Oklahoma State Department of Health
Creating a State of Health

Core Public Health Priorities
Public Health Imperatives
Mandated Inspections and Investigations

AIM: An opportunity exists to ensure the Oklahoma State Department of Health implements a clear process for Protective Health Services programs to comply with the laws, rules and standards for effective public health law enforcement programs. This effort should increase compliance rates of:

- Inspection frequency mandates, starting with 98%-100% of programs in compliance, moving to 100% beginning July 1, 2015, and maintaining 100% through 2020;

- Process mandates, starting with 0% of programs systematically assessed for compliance at February 26, 2015, moving through 30% of programs assessed for compliance with laws at July 1, 2015, and reaching 100% of programs assessed for compliance with laws by December 1, 2015; and moving for 15% semi-annual increases in the percentage of processes in compliance with mandates, starting July 1, 2015, through 2020.

- Programs subject to the Public Health Accreditation Board's administrative authority moving to 100% compliance with accreditation standards by January 1, 2017; and

- All programs whether or not subject to the Public Health Accreditation Board's administrative authority moving to 100% equivalence with accreditation standards by January 1, 2020.

This is important to work on immediately because effective public health law enforcement programs serve to promote and protect the public health. The baseline measurement is defined in the following metric: percentages of inspections, processes and programs in compliance with applicable laws, rules and standards.

An Act

ENROLLED HOUSE
BILL NO. 2742

By: Cox of the House

and

Standridge of the Senate

An Act relating to public health and safety; amending 63 O.S. 2011, Section 1-2503, as last amended by Section 65, Chapter 229, O.S.L. 2013 (63 O.S. Supp. 2015, Section 1-2503), which relates to definitions; modifying and adding certain definitions; amending 63 O.S. 2011, Section 1-2504, as amended by Section 2, Chapter 23, O.S.L. 2013 (63 O.S. Supp. 2015, Section 1-2504), which relates to the utilization of emergency medical personnel; adding certain personnel that may be utilized; amending 63 O.S. 2011, Section 1-2505, as amended by Section 3, Chapter 23, O.S.L. 2013 (63 O.S. Supp. 2015, Section 1-2505), which relates to levels of care; adding certain definition; requiring State Board of Health to promulgate certain rules; providing for codification; and providing an effective date.

SUBJECT: Oklahoma Emergency Response Systems Development Act

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 63 O.S. 2011, Section 1-2503, as last amended by Section 65, Chapter 229, O.S.L. 2013 (63 O.S. Supp. 2015, Section 1-2503), is amended to read as follows:

Section 1-2503. As used in the Oklahoma Emergency Response Systems Development Act:

1. "Ambulance" means any ground, air or water vehicle which is or should be approved by the Commissioner of Health, designed and equipped to transport a patient or patients and to provide appropriate on-scene and en route patient stabilization and care as

required. Vehicles used as ambulances shall meet such standards as may be required by the State Board of Health for approval, and shall display evidence of such approval at all times;

2. "Ambulance authority" means any public trust or nonprofit corporation established by the state or any unit of local government or combination of units of government for the express purpose of providing, directly or by contract, emergency medical services in a specified area of the state;

3. "Ambulance patient" or "patient" means any person who is or will be transported in a reclining position to or from a health care facility in an ambulance;

4. "Ambulance service" means any private firm or governmental agency which is or should be licensed by the State Department of Health to provide levels of medical care, including but not limited to comprehensive integrated medical care in emergency and nonemergency settings under the supervision of a physician, based on certification standards promulgated by the Board;

5. "Ambulance service district" means any county, group of counties or parts of counties formed together to provide, operate and finance emergency medical services as provided by Section 9C of Article X of the Oklahoma Constitution or Sections 1201 through 1221 of Title 19 of the Oklahoma Statutes;

6. "Board" means the State Board of Health;

7. "Certified emergency medical responder" means an individual certified by the Department to perform emergency medical services in accordance with the Oklahoma Emergency Response Systems Development Act and in accordance with the rules and standards promulgated by the Board;

8. "Certified emergency medical response agency" means an organization of any type certified by the Department to provide emergency medical care, but not transport. Certified emergency medical response agencies may utilize certified emergency medical responders or licensed emergency medical personnel; provided, however, that all personnel so utilized shall function under the direction of and consistent with guidelines for medical control;

9. "Classification" means an inclusive standardized identification of stabilizing and definitive emergency services provided by each hospital that treats emergency patients;

10. "CoAEMSP" means the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions;

11. "Commissioner" means the State Commissioner of Health;

12. "Community paramedic" means a licensed paramedic who meets the requirements of Section 1-2505 of this title;

13. "Community paramedic services" means services that include interventions intended to prevent unnecessary ambulance transportation or hospital emergency department use.

a. Community paramedic services must be part of a care plan ordered by a primary health care provider or a hospital provider in consultation with the medical director of an ambulance service. Such care plan must ensure that the services provided by a community paramedic do not duplicate services already provided to the patient, including home health and waiver services.

b. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care and minor medical procedures compliant with the community paramedic's scope of practice and approved by the ambulance medical director;

14. "Council" means the Trauma and Emergency Response Advisory Council created in Section ~~44~~ 1-103a.1 of this ~~act~~ title;

~~13.~~ 15. "Critical care paramedic" or "CCP" means a licensed paramedic who has successfully completed critical care training and testing requirements in accordance with the Oklahoma Emergency Response Systems Development Act and in accordance with the rules and standards promulgated by the Board;

~~14.~~ 16. "Department" means the State Department of Health;

~~15.~~ 17. "Emergency medical services system" means a system which provides for the organization and appropriate designation of personnel, facilities and equipment for the effective and coordinated local, regional and statewide delivery of health care services primarily under emergency conditions;

~~16.~~ 18. "Letter of review" means the official designation from CoAEMSP to a paramedic program that is in the "becoming accredited" process;

~~17.~~ 19. "Licensed emergency medical personnel" means an emergency medical technician (EMT), an intermediate emergency medical technician (IEMT), an advanced emergency medical technician (AEMT), or a paramedic licensed by the Department to perform emergency medical services in accordance with the Oklahoma Emergency Response Systems Development Act and the rules and standards promulgated by the Board;

~~18.~~ 20. "Licensure" means the licensing of emergency medical care providers and ambulance services pursuant to rules and standards promulgated by the Board at one or more of the following levels:

a. ~~Basic~~ basic life support,

b. ~~Intermediate~~ intermediate life support,

c. ~~Paramedic~~ paramedic life support,

d. ~~Advanced~~ advanced life support,

e. ~~Stretcher~~ stretcher aid van, and

f. ~~Specialty~~ specialty care, which shall be used solely for interhospital transport of patients requiring specialized en route medical monitoring and advanced life support which exceed the capabilities of the equipment and personnel provided by paramedic life support.

Requirements for each level of care shall be established by the Board. Licensure at any level of care includes a license to operate at any lower level, with the exception of licensure for specialty care; provided, however, that the highest level of care offered by

an ambulance service shall be available twenty-four (24) hours each day, three hundred sixty-five (365) days per year.

Licensure shall be granted or renewed for such periods and under such terms and conditions as may be promulgated by the Board;

~~19.~~ 21. "Medical control" means local, regional or statewide medical direction and quality assurance of health care delivery in an emergency medical service system. On-line medical control is the medical direction given to licensed emergency medical personnel, certified emergency medical responders and stretcher aid van personnel by a physician via radio or telephone. Off-line medical control is the establishment and monitoring of all medical components of an emergency medical service system, which is to include stretcher aid van service including, but not limited to, protocols, standing orders, educational programs, and the quality and delivery of on-line control;

~~20.~~ 22. "Medical director" means a physician, fully licensed without restriction, who acts as a paid or volunteer medical advisor to a licensed ambulance service and who monitors and directs the care so provided. Such physicians shall meet such qualifications and requirements as may be promulgated by the Board;

~~21.~~ 23. "Region" or "emergency medical service region" means two or more municipalities, counties, ambulance districts or other political subdivisions exercising joint control over one or more providers of emergency medical services and stretcher aid van service through common ordinances, authorities, boards or other means;

~~22.~~ 24. "Regional emergency medical services system" means a network of organizations, individuals, facilities and equipment which serves a region, subject to a unified set of regional rules and standards which may exceed, but may not be in contravention of, those required by the state, which is under the medical direction of a single regional medical director, and which participates directly in the delivery of the following services:

a. medical call-taking and emergency medical services dispatching, emergency and routine, including priority dispatching of first response agencies, stretcher aid van and ambulances,

b. emergency medical responder services provided by emergency medical response agencies,

c. ambulance services, both emergency, routine and stretcher aid van including, but not limited to, the transport of patients in accordance with transport protocols approved by the regional medical director, and

d. directions given by physicians directly via radio or telephone, or by written protocol, to emergency medical response agencies, stretcher aid van or ambulance personnel at the scene of an emergency or while en route to a hospital;

~~23.~~ 25. "Regional medical director" means a licensed physician, who meets or exceeds the qualifications of a medical director as defined by the Oklahoma Emergency Response Systems Development Act, chosen by an emergency medical service region to provide external medical oversight, quality control and related services to that region;

~~24.~~ 26. "Registration" means the listing of an ambulance service in a registry maintained by the Department; provided, however, registration shall not be deemed to be a license;

~~25.~~ 27. "Stretcher aid van" means any ground vehicle which is or should be approved by the State Commissioner of Health, which is designed and equipped to transport individuals on a stretcher or gurney type apparatus. Vehicles used as stretcher aid vans shall meet such standards as may be required by the State Board of Health for approval and shall display evidence of such approval at all times. Stretcher aid van services shall only be permitted and approved by the Commissioner in emergency medical service regions, ambulance service districts, or counties with populations in excess of ~~300,000~~ four hundred thousand (400,000) people. Notwithstanding the provisions of this paragraph, stretcher aid van transports may be made to and from any federal or state veterans facility;

~~26.~~ 28. "Stretcher aid van patient" means any person who is or will be transported in a reclining position on a stretcher or gurney, who is medically stable, nonemergent and does not require any medical monitoring equipment or assistance during transport; and

~~27.~~ 29. "Transport protocol" means the written instructions governing decision-making at the scene of a medical emergency by ambulance personnel regarding the selection of the hospital to which the patient shall be transported. Transport protocols shall be developed by the regional medical director for a regional emergency medical services system or by the Department if no regional emergency medical services system has been established. Such transport protocols shall adhere to, at a minimum, the following guidelines:

a. nonemergency, routine transport shall be to the facility of the patient's choice,

b. urgent or emergency transport not involving life-threatening medical illness or injury shall be to the nearest facility, or, subject to transport availability and system area coverage, to the facility of the patient's choice, and

c. life-threatening medical illness or injury shall require transport to the nearest health care facility appropriate to the needs of the patient as established by regional or state guidelines.

SECTION 2. AMENDATORY 63 O.S. 2011, Section 1-2504, as amended by Section 2, Chapter 23, O.S.L. 2013 (63 O.S. Supp. 2015, Section 1-2504), is amended to read as follows:

Section 1-2504. A. Any hospital or health care facility operating within the state may utilize ~~Emergency Medical Technician, Intermediate, Advanced Emergency Medical Technician or Paramedic or Critical Care Paramedic~~ emergency medical technician, intermediate emergency medical technician, advanced emergency medical technician or paramedic, community paramedic or critical care paramedic personnel for the delivery of emergency medical patient care within the hospital or health care facility. All licensed ambulance services shall use ~~Emergency Medical Technician, Intermediate, Advanced Emergency Medical Technician~~ emergency medical technician, intermediate emergency medical technician, advanced emergency medical technician or ~~Paramedic~~ paramedic personnel for on-scene patient care and stabilization and the delivery of prehospital and en route emergency medical care.

B. Any hospital or health care facility operating within the state may utilize community paramedic personnel for the delivery of

community paramedic services for patients who come to the hospital or health care facility who reside in this state.

C. While participating in an ~~Emergency Medical Technician, Intermediate, Advanced Emergency Medical Technician~~ emergency medical technician, intermediate emergency medical technician, advanced emergency medical technician, community paramedic or ~~Paramedic~~ paramedic training course approved by the State Department of Health, the student shall be allowed to perform in the hospital, clinic or prehospital setting, while under the direct supervision of a physician, registered nurse, or licensed emergency medical personnel who are licensed at a level equal to or above the level of training of the student, or other allied health preceptor, any of the skills determined to be appropriate for the training level of the student by the Department.

~~C.~~ D. The student shall be allowed to perform any of the skills determined to be appropriate by the Department for the training level of the student while performing community paramedic services under the direct supervision of a physician, registered nurse or emergency medical personnel who are licensed at a level equal to or above the level of training of the student, or other allied health preceptor.

E. A registered nurse or licensed practical nurse may be used in the back of an ambulance during an interhospital transfer to supplement the skills of licensed emergency medical personnel. A registered nurse or licensed practical nurse functioning in this fashion must be following written orders of a physician or be in direct radio or telephone contact with a physician.

SECTION 3. AMENDATORY 63 O.S. 2011, Section 1-2505, as amended by Section 3, Chapter 23, O.S.L. 2013 (63 O.S. Supp. 2015, Section 1-2505), is amended to read as follows:

Section 1-2505. Personnel licensed in the following levels of care may perform as designated under their classification:

1. "Emergency ~~Medical Technician~~ medical technician (EMT)" means an individual licensed by the State Department of Health following completion of a standard ~~Basic Emergency Medical Technician~~ basic emergency medical technician training program approved by the Department, who has met such other standards of competence and character as may be required, and who has passed a standard licensing examination of knowledge and skill, administered

by the Department or other entity designated by the Department. The licensed ~~Emergency Medical Technician~~ emergency medical technician is allowed to perform such skills as may be designated by the Department;

2. "Intermediate emergency medical technician (IEMT)" means an individual licensed as an EMT, who has completed an intermediate training program approved by the Department, who has met such other standards of competence and character as may be required, and who has passed a standard licensing examination of knowledge and skill administered by the Department or other entity designated by the Department. The ~~Intermediate~~ intermediate emergency medical technician is allowed to perform such skills as may be designated by the Department;

3. "Advanced ~~Emergency Medical Technician~~ emergency medical technician (AEMT)" means an individual licensed as an ~~Emergency Medical Technician~~ emergency medical technician or ~~Intermediate~~ intermediate emergency medical technician who has completed an AEMT training program approved by the Department, who has met such other standards of competence and character as may be required, and who has passed a standard licensing examination of knowledge and skills administered by the Department or other entity designated by the Department. The ~~Advanced Emergency Medical Technician~~ advanced emergency medical technician is allowed to perform such skills as may be designated by the Department; ~~and~~

4. "Community paramedic" means an individual who meets the provisions of paragraph 5 of this section and:

a. possesses two (2) years of full-time service as a paramedic or its part-time equivalent, and

b. completes a training program from an entity approved by the Department; and

5. "Paramedic", including community paramedic, means an individual licensed as an EMT, ~~Intermediate~~ IEMT or AEMT, who has completed a standard ~~Paramedic~~ paramedic training program, who has met such other standards of competence and character as may be required, and who has passed a standard licensing examination of knowledge and skill administered by the Department or other entity designated by the Department. The ~~Paramedic~~ paramedic is allowed to perform such skills as may be designated by the Department.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-2509.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

The State Board of Health shall promulgate rules to implement the provisions of the Oklahoma Emergency Response Systems Development Act.

