STATE BOARD OF HEALTH

OKLAHOMA STATE DEPARTMENT OF HEALTH

NCED National Center for Employee Development
Conference Room J
2801 East State Highway 9
Norman, OK 73071-1104

August 15-17, 2014

Ronald Woodson, President of the Oklahoma State Board of Health, called the 392nd special meeting of the Oklahoma State Board of Health to order on Friday, August 15th, 2014, at 7:01 p.m. The final agenda was posted at 11:00 a.m. on the OSDH website on August 14, 2013; at 10:55 a.m. on the OSDH building entrance on August 14, 2014; and at 1:00 p.m. on the National Center for Employee Development Building entrance on August 14, 2014.

ROLL CALL

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

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

Visitors in attendance: See list

Call to Order and Opening Remarks
Dr. Woodson called the meeting to order. He thanked all distinguished guests and staff for their attendance. He acknowledged special guests in attendance for the meet and greet as well as the Board meeting.

Dr. Woodson kicked off the retreat with a brief presentation. The theme for the presentation was optimism vs. pessimism. He began by highlighting the public health issues faced in the last 100 years as well as the accomplishments and advances in science and public health. Dr. Woodson described the transition from an era of infectious diseases, poor sanitation, workplace accidents, and poor food to an era of chronic diseases. Although there are still many challenges ahead, the accomplishments are encouraging. Dr. Woodson concluded with his thoughts on kicking off and ending the retreat with optimism in mind.

Dr. Woodson introduced Dr. Arnold Bacigalupo as the retreat facilitator and founder & President of Voyageur One. He briefly described the partnership between the Board and Dr. Bacigalupo explaining that Dr. Bacigalupo has been involved in the OSDH strategic planning process since 2008.

Dr. Bacigalupo thanked Dr. Krishna for the welcome. He briefly recounted the objectives of previous Board retreats since 2008 and then proceeded to discuss the 2014 retreat objectives: *Discuss the current public health landscape; and Provide strategic direction to OSDH Senior Leadership.*

Dr. Woodson extended a special thanks to Department staff and Dr. Cline for their continued quality

improvement efforts as illustrated through the Story Boards arranged in the conference room and thanked Board members for their commitment to public health.

ADJOURNMENT

Ms. Wolfe moved to adjourn. Second Mr. Starkey. Motion carried.

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

The meeting adjourned at 7:45 p.m.

Saturday, August 16, 2014

ROLL CALL

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

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

Visitors in attendance: See list

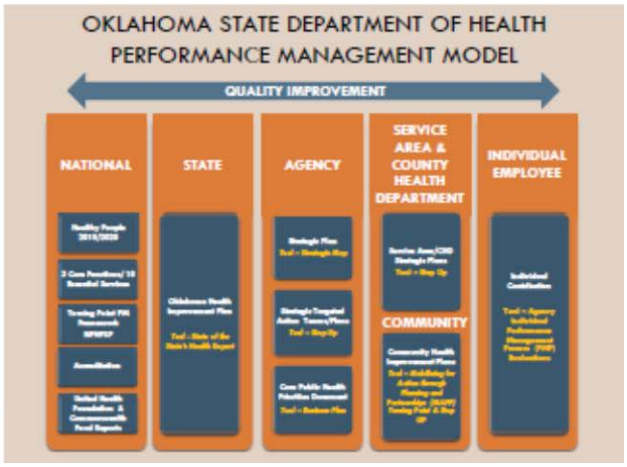
Call to Order and Opening Remarks

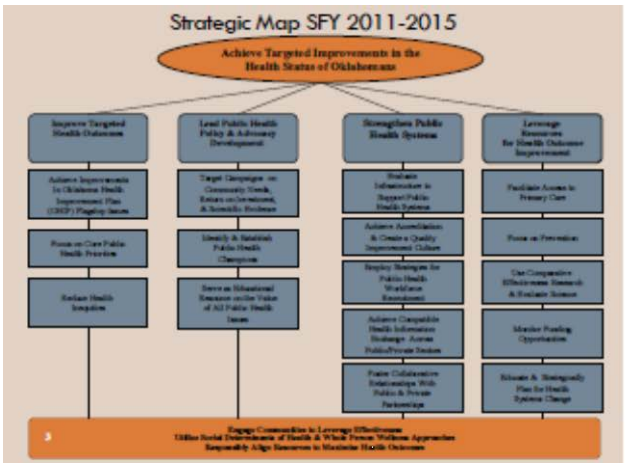
Dr. Woodson called the meeting to order at 8:30 a.m. and welcomed those in attendance. He acknowledged special guests Victoria Bartlett, First Lady of Tulsa; Bruce Dart, Director, Tulsa County Health Department; Bob Jamison of the Oklahoma City-County Health Department; Gary Raskob, Dean of the OU College of Public Health and member of the Oklahoma City-County Board of Health; Tracey Strader, Executive Director of the Tobacco Settlement Endowment Trust; and James Allen, Director, Partnerships for Health Improvement. Dr. Bacigalupo provided a brief overview of the retreat objectives and directed attention to Dr. Cline for the Strategic Plan Review presentation.

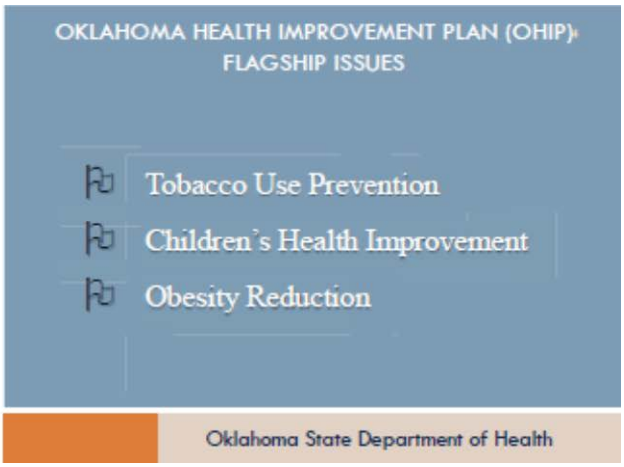
STRATEGIC PLAN REVIEW

Terry L. Cline, Ph.D., Commissioner of Health

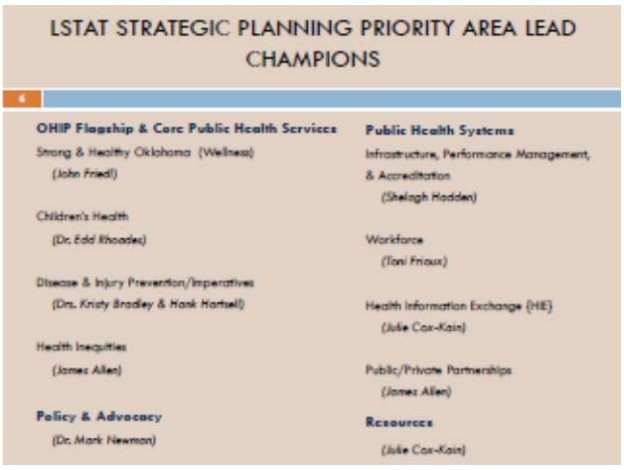

STATE BOARD OF HEALTH
ANNUAL RETREAT
SFY 2011-2015 STRATEGIC MAP UPDATE
TERRY L. CLINE, PH.D.
Oklahoma State Department of Health


OKLAHOMA STATE DEPARTMENT OF HEALTH
PERFORMANCE MANAGEMENT MODEL
QUALITY IMPROVEMENT
NATIONAL
STATE
AGENCY
SERVICE AREA & COUNTY HEALTH DEPARTMENT
COMMUNITY
INDIVIDUAL EMPLOYEE


Strategic Map SFY 2011-2015
Achieve Targeted Improvements in the Health Status of Oklahomans


OKLAHOMA HEALTH IMPROVEMENT PLAN (OHIP)
FLAGSHIP ISSUES
Tobacco Use Prevention
Children's Health Improvement
Obesity Reduction
Oklahoma State Department of Health


CORE PUBLIC HEALTH PRIORITIES
Children's Health
Infant Mortality
Prenatal Care
Disease & Injury Prevention
Immunization
Motor Vehicle Crash Deaths
Preventable Hospitalizations
Prescription Drug Deaths (New)
Imperatives
All Hazards Preparedness
Infectious Disease
Mandates
Strong & Healthy Oklahoma (Wellness)
Cardiovascular Health
Obesity
Tobacco
Oklahoma State Department of Health


LSTAT STRATEGIC PLANNING PRIORITY AREA LEAD CHAMPIONS
OHP Flagship & Core Public Health Services
Strong & Healthy Oklahoma (Wellness)
(John Friedl)
Children's Health
(Dr. Edd Rhoades)
Disease & Injury Prevention/Imperatives
(Drs. Kristy Bradley & Hank Hartsell)
Health Inequities
(James Allen)
Policy & Advocacy
(Dr. Mark Newman)
Public Health Systems
Infrastructure, Performance Management, & Accreditation
(Shelagh Hadden)
Workforce
(Toni Prioux)
Health Information Exchange (HIE)
(Julie Cox-Kain)
Public/Private Partnerships
(James Allen)
Resources
(Julie Cox-Kain)

