OF A MOTION AND VOTE TO RETURN TO OPEN SESSION.

Dr. Stewart moved Board approval to move out of Executive Session at 12:40 PM. Second Ms. Wolfe. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart, Wolfe
ABSENT: Gerard

CONSIDERATION, POSSIBLE ACTION AND VOTE ON MATTERS DISCUSSED IN EXECUTIVE SESSION.

No action taken.

NEW BUSINESS

Mr. Tom Gruber, Senior Deputy Attorney General, advised the Board, according to Oklahoma law, that new business information received within the last 24 hours met the criteria for going into Executive Session.

CONSIDERATION OF A MOTION AND VOTE TO ADJOURN INTO EXECUTIVE SESSION PURSUANT TO 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of the Interim Commissioner of Health.

Dr. Grim moved Board approval to move into Executive Session at 12:41. Second Dr. Stewart. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart, Wolfe
ABSENT: Gerard

CONSIDERATION OF A MOTION AND VOTE TO RETURN TO OPEN SESSION.

Dr. Krishna moved Board approval to move out of Executive Session at 2:29 PM. Second Dr. Grim. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart
ABSENT: Gerard, Wolfe

CONSIDERATION, POSSIBLE ACTION AND VOTE ON MATTERS DISCUSSED IN EXECUTIVE SESSION.

Dr. Stewart moved Board approval to accept the resignation letter of Preston Doerflinger, Interim Commissioner of Health effective immediately. Second Dr. Krishna. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart
ABSENT: Gerard, Wolfe

Dr. Stewart moved Board approval to appoint Brian Downs as Acting Commissioner of Health until an Interim Commissioner of Health can be identified. Second Dr. Alexopulos. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart
ABSENT: Gerard, Wolfe

Ms. Burger shared that the Board does have a committee that will begin to vet potential Interim Commissioners. The committee will make recommendations to the Board. The Board hopes to have candidates ready for vetting in the next 30-60 days.

ADJOURNMENT

Dr. Grim moved Board approval to Adjourn. Second Dr. Alexopulos. Motion carried.

AYE: Alexopulos, Burger, Grim, Krishna, Legako, Starkey, Stewart
ABSENT: Gerard, Wolfe

The meeting adjourned at 2:34 p.m.

Approved

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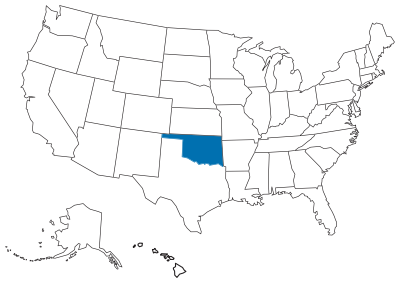
Martha Burger, M.B.A.
President, Oklahoma State Board of Health
March 13, 2018



Joint Commission

Final Report Draft

Oklahoma State Department of Health

OKC-COUNTY HEALTH DEPARTMENT

TULSA HEALTH Department

Executive Summary

Over the last few weeks Advisory Committees have been meeting to develop core recommendations in the following identified areas: legal/legislative, budget and programs, data and IT infrastructure. Many of these recommendations were formed with input from Oklahoma State Department of Health employees and the general public. Clear themes and trends have emerged as a result of this work and should be considered central to our efforts to move forward in adopting recommendations and developing an actionable plan forward. Resource allocation and decision-making autonomy is found across all recommendations, explicitly or implicitly, illustrating a consensus among advisors. Resource allocation cannot just consider population density, however, as the needs of the rural communities are multi-faceted and per capita funding allocation alone will not address the needs of those citizens residing in our rural communities.

Efforts to improve health outcomes must focus on increasing efficiency, encouraging autonomous decision-making at the local level to develop community specific partnerships and governance structures that best meet the needs. Examples of implementation may include shared jurisdictional arrangements enabling multi-county or regional delivery of programs and services and development of joint governance structures to allow for equal partnership between local, regional and state health departments. Another theme that emerged across all Advisory Committees is the need to update and modernize public health data and IT infrastructure that supports it. Real time public health data is a critical missing link for decision makers to develop programs, policies and services to meet the needs of Oklahoma communities. Transparency of public health data is not limited to the traditional health data we associate with health outcomes but must also include the financial and operational data that drives those outcomes.

Finally, each Advisory Committee recognized the evolution of public health over the last decade requires an ability to develop relationships with non-traditional partners in the community. The opioid epidemic, challenges in resource sustainability and increases in natural disaster are examples of the need for public health to move away from program-driven delivery of services, and towards population-driven strategies that reflect community identified needs. Defining foundational public health services is only the starting line for these efforts, articulating the specific clinical and community strategies that will impact health outcomes for the greatest number of Oklahoma residents is a collaborative endeavor. A joint council that contains representation from state, local and city-county health departments is one of the most important steps we can take to improve health and address disparities in the communities we serve.

Mary Fallin
Governor

FILED
NOV 07 2017
OKLAHOMA SECRETARY OF STATE

EXECUTIVE DEPARTMENT
EXECUTIVE ORDER 2017-36

To the Honorable Members of the Oklahoma House of Representative and the Honorable Members of the Oklahoma State Senate.

I, Mary Fallin, Governor of the State of Oklahoma, pursuant to the powers and authority vested in me by Sections 1 and 2 of Article VI of the Oklahoma Constitution hereby direct as follows:

1. I hereby create a Joint Commission on Public Health and appoint Gary Cox, Executive Director of Oklahoma County Health Department as its Chairman.

2. Additional members of the Joint Commission shall be appointed by Preston Doerflinger, Interim Director of the State Health Department from the following stakeholders:

Representatives of the County Health Department including the Oklahoma City County Health Department, Tulsa County Health Department, as well as the Oklahoma State Department of Health staff, public health advocates and agency partners.

3. The Joint Commission shall develop a plan of excellence for Public Health in the State of Oklahoma and shall provide guidance as to the proposed FY2019 budget for the Oklahoma Health Department.

IN WITNESS WHEREOF, I have set my hand and caused the Great Seal of the State of Oklahoma to be affixed at Oklahoma City, Oklahoma, this 7th day of November, 2017.

BY THE GOVERNOR OF THE STATE OF OKLAHOMA

Mary Fallin

MARY FALLIN

ATTEST:

SECRETARY OF STATE

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Joint Commission Appointees:

Preston Doerflinger	Interim Commissioner, OSDH
Brandie Combs	OSDH County Administrator, Comanche
Mike Echelle	Former OSDH County Administrator, Pittsburg Co. St. Francis - Warren Clinic Director
Tribal Representative Senator A.J. Griffin	Oklahoma State Senate
Representative Dale Derby	Oklahoma State House of Representatives
Ann Paul, MPH	THD Board of Health Member Chief Strategy Officer at St. John Health System Tulsa, OK
Jenny Alexopulos, DO	OSDH Board of Health Member Director of Medical Education at OSU Medical Center Professor of Family Medicine, Tulsa, OK
Erika Lucas	OCCHD Board of Health Member Owner/Consultant
Bruce Dart, Ph.D.	THD, Executive Director
Gary Cox, JD, Chairman	OCCHD, Executive Director

Joint Commission Advisors:

LEGISLATIVE / LEGAL ADVISORS

Dr. Gary Raskob	Dean, College of Public Health, OUHSC
Tammie Kilpatrick (Chair)	FKG Consulting
Scott Adkins	Scott Adkins Consulting
Chanteau Orr, Legal Services	THD
Myron Coleman, Legal Counsel	OCCHD
Julie Ezell, General Counsel	OSDH
Buffy Heater	OSDH

BUDGET / PROGRAM ADVISORS

Michael Romero, CFO	OSDH
Tony Miller, Director Financial Services	OCCHD
Reggie Ivey, COO, Co-Chair	THD
Tina Johnson	OSDH
Kristy Bradley	OSDH
Hank Hartsell	OSDH
Phil Maytubby, Director Public Health Protection Division	OCCHD
Priscilla Haynes Preventive Health Services	THD
Patrick McGough, Co-Chair Deputy Director, Clinical Services	OCCHD

DATA ADVISORS

David Kendrick, MD (Chair)	Medical Informatics at OU-Tulsa
Megan Holderness	OCCHD
Kelly VanBuskirk Health Data & Policy Division Chief	THD
Becki Moore	OMES
Derek Pate	OSDH
Matt Singleton	OMES
Secretary: Kay Hulin	OCCHD

Below please find an executive summary of recommendations set forth by each advisory committee. For full recommendations, please review the full report (pages 11 – 15) and see attached addendum.