SECTION 5. This act shall become effective November 1, 2016.

Passed the House of Representatives the 28th day of April, 2016.

Presiding Officer of the House of Representatives

Passed the Senate the 11th day of April, 2016.

Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this 2nd day of May, 2016, at 3:40 o'clock P M.

By: Audrey Rockwell

Approved by the Governor of the State of Oklahoma this 5th day of May, 2016, at 2:55 o'clock P M.

Governor of the State of Oklahoma

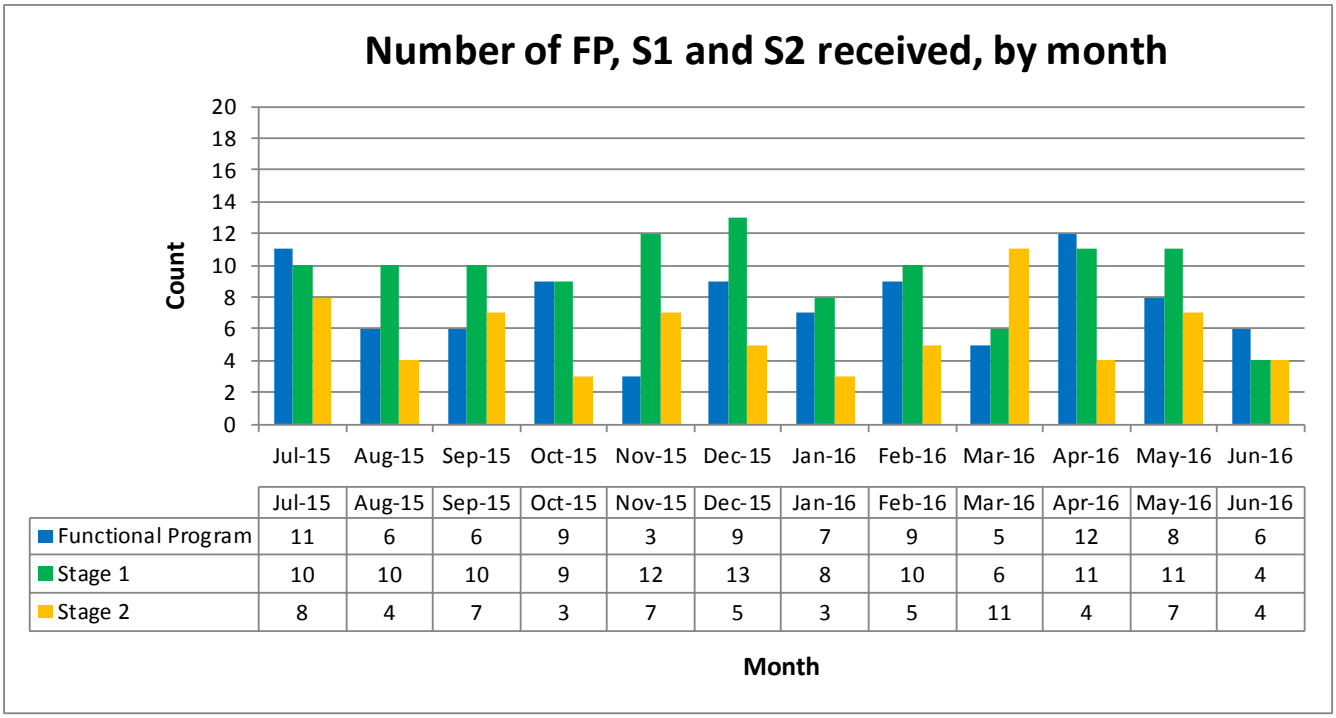
OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this 5th day of May, 2016, at 3:38 o'clock P. M.

By: Chris Benge

Plan Review Processing days: July 2015 through June 2016

Figure 1: Number of Functional Programs, Stage-1 and Stage-2 Plans received, by month



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Functional Program	11	6	6	9	3	9	7	9	5	12	8	6
Stage 1	10	10	10	9	12	13	8	10	6	11	11	4
Stage 2	8	4	7	3	7	5	3	5	11	4	7	4

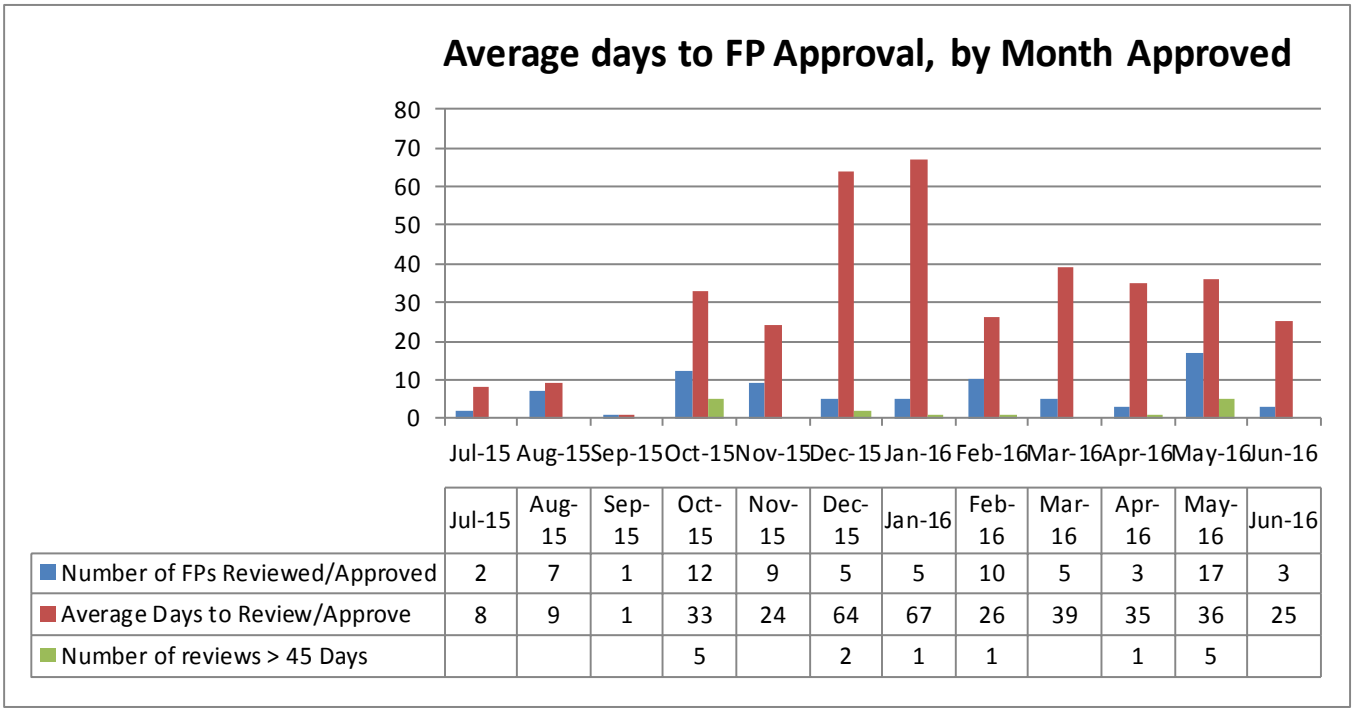
Functional Program

Table 1: Summary of Functional program status

	Number	Average days	# reviews > 45 days	% of reviews > 45 days
FP Received	91	-	-	-
FP Approved/Reviewed	83	33	15	19%
FP Approved (1st submittal)	78	33	15	19%
FP Approved (2nd submittal)	1	29	0	0%
FP Rejected (1st submittal)	2	21	0	0%
FP Not Reviewed	7	71	3	43%
FP canceled	1	-	-	-

Plan Review Processing days: July 2015 through June 2016

Figure 2: Average days to FP Approval, by Month Approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of FPs Reviewed/Approved	2	7	1	12	9	5	5	10	5	3	17	3
Average Days to Review/Approve	8	9	1	33	24	64	67	26	39	35	36	25
Number of reviews > 45 Days				5		2	1	1		1	5	

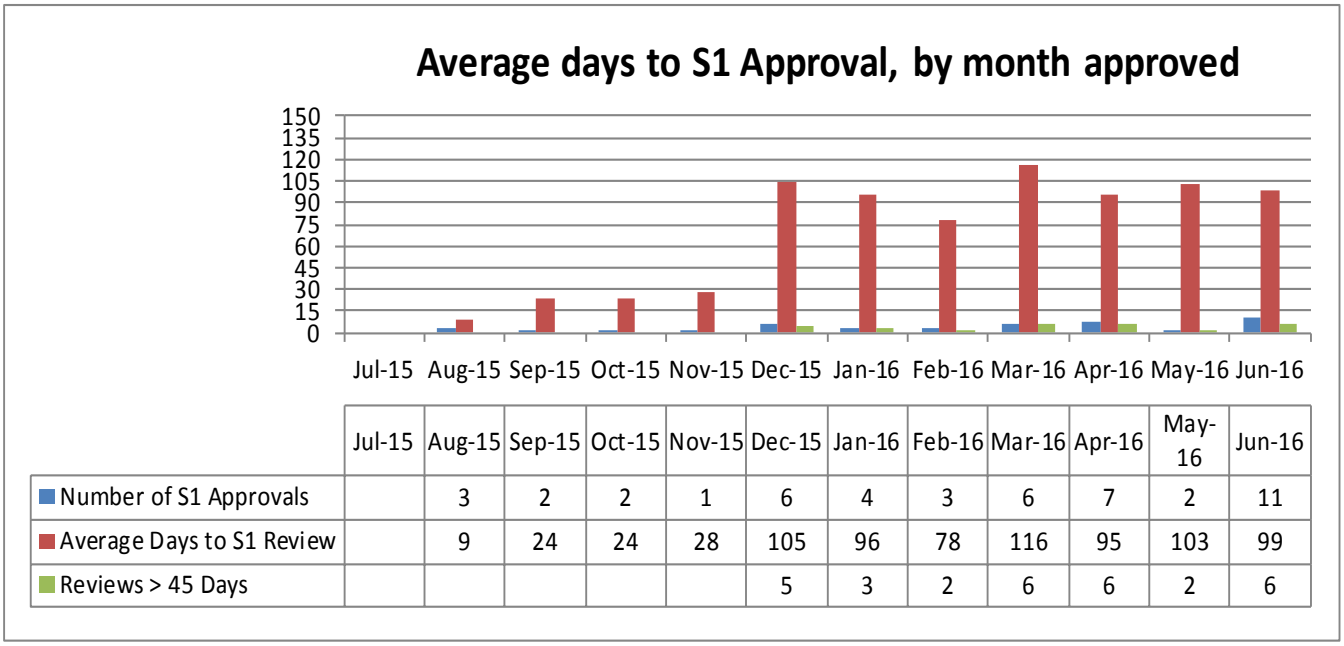
Stage 1

Table 2: Summary of Stage 1 Plan status

	Number	Average days	# reviews > 45 days	% of reviews > 45 days
Stage 1 Received	114	-	-	-
Stage 1 Approved	47	86	30	64%
Stage 1 Approved (1st submittal)	21	59	11	52%
Stage 1 Approved (2nd submittal)	20	100	14	70%
Stage 1 Approved (3rd submittal)	4	145	4	100%
Stage 1 Approved (4th submittal)	1	117	1	100%
Stage 1 Rejected (1st submittal)	82	63	57	70%
Stage 1 Rejected (2nd submittal)	13	47	6	46%
Stage 1 Not Approved	56	170	48	86%
Stage 1 Not Reviewed	11	56	6	55%

Plan Review Processing days: July 2015 through June 2016

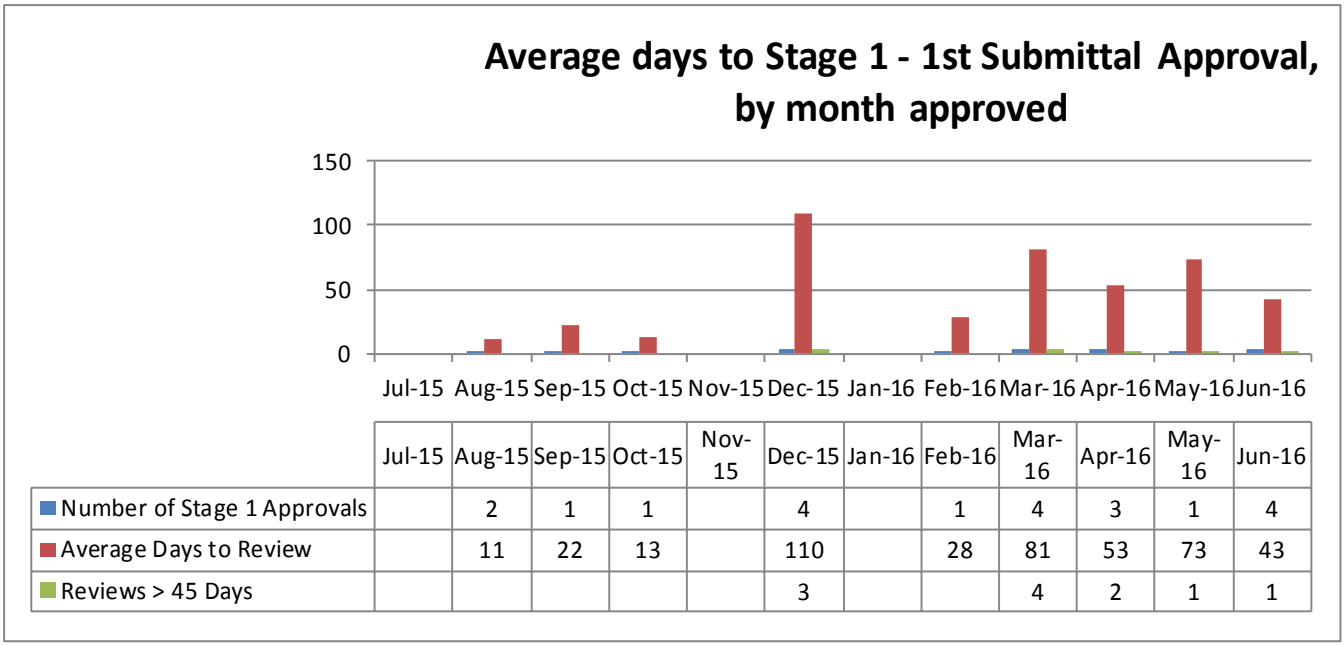
Figure 3: Average days to Stage 1 Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of S1 Approvals		3	2	2	1	6	4	3	6	7	2	11
Average Days to S1 Review		9	24	24	28	105	96	78	116	95	103	99
Reviews > 45 Days						5	3	2	6	6	2	6

Note: Some Stage 1 reviews may include multiple submissions.