CORE PERFORMANCE MEASURES SCORECARD PUBLIC HEALTH IMPERATIVES

7

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Inspection - % state mandated non-complaint inspections meet frequency requirements	99%	95%	100%	100%
Inspection - % state mandated complaint inspections meet time deadlines	66%	90%	91%	100%
Infectious Disease - % of immediately notifiable reports in which investigation is initiated by ADS within 1.5 minutes	95%	95%	98%	95%
Infectious Disease - Incidence of tuberculosis, pertussis, hepatitis A, and indigenously-acquired measles cases per 100,000	6.8	7.0	8.8	6.86
Preparedness - Improve State Score on National Health Security Preparedness Index by 0.5%	N/A	N/A	7.3	8.3

CORE PERFORMANCE MEASURES SCORECARD PUBLIC HEALTH PRIORITY PROGRAMS

8

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Children - # infant deaths per 1000 live births	7.5	7.5	Not Yet Released	7.4
Children - % first trimester prenatal care	66.3%	68%	68.5%	71.1%
Injury - # motor vehicle injuries in infants less than one year of age	104	97	97	93
Prevention - # preventable hospitalizations per 1000 Medicare enrollees	81	79.65	76.9	76.95
Immunization - % immunized (19-35 months)	77.3%	80%	64.7%	73.9%
Obesity - % adults who are obese	32.2%	31.7%	32.5%	29.3%
Tobacco - % adults who smoke	23.3%	23%	23.7%	21%
Cardiovascular - cardiovascular deaths/100,000	302.9	263.3	Not Yet Released	236.9

CORE PERFORMANCE MEASURES SCORECARD INFRASTRUCTURE & POLICY

9

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Accreditation - # of PHAB accredited OSDH Health Departments in OK	2	4	2	5
PH Partnerships - # certified healthy community	52	110	88	120
PH Partnerships - # certified healthy schools	314	591	533	605
Workforce - % of turnover agency wide	13.1%	12.0%	11.7%	11%
Immunization Interoperability - # of interoperable immunization systems	0	0	0	3
Policy - # community organizations supporting OHIP legislation	11	12	12	17

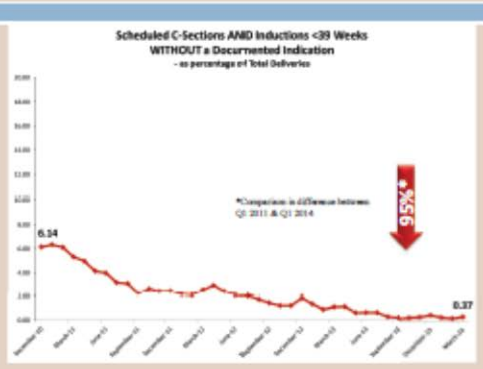
ACHIEVEMENTS

10

Oklahoma State Department of Health

Every Week Counts Initiative

11

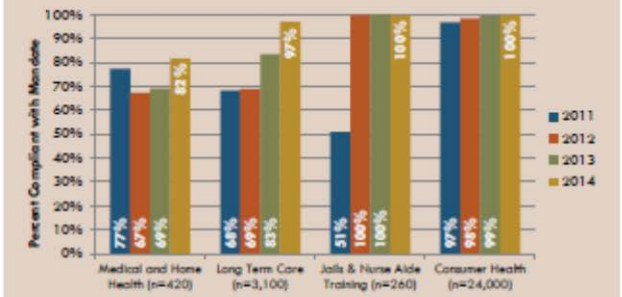


ACHIEVEMENTS

12

- In 2012, 35.2% of mothers breastfed their infants at 6 months of age – baseline in 2008 was 30.5%. Rate has risen steadily over past 5 years. Additionally, 79.8% of OK WIC mothers initiate breastfeeding and the breastfeeding initiation rate of clinics with an established Breastfeeding Peer Counselor Program is 81.8% .
- Last Trimester Smoking (CY2011) – 18% of pregnant women smoke in the last three months of pregnancy, which is down from the baseline of 19.6% in 2005, or about 650 fewer pregnant women smoking during pregnancy. PSAs, mass marketing, 5 A's and fax referral programs targeted at pregnant women are making a difference.
- Abusive Head Trauma (CY 2011) – Abusive head trauma incidents have decreased from 37 in 2007 to 31 in 2011. The number of birthing hospitals that have implemented the Period of Purple Crying parent education program to prevent abusive head trauma has increased from 1 in 2010 to 35 by the end of 2013, with 7 more in process for 2014.

Inspections and Investigations completed in compliance with frequency mandates by program areas 2011 - 2014



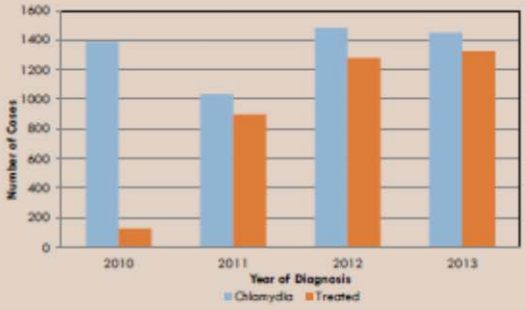
ACHIEVEMENTS
MANDATES STRATEGIC TARGETED ACTION TEAM

- Medical Facilities Service cleared a backlog of 91 laboratory inspections, completed workload required in federal law and rule in third quarter FFY2014; rolling out "Clean in 2015" project.
- Collaborated with Indian Health Service, Citizen Potawatomi Nation to approve 200 tattoo artists for convention on tribal land – 1st such collaboration among a state, IHS & tribe.
- Implemented National Fingerprint Based Background Check program; 125-150 fingerprinted/day.
- Improved high priority nursing home complaints investigated within 10 days, from 37% (2011) to 97% (2014).

POLICY ACHIEVEMENTS

- Public policy which could have negatively impacted public health outcomes and which failed to be enacted was:
  - HB 2595 – Related to raw milk sales
  - SB 1851 – Transfer of inspection of Oklahoma and Tulsa County farmers markets to the Department of Agriculture
  - SB 1915 – Expanded the ability of unlicensed entities to sell home baked goods
  - SB 1892 - Would have changed the tax on vapor products and other smokeless tobacco products to a lower rate
  - HB 2789 – Would have eliminated the Children's First program
- 2014 Legislative Session
  - Failed to get multi-unit housing smoking notification
  - Failed to get storm shelter rebate program
  - Passed SB 1602 - prohibits the sale of vapor products to minors
- 2015 Legislative Session
  - Continued focus on improvement to health outcomes for population as a whole
  - Utilize opportunities to make improvements in programs and policies

Pregnant Females Diagnosed with Chlamydia in Oklahoma & Appropriately Treated, 2010-2013



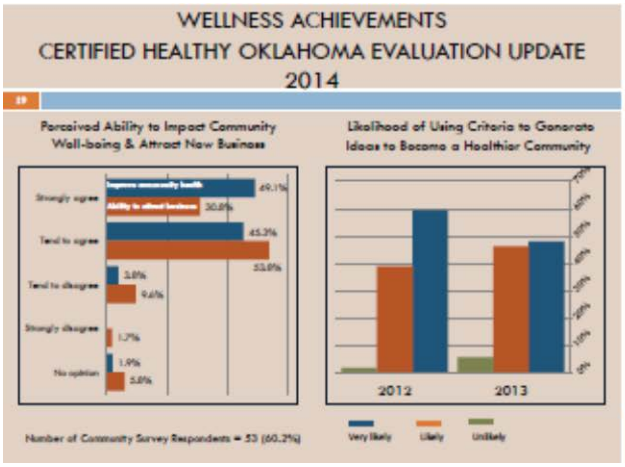
2013 National Health Security Preparedness Index (Select Measures)

Measure	National Average	Oklahoma Results
Management of Volunteers During Emergencies	3.7	6.9
Laboratory Testing	7.6	8.7
Incident Management & Multi-Agency Coordination	8.0	9.1
Medical Material Management, Distribution and Dispensing	9.3	9.8
Countermeasure Utilization and Effectiveness	8.7	8.9

http://www.nhspi.org/

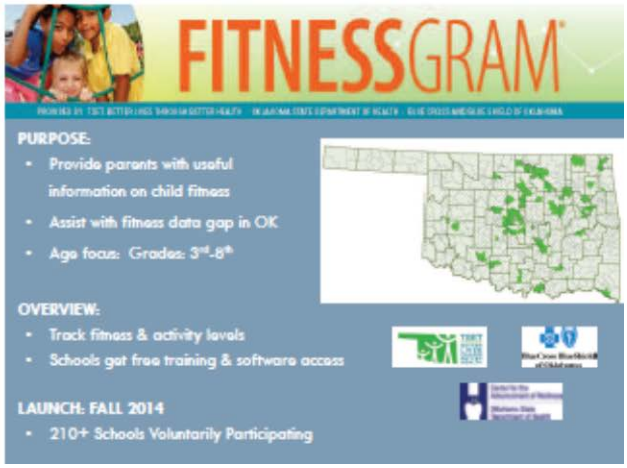
WELLNESS ACHIEVEMENTS
GROWTH IN CERTIFIED HEALTHY OKLAHOMA BY YEAR[1,2]