Advisory Committee Recommendations

Budget/Program Assessment

The Budget/Program Assessment Advisory Committee was tasked with developing recommendations that address transparency in budget forecasting and funding sources. In addition, this committee was tasked with developing recommendations to address governance of the overall public health system to include strategies to become more lean and efficient,

effectively developing partnerships, engaging in resource-sharing and determining the applicability of defining foundational public health areas and capabilities.

- Develop and implement a transparent zero-based budgeting, billing and overall financial system for the Oklahoma State Department of Health (OSDH) that can easily be assessed, shared and reported on.
- Adopt the Foundational Public Health Services Model and ensure programming and budgets align with the foundational areas and capabilities. Determine a formula to appropriate public health funds by region/county, which incorporates per capita funding, community population and needs, and allows for autonomous county decision making, with general administrative oversight and monitoring remaining as a central office function.
- Conduct an environmental health program/services scan to identify opportunities to reduce duplication, develop public/private partnerships, and consider co-locating programs/services to create comprehensive, holistic service in each community.
- Develop and establish an evaluation system that will allow the Oklahoma State Board of Health to receive updates and engage partners in the implementation of a statewide strategic plan.
- Create a Joint Council to review health data, plan health initiatives, prioritize services, develop private/public partnerships, evaluate outcomes, and review per capita public health spending in each county. This Council would include all governmental public health agencies as partners, and consist of the state Commissioner of Health, Regional Administrative Directors, and the Executive Directors of the Oklahoma City-County Health Department, and Tulsa City-County Health Department.

Data Assessment

The Data Assessment Advisory Committee was tasked with developing recommendations that address the health assessment process, access to data, and effective messaging to the public. This included addressing needs to modernize IT infrastructure and enhance the ability for decision makers to utilize real time data to inform strategies.

1. Maintain a cadence of collaboration:

By working together across agency and public-private sector boundaries, the Data Committee was able to make progress in just a few short meetings. In order to sustain and build on this progress we request that our meetings continue as we enter the crucial phase of planning short, medium and longer term strategy for public health information infrastructure and pursue funding to support and sustain these efforts.

2. Modernize Oklahoma's public health data infrastructure:

Significant gaps and inefficiencies exist in Oklahoma's public health data infrastructure, and we recommend the following improvements be made:

Implement a statewide public health electronic medical records system to provide real time data for health improvement. This data system should integrate disease surveillance, immunization registry, electronic Master Patient Index (eMPI), link all public health systems, OHCA and

OSDMHSAS systems and should leverage existing resources and investments. These data systems and analysis can provide the data needed to address public health challenges, gaps in coverage, needed resources, community interventions and evaluation of effectiveness towards improving community health.

This goal includes short-, mid-, and long-term objectives identified by committee members.

Short-term:

- Complete upgrades and deployment of the public health immunization bi-directional messaging.
- Continue state agency interoperability project to link public health systems, OHCA, and ODMHSAS, and other state agencies.
- Planning for state/city-county data integration solutions with PHIDDO, PHOCIS, and OSIIS.
- Legal review of secondary use of state public health data in external systems (i.e., Health Information Exchange (HIE), Electronic Health Record (EHR), Insurance).
- Pursue available funding for implementation and long-term sustainability for HIE and public health interoperability for state match funding.
- Coordinate with existing HIEs to leverage clinical data exchange and public health messaging

Mid-term:

- Synchronize eMPI's between state and private sector
- Synchronize provider and services directory/index
- Participate in national initiative, Digital Bridge, for electronic case reporting
- Evaluate potential implementation plans for integrated statewide public health analytics system
- Implement state/city-county data integration solutions with PHIDDO, PHOCIS, and OSIIS

Long-term:

- Deploy statewide Public Health EHR
- Evaluate potential implementation strategies for statewide syndromic surveillance monitoring

Legislative/Legal

The Legislative/Legal Advisory Committee was tasked with developing recommendations that address opportunities to proactively work with locally elected officials to improve transparency in public health through budgeting, accountability and modernized legislation.

- Develop statewide coalition who will provide input to the Joint Commission and educate around public health generally and the Joint Commission's recommendations.
- Develop a cohesive and unified message for communication around both public health and the recommendations of the Joint Commission.
- Work with the Governor and Legislature to develop strategy for implementation of the Joint Commission Policy recommendations.

- Continue the Joint Commission through implementation of policy reforms and facilitate additional opportunities for healthcare, education and business community stakeholders to participate in the process.

Summary

We are appreciative of the good work that has been undertaken and accomplished by the Advisory Committees. Addressing the core, thematic areas identified by the Joint Commission is a first step in restoring the credibility of our state's public health system to the communities we serve and putting Oklahoma on a path to health improvement. We offer these final thoughts in regard to the path forward.

- For Oklahoma's public health system to work cohesively, and to build a path forward to modernize, a true partnership must be emboldened to provide oversight for our system. The development of a Joint Council to perform this function and formalize the expectation for transparency and accountability among public health system stakeholders should include representation from the OSDH, the metropolitan health departments of Oklahoma City and Tulsa, and the local county health departments.
- As we embark on this next chapter of OSDH administration, and consider the ability to develop these partnerships, input from members of the proposed Joint Council should be incorporated in the search for the next leader of our state's public health system.
- Resources, both state and federal, must be distributed equitably based on need and population, with attention given to balancing the distribution to adjust for disparities in our rural communities which may not have access to the public-private partnerships of the more populous communities.
- Counties, in cooperation with Central Office, must be able to exercise local control over defining and implementing foundational public health services to best meet the needs of the communities they serve.
- Finally, we cannot afford to ignore the evolution of public health, and the explicit need to modernize our systems for resource allocation, data and IT infrastructure.

While much work has been put into the development of the recommendations included in this report, the work to transform Oklahoma's public health system is only just beginning. It is now time to create actionable plans to operationalize and implement. Continuing to engage public health leaders, locally elected officials, and other diverse stakeholders already participating as members of the Joint Commission will be critical to this next step in modernizing the Oklahoma Public Health System.

Current Status of the Joint Commission on Public Health

The Joint Commission kicked off its work on January 5, 2018, bringing together diverse stakeholders from the public, private and non-profit sectors to first educate and build awareness of the current state of public health in Oklahoma.

Since that time, three advisory committees were formed, chaired by members of the Joint Commission and tasked with developing recommendations that address the following areas:

- Budget and Programs, Co-Chairs Dr. Patrick McGough, Oklahoma City-County Health Department and Mr. Reggie Ivey, Tulsa City-County Health Department
- Legislative/Legal, Chair: Ms. Tammie Kilpatrick, FKG Consulting
- Data Assessment, Chair: Dr. David Kendrick, MyHealth Access Network

Advisory committees each met for the first time immediately following the Joint Commission kick-off meeting on January 5th.

Budget and Program Advisory Committee

The Budget and Program Advisory Committee met six times over a period of three weeks (January 5 – February 9) to develop a robust set of recommendations for the Joint Commission's review and approval. The Committee utilized a set of guiding questions to provide structure and framework to committee discussions.