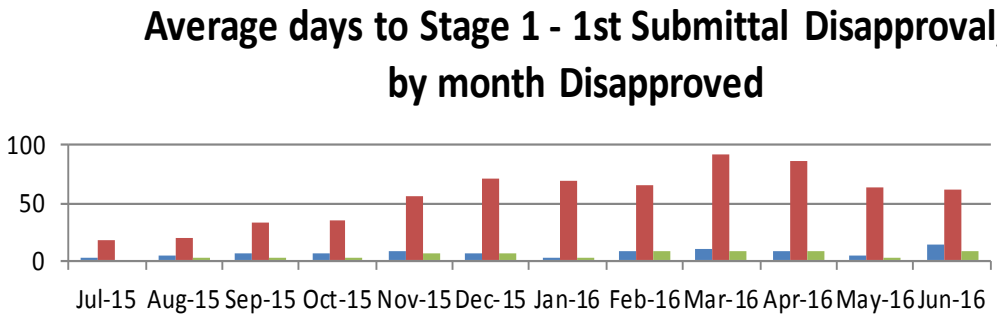
Figure 4: Average days to Stage 1 - 1st Submittal Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of Stage 1 Approvals		2	1	1		4		1	4	3	1	4
Average Days to Review		11	22	13		110		28	81	53	73	43
Reviews > 45 Days						3			4	2	1	1

Plan Review Processing days: July 2015 through June 2016

Figure 5: Number of Stage 1 - 1st Submittal Disapproval, by month Disapproved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of S1 Disapprovals (1st submittal)	1	4	6	7	8	7	3	9	10	9	4	14
Average Days to Review	18	19	33	35	56	72	70	66	93	87	63	62
Reviews > 45 Days		1	2	2	6	6	3	8	8	9	3	9

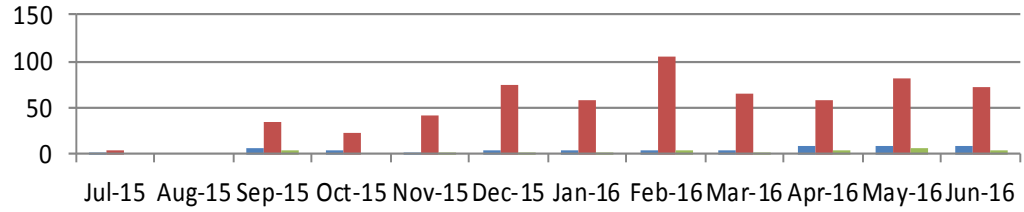
Stage 2

Table 3: Summary of Stage 2 Plan status

	Number	Average days	# reviews > 45 days	% reviews > 45 days
Stage 2 Received	68			
Stage 2 Approved	52	62	28	54%
Stage 2 Approved (1st submittal)	33	47	14	42%
Stage 2 Approved (2nd submittal)	16	85	11	69%
Stage 2 Approved (3rd submittal)	3	102	3	100%
Stage 2 Rejected (1st submittal)	26	49	13	50%
Stage 2 Rejected (2nd submittal)	4	31	3	75%
Stage 2 Not Approved	7	118	6	86%
Stage 2 Not Reviewed	8	37	3	38%
Cancelled	1			

Plan Review Processing days: July 2015 through June 2016

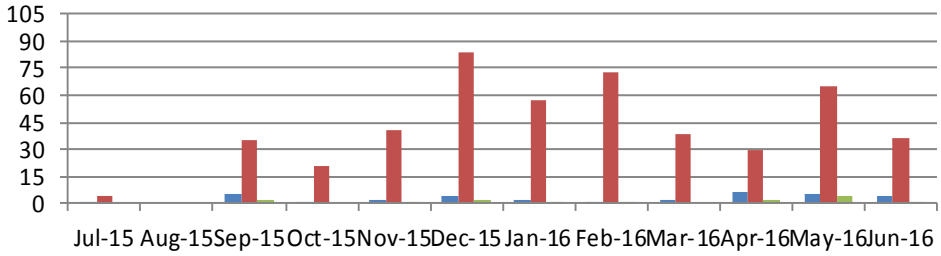
Figure 5: Average days to Stage 2 Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of S2 Approvals	1		7	3	2	5	3	3	3	9	8	8
Average days Stage 2 review	4		34	24	41	74	58	104	66	58	82	73
Reviews > 45 Days			3		1	2	2	3	1	4	7	5

Note: Some Stage 2 reviews may include multiple submissions

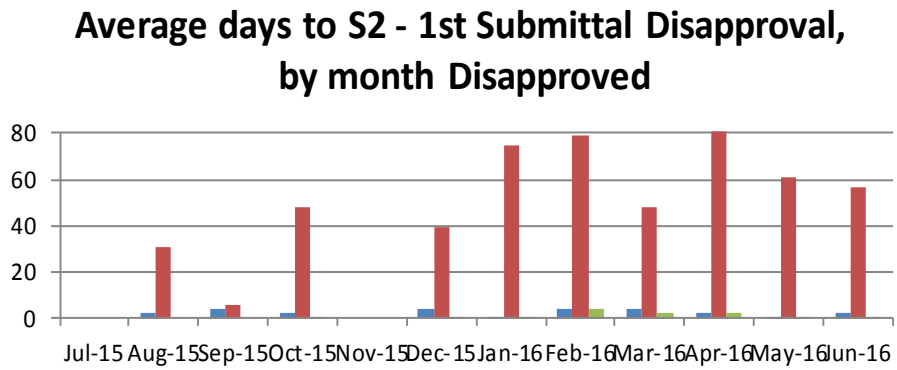
Figure 6: Average days to Stage 2 - 1st Submittal Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Nuber of S2 - 1st Submittal Approval	1		5	1	2	4	2	1	2	6	5	4
Average Days to Review	4		35	21	41	84	57	73	39	30	65	36
Reviews > 45 Days			2		1	2	1	1		2	4	1

Plan Review Processing days: July 2015 through June 2016

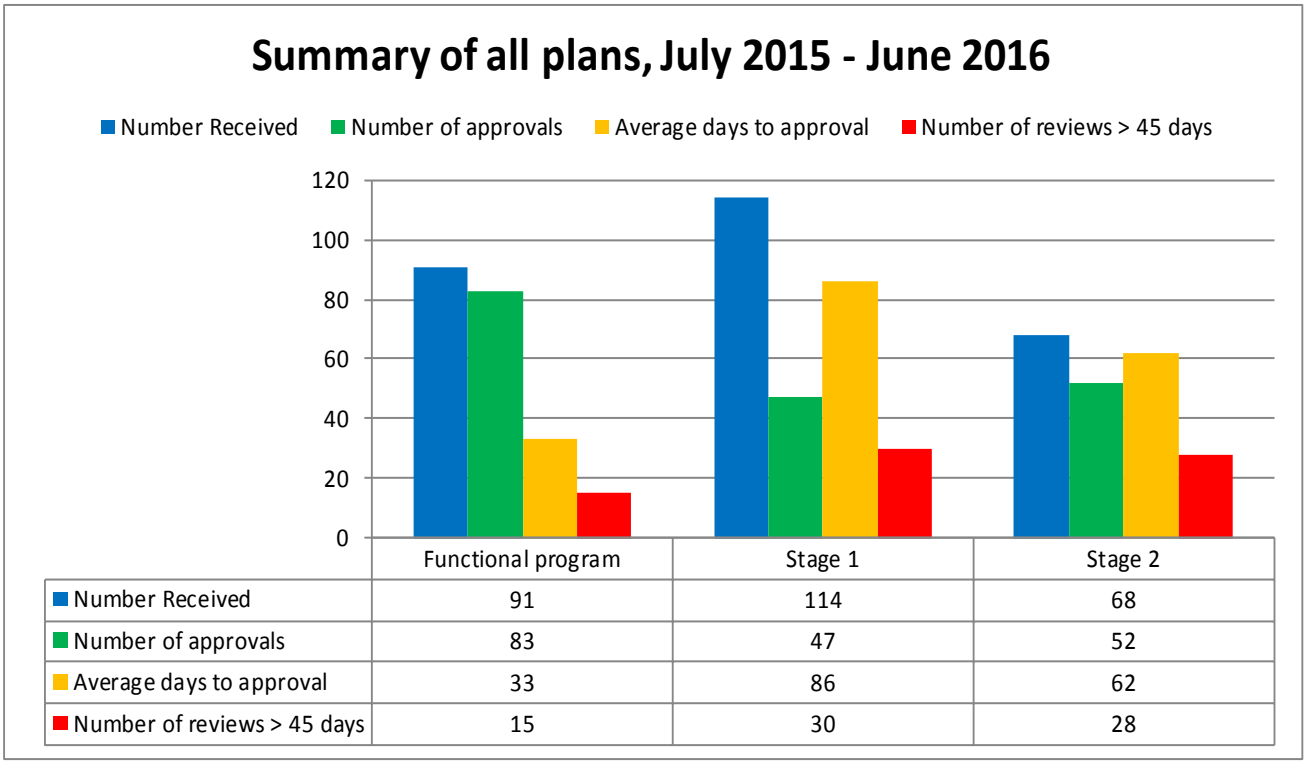
Figure 7: Average days to Stage 2 - 1st Submittal Disapproval, by month disapproved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Nuber of S2 - 1st Submittal Disapproval		2	4	2		4	1	4	4	2	1	2
Average days to review		31	6	48		39	75	79	48	90	61	57
Reviews > 45 Days				1		1	1	4	2	2	1	1

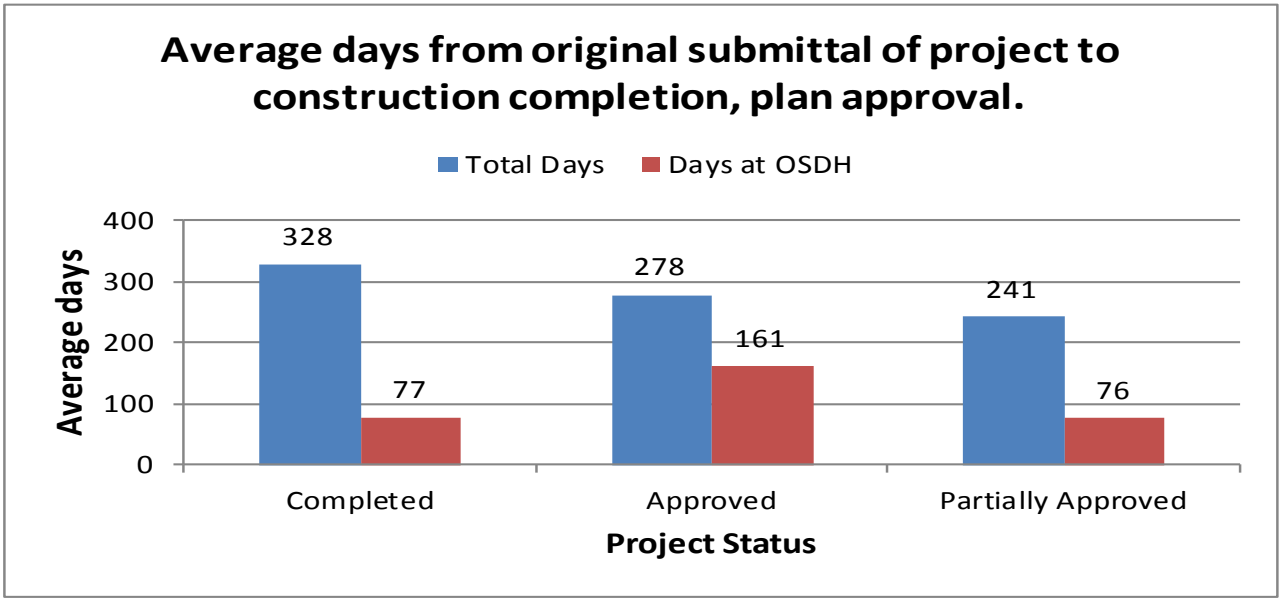
Plan Review Processing days: July 2015 through June 2016

Figure 8: Average days to approval of plans, by stage



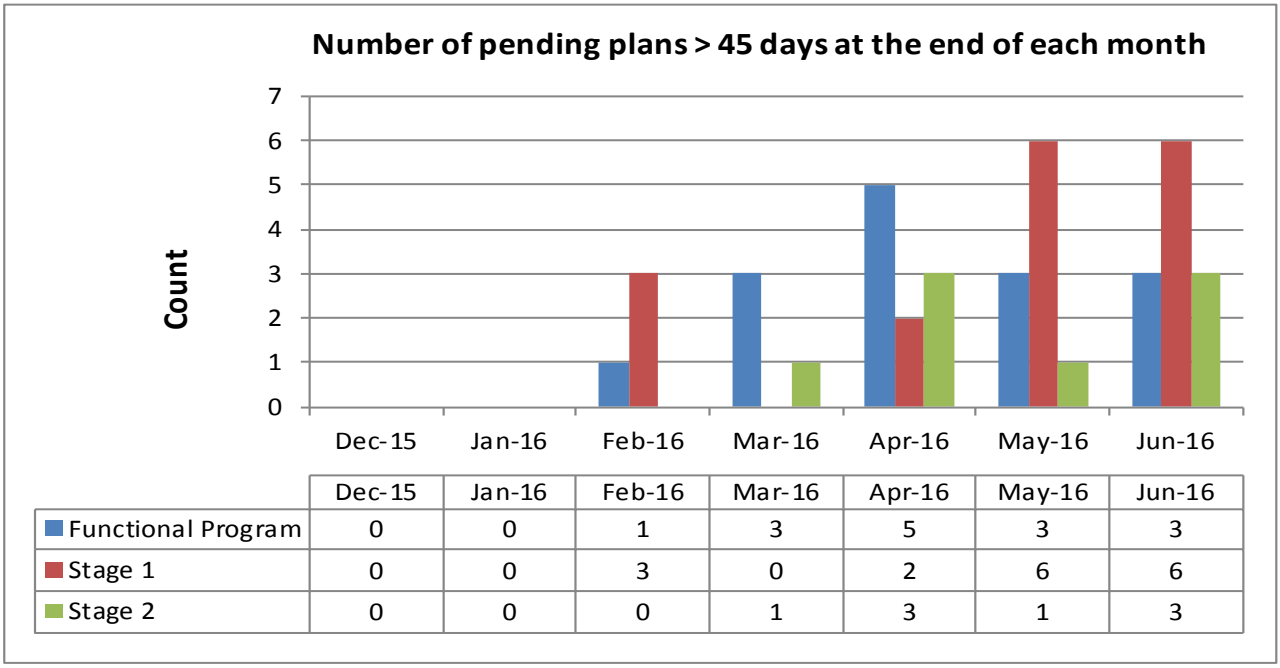
	Functional program	Stage 1	Stage 2
Number Received	91	114	68
Number of approvals	83	47	52
Average days to approval	33	86	62
Number of reviews > 45 days	15	30	28

Figure 9: Average days from original submittal of project to construction completion, plan approval.