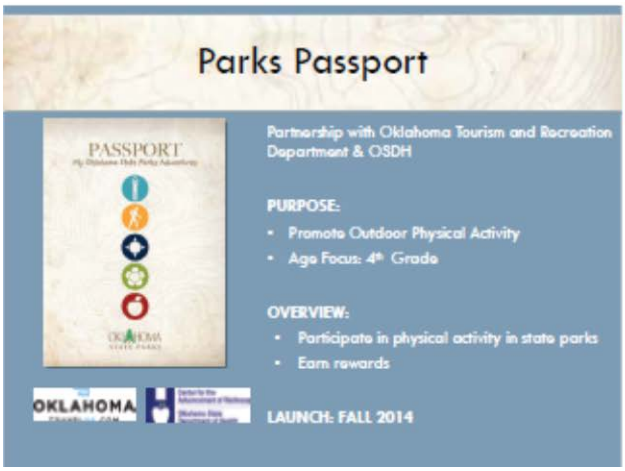
[1] Certified Health Restaurants were added in 2009
[2] Certified Health Campuses, Communities, and Schools were added in 2011

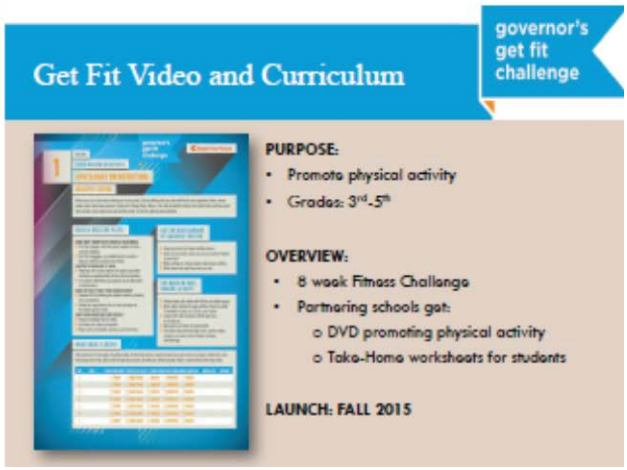

WELLNESS ACHIEVEMENTS
CERTIFIED HEALTHY OKLAHOMA EVALUATION UPDATE 2014
Perceived Ability to Impact Community Well-being & Attract New Business
Likelihood of Using Criteria to Generate Ideas to Become a Healthier Community
2012
2013

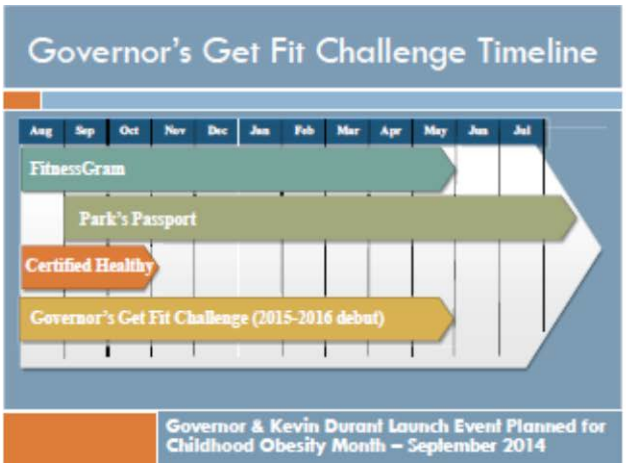

MOVING FORWARD
Upcoming Wellness Initiatives

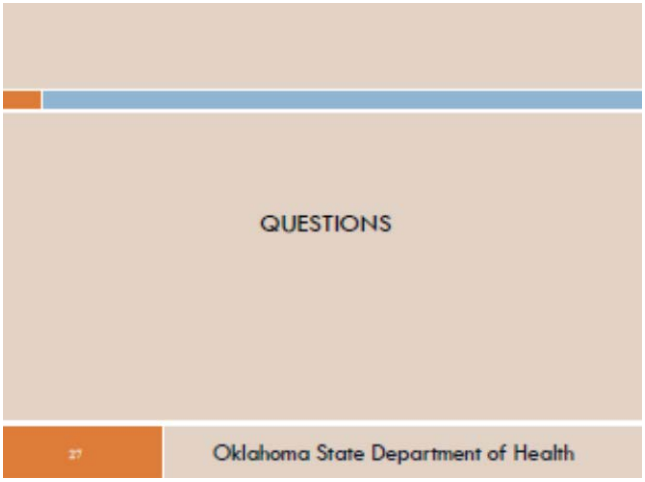

governor's get fit challenge
Parks Passport
FITNESSGRAM®
Governor's Get Fit Video


FITNESSGRAM
PURPOSE:
Provide parents with useful information on child fitness
Assist with fitness data gap in OK
Age focus: Grades: 3rd-8th
OVERVIEW:
Track fitness & activity levels
Schools get free training & software access
LAUNCH: FALL 2014
210+ Schools Voluntarily Participating


Parks Passport
PASSPORT
Partnership with Oklahoma Tourism and Recreation Department & OSDH
PURPOSE:
Promote Outdoor Physical Activity
Age Focus: 4th Grade
OVERVIEW:
Participate in physical activity in state parks
Earn rewards
LAUNCH: FALL 2014


Get Fit Video and Curriculum
governor's get fit challenge
PURPOSE:
Promote physical activity
Grades: 3rd-5th
OVERVIEW:
8 week Fitness Challenge
Partnering schools get:
DVD promoting physical activity
Take-Home worksheets for students
LAUNCH: FALL 2015



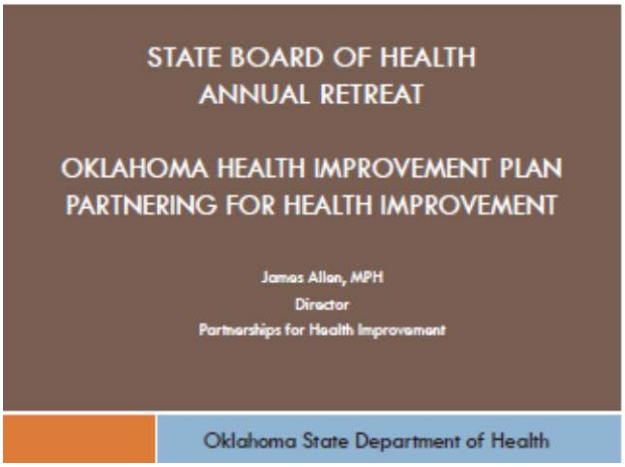


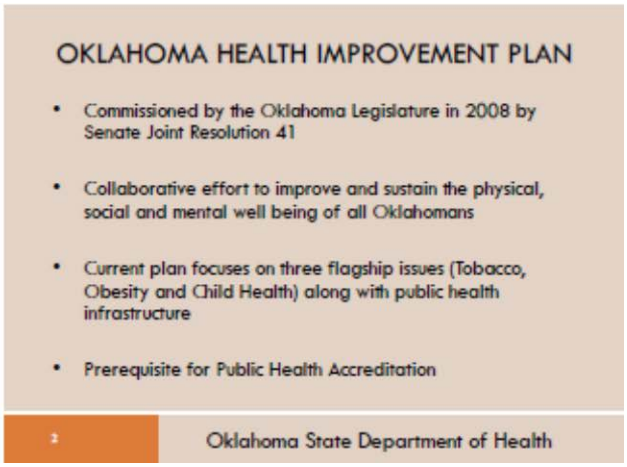
Dr. Stewart and Tim Starkey briefly discuss vaccine shortage in recent years for privately insured patients. Dr. Stewart inquired as to whether or not physicians may use Vaccines For Providers (VFC) stock and replace it or pay for it. Toni Frioux responded that unfortunately, the federal guidelines for VFC vaccines use are very strict and does not make allowances for this. Dr. Cline invited members of the Board to attend the Governor's Get Fit Launch on September 26th at the Capitol. Kevin Durant will join Governor Fallin to launch a series of challenges to Oklahoma students around physical health and fitness.

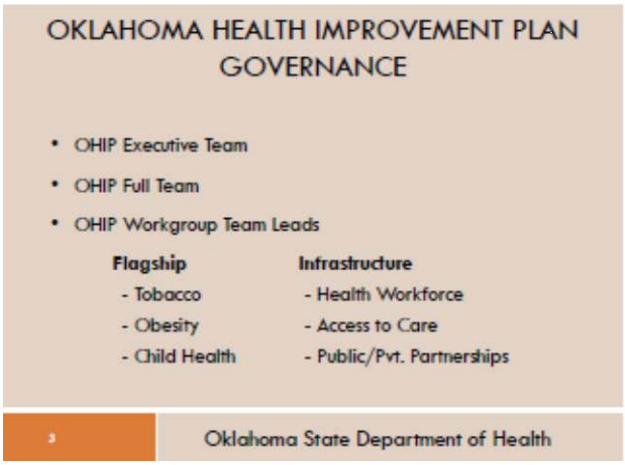
The presentation concluded.