Guiding Questions

1. In an effort to be transparent, should the Oklahoma State Department of Health have a financial and budgeting system that provides revenue and expenditure data that is real time, clear, and reflects federal and state allocations?
2. What internal controls and reporting structure should be implemented?
3. What potential changes could be made to the current County Health Department system structure to better serve Oklahomans?
4. Should this committee recommend per capita spending in the counties, with a weighted hybrid formula for rural/smaller counties with limited resources?
5. Is the public health system in Oklahoma targeting, to the fullest extent possible, specific measures that impact our national health ranking i.e. chronic disease reduction, uninsured reduction, increased immunization rates?
6. How do we increase efficiencies and avoid duplication of services and staff among counties (including metro areas) and Central Office?
7. Would increased autonomy and independence in budgeting and program efforts at a County Health Department level prove beneficial? If so, how/why?
8. Would county private public partnerships with hospitals, insurance, clinics, education, mental health and other prove beneficial?
9. Could co-located partners with public health (mental health, primary care, & other community resources) act as a driver for comprehensive/holistic services and additional resources needed to address upstream causes of poor health?

The guiding questions assured the process maintained clear intent and aligned with the stated role of the budget and program advisory committee. They were an effective tool in engaging advisors in healthy and open dialogue regarding critical gaps in the current budget and

programming processes in place at OSDH, while also identifying strengths that could be leveraged in path forward to modernize Oklahoma's public health system.

Data Assessment

Members of the data assessment advisory committee included representatives from the primary stakeholder organizations for public health data including the OSDH, the Office of Management and Enterprise Services, MyHealth Access Network, the Tulsa Health Department and the Oklahoma City-County Health Department. The committee met four times between January 5 and February 9, 2018. A short and long-term planning document provided by the Interim Commissioner was utilized to guide the committees work. The committee approached its work by identifying "buckets" of information needed to inform recommendations:

1. Assets List – intended to uncover all public and private data systems and assets in use by state, county, private, federal and tribal entities.
2. Delivery System – review of data delivery systems, strengths, weaknesses, opportunities and threats to a cohesive public health data system.
3. Issue Identification – discuss, review and prioritize areas for data infrastructure for the committee to address including interoperability between existing public health system stakeholders, integration with private healthcare systems, and operating system conflicts.

Following the process of identifying information for each bucket, the committee moved forward to identify short and long-term goals ultimately used to frame final recommendations.

Short Term Goals:

1. Establish regular correspondence with city-county health departments to review objectives, timelines, and status of deliverables.
2. Complete TCCHD data request to support the George Kaiser Family Foundation (GKFF) child health initiative project in Tulsa.
3. Achieve API functionality for OCCHD and TCCHD data requests from PHOCIS, OSIIS and PHIDDO.

Long Term Goals:

1. Create the framework for integrated public health data.
2. Develop an analytics platform to integrate public health data with social services and community level data.
3. Obtain federal funds to support the development of a Statewide Public Health EHR and healthcare data interoperability.

Legislative/Legal

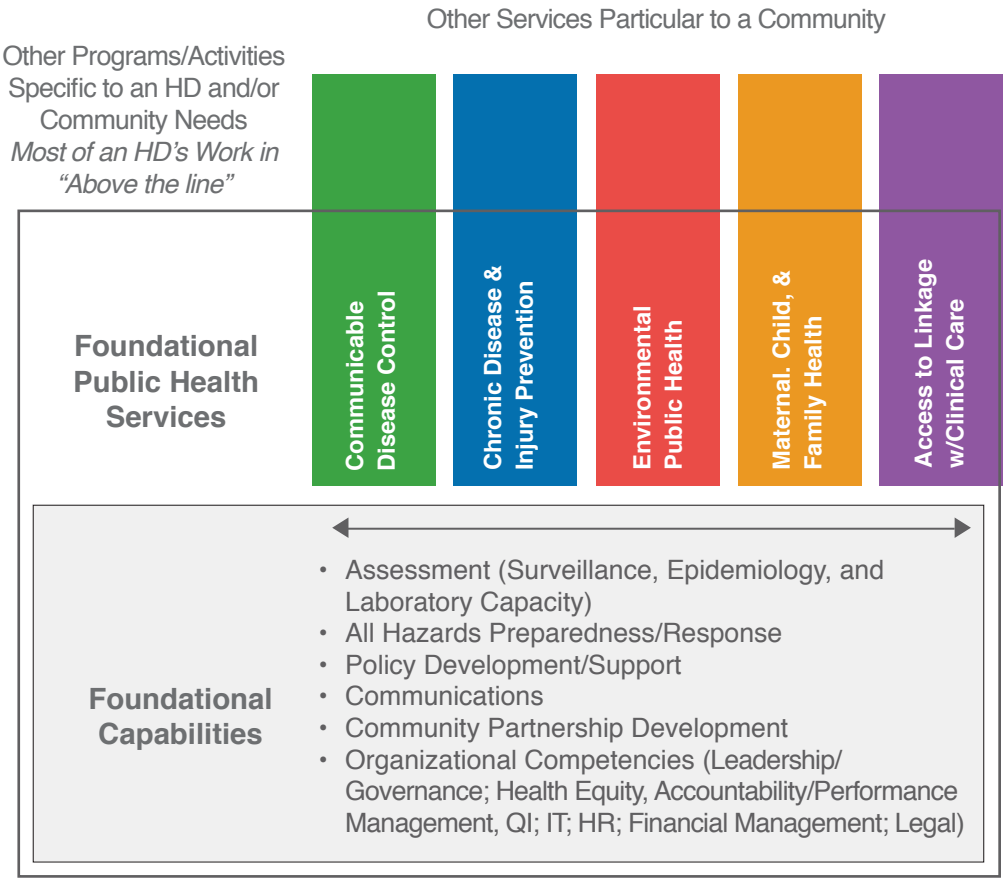
Members of the Legislative/Legal Advisory Committee met four times between January 5 and February 2, 2018. The committee began its work by developing a mission statement to guide development of recommendations. The mission statement reflects the committee's role is to: Advise the Joint Commission regarding potential necessary changes to Oklahoma law and will help make the recommendations of the Join Commission become reality to the extent legislation or regulations are needed. The committee will assist the Joint Commission in communicating the role of government in public health and prioritizing policy objectives accordingly. The committee will assist with research, drafting, and mechanics or passing legislation, including education around the value of public health and its impact on jobs and the economy, as well as

the close interdependency of health and wellness, education and the economy, which all work to develop a healthier and more vibrant state. The committee ultimately framed its discussion of recommendations to support this mission, articulating two priority components for development:

1. Plan to educate the legislature on the value of public health calling to attention misconceptions and misperceptions of public health, advocates and messengers of public health, and current and future definitions of public health.
2. Communication and messaging of final recommendations on behalf of the Joint Commission through the development of appropriate infographic tools to be jointly designed and used.

Foundational Capabilities

Specific references to defining the foundational public health capabilities and areas are made across recommendations to the Joint Commission. As a refresher, this below graphic illustrates the concept that most of public health efforts should focus on foundational programs and capabilities within the boundaries of the light blue outlined rectangle. Limited resources and focus should be placed on additional programs outside of this box.



Public Health: An Essential Service

Oklahoma's public health system provides a critical and unique role in protecting the public's health which includes the provision of essential health services to all families and communities throughout the state. The role of public health is to protect and work with others to improve the health of all Oklahomans, and to serve as the fundamental linkage between the healthcare delivery system and the residents it serves. Health disparities in Oklahoma continue to drive overall health outcomes in the wrong direction, with urban areas such as Oklahoma City and Tulsa experiencing double digit differences in life expectancy depending on zip code of residence. Rural and urban geographies, and varying population densities throughout the state also contribute to health disparities, demonstrating a need to tailor public health initiatives to the wide variation in state demographics.