Plan Review Processing days: July 2015 through June 2016

Figure 10: Number of plans pending for > 45 days at the end of each month



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Functional Program	0	0	1	3	5	3	3
Stage 1	0	0	3	0	2	6	6
Stage 2	0	0	0	1	3	1	3

Note: The backlog of submittals pending >45 days was cleared effective July 11, 2016.

Table 4: Number of Projects by cost categories

Cost	Frequency	Percent	Average processing days
<= $50,000	13	12%	67
$50,001 - 100,000	7	7%	114
$100,001 - 500,000	31	29%	82
$500,001 - 1,000,000	16	15%	134
$1,000,001 - 5,000,000	28	26%	70
$5,000,001 - 10,000,000	1	1%	69
$10,000,001 - 15,000,000	6	6%	21
> $15,000,000	4	4%	78

Plan Review Processing days: July 2015 through June 2016

Table 5: FP received on Template

Received on Template	Count	Percent	Average processing days
Yes	30	33%	33
No	60	67%	33

Table 6: Simultaneous submission of FP and Stage 1 plan

Simultaneous submission	Count	Percent	Average processing days
Yes	59	69%	20
No	26	31%	21

Oklahoma State Department of Health
Creating a State of Health

Oklahoma Statutes Citationized
Title 63. Public Health and Safety
Chapter 1 - Oklahoma Public Health Code
A. Licensing and Regulations (cont.)
Article Article 7 - Hospitals and Related Institutions
Section 1-707 - Rules and Standards

A. The State Board of Health, upon the recommendation of the State Commissioner of Health and with the advice of the Oklahoma Hospital Advisory Council, shall promulgate rules and standards as it deems to be in the public interest for hospitals, on the following:

1. Construction plans and location, including fees not to exceed Two Thousand Dollars ($2,000.00) for submission or resubmission of architectural and building plans, and procedures to ensure the timely review of such plans by the State Department of Health. Said assessed fee shall be used solely for the purposes of processing approval of construction plans and location by the State Department of Health;

2. Physical plant and facilities;

3. Fire protection and safety;

4. Food service;

5. Reports and records;

6. Staffing and personal service;

7. Surgical facilities and equipment;

8. Maternity facilities and equipment;

9. Control of communicable disease;

10. Sanitation;

11. Laboratory services;

12. Nursing facilities and equipment; and

13. Other items as may be deemed necessary to carry out the purposes of this article.

B. 1. The State Board of Health, upon the recommendation of the State Commissioner of Health and with the advice of the Oklahoma Hospital Advisory Council and the State Board of Pharmacy, shall promulgate rules and standards as it deems to be in the public interest with respect to the storage and dispensing of drugs and medications for hospital patients.

2. The State Board of Pharmacy shall be empowered to inspect drug facilities in licensed hospitals and shall report violations of applicable statutes and rules to the State Department of Health for action and reply.

C. 1. The Commissioner shall appoint an Oklahoma Hospital Advisory Council to advise the Board, the Commissioner and the Department regarding hospital operations and to recommend actions to improve patient care.

2. The Advisory Council shall have the duty and authority to:

a. review and approve in its advisory capacity rules and standards for hospital licensure,

b. evaluate, review and make recommendations regarding Department licensure activities, provided however, the Advisory Council shall not make recommendations regarding scope of practice for any health care providers or practitioners regulated pursuant to Title 59 of the Oklahoma Statutes, and

c. recommend and approve:

(1) quality indicators and data submission requirements for hospitals, to include:

(a) Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators Available as part of the standard inpatient discharge data set, and

(b) for acute care intensive care unit patients, ventilator-associated pneumonia and device-related blood stream infections, and

(2) the indicators and data to be used by the Department to monitor compliance with licensure requirements, and

d. to publish an annual report of hospital performance to include the facility specific quality indicators required by this section.

D. 1. The Advisory Council shall be composed of nine (9) members appointed by the Commissioner with the advice and consent of the Board. The membership of the Advisory Council shall be as follows:

a. two members shall be hospital administrators of licensed hospitals,

b. two members shall be licensed physicians or practitioners who have current privileges to provide services in hospitals,

c. two members shall be hospital employees, and

d. three members shall be citizens representing the public who:

(1) are not hospital employees,

(2) do not hold hospital staff appointments, and

(3) are not members of hospital governing boards.

2. a. Advisory Council members shall be appointed for three-year terms except the initial terms after November 1, 1999, of one hospital administrator, one licensed physician or practitioner, one hospital employee, and one public member shall be one (1) year. The initial terms after the effective date of this act of one hospital administrator, one licensed physician or practitioner, one hospital employee, and one public member shall be two (2) years. The initial terms of all other members shall be three (3) years. After initial appointments to the Council, members shall be appointed to three-year terms.

b. Members of the Advisory Council may be removed by the Commissioner for cause.

E. The Advisory Council shall meet on a quarterly basis and shall annually elect from among its members a chairperson. Members of the Council shall serve without compensation but shall be reimbursed by the Department for travel expenses related to their service as authorized by the State Travel Reimbursement Act.

Historical Data

Laws 1963, SB 26, c. 325, art. 7, § 707, emerg. eff. July 1, 1963; Amended by Laws 1968, SB 346, c. 86, § 1, emerg. eff. April 1, 1968; Amended by Laws 1999, HB 1184, c. 93, § 6, eff. November 1, 1999 (superseded document available); Amended by Laws 1999, HB 1188, c. 213, § 2, emerg. eff. July 1, 1999 (superseded document available); Amended by Laws 2006, HB 2842, c. 315, § 16, emerg. eff. June 9, 2006 (superseded document available).

Oklahoma State Department of Health
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OSDH Hospital-Related Legislative Summary

HB 1036 (Rep Faught, Sen Smalley) requires Emergency Medical Services stretcher van passengers to be screened before transport to a medically licensed facility. It states screening is provided by a certified medical dispatching protocol. (Assigned to OSDH Deputy Commissioner for Protective Health Services.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/HB/1036.pdf

HB2549 (Rep. Cox, Sen. Quinn) modifies the definition of "owner" in the Nursing Home Care Act. Crucial piece in moving forward with the Nursing Home Upper Payment Limit program. - (Assigned to OSDH Deputy Commissioner for Protective Health Services.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/HB/2549.pdf

HB2742 (Rep Cox, Sen Standridge) modifies and adds definitions relating to public health and safety, utilization of emergency medical personal and levels of care. The bill allows any hospital or health care facility operating within the state to utilize emergency medical technician, intermediate emergency medical technician, advanced emergency medical technician, or paramedic, community paramedic or critical care paramedic personal for the delivery of emergency medical patient care within the hospital or health care facility who reside in this state and the delivery of emergency care on-scene patient care and stabilization. (Assigned to OSDH Deputy Commissioner for Protective Health Services.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/HB/2742.pdf

HB2797 (Rep Ann Coody, Sen Griffin) requires the State Department of Health to develop, update annually and maintain an electronic form containing information concerning public and private agencies and services available to assist a woman through pregnancy, upon childbirth and while the child is dependent. It provides required information to provide on said list. It requires the Department to index this form geographically and readily accessible on its website. It provides a statement required to be included on said website. It requires said statement to include a hyperlink to the Department's website containing the aforementioned information and available in a downloadable format appropriate for display. It requires that the Department make available to each facility in Oklahoma which is open to the public, containing a restroom available to the public and licensed by the Department to post signage in its restroom containing the aforementioned statement on or before January 1, 2018. Implementation of some sections is contingent upon appropriation specifically for related activities. (Assigned to OSDH General Counsel.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/HB/2797.pdf

SB884 (Sen Brooks, Rep Cox) exempts Department of Corrections hospitals from being required to obtain a license from the State Department of Health to operate. (Assigned to OSDH Deputy Commissioner for Protective Health Services.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/884.pdf

SB983 (Sen. Thompson, Rep. Martin) creates an advisory for the State's HIT coordinator with regard to health information exchange and privacy. (Assigned to OSDH Senior Deputy Commissioner.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/983.pdf

SB1147 (Sen Crain, Rep Faught) requires the medical certificate portion of death certificate data to be entered into a prescribed electronic system provided by the State Registrar of Vital Statistics by July 1, 2017. (Assigned to OSDH Chief Operating Officer.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/1147.pdf

SB1149 (Sen Griffin, Rep Cox) allows a municipal governing body to engage in transactions to manage, lease or operate a medical facility outside the municipal limits to provide an economic benefit to the community or lessen the burden of government. It allows a Board of Control to undertake the management, lease or operation of any other medical facility or institution. The bill allows any trust created pursuant to the measure to engage in activities outside of the geographic boundaries of its beneficiary if the activity provides a benefit to a large class of the public within the beneficiary's geographic area or lessen burdens of government. (Assigned to OSDH Deputy Commissioner for Protective Health Services.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/1149.pdf

SB1179 (Sen Smalley, Rep Cox) expands definitions used in the Oklahoma Medical Loan Repayment Program to include health center and teaching health center. The bill permits the Physician Manpower Training Commission to accept donations of public or private funds to assist in funding the Medical Loan Repayment Program. It also permits the commission to contract with other public entities and non-profit corporations for the endowment, management and administration of such funds. (Assigned to OSDH Senior Deputy Commissioner.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/1179.pdf

SB1386 (Sen. David, Rep. Mulready) authorizes Oklahoma to pursue two separate federal waivers: a 1332 waiver to the federal treasury and an 1115 DSRIP waiver for delivery system and payment reform. (Assigned to OSDH Senior Deputy Commissioner.)
https://www.sos.ok.gov/documents/legislation/55th/2016/2R/SB/1386.pdf

Oklahoma State Department of Health
Creating a State of Health

Vision

Creating a State of Health

Mission

To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy.

Values

Leadership - To provide vision and purpose in public health through knowledge, inspiration and dedication and serve as the leading authority on prevention, preparedness and health policy.

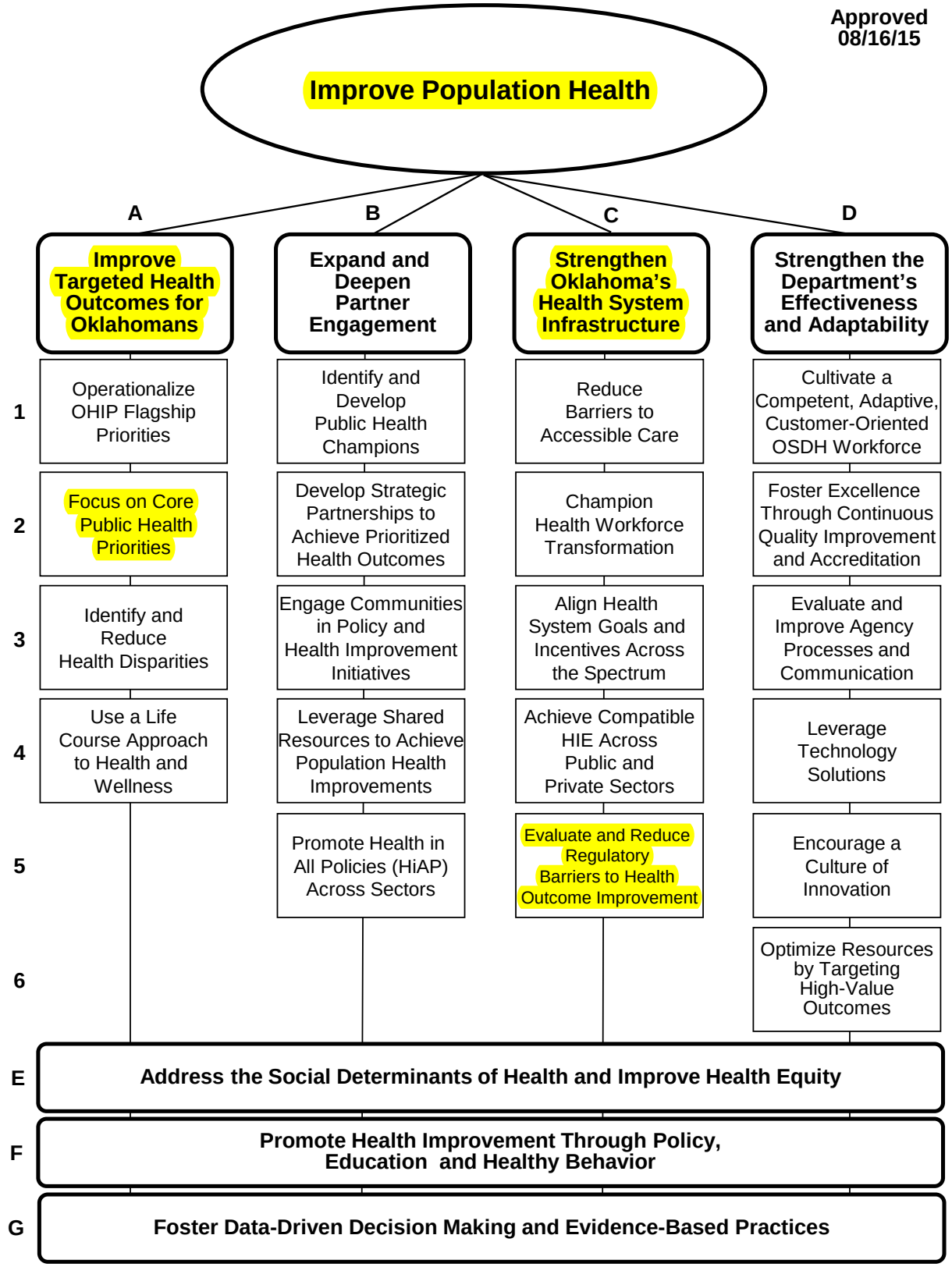
Integrity - To steadfastly fulfill our obligations, maintain public trust, and exemplify excellence and ethical conduct in our work, services, processes, and operations.