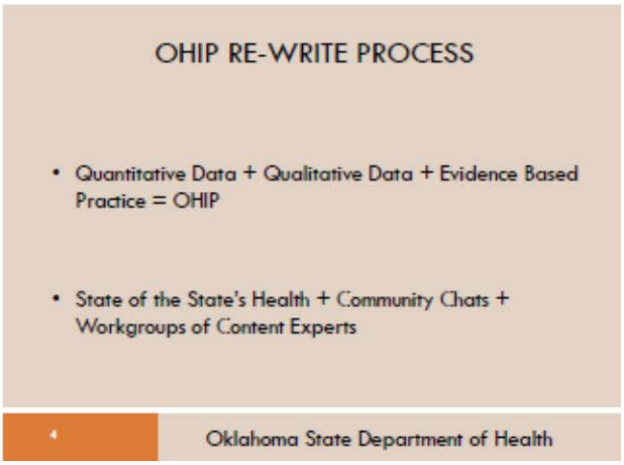
OKLAHOMA HEALTH IMPROVEMENT PLAN

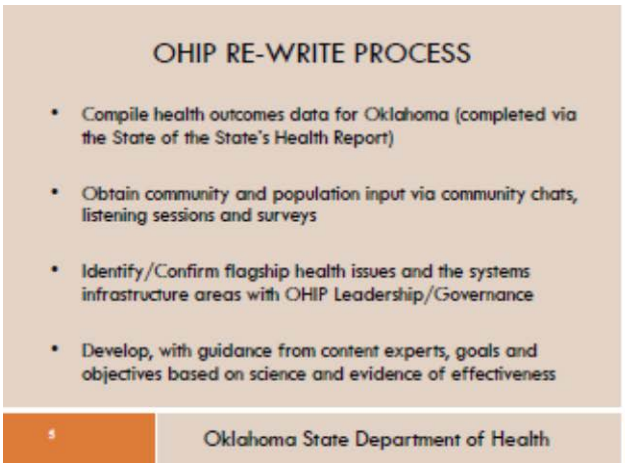
Terry L. Cline, Ph.D., Commissioner of Health; James Allen, M.P.H., Director, Partnerships for Health Improvement


STATE BOARD OF HEALTH
ANNUAL RETREAT
OKLAHOMA HEALTH IMPROVEMENT PLAN
PARTNERING FOR HEALTH IMPROVEMENT
James Allen, MPH
Director
Partnerships for Health Improvement
Oklahoma State Department of Health


OKLAHOMA HEALTH IMPROVEMENT PLAN
Commissioned by the Oklahoma Legislature in 2008 by Senate Joint Resolution 41
Collaborative effort to improve and sustain the physical, social and mental well being of all Oklahomans
Current plan focuses on three flagship issues (Tobacco, Obesity and Child Health) along with public health infrastructure
Prerequisite for Public Health Accreditation
2
Oklahoma State Department of Health

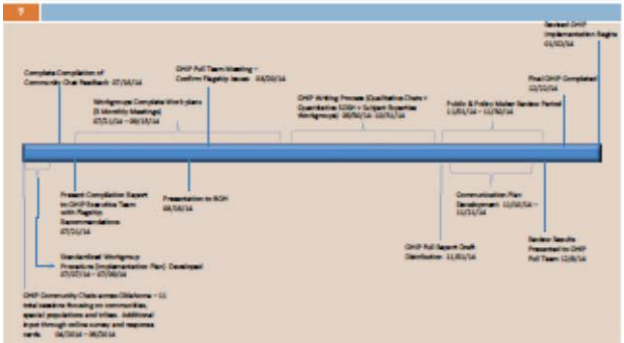

OKLAHOMA HEALTH IMPROVEMENT PLAN GOVERNANCE
OHIP Executive Team
OHIP Full Team
OHIP Workgroup Team Leads
Flagship
- Tobacco
- Obesity
- Child Health
Infrastructure
- Health Workforce
- Access to Care
- Public/Pvt. Partnerships
3
Oklahoma State Department of Health


OHIP RE-WRITE PROCESS
Quantitative Data + Qualitative Data + Evidence Based Practice = OHIP
State of the State's Health + Community Chats + Workgroups of Content Experts
4
Oklahoma State Department of Health


OHIP RE-WRITE PROCESS
Compile health outcomes data for Oklahoma (completed via the State of the State's Health Report)
Obtain community and population input via community chats, listening sessions and surveys
Identify/Confirm flagship health issues and the systems infrastructure areas with OHIP Leadership/Governance
Develop, with guidance from content experts, goals and objectives based on science and evidence of effectiveness
5
Oklahoma State Department of Health


OHIP RE-WRITE PROCESS
Compile Quantitative + Qualitative + Subject Matter Expertise into a single, comprehensive OHIP
Obtain public feedback on this OHIP with attention to the communities and populations involved in the Community Chat process
New OHIP and realigned workgroups begin implementation of action plans in January of 2015
Process will begin again in five years for 2020
6
Oklahoma State Department of Health

OHIP RE-WRITE TIMELINE



A CLOSER LOOK AT THE COMMUNITY CHAT PROCESS AND OUTCOME

COMMUNITY CHATS

General Community Chats
Tulsa- April 16 (36 attendees)
Enid- April 17 (27 attendees)
OKC- May 14 (30 attendees)
McAlester- June 5 (38 attendees)
Lawton- June 9 (45 attendees)

African American Community Chats
Tulsa- April 14 (28 attendees)
OKC- May 6 (37 attendees)

Hispanic Community Chats
OKC- May 5 (33 attendees)
Guymon- June 19 (49 attendees)

Tribal Consultations
Tahlequah- April 7 (36 attendees)
Little Axe- June 16 (47 attendees)

Total Attendance (406)
General: 176
African American: 65
Hispanic: 82
Tribal: 83

Online Surveys
English – 108
Spanish – 23

Oklahoma State Department of Health

WHAT WE'VE HEARD

- Health Access
  - Health Care (Medicaid expansion cited)
  - Preventive Services
  - Healthy Foods
  - Outlets for Physical Activity
  - Health Services/Health Education
- Social Determinants
  - Transportation
  - Economic Development/Funding
  - Education
- Behavioral Health

POPULATION-SPECIFIC FEEDBACK

- African American Community:
  - Strong community focus
  - Safety
  - Loss of inner city sports leagues and other outlets for physical activity in safe places
  - Economic development
  - Educational attainment
  - Increase focus on primary prevention

POPULATION-SPECIFIC FEEDBACK

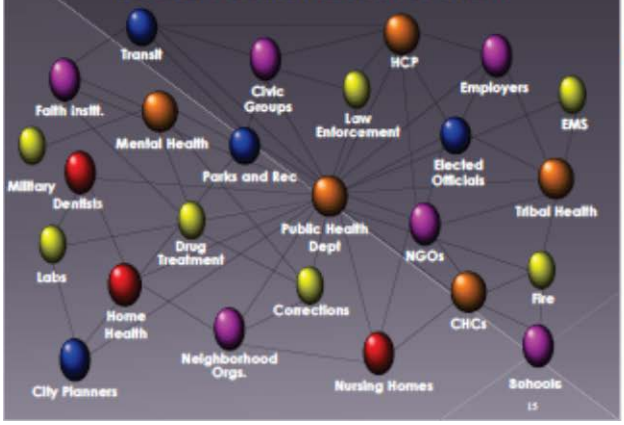
- Hispanic Community
  - Adolescent pregnancy
  - School health/health education
  - Youth are sometimes the only English speaking members of the family, which can place a burden upon them
  - Economic development
  - Family focus/involve families

TRIBAL CONSULTATION

- Tribes have developed several promising practices that they are willing to share
- Very practiced in the integration of mind, body and spirit
- Health literacy needs to be a focus
- Greater collaboration with partners will help accelerate health improvement
- Chronic disease prevalence/prevention focus (Diabetes)
- Lack of tribal-specific data

SOCIAL – ECOLOGICAL MODEL

LOCAL PUBLIC HEALTH SYSTEM



WHAT DRIVES HEALTHY BEHAVIOR?

Individual/Social Factors

- Cost/Benefit Analysis
  - Probability of outcomes
  - Perception of those outcomes
  - Alignment of outcomes with social norms
  - Motivation to comply with those norms
- Locus of Control
  - Perceived ability to change course
  - Past experience, trauma
  - Influence over circumstances
- Proximity to Immediate Needs
  - Separation of behavior and reward
  - Additive behaviors

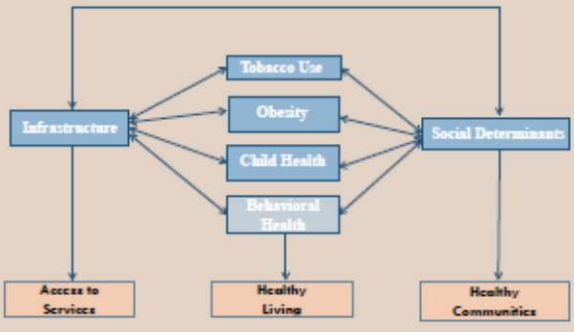
Environmental Factors

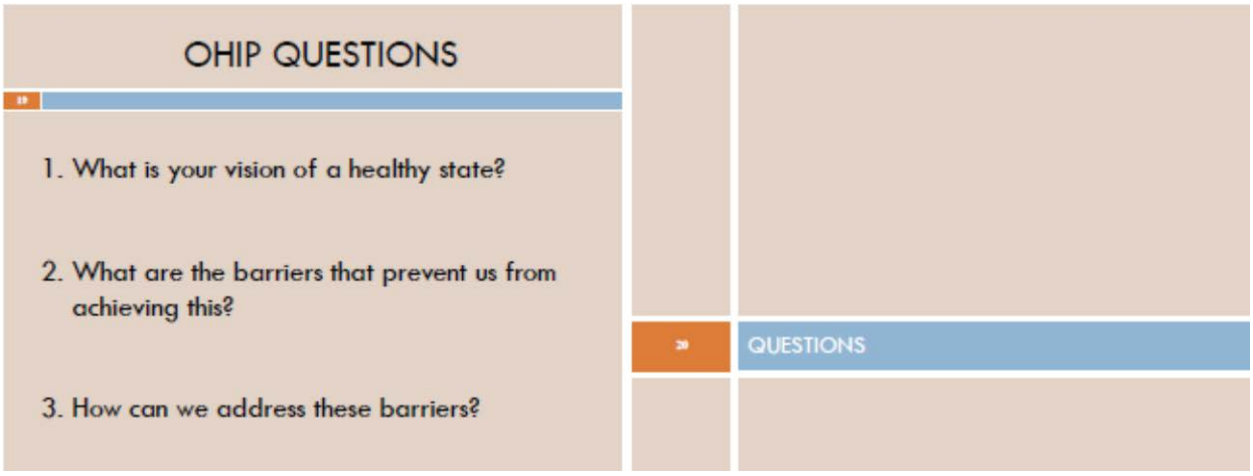
- Path of Least Resistance
  - Is the healthy choice the easy choice?
- Location, Location, Location
  - Physical and geographical barriers
  - Proximity to social support
- Living Conditions, Safety, Stressors
- Access to Necessary Resources (not just health care)
- Policy Supportive of Health