Modernization of Public Health

Oklahoma has an advantage over other states pursuing modernization in that the challenges to the state appear to be surmountable with existing funds, if allocated and resourced efficiently and effectively. The Oklahoma governmental public health system will need to learn from those states already delving into the work of adopting and implementing the foundational areas and capabilities. To that end, Oklahoma should benefit specifically from the work done by Ohio, Oregon and Washington to define and develop pathways to implement the foundational public health capabilities and focus its efforts on implementing recommendations provided to address the critical gaps in information technology, workforce, performance management, accountability and local engagement.

A key takeaway from experiences in Ohio, Washington and Oregon is time was taken to carefully craft a vision for how a modern public health system should operate, and what defines it. From initial assessment, to development of recommendations and implementation plans, each state took anywhere from 12 to 18 months to assemble stakeholders, expertise and data to craft plans. Ultimately, each state settled on a different tool for the path forward.

Ohio relied significantly on codifying and linking modernization to public health accreditation, mandating all local health departments be accreditation ready by 2020. Work to operational the foundational public health services is currently underway to achieve this mandate. Oregon utilized the road map to achieving foundational public health services as the path forward, and two years after beginning the process to study and prepare for modernization utilized a combination of legislative policy and the development of the Public Health Modernization Manual as the foundation for implementing taskforce recommendations. The Public Health Modernization Manual was recently published (September 2017) and offers other states an opportunity to learn about Oregon's approach to implementing foundational capabilities and programs.[1] Washington state opted to define a set of basic capabilities and programs to be present in every community and recommended the state hold primary responsibility for funding and resourcing these programs. In designating the state primarily responsible, stakeholders published "A Plan to Rebuild and Modernize Washington's Public Health System" in December 2016 and utilized recommendations from the document to advocate for needed changes to pursue public health modernization in the 2017 legislative session, with plans to continue advocacy into the 2018 session.

The Joint Commission should consider the importance of public and private stakeholder engagements, emphasizing the involvement of local partnerships in stabilizing delivery of public

health services as well as how and if these tools can be adapted or utilized in the development of implementation and action plans as work moves forward.

Refresher – Current State of Oklahoma's Public Health System

The Oklahoma State Department of Health (OSDH) is one of the four state agencies charged with providing for the overall health and well-being of Oklahoma residents[2]. Other state agencies responsible for health and well-being include the Oklahoma Healthcare Authority, the state's Medicaid Agency; the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS); and the Oklahoma Department of Human Services (OKDHS). The governmental public health system in Oklahoma includes the OSDH, the State Board of Health (SBOH), and two independent city-county health department (CCHD). The OSDH State Commissioner of Health is appointed by the SBOH, which is comprised of members appointed by the Governor of Oklahoma with approval from the Oklahoma Senate.

Oklahoma is comprised of seventy-seven counties, of which seventy-five are under the administrative oversight of OSDH, and currently divided into fifteen administrative districts, each assigned a regional director. The two-independent city-county health departments Oklahoma City-County and Tulsa City-County health departments (OCCHD and TCCHD, respectively) with independent Boards of Health (BOH), are located in the primarily urban centers of the state. Additionally, Oklahoma is home to several independent Tribal Public Health Departments (TPHD).

The Oklahoma *Public Health Code* grants the powers and duties of the OSDH, SBOH, the Commissioner of Health, and the two CCHDs. Among other powers, the SBOH has the authority to adopt rules and standards necessary to carrying out the *Public Health Code* and establish divisions, section, bureaus, offices and positions within the State Department of Health.[3] The State Commissioner of Health has, among the duties of the position, the ability to appoint and fix the duties on any employees needed to run a local health department.[3] The *Public Health Code* further allows for the Commissioner to organize local health county departments in districts or cooperative departments of health, as appropriate, and with corresponding agreements with the local government to determine what health services will be provided, by whom, and any funds provisioned for services.[3] The *Public Health Code* further codifies the formation of city-county health department in counties with a population of more than 225,000 and a city within its boundaries with a population of more than 150,000, as reported by the most recent federal census; and requires these departments be governed by local municipalities, and operate independently of the OSDH. As of the 2010 federal census, Cleveland County had reached a population of over 250,000, however, the largest city in the county, Norman, sits just below the requirement of 150,000 as of 2016 population estimates.[4] It is reasonable to project Cleveland would reach the population requirements for an independent CCHD by the 2020 Census.

Oklahoma is home to 38 federally recognized tribal nations, of which three independent tribal health departments operate including the Chickasaw, Choctaw and Cherokee Nation Health Services. The OSDH recently (2012) designated the Office of the Tribal Liaison (OTL) within OSDH, a position intended to advocate for tribal nations and foster partnerships to support tribal public health goals. Federally Qualified Health Centers (FQHCs) are intended to provide for the healthcare needs of the under and uninsured in Oklahoma. They are expected to offer a comprehensive primary clinical care services, including dental and vision in some locations. In

Oklahoma, 20 FQHCs provide services to residents in 60 locations, regardless of ability to pay or immigration status. As of 2016, FQHCs served more than 200,000 patients statewide.[5]

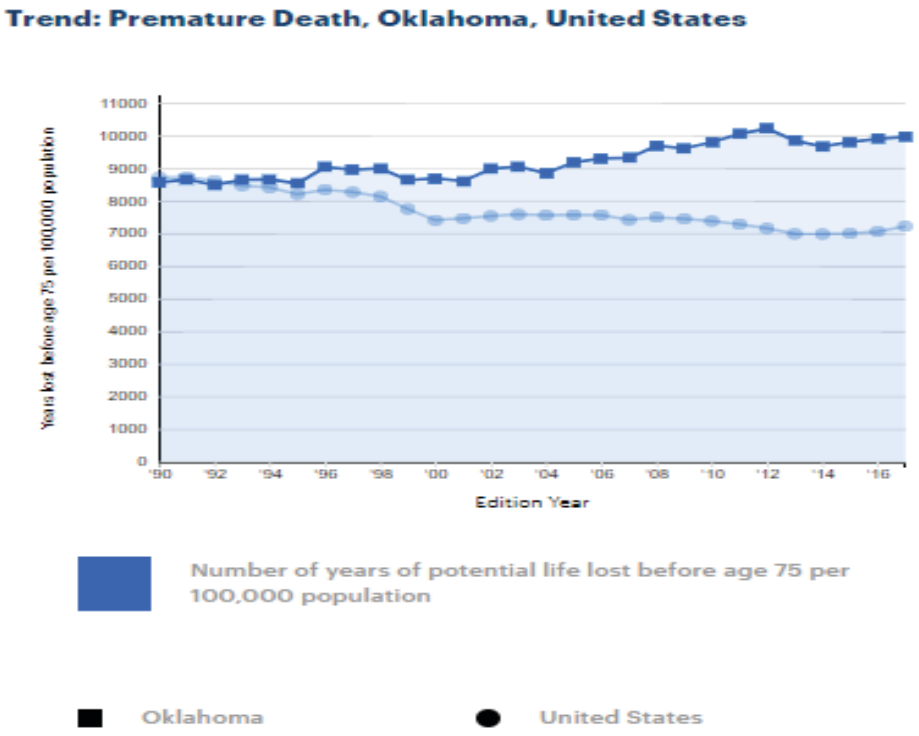
Other Safety Net Health Providers

Nearly 500 community service providers provide additional support for Oklahoma residents to address upstream public health needs addressing food insecurity, housing insecurity and quality, interpersonal violence, transportation, and utility needs. Oklahoma's recent successful application to CMS Innovation Center as an Accountable Health Community will enhance connectivity of screening, referrals and tracking systems. Connecting the various data systems will be made possible through existing community risk assessment and case management tools being developed by the two CCHDs investments in public health data collection tools.