Community - To respect the importance, diversity, and contribution of individuals and community partners.

Service - To demonstrate a commitment to public health through compassionate actions and stewardship of time, resources, and talents.

Accountability - To competently improve the public's health on the basis of sound scientific evidence and responsible

Oklahoma State Department of Health
Strategic Map: 2015-2020



Discussion of the strategic map included the following points.

- The central challenge, "Improve population health:"
  - Emphasizes "moving the needle" – achieving measureable improvements on specific health issues that impact Oklahomans
  - Stresses using a population health approach – including working effectively with partners to address the needs of populations with unique health needs
- Strategic Priority A, "Improve targeted health outcomes for Oklahomans:"
  - Focuses on addressing specific health issues that Oklahomans face
  - Emphasizes improving specific health issues identified by Oklahoma's State Health Improvement Plan
  - Stresses achieving targeted outcomes that demonstrate health improvement
- Strategic Priority B, "Expand and deepen partner engagement:"
  - Recognizes that the Department of Health will have limited impact if it works alone
  - Stresses working collaboratively with both public and private partners in order to achieve significant improvements in population health
  - Includes engaging communities and supporting their efforts to improve population health
- Strategic Priority C, "Strengthen Oklahoma's health system infrastructure:"
  - Focuses on using all of Oklahoma's health assets to address and improve population health
  - Emphasizes increasing collaboration across such partners as public health, the health care delivery system and the entire public and private sectors
  - Includes aligning incentives and strengthening essential aspects of the health infrastructure – such as the health care workforce and Health Information Exchange – to achieve this priority
- Strategic Priority D, "Strengthen the Department's effectiveness and adaptability:"
  - Recognizes the need for the Department to develop the required capabilities to achieve Strategic Priorities A, B and C
  - Focuses on addressing the Department's needs and issues in order to increase its effectiveness and adaptability
  - Includes increasing the Department's emphasis on future requirements, innovation, and adapting to a changing external environment
- At the bottom of the strategic map there are three cross-cutting strategic priorities. In strategic map logic, cross-cutting strategic priorities:
  - Are placed at the bottom of the strategic map to show that they are foundational to the strategy
  - Span the map from left to right to demonstrate that efforts to achieve the cross-cutting priorities will be embedded in the efforts to implement all the other strategic priorities on the map
  - No plan to implement the other strategic priorities will be considered complete unless it includes emphasis on the cross-cutting priorities.
- Cross-cutting Strategic Priority E, "Address the social determinants of health and improve health equity:"
  - Recognizes the importance of addressing issues related to health equity in order to improve the health status of groups within the state that are disadvantaged in terms of health
  - Emphasizes the critical role that the social determinants of health – such as education, poverty and the built environment – have on the health status of Oklahomans
- Cross-cutting Strategic Priority F, "Promote health improvement through policy, education and healthy behavior:"
  - Focuses on the essential role of the Department of Health in promoting health improvement by emphasizing prevention
  - Emphasizes three ways the Department promotes health improvement: public policy, educational efforts, and promoting healthy behavior
- Cross-cutting Strategic Priority G, "Foster data-driven decision making and evidence-based practices:"
  - Emphasizes the Department's efforts to model data-driven decision making and the effective use of evidence-based practice

- Includes encouraging partners and other organizations throughout the state to incorporate these capabilities into their efforts to improve the health of Oklahomans

Strategic Priority A, "Improve targeted health outcomes for Oklahomans," is supported by the following strategic objectives.

- Strategic Objective A-1, "Operationalize the Oklahoma Health Improvement Plan flagship priorities:"
  - Focuses on OHIP's four flagship issues:
    - Children's health improvement
    - Tobacco use prevention
    - Obesity reduction
    - Behavioral health improvement
  - Emphasizes continuing efforts to reach the targeted goals established by the Oklahoma Health Improvement Plan
- Strategic Objective A-2, "Focus on core public health priorities:"
  - Recognizes their critical importance in improving targeted health outcomes for Oklahomans
- Strategic Objective A-3, "Identify and reduce health disparities:"
  - Recognizes that even though many Oklahomans have optimal health, a number of populations in the state experience significant disparity in areas such as infant mortality, life expectancy, and so on
  - Stresses efforts to identify, address and reduce these disparities
- Strategic Objective A-4, "Use a life course approach to health and wellness:"
  - Focuses on the importance of considering health and wellness across the entire life span from prenatal care through end-of-life care
  - Recognizes the significance of adverse childhood experiences (ACEs) and the impact these experiences have on health throughout a person's life
  - Emphasizes using a life course approach in developing and delivering the Department's programs and services as a key strategy for achieving targeted health outcomes for Oklahomans

Strategic Priority B, "Expand and deepen partner engagement," is supported by the following strategic objectives.

- Strategic Objective B-1, "Identify and develop public health champions:"
  - Focuses on identifying thought leaders and other influential leaders throughout the state to serve as champions for public health and advocates for health improvement efforts
  - Emphasizes providing support, development and encouragement for these champions to help them carry out efforts to improve health and encourage others to do so
- Strategic Objective B-2, "Develop strategic partnerships to achieve prioritized health outcomes:"
  - Focuses on extending the Department's effectiveness by engaging both public and private partners in carrying out health improvement efforts
  - Emphasizes aligning the Department's efforts to improve targeted health outcomes with the health improvement agendas of partner organizations in order to increase effectiveness and optimize resources
- Strategic Objective B-3, "Engage communities in policy and health improvement initiatives:"
  - Recognizes the critical role that communities health improvement efforts plan in improving the health of Oklahomans
  - Stresses supporting community health improvement initiatives, encouraging the use of best practices in achieving population health improvements
  - Emphasizes working with communities to identify and implement appropriate policies that address the social determinants of health and foster improvements in population health
- Strategic Objective B-4, "Leverage shared resources to achieve population health improvements:"
  - Recognizes the extent of the challenge to improve health, particularly with the limited resources available to the Department

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

Strategic Priority C, "Strengthen Oklahoma's health system infrastructure," is supported by the following strategic objectives.

- Strategic Objective C-1, "Reduce barriers to accessible care:"
  - Recognizes the importance of ensuring that Oklahomans have access to high-quality, affordable health care no matter where they live in the state or what their economic circumstance are
  - Stresses increasing the close working relationship between public health and the health care delivery system in order to carry out this objective
- Strategic Objective C-2, "Champion health workforce transformation:"
  - Focuses on the Department's role in developing an adequate supply of competent health professionals across Oklahoma to meet current and future needs
  - Emphasizes the Department's role in working with appropriate partners to recruit, develop, support and retain that workforce
- Strategic Objective C-3, "Align health system goals and incentives across the spectrum:"
  - Emphasizes the Department's role in working with public and private partners to align health system goals across the state
  - Includes efforts to align financial and other incentives to improve the effectiveness of Oklahoma's health system
- Strategic Objective C-4, "Achieve compatible Health Information Exchange across public and private sectors:"
  - Focuses on the critical importance of Health Information Exchange in supporting systematic approaches to improving population health
  - Emphasizes the need for both compatible HIE infrastructure and the appropriate use of HIE by public and private partners
  - Stresses the Department's leadership and convening role in aligning organizations to achieve this objective
- Strategic Objective C-5, "Evaluate and reduce regulatory barriers to health outcome improvement:"
  - Recognizes that transformational change across the health system requires appropriate regulatory requirements and compliance efforts to meet current and future needs
  - Includes efforts to optimize regulatory policies and remove regulatory barriers in order to strengthen Oklahoma's health system infrastructure

Strategic Priority D, "Strengthen the Department's effectiveness and adaptability," is supported by the following strategic objectives.

- Strategic Objective D-1, "Cultivate a competent, adaptive, customer-oriented Oklahoma State Department of Health workforce:"
  - Focuses on the Department's workforce as an essential resource for ensuring the effectiveness and adaptability of the Department
  - Emphasizes the Department's efforts to recruit, develop, support and retain an outstanding workforce within the Department
  - Stresses the essential competencies of that workforce – including a strong customer orientation and the ability to adapt to rapidly changing needs and emerging opportunities

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

Oklahoma State Department of Health
Creating a State of Health

Health Facility Plan Review Process Improvement Team
Executive Summary
July 15, 2016

The Health Facility Plan Review Process Improvement Team held their tenth meeting on July 15, 2016. Present were Henry Hartsell, David Foss, Connie McFarland, Craig Jones, Roger Knak, Danny Coats, Naresh Bhanderi, James Joslin, Terri Cook, Lee Martin, Don Maisch, John Larson, Jon Mercer, LaWanna Halstead, Pat Rogers, Walt Joyce, Joyce Clark, Dwayne Robinett, Ginger Thompson, Matt Adams, Bobby Kunkle David Wright, Kenyan Morgan, Kiersten Hamill, Kari Holder, Ginger Thompson and Debbie Raison.

The team reviewed the March 25, 2016 executive summary and recapped the project to date.

The team used the Adopt-Adapt-Abandon approach throughout the meeting. They noted that the functional program template takes longer for the Oklahoma State Department of Health's staff to review, because of overlap between multiple templates, templates filled out incorrectly, and projects with multiple sites or areas. The team agreed to continue use of the templates with these adaptations:

- Suggest facilities use the templates as checklists in writing a unified program covering multiple areas;
- Develop an interactive template that prompts the user to identify the areas that are included in the project, and that autofills standard information in each section of the templates; and
- Provide examples of successfully completed templates. The Oklahoma Hospital Association will reach out to its membership for volunteers to provide examples.

The group reviewed the data on processing times for functional programs, and stage one and two design and construction plan submittals. OSDH staff reported that the backlog of review was cleared effective July 11, 2016, and that all programs and plans on file that had not been reviewed were pending 45 days or less. Suggestions to improve the data reports were included on the "next steps" list.

Team members reviewed additional information on solutions previously raised in previous meeting. The group discussed the pros and cons of self-certification of plans, dispute resolution, development of a detailed process to ensure timely review of programs and plans, and consideration of updates to OAC 310:615, 667, 675, Life Safety Code and FGI Guidelines. The majority voted to continue work on each of the four solution areas. OSDH staff will work on processes and evaluations of self-certificate of plans, dispute resolution, and the timely plan review process. Subcommittees based on facility types will work on updates to Oklahoma's physical plant requirements in light of the CMS adoption of the 2012 Life Safety Code and the FGI Guidelines.

New barriers and critical questions included:

- Why are there fewer stage two reviews than stage one reviews?
- Should some measures of the scope of projects be added to data?
- Can projects be categorized by complexity, such as the hours required to review them?
- Can the Commissioner of Health adopt or provide waivers to provide relief during the rulemaking process?
- How does Life Safety Code 101 impact facilities? Will they need a waiver and who should they petition?
- Is there a way to have a portal or other capability to check the status of approval?

Next steps include:

- Categorize and count the reasons for rejections of design and construction plans;
- Include data on stage one plans that are "approved with comments;"
- Track the timeframes for internal steps in OSDH staff reviews, separately identifying times for staff to complete functional program and stage one plan reviews;
- Track companies that submit stage one plans but do not submit stage 2 plans; and
- Identify the number of facilities using the template as a checklist but not submitting the forms;
- Provide announcement regarding the template, the review process explanation, the rule outline (OAC 310:667) outline to be shared with companies and associations to ask for volunteers for a beta test;
- Add labels for number of cases and months to Figure 9 on page 7;
- Form the four subcommittees to study updates to the physical plant requirements; and
- Research whether there is a program or tool to develop functional programs under FGI guidelines, that might be used to improve the OSDH templates for multiple areas;
- The Oklahoma Hospital Association will ask membership to participate in a beta test.

ORIGINAL AIM Statement: An opportunity exists to ensure the Oklahoma State Department of Health implements clear, reasonable and timely management practices for construction and plan reviews for hospitals and other health facilities in compliance with applicable state and federal laws and rules and up-to-date guidelines. This effort should decrease the time required to complete approvals of plans and construction projects, moving from the current “sample” means days, to a 15% reduction by December 31, 2015. This is important to work on immediately because timely plan reviews and inspections give health facilities important information needed to achieve and maintain compliance with construction and review standards. Timely reviews and inspections have the potential to affect patient health and safety, to ensure compliance with building and safety codes, to improve the efficiency and cost-effectiveness of state government services, and to reduce compliance costs for health facilities. The baseline is measured as the mean number of days at the four major stages of the plan review process.
Data Set reports.