PROPOSED HEALTHY OKLAHOMA FRAMEWORK

Access to Services	Healthy Living	Healthy Communities
Oklahomans' access to information and health or social services that can help them achieve better if not the best health outcomes possible.	Focused on equipping Oklahomans to take an active role in improving their own health and supporting their families and friends in making healthy choices.	Speaks to community members and their institutions working together to positively impact the natural as well as human-formed conditions that influence health and/or risk for injury.

OHIP THEORETICAL MODEL





The presentation concluded.

Dr. Bacigalupo asked the groups to consider the following questions and report out. Below are the common themes for each group.

Vision of Healthy State

Vision for a healthy state included: improvements to the built environment to include bike trails, pedestrian walkways, safe parks, green space; community gardens, farmers markets, and healthy corner stores; tobacco and/or smoke free indoor and outdoor public spaces; access to care; 100% of citizens covered by insurance; low crime, good transportation; and high performing schools.

Barriers

Culture; politics, lack of education; inadequate information systems; lack of knowledge regarding health and healthcare and difference between the two; balancing individual rights versus public good; lack of funding, resources and infrastructure; insurance providers are unwilling to provide rebates or incentives on improved health outcomes; lack of community champions; poverty; and complacency.

Recommended Strategies

Policy; population outreach using diverse media formats; engage communities of faith; engage education systems to begin health education earlier; support policies that support the healthy choice as the first choice; modify healthcare system to increase focus on prevention; rebates and economic incentives for healthy habits and improved health outcomes; conditions on the use of food stamps; targeted 10-20 minute community presentations by the Board members; robust and highly interactive health risk assessment for individuals using cell phone technology; establish healthy living pact.

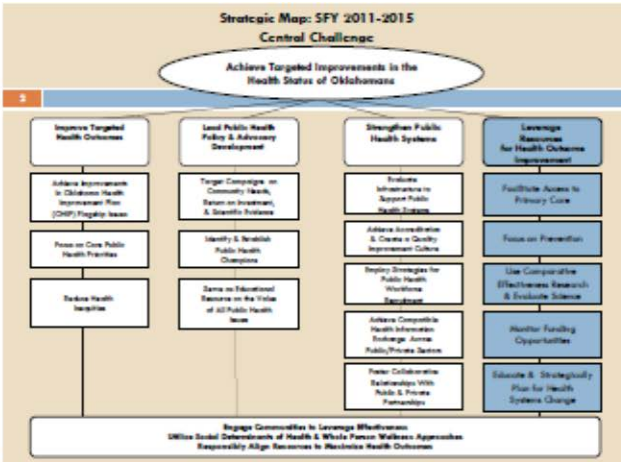
OHIP ACCESS TO CARE

Julie Cox-Kain, M.P.A., Senior Deputy Commissioner

OKLAHOMA STATE DEPARTMENT OF HEALTH

LEVERAGE RESOURCES FOR HEALTH OUTCOME IMPROVEMENT YEAR END REVIEW

August 2014



3 Overview of the ACA

Patient Protection and Affordable Care Act

Enacted March 23, 2010, and upheld by the Supreme Court June 28, 2012, the PPACA (ACA) established the Health Insurance Exchange Marketplace (opened Oct. 1, 2013) to help individuals and small business obtain health insurance coverage (including stand-alone dental)

Original provisions include:

- Provides premium tax credits and cost-sharing reductions for low and middle-income individuals who purchase health insurance through a Marketplace
- Provides a tax credit to eligible small businesses
- Originally required an expansion of Medicaid to cover additional adults and children with low incomes
- Requires individuals to obtain health insurance (or an exemption) or pay a tax penalty

Patient Protection and Affordable Care Act

- Simplifies the eligibility rules for Medicaid and the Children's Health Insurance Program (CHIP)
- Requires most individuals to purchase health insurance or pay a tax penalty
- Required large businesses to provide health insurance to employees or pay a tax penalty
- Guaranteed issue (no pre-existing condition exclusion)
- American Indian/Alaskan Native (AI/AN) special provisions
- Extended children's coverage on parent's health plan to age 26
- No co-pay for A & B rated clinical preventive services
- Medical Loss Ratio limitations – caps on administrative and overhead costs of insurance companies (80% - 85% must be spent on healthcare)
- Created the Prevention and Public Health Fund

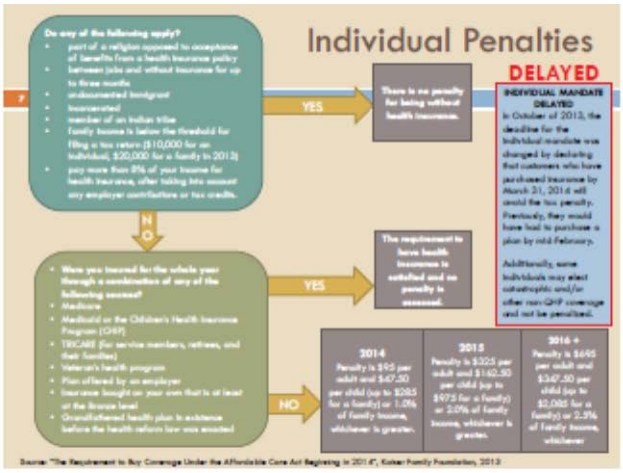
ACA Delays and Changes for Individuals

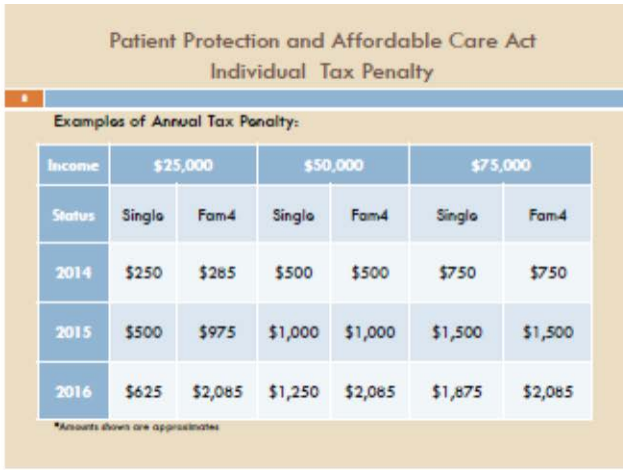
More than 40 significant changes have been made to the ACA:

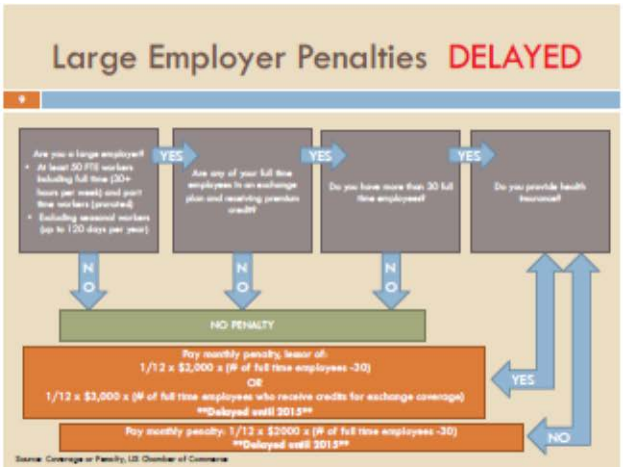
16 passed by Congress, 2 by the Supreme Court, and 24 made by the Administration