Critical Gaps for Oklahoma

Oklahoma has historically performed well in responding to public health emergencies, leading the nation in its ability to coordinate responses to domestic terror and national disasters. Despite demonstrating the ability to collaborate and coordinate resources during an emergency, Oklahoma has been unable to transfer this success to collaborate and coordinate resources for ongoing public health needs. As a state Oklahoma's overall health outcomes and trends have consistently diverged from national trends for premature death since the mid-1990s[6].

Figure : America's Health Ranking, 2017



America's Health Rankings most recent publication (2017) reports Oklahoma's ranking at 43, representing an improvement from 46 in overall health outcomes since 2016.[1] Despite this poor ranking in overall health outcomes, Oklahoma ranks 25th in public health funding at $87/capita, suggesting the system is sufficiently funded, but that resources are poorly allocated. Efforts to modernize public health in other states (Oregon, Washington) highlight the challenges faced by state's like Oklahoma, struggling with critical infrastructure gaps.

Table 1: Select Financial, Governance and Workforce Metrics State Comparison[1]

	Total Revenue (FY 15)	Total Population (2010)	Public Health Spending	Source of Funding			Total FTEs (FY 15)	Local Health Offices	Health Ranking (2017)
				Fees and Fines	State General Funds	Federal Funds			
OK	$349,740,633	3,930,864	$87	1.30%	16.30%	56.70%	2,206	68	43
OR	$234,501,887	4,142,776	$81	12.30%	8.50%	63.10%	674	34	20
WA	$118,226,771	7,384,721	$138	2.30%	22.30%	62.40%	532	12	3
VT	$510,767,432	623,657	$93	16.70%	11.80%	50.10%	1576	35	9

Increasing demand on safety net providers has resulted in additional burdens the public health system is ill-equipped to handle.

The rate of Oklahoma's uninsured remains among the highest in the nation. CCHDs, CHDs, community health clinics and medical school providers such as OU and OSU Physicians, are under resourced to meet the demands for primary preventive clinical care, forcing residents to rely on the most expensive settings for care, emergency departments. Poor allocation of resources combined with barriers to leveraging existing resources and partnerships are preventing the creation of holistic networks for health and well-being.

Recommendations:

- Develop a transparent budgeting and financial system that identifies all funding (federal state, and local) allocations received and disbursed through the Oklahoma State Department of Health (OSDH); (*Program & Budget*)
- Define how categorical funds are determined for core public health services in each county; (*Program & Budget*)
- Provide monthly reports on fiscal year revenue and expenditures of all state appropriations by department or program *(In alignment with the Corrective Action Report)*; (*Program & Budget*)
- Develop a process to engage stakeholders in program funding decisions; (*Program & Budget*)
- Create a format to share budget and financial data information to stakeholders (i.e. Oklahoma State Board of Health, County Administrators, Legislators and the general public). (*Program & Budget*)
- Recommend that all 68 county health departments under the jurisdiction of the OSDH conduct an environmental health program/services scan to identify opportunities to reduce duplication, develop public/private partnerships, and consider co-locating programs/services to create comprehensive, holistic service in each community. (*Program & Budget*)
- Identify per capita funding by county from all sources. Evaluate per capita spending to ensure all counties have resources from state, federal, local and other sources to support implementation of adopted foundational services, programs, and capabilities. (*Program & Budget*)
- Develop statewide coalition who will provide input to the Joint Commission and educate around public health generally and the Joint Commission's recommendations. (*Legislative/Legal*)
- Develop a cohesive and unified message for communication around both public health and the recommendations of the Joint Commission. (*Legislative/Legal*)

Changes in the nature of preventable diseases such as recent Ebola and Zika outbreaks, alongside previously controlled infectious diseases such as syphilis, measles, and mumps returning to our state challenge resources to provide appropriate protections and immunizations. Preventable chronic disease epidemics including opioid abuse, cardiovascular disease, diabetes, and cancers continue to take Oklahoman's lives at alarming rates.

Recommendations:

- Identify the funding streams that align with the **Foundational Public Health Services Model** and determine a formula to appropriate public health funds by region, using the foundational areas and capabilities to improve health outcomes throughout Oklahoma. (*Program & Budget*)
- Adopt the Foundational Public Health Services Model and ensure programming and budgets align with the foundational areas and capabilities while developing and maintaining, at a minimum, a quarterly evaluation (i.e. expenditures, revenue, etc.). Additionally, utilize accountability metrics to measure and track the progress of the Foundational Public Health Services to ensure annual ROI. (*Program & Budget*)
- Develop a strategic plan for those counties that consistently perform poorly on health indicators and assessments, utilizing research and evidence-based practice to employ targeted interventions, technical support and resources to those counties that contribute most to Oklahoma's poor health ranking. (*Program & Budget*)

Lack of coordination between and among public health, mental health, substance abuse and primary care impedes the ability of providers to impact preventable chronic disease epidemics.

Historic lack of communication and partnership between the OSDH, CHDs it oversees, and the independent CCHDs has resulted in continued lagging health outcomes and poor resource allocation. Inadequate data collection and reporting systems prevent the public health system from harnessing the power of available technology and analytics. Poor utilization of data and technology infrastructure obstruct data-driven decision making and resource allocation. An inability to develop and implement meaningful policy at the local level stifles innovation, preventing public health practitioners from implementing evidence-based and promising practices emerging across the nation.

Recommendations:

- Create a Joint Council to review health data, plan health initiatives, prioritize services, develop private/public partnerships, evaluate outcomes, and review per capital public health spending in each county. This Council would consist of the state Commissioner of Health, Regional Administrative Directors, and the Executive Directors of the Oklahoma City-County Health Department, and Tulsa City-County Health Department. (*Program & Budget*)
- Recommend that the Oklahoma State Department of Health work across programs/services to ensure the Foundation Public Health Services Model is aligned regionally. Consider assessing the programs/services that could be deployed from the OSDH Central Office to County Health Departments to increase or enhance the current program/services offered in counties throughout Oklahoma. (*Program & Budget*)
- Recommend that local public health authorities (i.e. Regional Administrative Directors, County Commissioners, and Local Boards of Health etc.) have the flexibility to determine the best method to implement the foundational capabilities/programs and to utilize Ad Valorem tax revenue to meet each county's unique needs with general administrative oversight from OSDH to monitor grant deliverables and ensure public health laws are applied. (*Program & Budget*)

- Maintain a cadence of collaboration: By working together across agency and public-private sector boundaries, the Data Committee was able to make progress in just a few short meetings. In order to sustain and build on this progress we request that our meetings continue as we enter the crucial phase of planning short, medium and longer term strategy for public health information infrastructure and pursue funding to support and sustain these efforts. (*Data Assessment*)
- Modernize Oklahoma's public health data infrastructure. Significant gaps and inefficiencies exist in Oklahoma's public health data infrastructure, and we recommend the following improvements be made: Implement a statewide public health electronic medical records system to provide real time data for health improvement. This data system should integrate disease surveillance, immunization registry, electronic Master Patient Index (eMPI), link all public health systems, OHCA and OSDMHSAS systems and should leverage existing resources and investments. These data systems and analysis can provide the data needed to address public health challenges, gaps in coverage, needed resources, community interventions and evaluation of effectiveness towards improving community health.
    - This goal includes short-, mid-, and long-term objectives identified by committee members.

➞ ***Challenges of changing public health expertise needs and an aging workforce further exacerbate challenges to delivering strategic initiatives.***

Nearly 25% of the Oklahoma public health workforce is expected to be eligible for retirement in 2020.[2] Recruiting and retaining talent with the necessary public health expertise is a challenge in emerging areas of need including public health analytics and economists, often charged with developing the business case for harnessing the planning and assessment capabilities necessary for developing state and county health improvement plans.