Inspection Frequency Mandates Report
For Quarter Ending March 2014 or Fiscal Year To Date Ending March 2014
Sorted by Program and Mandate Classification

DRAFT

Mandate Class	PHS Program	Facility Type	Facility Mandate	Description	Draft Data Standard	(S)statute, (R)rule, or (C)contract (Tier#)	Citation/Contract			Report Period	For the applicable State of Federal Qtr was/is this IFM Met (M) or Not Met (NM)	Actual Score	Numerator	Denominator	Notes
3.1.1 Fed Not Comp	MFS	ASC	Deemed ASCs: 5% to 10% surveyed annually; Tier 1	SAs will perform validation surveys on a 5% - 10% sample of accredited, deemed ASCs. The ASCs to be surveyed will be selected by CMS based on the accreditation survey schedule of deemed ASCs that are surveyed by accreditation organizations (AOs) in FY2012. Surveys must be completed within 60 days of completion of the AO survey.	Numerator: # Active deemed ASCs surveyed Denominator: 5% of Active deemed ASCs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0846S	C1	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-P-2 p.38				M	#DIV/0!	0	0	
3.1.1 Fed Not Comp	MFS	ASC	Non-Deemed ASCs: >=25% of all ASCs Surveyed annually; Tier 2	States will perform surveys totaling 25% of all non-accredited, non-deemed ASCs, or at least 1, whichever is greater, unless all non-deemed ASCs were surveyed in FY2010 and FY 2011. States will select ASCs for survey, focusing on ASCs that have not been surveyed in more than 6 years and/or ASCs that represent a greater risk of having quality problems, based on their recent compliance history and any other important factors known to the State.	Numerator: # Active non-deemed ASCs surveyed Denominator: # Active non-deemed ASCs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0846S	C2	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-P-1 p.38				M	100.0%	3	3	
3.1.1 Fed Not Comp	MFS	ESRD	End Stage Renal Disease Providers; >= 10% of all ESRDs Surveyed annually; Tier 2	States survey a 10% targeted sample of ESRD facilities, selected from a CMS list that identifies those facilities most at risk of providing poor care;	Numerator: # Active ESRDs surveyed Denominator: 10% of the # of Active ESRDs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0846S	C2	42 CFR 491 Subpart A, except for 42 CFR 491.3. CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-N-2, p. 34				M	#DIV/0!	0	0	
3.1.1 Fed Not Comp	MFS	HHA	HHA- 36.9-Month Max Interval Tier 1	36.9-Mo. Max. Interval: No more than 36.9 months elapses between surveys for any particular agency. Surveys Pursuant to Complaints: Extended surveys are required after each complaint investigation that finds substantiated CoPs out of compliance (both deemed & not deemed HHAs).	Numerator: # Active HHAs surveyed w/in 36 mos. Denominator: # Active HHAs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0812D	C1	USC Section 1891(c)(2)(A) CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-B, p. 19				M	100.0%	28	28	
3.1.1 Fed Not Comp	MFS	Hosp	Deemed Hospital and Critical Access Hosp. (CAH); 1% or 1 whichever is > annually; Tier 1	Conduct validation surveys on approximately 1% of accredited, deemed hospitals (or at least 1 in each State, whichever is greater) as part of the State's baseline budget - Tier 1	Numerator: # of Hospitals surveyed Denominator: # of Hospitals in Sample Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0831D	C1	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD §4-F & G, p. 24				M	100.0%	1	1	

Inspection Frequency Mandates Report
For Quarter Ending March 2014 or Fiscal Year To Date Ending March 2014
Sorted by Program and Mandate Classification

DRAFT

Mandate Class	PHS Program	Facility Type	Facility Mandate	Description	Draft Data Standard	(S)statute, (R)rule, or (C)contract (Tier#)	Citation/Contract			Report Period	For the applicable State of Federal Qtr was/is this IFM Met (M) or Not Met (NM)	Actual Score	Numerator	Denominator	Notes
3.1.1 Fed Not Comp	MFS	Hosp	NON-DEEMED HOSPITALS & CAHS; <=5yr Interval ; Tier 2	No more than 5.0 years elapses between surveys for any non-accredited hospital or CAHs;	Measure: # Active Providers with survey interval <= 5yrs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0843D	C2	310:667-59-3 in accordance to OAC 310:667-1-4. CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-J, p. 27				M	#DIV/0!	0	0	
3.1.1 Fed Not Comp	MFS	Hosp	NON-DEEMED HOSPITALS & Critical Access Hospitals; >= 5% annually; Tier 2	States survey at least 1, but not less than 5% of the short-term, acute care, non-accredited hospitals, and 5% of non-accredited CAHS, selected from CMS lists that identify those hospitals/CAHs more at risk of providing poor care	Numerator: # Active Providers surveyed Denominator: # Active Providers Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0844S	C2	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-J, p. 27				M	#DIV/0!	0	0	
3.1.1 Fed Not Comp	MFS	Hospice	Non-Deemed Hospice; >= 5% of providers annually; ***Tier 2***	5% Targeted Surveys: Each year, the State surveys 5% of Hospices based on State judgment for those providers more at risk of quality problems. The sample is drawn only from non-deemed providers/suppliers. Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 providers of each type are exempt from this requirement.	Numerator: # Active Hospices surveyed Denominator: 5% of the # Active Hospices Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0840S	C2	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-Q-6, p. 41				M	100.0%	23	23	
3.1.1 Fed Not Comp	MFS	Lab	CLIA Certified labs biennial inspection	100 % of CLIA certified labs are inspected before certificates of Registration or Compliance expire(biennially)	Numerator: # Certified labs surveyed pior to certificate expiration Denominator: # Certified labs with certificates expiring in the year	C	CMS 1864 Agreement, Article V-section C [42 U.S.C. 1395aa]; SOM 6102.1, 6420, 6422,FFY10 SAPR, Criterion 6, Performance Indicator 1 & 2				M	100.0%	25	25	
3.1.1 Fed Not Comp	MFS	OPT	Outpatient Physical Therapy (OPT) Providers; >= 5% of providers annually; ***Tier 2***	5% Targeted Surveys: Each year, the State surveys 5% of the providers in the State (or at least 1, whichever is greater), based on State judgment for those providers more at risk of quality problems. Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 providers of this type are exempt from this requirement.	Numerator: # Active OPTs surveyed Denominator: 5% of the # Active OPTs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0840S	C2	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-Q-2, p. 39				M	100.0%	1	1	

Inspection Frequency Mandates Report
For Quarter Ending March 2014 or Fiscal Year To Date Ending March 2014
Sorted by Program and Mandate Classification

DRAFT

Mandate Class	PHS Program	Facility Type	Facility Mandate	Description	Draft Data Standard	(S)statute, (R)rule, or (C)contract (Tier#)	Citation/Contract			Report Period	For the applicable State of Federal Qtr was/is this IFM Met (M) or Not Met (NM)	Actual Score	Numerator	Denominator	Notes
3.1.1 Fed Not Comp	MFS	RHC	Rural Health Clinics (RHSc); >= 5% of providers annually; Tier 2	5% Targeted Surveys: Each year, the State surveys 5% of the RHCs in the State (or at least 1, whichever is greater), based on State judgment for those RHCs most at risk of quality problems Some of the targeted surveys may qualify to count toward the Tier 3 and 4 priorities. States with fewer than 7 RHCs of this type are exempt from this requirement.	Numerator: # Active RHCs surveyed Denominator: 5% of the # Active RHCs Source: CMS Oklahoma FY 2011 SPSS SCORE SHEET.xlsx; Casper Report 0840S	C2	CMS 1864 Agreement [42 U.S.C. 1395aa]: MPD § 4-Q-4, p. 40				M	100.0%	3	3	

Inspection Frequency Mandates Report Through State Fiscal Year and Quarter End June 2016

Protective Health Services
Oklahoma State Department of Health

	SFY14		SFY15		Q1 SFY16		Q2 SFY16		Q3 SFY16		Q4 SFY16		SFY16	
CHS IFMs	8		8		8		8		8		8		8	
Inspections Meeting mandates	23,744		24,239		9,769		6,536		4,343		3,975		24,623	
Inspections Required	23,914	99.3%	24,240	100.0%	9,770	100.0%	6,536	100.0%	4,343	100.0%	3,975	100.0%	24,624	100.0%
HRDS IFMs	3		3		3		3		3		3		3	
Inspections Meeting mandates	266		264		60		59		137		59		315	
Inspections Required	267	99.6%	264	100.0%	60	100.0%	59	100.0%	137	100.0%	59	100.0%	315	100.0%
LTC IFMs	24		24		24		24		24		24		24	
Inspections Meeting mandates	3,025		2,785		844		789		758		755		3,146	
Inspections Required	3,126	96.8%	2,830	98.4%	845	99.9%	791	99.7%	758	100.0%	755	100.0%	3,149	99.9%
Note:														
MFS IFMs	14		14		14		14		14		14		14	
Inspections Meeting mandates	344		285		93		131		83		91		398	
Inspections Required	422	81.5%	287	99.3%	93	100.0%	132	99.2%	85	97.6%	91	100.0%	401	99.3%
Note:														
All PHS IFMs	49		49		49		49		49		49		49	
Inspections Meeting mandates	27,379		27,573		10,766		7,515		5,321		4,880		28,482	
Inspections Required	27,729	98.7%	27,621	99.8%	10,768	100.0%	7,518	100.0%	5,323	100.0%	4,880	100.0%	28,489	100.0%

Inspection Frequency Mandates Report Through State Fiscal Year and Quarter End June 2016

Protective Health Services
Oklahoma State Department of Health

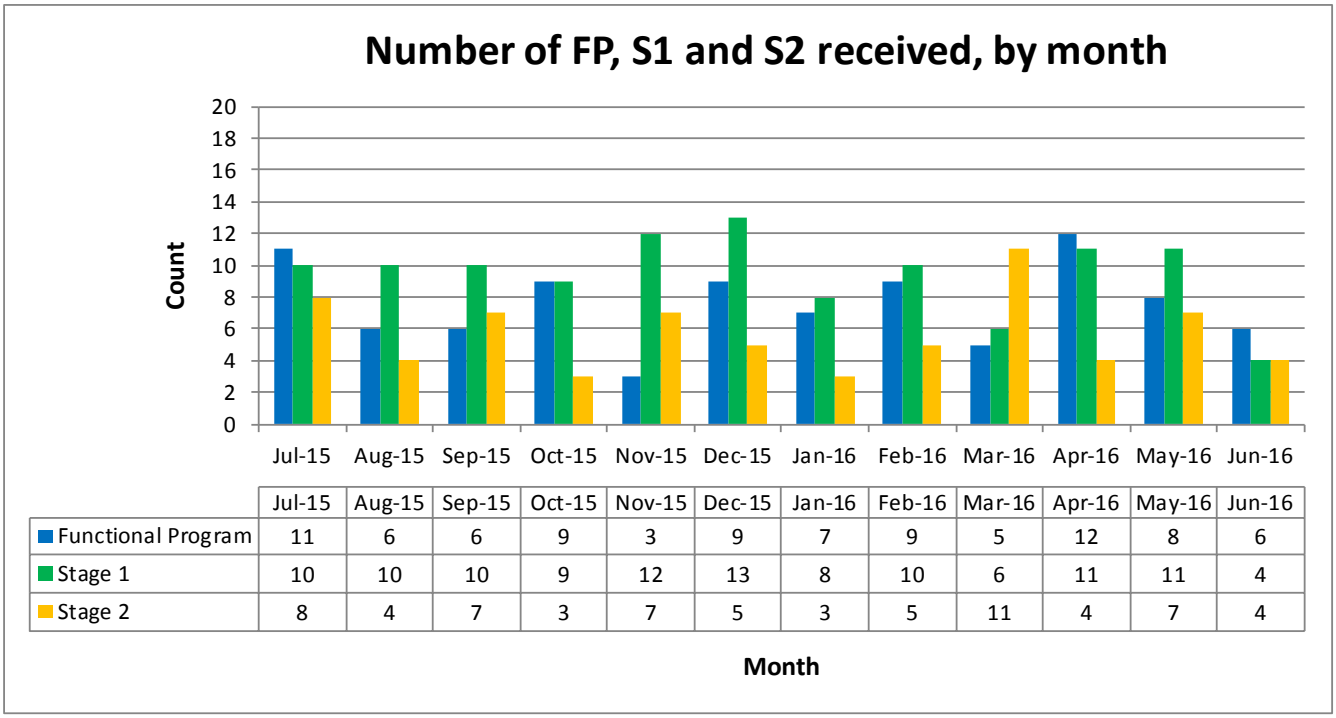
COMPLAINT vs. NON-COMPLAINT IFMs	FY14		FY15		Q1 SFY16		Q2 SFY16		Q3 SFY16		Q4 SFY16		SFY16	
Count of Complaint IFMs	17		17		17		17		17		17		17	
IFM's Currently Reporting Met	10	59%	16	94.1%	16	94.1%	16	94.1%	15	88.2%	17	100.0%	15	88.2%
IFM's Currently Reporting Not Met	7	41%	1	5.9%	1	5.9%	1	5.9%	2	11.8%	-	0.0%	2	11.8%
Inspections Meeting mandates	1,362	93.1%	1,206	96.4%	458	99.8%	345	99.1%	297	99.3%	275	100.0%	1,375	99.6%
Inspections Required	1,463		1,251		459		348		299		275		381	
Count of Non-Complaint IFMs	32		32		32		32		32		32		32	
IFM's Currently Reporting Met	28	88%	32	100.0%	32	100.0%	32	100.0%	32	100.0%	32	100.0%	32	100.0%
IFM's Currently Reporting Not Met	4	13%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Inspections Meeting mandates	26,017	99%	26,367	100.0%	10,308	100.0%	7,170	100.0%	5,024	100.0%	4,605	100.0%	27,107	100.0%
Inspections Required	26,266		26,370		10,309		7,170		5,024		4,605		27,108	

STATE IFMs	FY14		FY15		Q1 SFY16		Q2 SFY16		Q3 SFY16		Q4 SFY16		SFY16	
Count of State Complaint IFMs	12		12		12		12		12		12		12	
IFM's Currently Reporting Met	5	41.7%	10	83.3%	11	91.7%	11	91.7%	12	100.0%	12	100.0%	12	100.0%
IFM's Currently Reporting Not Met	7	58.3%	2	16.7%	1	8.3%	1	8.3%	-	0.0%	-	0.0%	-	0.0%
Inspections Meeting mandates	935	91.0%	810	95.0%	323	99.7%	247	99.2%	230	100.0%	218	100.0%	1,018	99.7%
Inspections Required	1,027		853		324		249		230		218		1,021	
Count of State Non-Complaint IFMs	15		15		15		15		15		15		15	
IFM's Currently Reporting Met	13	86.7%	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%	15	100.0%
IFM's Currently Reporting Not Met	2	13.3%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Inspections Meeting mandates	24,550	100.0%	24,932	100.0%	9,826	100.0%	6,773	100.0%	4,653	100.0%	4,223	100.0%	25,475	100.0%
Inspections Required	24,557		24,932		9,826		6,773		4,653		4,223		25,475	

CONTRACTED IFMs	FY14		FY15		Q1 SFY16		Q2 SFY16		Q3 SFY16		Q4 SFY16		SFY16	
Count of Contracted Complaint IFMs	5		5		5		5		5		5		5	
IFM's Currently Reporting Met	5	100.0%	5	100.0%	5	100.0%	5	100.0%	3	60.0%	5	100.0%	3	60.0%
IFM's Currently Reporting Not Met	-	0.0%	-	0.0%	-	0.0%	-	0.0%	2	40.0%	5	100.0%	2	40.0%
Inspections Meeting mandates	427	97.9%	396	99.5%	135	100.0%	98	99.0%	67	97.1%	57	100.0%	357	99.2%
Inspections Required	436		398		135		99		69		57		360	
Count of Contracted Non-Complaint IFMs	17		17		17		17		17		17		17	
IFM's Currently Reporting Met	15	88.2%	17	100.0%	17	100.0%	17	100.0%	17	100.0%	17	100.0%	17	100.0%
IFM's Currently Reporting Not Met	2	11.8%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Inspections Meeting mandates	1,467	85.9%	1,435	99.8%	482	99.8%	397	100.0%	371	100.0%	382	100.0%	1,632	99.9%
Inspections Required	1,709		1,438		483		397		371		382		1,633	