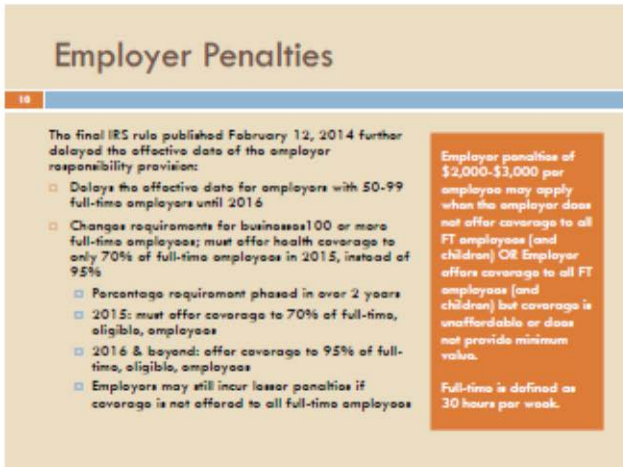
Top 10 Changes or Delays

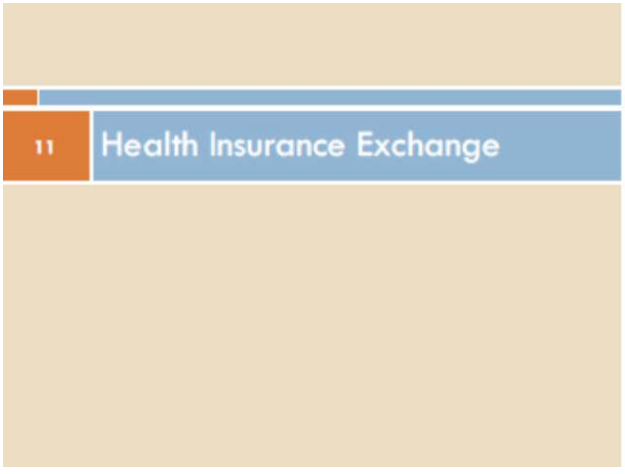
- Individual Mandate
- Employer Coverage Levels/Penalties
- Requirements for Qualified Health Plans
- Concessions for hardship waiver, individual mandate and qualified health plan if plan cancelled
- SHOP Delay
- SHOP Employee choice
- Basic Health Plan
- Deductibles
- Cost Sharing
- Risk Corridor Program

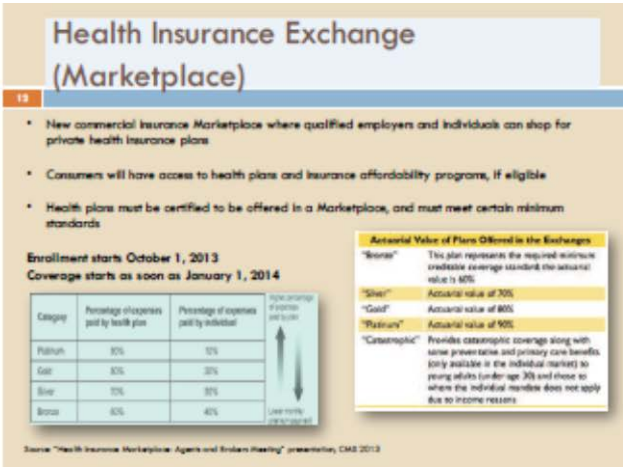

Individual Penalties
DELAYED
YES
NO
INDIVIDUAL MANDATE DELAYED
2014
2015
2016 +


Patient Protection and Affordable Care Act
Individual Tax Penalty
Examples of Annual Tax Penalty:
Income
$25,000
$50,000
$75,000
Status
Single
Fam4
2014
$250
$285
$500
$500
$750
$750
2015
$500
$975
$1,000
$1,000
$1,500
$1,500
2016
$625
$2,085
$1,250
$2,085
$1,875
$2,085
*Amounts shown are approximates


Large Employer Penalties DELAYED
YES
NO
NO PENALTY
YES
NO


Employer Penalties
The final IRS rule published February 12, 2014 further delayed the effective date of the employer responsibility provision:
Delays the effective date for employers with 50-99 full-time employers until 2016
Changes requirements for businesses100 or more full-time employees; must offer health coverage to only 70% of full-time employees in 2015, instead of 95%
Percentage requirement phased in over 2 years
2015: must offer coverage to 70% of full-time, eligible, employees
2016 & beyond: offer coverage to 95% of full-time, eligible, employees
Employers may still incur lesser penalties if coverage is not offered to all full-time employees
Employer penalties of $2,000-$3,000 per employee may apply when the employer does not offer coverage to all FT employees (and children) OR Employer offers coverage to all FT employees (and children) but coverage is unaffordable or does not provide minimum value.
Full-time is defined as 30 hours per week.


11
Health Insurance Exchange


Health Insurance Exchange (Marketplace)
New commercial insurance Marketplace where qualified employers and individuals can shop for private health insurance plans
Consumers will have access to health plans and insurance affordability programs, if eligible
Health plans must be certified to be offered in a Marketplace, and must meet certain minimum standards
Enrollment starts October 1, 2013
Coverage starts as soon as January 1, 2014
Actuarial Value of Plans Offered in the Exchanges
"Bronze"
"Silver"
Actuarial value of 70%
"Gold"
Actuarial value of 80%
"Platinum"
Actuarial value of 90%
"Catastrophic"

Health Insurance Exchange (Federally Facilitated Marketplace)

13

- Healthcare.gov is the federally-facilitated marketplace (FFM) where qualified employers and individuals can shop for private health insurance plans
- Issuers of Qualified Health Plans (QHP) for the FFM in Oklahoma include Aetna, Blue Cross Blue Shield of Oklahoma, CommunityCare HMO, GlobalHealth and Coventry Health Care of Kansas
- Over 60 QHPs are offered: 18 Bronze Plans, 18 Silver Plans, 18 Gold Plans and 7 Platinum Plans

Number of Individuals Who Selected a Marketplace Plan through the FFM (Oct. 1, 2013 – April 19, 2014)

State	Total	American Indian/Alaska Native	Asian	Native Hawaiian/Pacific Islander	African-American	Latino	White	Multiracial	Unknown/Other
Oklahoma	69,221	1,638	3,588	51	4,762	3,952	36,960	1,793	16,477

CMS does not yet have comprehensive and accurate data about effectuated enrollment (that is, the number of individuals who have effectuated their enrollment and gained coverage through payment of the first premium). However, some issuers (i.e. BCBS Association, Aetna, WellPoint, Health Care Services Corporation, and Blue Shield of California) have made public statements believing that nationally 80% to 90% of the people who have selected a Marketplace plan have made premium payments. Additionally, some issuers voluntarily decided to provide flexibility in the deadline by which exchange enrollees must pay their first month's premium.

Source: ASPE Issue Brief: For the period October 1, 2013 – March 31, 2014 Health Insurance Marketplace, Summary Enrollment Report, http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment_Apr2014/ib_2014apr_enrollment.pdf, p. 24

Oklahoma Enrollment

ACA Enrollment Totals
Market Place Selections: 69,221
Change in Medicaid/CHIP Enrollment: 38,278

14

CHARACTERISTICS OF MARKETPLACE PLAN SELECTIONS:

By Gender:	Number	% of Total
Female	38,472	56%
Male	30,732	44%
Subtotal With Known Data	69,204	100%
Unknown	17	N/A

By Age:	Number	% of Total
Age < 18	4,389	6%
Age 18-25	7,583	11%
Age 26-34	12,712	18%
Age 35-44	11,983	17%
Age 45-54	14,990	22%
Age 55-64	17,564	25%
Age 265	153	0%
Subtotal With Known Data	69,377	100%
Unknown	N/A	N/A
Ages 18 to 34	20,275	29%
Ages 0 to 34	24,674	36%

Source: ASPE Issue Brief: For the period October 1, 2013 – March 31, 2014 Health Insurance Marketplace, Summary Enrollment Report

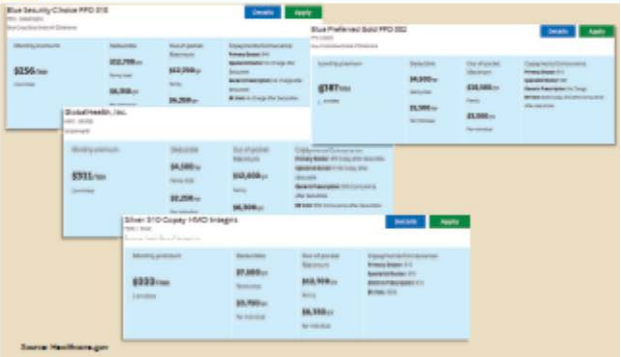
First Premium Payments

15

- In April the nation's largest health insurers were surveyed and reported that 15-20% of their new customers had not yet paid their first premium – which meant they were not yet covered
- Because more than 3 million people signed up for coverage that didn't begin until May 1 or later; their premiums weren't due until at least April 30
- Final numbers regarding payment of initial premiums have not yet been reported

Healthcare.gov Example Premiums & Deductibles

16



Source: Healthcare.gov

Enrollment Assisters

17

The Affordable Care Act (ACA) creates several new entities to advise and help consumers make health insurance purchase decisions. Those entities include Navigators, Certified Application Counselors, Assisters, and Web Brokers.