Recommendations:

- Work with the Governor and Legislature to develop strategy for implementation of the Joint Commission Policy recommendations. (*Legislative/Legal*)
- Continue the Joint Commission through implementation of policy reforms and facilitate additional opportunities for healthcare, education and business community stakeholders to participate in the process *(Legislative/Legal)*
- Develop a Healthy Equity office that focuses on the Social Determinants of Health and ensures the social factors that impact health outcomes are a central discussion in all public health planning while exploring how to incorporate broad services like Trauma Informed Care, which has led to health improvements in states with a similar urban/rural mix as Oklahoma. (*Program & Budget*)

➞ ***Lack of transparency and joint governance mechanisms combined with inadequate performance management and financial data systems to track progress and resource allocation have challenged the ability of the SBOH***.

Lack of timely, accurate performance data prevents necessary adjustments to the state governmental public health system to assure the flexibility required to meet the challenges described above.

Recommendations:

- Formalize through legislative action the work of the Joint Commission as an Advisory body responsible for operationalizing and implementing the recommendations provided in this report and through policy reform where appropriate. The advisory body should also facilitate additional opportunities for healthcare, education and business community stakeholders to participate in the process. *(Legislative/Legal)*
- Recommend that OSDH develop and establish a public health evaluation system grounded in evidence-based practice and research. Develop and maintain an annual evaluation of the Foundational Programs/Capabilities, including quarterly budget reports (i.e. expenditures, revenue, etc.) and submit the data to the OSDH Board of Health and the Joint Council. Establish a statewide health needs assessment and strategic plan with an evaluation component for each county and region. (*Program & Budget*)
- Implement a Zero-based Budgeting process *(In alignment with the Corrective Action Report)* (*Program & Budget*)
- Identify resources to improve or replace the current billing and financial management system to improve: insurance billing, relevant and real time budget reporting, cost benefit analysis, and ROI. (*Program & Budget*)
- Ensure that Quality Improvement is used intentionally by OSDH, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community. (*Program & Budget*)

Next Steps

The recommendations set forth in this report provide a framework for development of actionable plans. Advisory committees should be empowered to develop implementation plans to support the described recommendations, inclusive of short and long-term goals, objectives and measures to create an improvement plan which can be evaluated for progress. For Oklahoma's public health system to work cohesively, and to build a path forward to modernize, a true partnership must be emboldened to provide oversight for our system. The development of a Joint Council to perform this function and formalize the expectation for transparency and accountability among public health system stakeholders is an important step to improving health and overall quality of life for the great citizens of Oklahoma.

[1] Oregon Health Authority, Public Health Division. "Public Health Modernization Manual". September, 2017.
[2] Oklahoma State Department of Health. Community and Family Health Services Administration. Updated 1.06.2016
[3] OK. Gen. Laws Ann. Chapter 1. Public Health Code. 2016
[4] U.S. Census. QuickFacts: Cleveland County and Norman City, Oklahoma. 2017.
[5] 2016 Health Center Profile: Health Center Program Grantee Data. HRSA, 2017.
[6] America's Health Rankings. Annual Report: 2017.

Oklahoma State
Department of Health

TULSA HEALTH
Department

Joint Commission

Appendix Draft

Oklahoma State Department of Health

OKC-COUNTY HEALTH DEPARTMENT

TULSA HEALTH Department

Report to the Joint Commission – DRAFT Recommendations

Executive Summary

Over the last few weeks Advisory Committees have been meeting to develop core recommendations in the following identified areas: legal/legislative, budget and programs, data and IT infrastructure. Clear themes and trends have emerged as a result of this work and should be considered central to our efforts to move forward in adopting recommendations and developing an actionable plan forward. Accountability resource allocation, and decision-making autonomy is found across all recommendations, explicitly or implicitly, illustrating a consensus among advisors. Resource allocation cannot just consider population density, however, as the needs of the rural communities are multi-faceted and per capita funding allocation alone will not address the needs of those citizens residing in our rural communities. Efforts to improve health outcomes must focus on increasing efficiency, allowing local health departments to develop community specific partnerships and governance structures that best meet the needs. Examples of implementation may include shared jurisdictional arrangements enabling multi-county or regional delivery of programs and services and development of joint governance structures to allow for equal partnership between local, regional and state health departments. Another theme that emerged across all Advisory Committees is the need to update and modernize public health data and financial IT infrastructure. Real time public health data is a critical missing link for decision makers to develop programs, policies and services to meet the needs of Oklahoma communities. Transparency of public health data is not limited to the traditional health data we associate with health outcomes, but must also include the financial and operational data that drives those outcomes. Finally, each Advisory Committee recognized the evolution of public health over the last decade requires an ability to develop relationships with non-traditional partners in the community. The opioid epidemic, challenges in resource sustainability and increases in natural disaster are examples of the need for public health to move away from program-driven delivery of services, and towards population-driven strategies that reflect community identified needs and avoid duplications. Defining foundational public health services is only the starting line for these efforts, articulating the specific clinical and community strategies that will impact health outcomes for the greatest number of Oklahoma residents is a collaborative endeavor that will require multi-stakeholder engagement from our local health department experts and the communities they serve.

Advisory Committee Recommendations

Budget/Program Assessment

The Budget/Program Assessment Advisory Committee was tasked with developing recommendations that address transparency in budget forecasting and funding sources. In addition, this committee was tasked with developing recommendations to address governance of the overall public health system to include strategies to become more lean and efficient, effectively developing partnerships, engaging in resource-sharing and determining the applicability of defining foundational public health areas and capabilities.

- Develop a transparent budgeting and financial system that identifies all funding (federal state, and local) allocations received and disbursed through the Oklahoma State Department of Health (OSDH), in addition to the following:
    - Define how categorical funds are determined for core public health services in each county;
    - Provide monthly reports on fiscal year revenue and expenditures of all state appropriations by department or program (In alignment with the Corrective Action Report);
    - Develop a process to engage stakeholders in program funding decisions;
    - Create a format to share budget and financial data information to stakeholders (i.e. Oklahoma State Board of Health, County Administrators, Legislators and the general public).
- Identify resources to improve or replace the current billing and financial management system to improve: insurance billing, relevant and real time budget reporting, cost benefit analysis, and ROI.
- **Implement a Zero-based Budgeting** process *(In alignment with the Corrective Action Report)*
- Identify the funding streams that align with the **Foundational Public Health Services Model** and determine a formula to appropriate public health funds by region, using the foundational areas and capabilities to improve health outcomes throughout Oklahoma.
- Adopt the Foundational Public Health Services Model and ensure programming and budgets align with the foundational areas and capabilities while developing and maintaining, at a minimum, a quarterly evaluation (i.e. expenditures, revenue, etc.). Additionally, utilize accountability metrics to measure and track the progress of the Foundational Public Health Services to ensure annual ROI.
- Recommend that the Oklahoma State Department of Health work across programs/services to ensure the Foundation Public Health Services Model is aligned regionally, and consider assessing the programs/services that could be deployed from the OSDH Central Office to County Health Departments to increase or enhance the current program/services offered in counties throughout Oklahoma. Additionally, it is recommended that local public health authorities (i.e. Regional Administrative Directors, County Commissioners, and Local Boards of Health etc.) have the flexibility to determine the best method to implement the foundational capabilities/programs and to utilize Ad Valorem tax revenue to meet each county's unique

needs. The OSDH would provide general administrative oversight, monitor grant deliverables, and ensure public health laws are applied.