Plan Review Processing days: July 2015 through June 2016

Figure 1: Number of Functional Programs, Stage-1 and Stage-2 Plans received, by month



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Functional Program	11	6	6	9	3	9	7	9	5	12	8	6
Stage 1	10	10	10	9	12	13	8	10	6	11	11	4
Stage 2	8	4	7	3	7	5	3	5	11	4	7	4

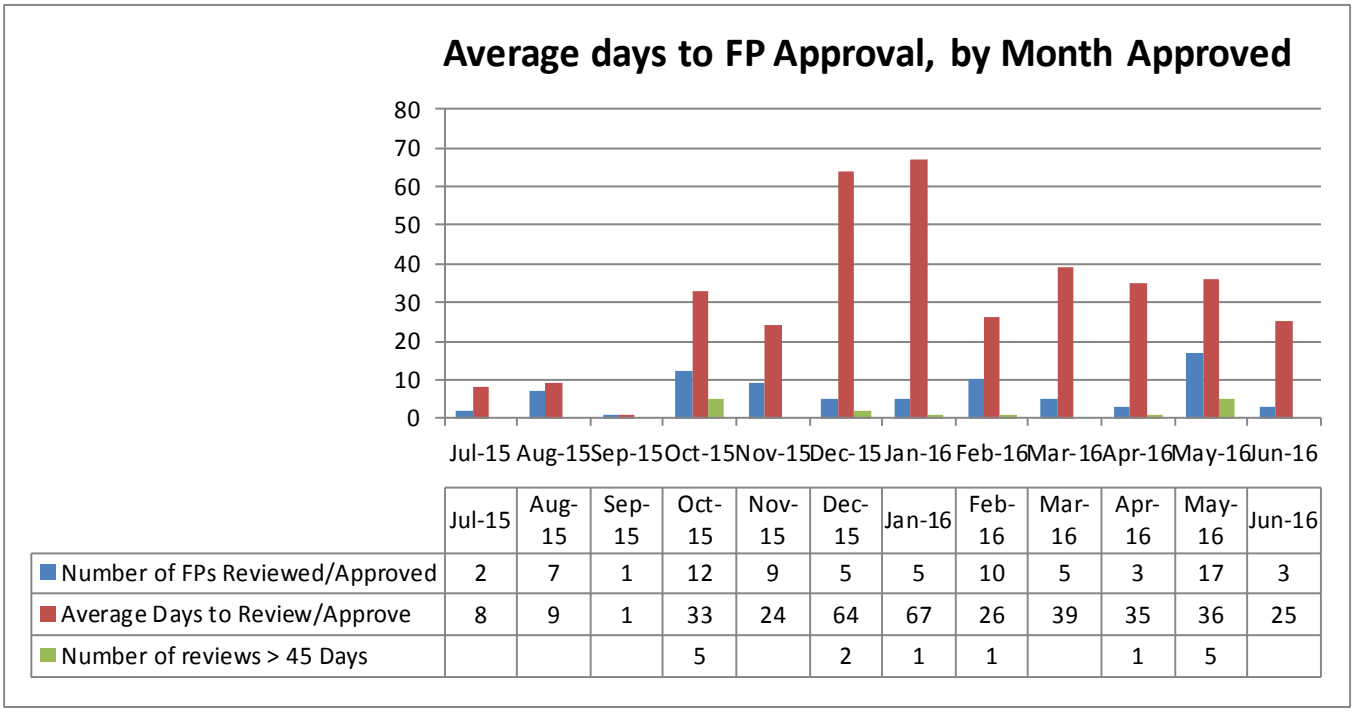
Functional Program

Table 1: Summary of Functional program status

	Number	Average days	# reviews > 45 days	% of reviews > 45 days
FP Received	91	-	-	-
FP Approved/Reviewed	83	33	15	19%
FP Approved (1st submittal)	78	33	15	19%
FP Approved (2nd submittal)	1	29	0	0%
FP Rejected (1st submittal)	2	21	0	0%
FP Not Reviewed	7	71	3	43%
FP canceled	1	-	-	-

Plan Review Processing days: July 2015 through June 2016

Figure 2: Average days to FP Approval, by Month Approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of FPs Reviewed/Approved	2	7	1	12	9	5	5	10	5	3	17	3
Average Days to Review/Approve	8	9	1	33	24	64	67	26	39	35	36	25
Number of reviews > 45 Days				5		2	1	1		1	5	

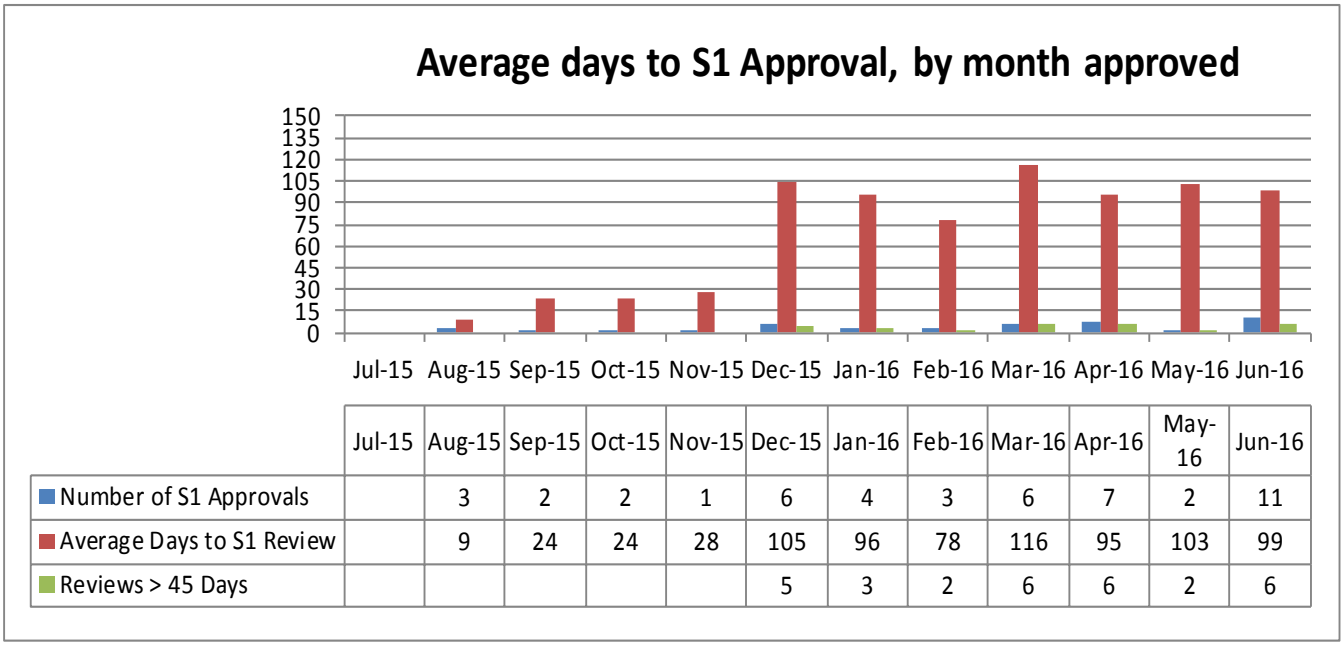
Stage 1

Table 2: Summary of Stage 1 Plan status

	Number	Average days	# reviews > 45 days	% of reviews > 45 days
Stage 1 Received	114	-	-	-
Stage 1 Approved	47	86	30	64%
Stage 1 Approved (1st submittal)	21	59	11	52%
Stage 1 Approved (2nd submittal)	20	100	14	70%
Stage 1 Approved (3rd submittal)	4	145	4	100%
Stage 1 Approved (4th submittal)	1	117	1	100%
Stage 1 Rejected (1st submittal)	82	63	57	70%
Stage 1 Rejected (2nd submittal)	13	47	6	46%
Stage 1 Not Approved	56	170	48	86%
Stage 1 Not Reviewed	11	56	6	55%

Plan Review Processing days: July 2015 through June 2016

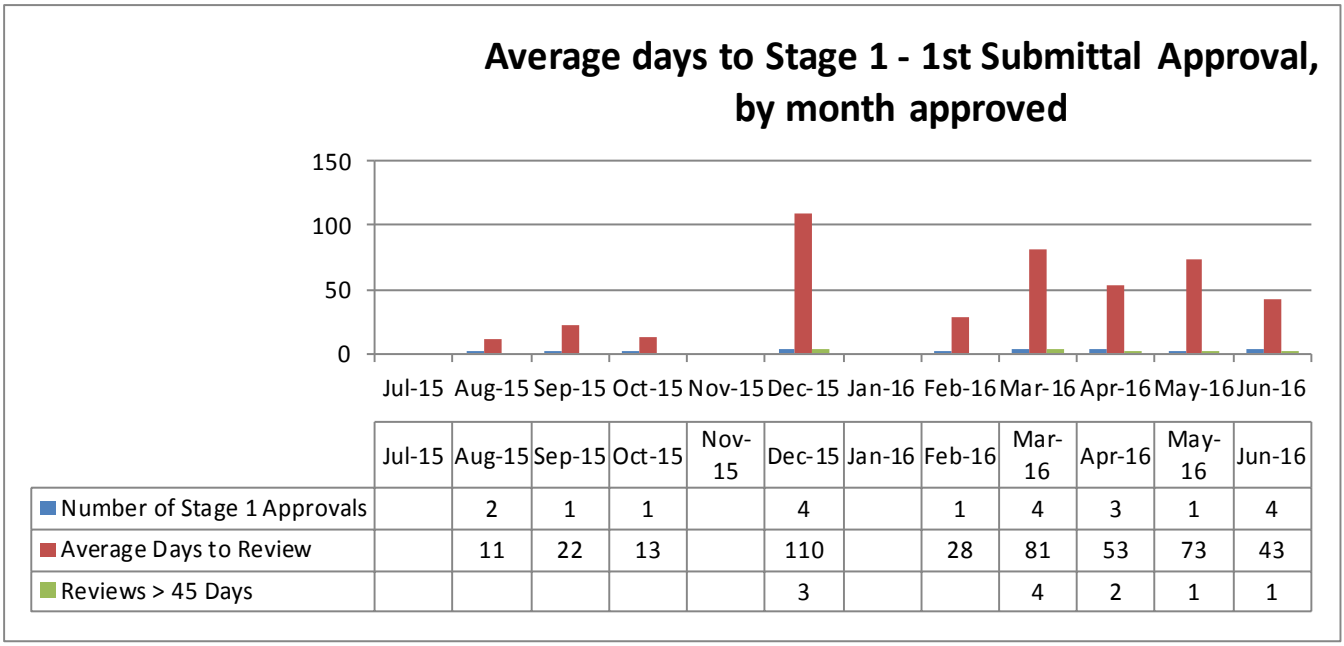
Figure 3: Average days to Stage 1 Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of S1 Approvals		3	2	2	1	6	4	3	6	7	2	11
Average Days to S1 Review		9	24	24	28	105	96	78	116	95	103	99
Reviews > 45 Days						5	3	2	6	6	2	6

Note: Some Stage 1 reviews may include multiple submissions.

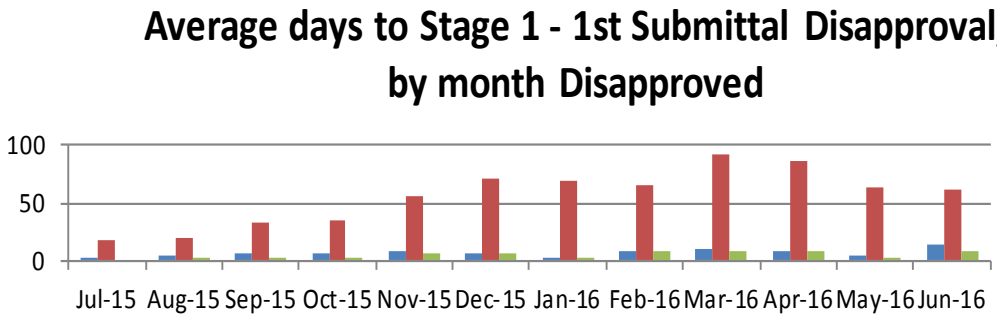
Figure 4: Average days to Stage 1 - 1st Submittal Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of Stage 1 Approvals		2	1	1		4		1	4	3	1	4
Average Days to Review		11	22	13		110		28	81	53	73	43
Reviews > 45 Days						3			4	2	1	1

Plan Review Processing days: July 2015 through June 2016

Figure 5: Number of Stage 1 - 1st Submittal Disapproval, by month Disapproved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of S1 Disapprovals (1st submittal)	1	4	6	7	8	7	3	9	10	9	4	14
Average Days to Review	18	19	33	35	56	72	70	66	93	87	63	62
Reviews > 45 Days		1	2	2	6	6	3	8	8	9	3	9

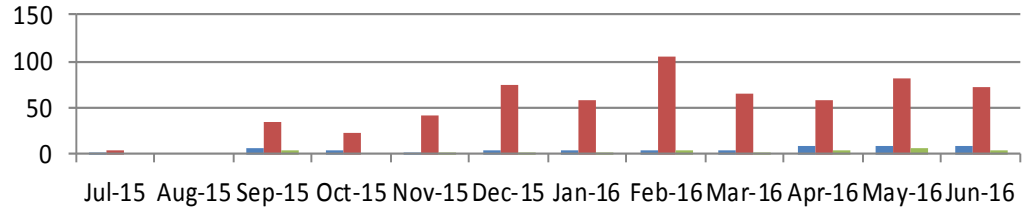
Stage 2

Table 3: Summary of Stage 2 Plan status

	Number	Average days	# reviews > 45 days	% reviews > 45 days
Stage 2 Received	68			
Stage 2 Approved	52	62	28	54%
Stage 2 Approved (1st submittal)	33	47	14	42%
Stage 2 Approved (2nd submittal)	16	85	11	69%
Stage 2 Approved (3rd submittal)	3	102	3	100%
Stage 2 Rejected (1st submittal)	26	49	13	50%
Stage 2 Rejected (2nd submittal)	4	31	3	75%
Stage 2 Not Approved	7	118	6	86%
Stage 2 Not Reviewed	8	37	3	38%
Cancelled	1			