- **Navigators** Help persons apply and enroll in the exchanges; understand and choose the right health plan; conduct outreach and provide information and services in a fair, impartial and culturally competent manner; They must maintain training in eligibility, enrollment and all insurance affordability program specifications (exchange funded)
- **Certified Application Counselors (CACs)** Each state exchange must have a CAC program, with similar training and privacy standards as Navigators and Assisters (not funded)
- **In-Person Assisters (IPAs)** are very similar to Navigators and CAC's, and must have the same standards and comply with the same standards; The IPA program is an additional program states may choose to provide (not federally funded)
- **Web brokers or Web entity brokers (WBE)** are state licensed entities who assist consumers to access health coverage through an issuer-based or Marketplace pathway or public-facing website

Navigators

18

Oklahoma Community Health Centers, Inc.	Little Dixie Community Action Agency, Inc.	Latino Community Development Agency
A consortium comprised of a variety of non-profit organizations providing assistance in Oklahoma	Part of a consortium with 14 additional Community Action Agencies across Oklahoma	A community based non-profit located in Oklahoma City
Serving 40 counties in 27 cities	Serving 43 counties	Serving 9 counties Canadian, Grady, Logan, Cleveland, McClain, Garvin, Lincoln, Pottawatomie, and Tulsa counties
Target groups/activities: Small business & business groups; Outreach and community events; Health fairs; Special population events by assisters partners; Store-specific outreach events run by partners	Target groups/activities: Provides enrollment assistance to low income families and individuals in local communities in Oklahoma; Analyzes on leveraging existing staff with local ties to be trained as Navigators	Target groups/activities: Largely dedicated to providing culturally competent bilingual services to the Latino community in the state

Source: https://localhelp.healthcare.gov/

Oklahoma HB3286

19

Signed into law by Governor Fallin on May 21, 2014, Oklahoma's House Bill 3286 is largely in-line with federal regulations but does provide some additional protections for Oklahoma consumers.

Oklahoma state Navigator law provides:

- Navigators must complete a background check and pay an annual licensing fee (up to $50)
- Requires Navigators to "record the name and contact information for each individual or group whom the navigator assists in enrolling in the exchange and the date of contact, to provide such information to the navigator entity immediately and to retain that information for up to three years;" This may contradict federal rules that Navigators never retain personally-identifying information – including names and contact information – after their session with the enrollee has ended, in order to protect enrollee privacy
- Navigators cannot provide recommendations about particular health plans or benefits or solicit anyone known to be currently insured

20 Enrollment by Market

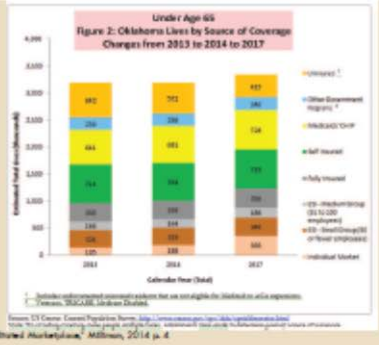
Insurance Market Migration

21

The size of the Oklahoma insurance market is expected to increase 5% between 2013 and 2017 (146,000).

The size of the individual market is projected to increase by 162% (220,000).

These increases are driven by premium assistance, the individual mandate, and enrollment into the FFM.



Source: "Oklahoma's Federally Facilitated Marketplace," Milliman, 2014 p. 4

Oklahoma Insurance Market Enrollments

23

Population Under Age 65 Best Scenario FFM 2013 & 2014

Market	2013	2013	2014 Pre-Launch	2014 Post-Launch	2017 Pre-Launch	2017 Post-Launch
Individual	108,677	134,985	399,999	188,177	681,812	355,464
SHI - Small Group	353,710	323,852	347,489	319,270	366,011	329,645
SHI - Medium Group	181,468	166,193	187,651	163,801	203,126	186,276
SHI - Large Group Fully Insured	368,447	354,700	362,769	339,883	376,741	350,114
SHI - Large Group Self Insured	779,768	714,125	756,929	703,847	788,024	719,028
Medicaid / CHIP	524,877	641,458	592,655	681,498	643,814	727,338
Other Government Programs	261,695	250,175	264,762	250,175	273,961	260,574
Uninsured	644,843	645,816	425,088	570,833	268,084	435,145
Total Non-Aged Population	3,228,485	3,187,404	3,187,422	3,187,484	3,490,575	3,353,583

Source: Milliman FFA 2013 report, figure 13 p. 23 & Milliman FFA 2014 updated report, figure 13 p. 27

Enrollment and Change in Medicaid/CHIP Among Non-Expansion States During FFM Open Enrollment Period

23

States that Declined Medicaid Expansion vs. US

State	Pre-ACA Uninsured under 65	Enrolled in FFM	Ratio of FFM enrollees to uninsured	% of Enrollees that qualify for Financial Assistance	% Under Age 35	Change in Medicaid/ CHIP Enrollment	Ratio of Change in Medicaid/ CHIP enrollment to uninsured
Oklahoma	641,916	69,221	10.8%	79.2%	55.6%	38,278	6.0%
Kansas	356,486	57,013	16.0%	78.7%	58.2%	22,498	6.3%
Texas	6,353,793	733,757	11.5%	83.8%	57.8%	3,214	0.1%
Louisiana	809,709	101,778	12.6%	87.8%	55.3%	-7,904	-1.0%
National	47,587,345	8,019,763	16.9%	84.7%	54.3%	4,824,044	10.2%

- Variance in Medicaid/CHIP enrollment on a state-by-state basis is also substantial.
- Louisiana reported a reduction in enrollment while Kansas and Oklahoma saw a 6% increase.
- Kansas and Oklahoma had a much larger portion of the population eligible for Medicaid, however, state reported methodology used to assess these figures may vary.
- Delays in transfer of data from FFM to State may result in impact report.

Source: Milliman FFA 2014 updated report, figure 19 & 20 pp. 30-31

Non-QHP Enrollment

24

Estimates show that the nearly 70,000 Oklahomans enrolled through the FFM.

Calculations suggest 50,200 Oklahomans will have non-ACA compliant plans in 2014.

Figure 27
Estimated Oklahoma Population with non-QHP in the Individual Market by FPL
Non-Aged Population Only (Under Age 65)

	2013	2014	2017
Under 138%	17,800	11,100	3,200
138% to 399%	13,000	5,000	1,000
400% to 599%	11,200	5,500	1,300
600% to 399%	13,500	6,000	1,200
Over 400%	28,500	22,600	3,500
Total	80,900	50,200	10,000

Source: These figures are modeled and projected using Milliman's proprietary actuarial models.

Figure 28
Estimated Oklahoma Population with non-QHP in the Individual Market by Age Bracket
Non-Aged Population Only (Under Age 65)

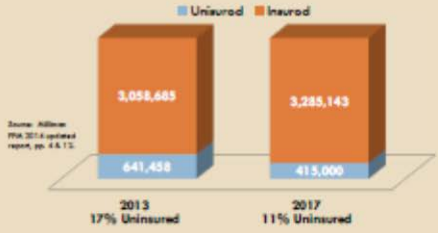
	2013	2014	2017
19 and Under	16,500	9,000	2,500
20 to 34	28,500	21,100	3,500
35 to 49	28,500	15,100	1,800
50 to 64	33,100	5,000	2,200
Total	80,900	50,200	10,000

Source: These figures are modeled and projected using Milliman's proprietary actuarial models.

All age brackets see substantial decreases in number of non-ACA compliant plans over time. The majority of the 20 to 34 age bracket are expected to keep the non-ACA compliant plans until the penalties introduced in 2017 entice them to select plans that are more comprehensive.

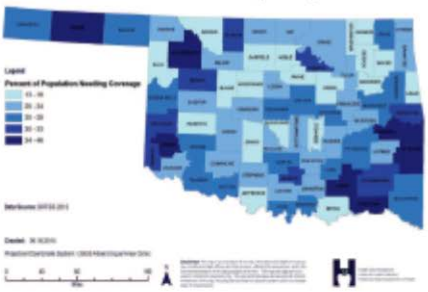
The Uninsured in Oklahoma

The uninsured population is expected to decrease by approximately 35% from 2013 to 2017. This reduction will be driven by the movement of this population to the individual FFM due to premium assistance and the increasing individual mandate tax penalty.

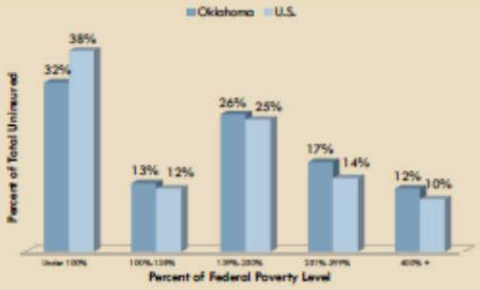


Oklahoma Total estimated population 3.7M

Map of Uninsured



Uninsured by Income Level, 2012



Employer Sponsored Coverage: National vs. Oklahoma

National: between 2000 and 2011, coverage for children through ESI declined by 12 percentage points while public coverage for children grew by 14.6 percentage points over this same period according to analysis conducted by the Economic Policy Institute in 2012. Despite this declining trend, ESI remains an important source of coverage, particularly for higher income families.

In 2012:
50% of all children or 36.9 million children were covered by ESI.

In 2014:
47% of all children or 37.8 million children are projected to be covered by ESI.

Oklahoma: The largest concentration of health insurance coverage is from ESI plans, providing health insurance to approximately 1.54 million individuals or about 42% of the total population. These plans include members insured by small and large employers through fully insured programs and self-insured large employers (more than 100 employees). Employer sponsored insurance (ESI) is projected to continue as a significant source of coverage despite implementation of the FFM. Milliman projects that ESI enrollment in Oklahoma will remain essentially flat.

Business Health and Wellness Survey

Goals: Collect information about Oklahoma employers' perspectives on health insurance and wellness programs as they relate to workforce costs, productivity, and other business needs, with a particular interest in matters related to access to healthcare services for Oklahomans.