- Recommend that all 68 county health departments under the jurisdiction of the OSDH conduct an environmental health program/services scan to identify opportunities to reduce duplication, develop public/private partnerships, and consider co-locating programs/services to create comprehensive, holistic service in each community.
- Develop a strategic plan for those counties that consistently perform poorly on health indicators and assessments, utilizing research and evidence based practice to employ targeted interventions, technical support and resources to those counties that contribute most to Oklahoma's poor health ranking.
- Recommend that OSDH develop and establish a public health evaluation system grounded in evidence-based practice and research. Develop and maintain an annual evaluation of the Foundational Programs/Capabilities, including quarterly budget reports (i.e. expenditures, revenue, etc.) and submit the data to the OSDH Board of Health and the Joint Council. Establish a statewide health needs assessment and strategic plan with an evaluation component for each county and region.
- Develop a Health Equity office that focuses on the Social Determinants of Health and ensures the social factors that impact health outcomes are a central discussion in all public health planning while exploring how to incorporate broad services like Trauma Informed Care, which has led to health improvements in states with a similar urban/rural mix as Oklahoma.
- Create a Joint Council to review health data, plan health initiatives, prioritize services, develop private/public partnerships, evaluate outcomes, and review per capital public health spending in each county. This Council would consist of the state Commissioner of Health, Regional Administrative Directors, and the Executive Directors of the Oklahoma City-County Health Department, and Tulsa City-County Health Department.
- Ensure that Quality Improvement is used intentionally by OSDH, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.
- Identify per capita funding by county from all sources. Evaluate per capita spending to ensure all counties have resources from state, federal, local and other sources to support implementation of adopted foundational services, programs, and capabilities.

Data Assessment

The Data Assessment Advisory Committee was tasked with developing recommendations that address the health assessment process, access to data, and effective messaging to the public. This included addressing needs to modernize IT infrastructure and enhance the ability for decision makers to utilize real time data to inform strategies.

1. Maintain a cadence of collaboration:

By working together across agency and public-private sector boundaries, the Data Committee was able to make progress in just a few short meetings. In order to sustain and build on this progress we request

that our meetings continue as we enter the crucial phase of planning short, medium and longer term strategy for public health information infrastructure and pursue funding to support and sustain these efforts.

2. Modernize Oklahoma's public health data infrastructure:

Significant gaps and inefficiencies exist in Oklahoma's public health data infrastructure, and we recommend the following improvements be made:

Implement a statewide public health electronic medical records system to provide real time data for health improvement. This data system should integrate disease surveillance, immunization registry, electronic Master Patient Index (eMPI), link all public health systems, OHCA and OSDMHSAS systems and should leverage existing resources and investments. These data systems and analysis can provide the data needed to address public health challenges, gaps in coverage, needed resources, community interventions and evaluation of effectiveness towards improving community health.

This goal includes short-, mid-, and long-term objectives identified by committee members.

Short-term:

- Complete upgrades and deployment of the public health immunization bi-directional messaging.
- Continue state agency interoperability project to link public health systems, OHCA, and ODMHSAS, and other state agencies.
- Planning for state/city-county data integration solutions with PHIDDO, PHOCIS, and OSIIS.
- Legal review of secondary use of state public health data in external systems (i.e., Health Information Exchange (HIE), Electronic Health Record (EHR), Insurance).
- Pursue available funding for implementation and long-term sustainability for HIE and public health interoperability for state match funding.
- Coordinate with existing HIEs to leverage clinical data exchange and public health messaging

Mid-term:

- Synchronize eMPI's between state and private sector
- Synchronize provider and services directory/index
- Participate in national initiative, Digital Bridge, for electronic case reporting
- Evaluate potential implementation plans for integrated statewide public health analytics system
- Implement state/city-county data integration solutions with PHIDDO, PHOCIS, and OSIIS

Long-term:

- Deploy statewide Public Health EHR
- Evaluate potential implementation strategies for statewide syndromic surveillance monitoring

Legislative/Legal

The Legislative/Legal Advisory Committee was tasked with developing recommendations that address opportunities to proactively work with locally elected officials to improve transparency in public health through budgeting, accountability and modernized legislation.

- Develop a statewide coalition of stakeholders who will provide input to the Joint Commission and help to education around public health generally and the Joint Commission's recommendations.
- Develop a cohesive and unified message for communication around both public health and the recommendations of the Joint Commission.
- Work with the Governor and Legislature to develop strategy for implementation of the Joint Commission Policy recommendations.
- Continue the Joint Commission through implementation of policy reforms and facilitate additional opportunities for healthcare, education and business community stakeholders to participate in the process.

Summary

We are appreciative of the good work that has been undertaken and accomplished by the Advisory Committees. Addressing the core, thematic areas including autonomous decision-making, shared jurisdictional arrangements, enhancing Data and IT infrastructure, defining foundational public health services, and developing a joint council to address health outcomes and disparities, is a first step in restoring the credibility of our state's public health system to the communities we serve, and putting Oklahoma on a path to health improvement. We cannot afford to ignore the evolution of public health, and the explicit need to modernize our systems for resource allocation, data and IT infrastructure. While much work has been put into the development of these recommendations, it is now time to create actionable plans to operationalize and implement. Continuing to engage public health leaders, locally elected officials, and other diverse stakeholders already participating as members of the Joint Commission will be critical to this next step in modernizing the Oklahoma Public Health System.

Suggestions Received from publichealthcommission@gmail.com

The counties most in need of services are poorer rural counties with low populations and no local assistance. If money is only distributed by population, the metro regions will be the only regions funded enough to provide needed services. Transportation is an issue for poorer counties. For all Oklahomans to receive equal medical care, the distribution of money can't be only where large populations reside and where alternative care is accessible. For equitable care, health workers are needed in all four corners of the state.

Reform is needed and a 12 story building in OKC full of administration staff is not needed. Our system works, it's just administration heavy. I advocate for local health departments to have more control and transparency; however, I feel we will be creating disparities and inequities if services are not readily accessible in poorer rural counties. Good work is accomplished at the central office, they just have too many programs and workers who are not providing the core 10 essential services of public health (see below). All counties have been asked to do more with less and some without any staff after March 1st. I believe services should come before administration. If we continue to the path of decentralization, all of Oklahoma will suffer. We will pay for increased teen pregnancy, std's, infant mortality, etc. The question we should be asking ourselves is how do we want to pay? We can choose to be proactive by providing services to all Oklahomans or reactive once the damage is done. Reactive carries a much higher price tag.

My suggestion is to require posting of the results of a health inspection prominently on the front entrance of all restaurants with a requirement that it remain there until the next inspection. I have noticed this practice in restaurants in a number of states.

It provides transparency of the work of the health department and also needed information regarding the restaurant.

There are too many counties in Oklahoma where restaurant inspection is not taken seriously if its done at all. Not too many years ago in Tulsa one would periodically read a report that a restaurant had been closed. However, this no longer seems to be a practice.

Possibly, with some time and effort a citizen may be able to view the health inspections on line, but the number of diners who do this must be quite small. If one is visiting from out of town are they really expected to do a search of a local health department for restaurant inspections.
I believe publicly posting health inspections is long overdue in Oklahoma.

In Public health the food stamp program could benefit from making some significant improvements and guidelines. It would be neat to see the wellness programs from the state health departments make a partnership with the Department of Human Services (DHS) to modify the food stamp program and

provide the families with education on nutrition and cooking. Our tax dollars for food stamps should have restrictions to only buying foods that have nutritional value, especially if our tax dollars are paying for it. The Federal program Women Infant Children (WIC) program is sufficient at this, why is the food stamp program providing similar guidelines?

Furthermore there should be some partnership with the SoonerCare insurance program and family planning. In order to qualify for SoonerCare, education should be provided on how to prevent unwanted pregnancies and parenting. This would prevent families from having multiple children on SoonerCare without getting some type of required education on ways to maximizes the benefits that they are seeking from public assistance.