Plan Review Processing days: July 2015 through June 2016

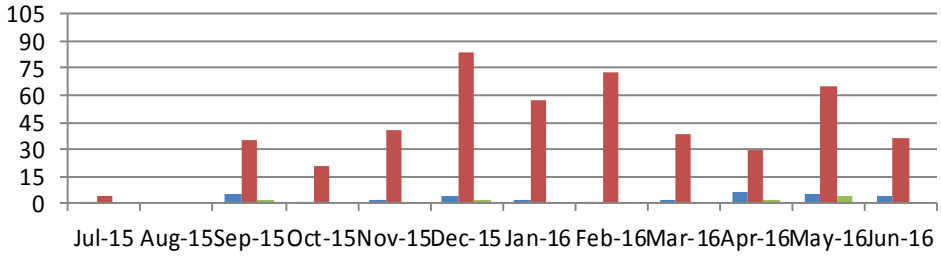
Figure 5: Average days to Stage 2 Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Number of S2 Approvals	1		7	3	2	5	3	3	3	9	8	8
Average days Stage 2 review	4		34	24	41	74	58	104	66	58	82	73
Reviews > 45 Days			3		1	2	2	3	1	4	7	5

Note: Some Stage 2 reviews may include multiple submissions

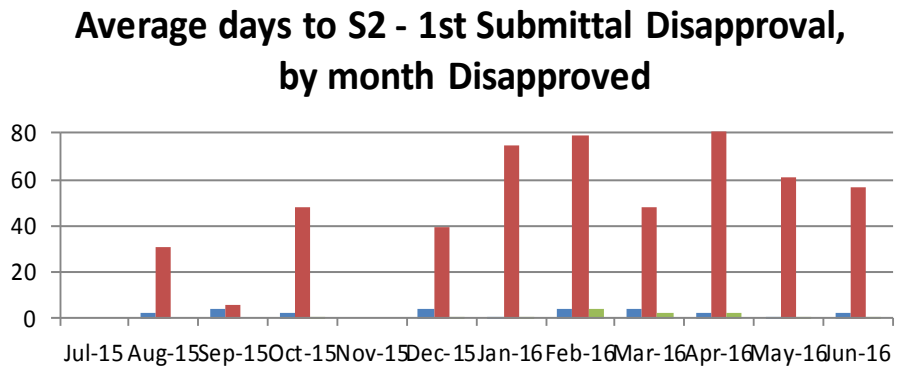
Figure 6: Average days to Stage 2 - 1st Submittal Approval, by month approved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Nuber of S2 - 1st Submittal Approval	1		5	1	2	4	2	1	2	6	5	4
Average Days to Review	4		35	21	41	84	57	73	39	30	65	36
Reviews > 45 Days			2		1	2	1	1		2	4	1

Plan Review Processing days: July 2015 through June 2016

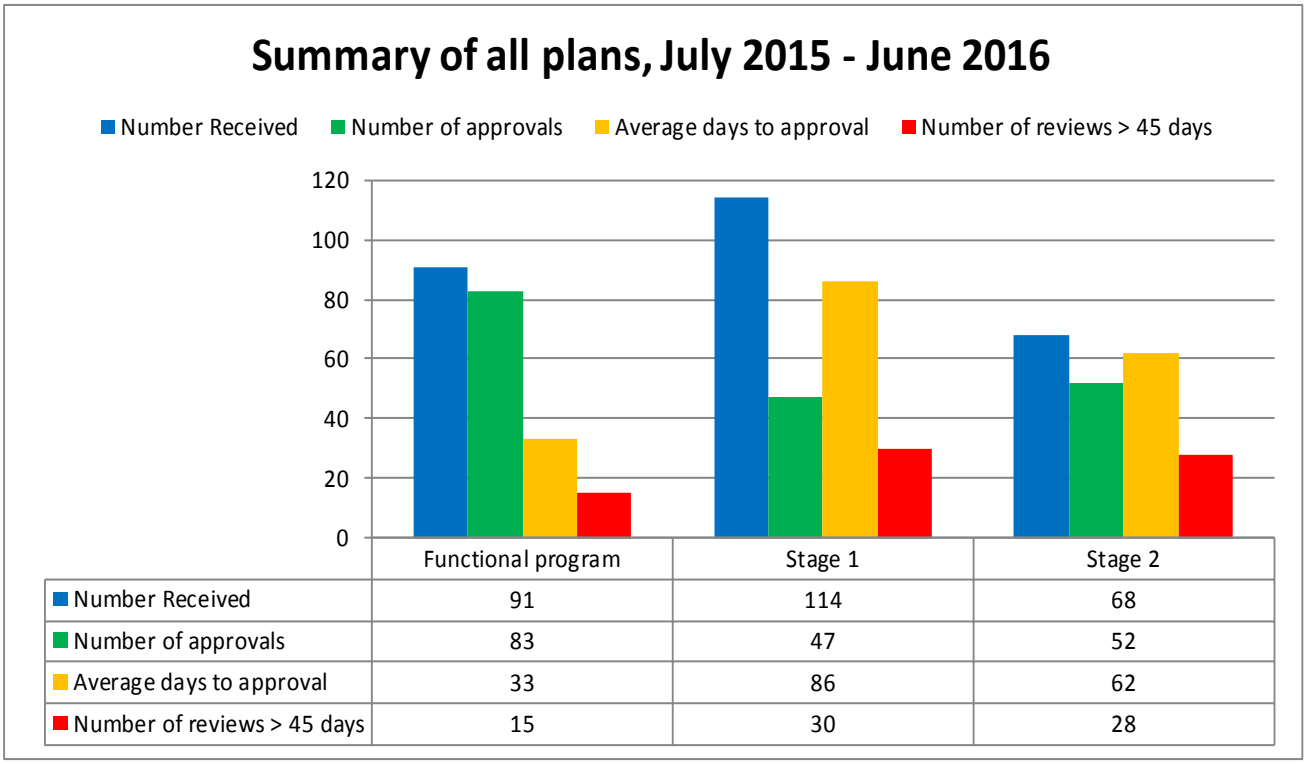
Figure 7: Average days to Stage 2 - 1st Submittal Disapproval, by month disapproved



	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Nuber of S2 - 1st Submittal Disapproval		2	4	2		4	1	4	4	2	1	2
Average days to review		31	6	48		39	75	79	48	90	61	57
Reviews > 45 Days				1		1	1	4	2	2	1	1

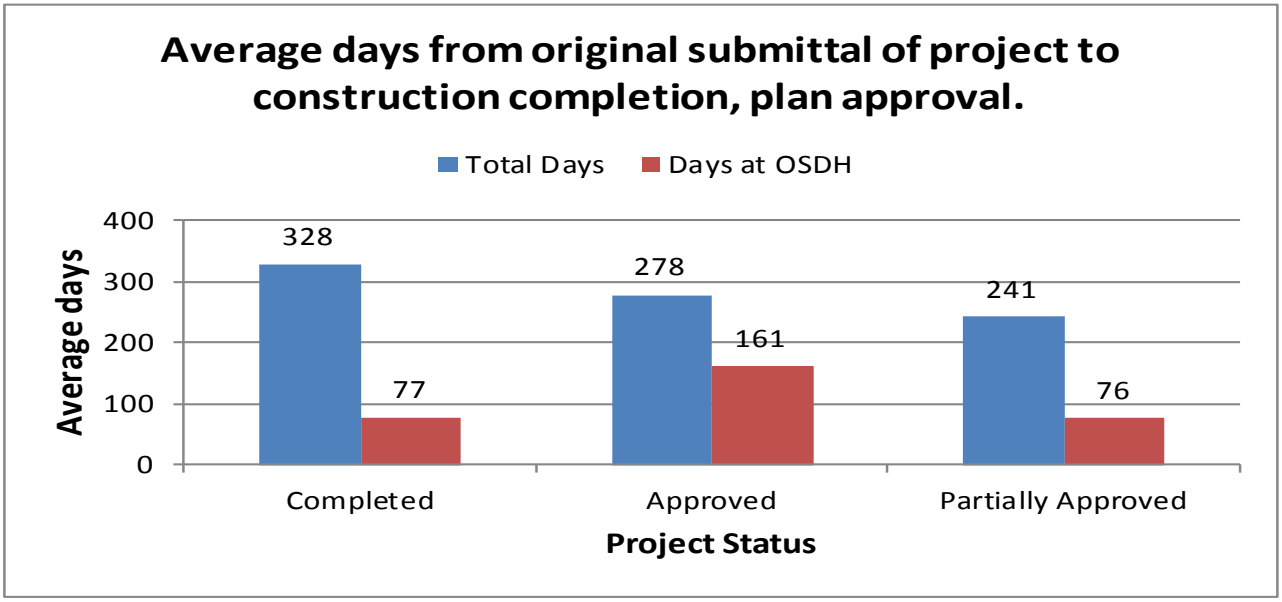
Plan Review Processing days: July 2015 through June 2016

Figure 8: Average days to approval of plans, by stage



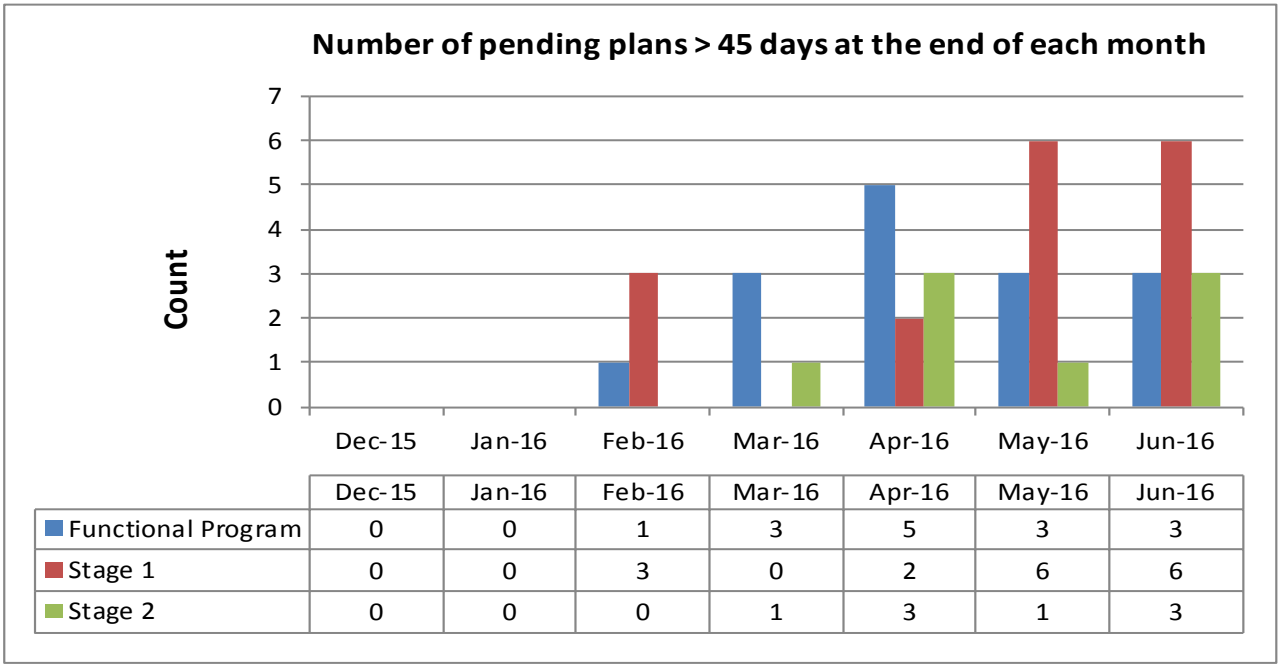
	Functional program	Stage 1	Stage 2
Number Received	91	114	68
Number of approvals	83	47	52
Average days to approval	33	86	62
Number of reviews > 45 days	15	30	28

Figure 9: Average days from original submittal of project to construction completion, plan approval.



Plan Review Processing days: July 2015 through June 2016

Figure 10: Number of plans pending for > 45 days at the end of each month



	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Functional Program	0	0	1	3	5	3	3
Stage 1	0	0	3	0	2	6	6
Stage 2	0	0	0	1	3	1	3

Note: The backlog of submittals pending >45 days was cleared effective July 11, 2016.

Table 4: Number of Projects by cost categories

Cost	Frequency	Percent	Average processing days
<= $50,000	13	12%	67
$50,001 - 100,000	7	7%	114
$100,001 - 500,000	31	29%	82
$500,001 - 1,000,000	16	15%	134
$1,000,001 - 5,000,000	28	26%	70
$5,000,001 - 10,000,000	1	1%	69
$10,000,001 - 15,000,000	6	6%	21
> $15,000,000	4	4%	78

Plan Review Processing days: July 2015 through June 2016

Table 5: FP received on Template

Received on Template	Count	Percent	Average processing days
Yes	30	33%	33
No	60	67%	33

Table 6: Simultaneous submission of FP and Stage 1 plan

Simultaneous submission	Count	Percent	Average processing days
Yes	59	69%	20
No	26	31%	21

Oklahoma State Department of Health
Creating a State of Health

Core Public Health Priorities
Public Health Imperatives
Mandated Inspections and Investigations

AIM: An opportunity exists to ensure the Oklahoma State Department of Health implements a clear process for Protective Health Services programs to comply with the laws, rules and standards for effective public health law enforcement programs. This effort should increase compliance rates of:

- Inspection frequency mandates, starting with 98%-100% of programs in compliance, moving to 100% beginning July 1, 2015, and maintaining 100% through 2020;

- Process mandates, starting with 0% of programs systematically assessed for compliance at February 26, 2015, moving through 30% of programs assessed for compliance with laws at July 1, 2015, and reaching 100% of programs assessed for compliance with laws by December 1, 2015; and moving for 15% semi-annual increases in the percentage of processes in compliance with mandates, starting July 1, 2015, through 2020.

- Programs subject to the Public Health Accreditation Board's administrative authority moving to 100% compliance with accreditation standards by January 1, 2017; and

- All programs whether or not subject to the Public Health Accreditation Board's administrative authority moving to 100% equivalence with accreditation standards by January 1, 2020.

This is important to work on immediately because effective public health law enforcement programs serve to promote and protect the public health. The baseline measurement is defined in the following metric: percentages of inspections, processes and programs in compliance with applicable laws, rules and standards.