Provide the public with health education in return for the services and benefits they want to receive. A partnership in State and Federal tax dollars.

Dear Commission,

Thank you for the hard but necessary work you are doing. I have been a local health dept employee for almost 13 years and I *still* believe in the work we do! It is important, life-changing and is imperative that we get it right.

I just wanted to share some feedback and suggestions:

1) To retain top talent throughout the state, allow employees to apply for and fill "state-level" jobs without requiring their workstation to be at the OSDH Central Office. It seems that if one wants to advance in their career at OSDH, many of those jobs/opportunities are located at the OSDH Central Office. I believe many talented people throughout Oklahoma do not want to move to OKC or commute to OKC for this and we are missing out on great people in these positions. I believe many of these positions could be located throughout the state in county offices or at least in "Regional Hubs" which would allow a true regional/ rural perspective in these positions/ programs. It would also free up office space at OSDH, and fill some of the space that is free in county health dept offices.

2) Please invite talented, qualified local health department employees to be a part of the commission and subcommittees. Results may be very different if it is a leadership-only commission.

3) At the local level, we absolutely need data to drive decision making. We are frustrated here feeling like we are responding to public health 5 years later (or longer) because the data we use is sometimes old and irrelevant. We need real-time data to make change and to be able to target effective interventions.

There are some activities at OSDH that add no value, do nothing to improve health outcomes, and are costly in staff and to businesses. Top of my list is the outdated Certificate of Need process for long term care and mental health facilities. It will take legislative action to terminate the CON process. It discourages new business and protects old monopolies. Other areas of health care got rid of CON years ago. It's time to get rid of this last vestige of the past that is costly and helps no one.

Good Morning,

As a former administrator, I applaud each and every employee for staying with OSDH for their own specific reasons in the midst of uncertainty, financial issues, and unfavorable media coverage. I've CC'd all my co-workers because I believe "transparency" is of the utmost importance and the ONLY avenue to build trust, rapport, and a team.

After yesterday's videoconference, I felt compelled to list my top 3 areas of improvement:

1) A more user-friendly version to capture ALL health education efforts & data. It's about relationships, partnerships, and going through all the steps to necessary to complete a successful health education event.

2) Local money should stay local and local people solve local needs, not other places. If county health departments' pay into systems/departments at the state level, those county health departments should be seen as a customers and should be an advocate for those departments at the county level. As a result, payment of systems/departments should equate to field representation among the county health departments. To further illustrate this point, I called OMES and he mentioned, "we get to work from home", not the ideal as when computer problems inhibit work.

3) More credence must be given to ACE's study and score for Oklahoma children. Several years ago, the state of Oregon mandated the ACE for every child. Let's look at positively functioning health departments and take a lesson. As a yesterday, it sounds like we don't need to go very far. Let's look at Oklahoma City and/or Tulsa for starters.

There are no easy solutions to this complicated challenge, but active listening to employees is a start.

Good afternoon!

First thank you for all you are doing to assist our agency. We greatly appreciate also listening to us and valuing our input.

Would it not be more productive to go to regional health departments. Utilize the larger counties and the staff from the smaller counties to have a better coverage of staff than what having to do now. We are traveling to other counties to cover those small and larger counties with nursing and clerical staff.

This does not provide continuity of care when you borrow from one county to cover than it limits services in the county you borrowed from. Counterproductive and the clients are uncertain of when can come for services even with a schedule. I think this must be discussed at many different level including legislature to get this to happen. I know that when we close Henryretta and Beggs that the clients had no difficulty with coming to Okmulgee. We find that individuals including ourselves when we need to get somewhere we make arrangements in some way. We do provide information on transits etc. to assist clients .

Concerns: Limited staff-expectations to continue coverage in all county health departments even if it means having to have staff (nurses and clerical) travel to those sites to cover from a distant cavity. I feel it is counterproductive especially with the number of clients actually seeing.

I mentioned in the meeting that I see the county like a foundation of a home that we are trying to restore or flip.

You must first have a strong foundation. I see the counties and the community and the citizens of Oklahoma needs and delivery of those core services is priority. Then you build upon that foundation with the program areas that will support those core programs(internal and external). This builds the framework that is supported upon the foundation.

The roof is the State office and its leadership and financial pieces along with the monitoring and auditing and also the grant writing etc. as the Board and Leadership is developing presently.

Our goal is to improve health outcomes; protect our citizens and deliver those important services. I believe in the one stop shopping and referral internal and external. Knowing our resources within our community. Partnership and education early is the key to prevention.

We must also stream line and be effective with what we have by regionalization of Health departments and utilizing staff we have to effectively work to get the outcomes desired. Not because within that legislature domain they promise to keep the health department that may see only 5 people a day and being paid the same those staff that multiple more clients. Those times should be over.

I believe every health dept. should look the same with the core services/directives delivery of care. Then the needs be determined by as mentioned community assessment to determine the what partnerships and additional help needed to write grants obtain help from the state level and add in those services within our local health department.

Thank you!

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Here's a copy of the comments I made at today's meeting with Dr. Cox.

Given Oklahoma's poor ranking in health outcomes such as heart disease, hypertension and diabetes - due to the high number of our friends, neighbors and family members affected by these and other chronic conditions, it seems like we should focus as much attention as possible on prevention.

We know there are many factors contributing to high rates of these preventable illnesses, and that a few key behaviors – diet, physical activity, tobacco and drug use are associated with most of our leading causes of premature death.

We know that many unhealthy behaviors result from adverse social and living conditions in which people find themselves, resulting in wide health disparities.

We also know that efforts to change individual behaviors are extremely challenging in the absence of places and social norms that support healthier choices and make it easier to be well.

Improving the environments where people spend the most time - such as worksites, schools, child care facilities, churches, neighborhoods and homes requires significant effort and collaboration with many organizations and community partners.

In lots of Oklahoma counties, the health department is one of the few or only entities able to work with these stakeholders in a comprehensive and ongoing way. Without a public health presence at the table, we miss numerous opportunities for creating healthier communities and better health outcomes in our state.

I didn't have a chance to sit through the meeting, but I, like everyone else, is very concerned about the direction our health department clinics are being sent. I too believe that a big solution is to cut the fat at the top and allow services to continue unchecked at the county level.

I have been hearing rumors that certain programs are being cut and would hope that this can be prevented.

On that note, in the future, I would like to see the addition of a clinic—namely, a men's clinic. It is easy to overlook the needs of men in our society for we forget that men can face the same economic struggles as women and children and often don't have as easy access to certain types of insurance such as Medicaid, as women and children.

I would also suggest that the paperwork be trimmed. The information on many of our forms are already duplicated on other forms. Plus, check in time is slowed down even more. It is not unusual for a client to take 15 minutes or more filling out paperwork. This is especially a problem when an appointment is scheduled from check in time to finishing with a clinician for 30 minutes.

The clinic where I work is small and will be even smaller come March, meaning fewer people to see our clients, meaning even less appointments to be offered.

I am truly in hopes that somehow, this can be averted.

Report to Joint Commission on Public Health
Town Hall Meeting Discussion Items

- Current system infrastructure is an effective model (central office providing overarching administrative functions – legal, communicable disease, accounting, etc), but there is a need for local control so counties can make decisions based on community needs.
    - Trend over the years has been a system focused more on the central office rather than individual county needs.
    - The system has worked in the past – counties worked together and state shifted resources as needs arose.
    - Don't look at a system solution to a leadership issue – look at improving the efficiencies and processes of our current system.

- State plan needs to be developed from ground up and allow for flexibility of delivery based on local needs.

- Many counties desire to integrate/co-locate with other service providers; there are vast differences in culture and need from county to county.

- Strong desire for improvement in IT infrastructure, data and social media presence.

- Desire local input to be sought and implemented for problems.