The information collected through the study will be used to support preparation of the Oklahoma Health Improvement Plan (OHIP) and health and wellness related workforce policy in the state.

At the core is the question "What needs, perceptions, resources and capabilities do businesses have when it comes to working toward a healthier Oklahoma?"

Milliman will conduct an information collection campaign that includes: an online survey of a broad base of employers, telephone polling of selected employer representatives, facilitated focus groups, and targeted discussions with two large employers identified by the State to provide an overview of the Oklahoma market.

Stakeholders include The Oklahoma State Department of Health (OSDH), in cooperation with:

- Governor Mary Fallin
- Oklahoma Department of Commerce (ODC)
- State Chamber of Oklahoma Research Foundation ("The Chamber")
- Oklahoma Employment Security Commission (OESC)
- Insure Oklahoma

30 Premium Impacts – Individual Market

Comparison of Pre-ACA and 2014 Rating Characteristics in Oklahoma

31

Characteristic	Pre-ACA Benefits / Rating: Individual	Pre-ACA Benefits / Rating: Small Group	2014 Rating Change
Covered Benefits	Generally comprehensive	Generally comprehensive	Essential Health Benefits (EHB) as mandated by the federal government. Includes pediatric dental and vision.
Attained Age	No restrictions.	No restrictions.	Referred to as the 3:1 age rating restriction, where an insurance provider may not charge a 64-year-old higher than three times what they charge a 21 year-old.
Gender	Ratings by gender.	Ratings by gender.	Gender may no longer be used to determine rates.
Health Status (Pre-existing conditions)	Allowed including exclusion/elimination of coverage.	Allowed with a limit of +/- 25% per class.	Not allowed. Guaranteed Issue.
Household Income (% of federal poverty level)	No federal subsidies	No federal subsidies	Federal subsidies in the individual market for people between 100% - 400 %of the Federal Poverty Level. Applies to non-expansion states, including OK).
Tobacco	No restrictions.	No restrictions.	The ACA allows for tobacco users to be charged up to 50% more in premiums than similar non-tobacco users.
ACA Taxes and Fees	N/A	N/A	New PPM fees, insurer fees, and a research trust fee will be applicable to individual and small group markets.
Transitional Reinsurance Program	N/A	N/A	Both individual and group plans pay an estimated $5.25 per member per month (for all group plans, whether in or out of the PPM). Only individual plans are eligible for benefits.

Source: Milliman ACA IA OK P.9

Percentage Change for Individual Medical Coverage

33

Sample Rate Impact by Pricing Cell

ACA Provision	2015 Plan 1: Urban to 2014 Bronze	2015 Plan 1: Rural to 2014 Bronze	2015 Plan 1: Urban to 2014 Silver	2015 Plan 1: Rural to 2014 Silver	2015 Plan 2: Urban to 2014 Bronze	2015 Plan 2: Rural to 2014 Bronze	2015 Plan 2: Urban to 2014 Silver	2015 Plan 2: Rural to 2014 Silver	Average Rate Change
Age 27, Healthy Male	35%	43%	86%	107%	13%	16%	61%	69%	55%
Age 27, Healthy Female	1%	7%	46%	55%	-17%	-13%	20%	26%	16%
Age 27, Unhealthy Male	6%	11%	54%	62%	-13%	-9%	26%	32%	21%
Age 27, Unhealthy Female	-21%	-17%	14%	21%	-36%	-32%	6%	-1%	-10%
Age 57, Healthy Male	28%	-4%	11%	27%	-41%	-58%	0%	-23%	-13%
Age 57, Healthy Female	-26%	-1%	15%	32%	-39%	-32%	4%	-10%	0%
Age 57, Unhealthy Male	-44%	-25%	-13%	-1%	-54%	-55%	-29%	-40%	-33%
Age 57, Unhealthy Female	-42%	-23%	-10%	3%	-53%	-47%	-27%	-38%	-29%
Average Rate Change -- Age 27	5%	11%	53%	61%	-14%	-10%	25%	32%	
Average Rate Change -- Age 57	-35%	-13%	1%	15%	-47%	-43%	-18%	-26%	

*Benefit changes were adjusted to account for 3 months of medical trend equal to 2%.

Source: Milliman ACA IA OK P.23

Family Coverage in the Individual Market

33

Pre & Post-ACA Monthly Rates

Plan participants	2013 Plan 1 Urban	2013 Plan 1 Rural	2013 Plan 2 Urban	2013 Plan 2 Rural	Bronze Urban	Bronze Rural	Silver Urban	Silver Rural
Healthy Dad, age 37	$156	$136	$190	$169	$188	$176	$272	$254
Healthy Mom, age 37	$211	$188	$258	$229	$188	$176	$272	$254
Healthy Son, age 12	$206	$183	$251	$224	$96	$90	$139	$131
Unhealthy Daughter 12	$163	$133	$200	$166	$96	$90	$139	$131
Pre Subsidy Total	$836	$741	$1,019	$908	$568	$532	$822	$770

Post-Subsidy Premium Cost

Family Income Level	Bronze Urban	Bronze Rural	Silver Urban	Silver Rural
100% FPL	$836		$17.2	$0* / $271*	$0*
200% FPL		$741	$225	$29	$479	$267
300% FPL		$1,019	$537	$341	$791	$579
400%+ FPL		$908	$568	$532	$822	$770

Source: Milliman P.25 ACA IA OK

* Family total premiums may differ slightly from HealthCare.gov premiums due to rounding.
* Families at or below 138% of FPL are eligible to enroll their children in Medicaid. This should be considered in terms of premiums and cost sharing, but will not affect the maximum allowed premium for the family.

Health Status and Gross Medical Cost PMPY for Individual FFM and Non-FFM Markets

34

Premium Subsidy Scenarios Under Age 65

		2013	2014	2015
High Take-Up Scenario				
Individual FFM	Gross Medical Cost PMPY	N/A	$7,225	$7,890
Individual Non-FFM	Gross Medical Cost PMPY	$3,690	$4,820	$5,564
Average		$3,690	$6,022	$6,727
Individual FFM	Health Status	N/A	1.083	1.017
Individual Non-FFM	Health Status	0.955	0.942	0.867
Average		0.955	1.0125	0.942
Best Estimate Scenario				
Individual FFM	Gross Medical Cost PMPY	N/A	$7,254	$8,243
Individual Non-FFM	Gross Medical Cost PMPY	$3,690	$4,897	$5,573
Average		$3,690	$6,076	$6,907
Individual FFM	Health Status	N/A	1.085	1.041
Individual Non-FFM	Health Status	0.955	0.945	0.867
Average		0.955	1.015	0.954
Low Take-Up Scenario				
Individual FFM	Gross Medical Cost PMPY	N/A	$7,203	$8,383
Individual Non-FFM	Gross Medical Cost PMPY	$3,690	$4,905	$6,026
Average		$3,690	$6,054	$7,205
Individual FFM	Health Status	N/A	1.088	1.05
Individual Non-FFM	Health Status	N/A	1.088	1.05
Average		0.955	0.941	0.9

Source: Milliman PPM OK pp.36, 37

Source: These figures are modeled and projected using Milliman's proprietary actuarial models.

Best Scenario of Subsidies PMPY for PMM Individuals

Type of Assistance	2014	2015
Total	$5,707	$6,390
Premium Assistance	$5,256	$5,881
Cost Sharing Assistance	$451	$508

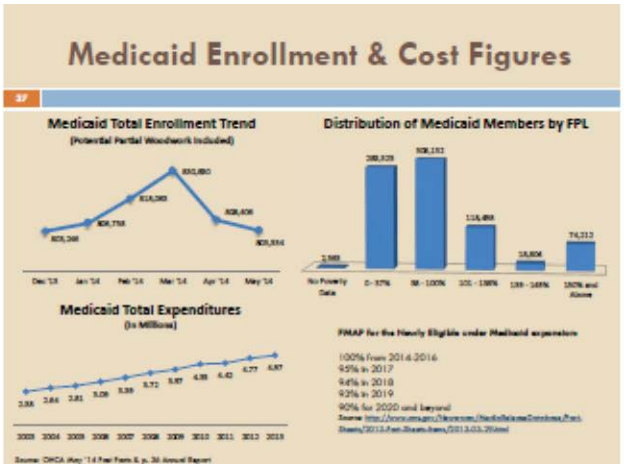
Individual Medical Summary of Modeled Benefit Plans

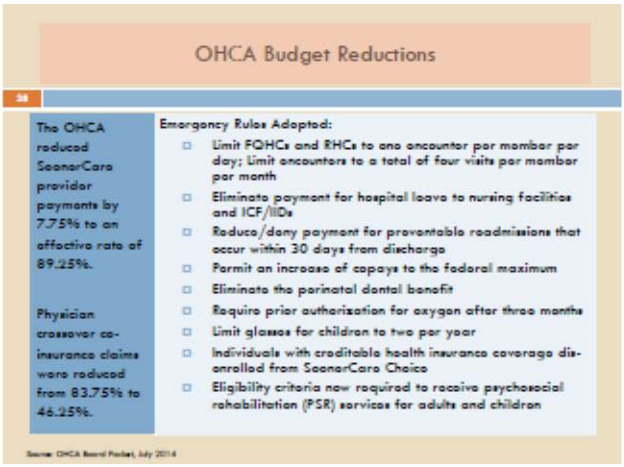
35

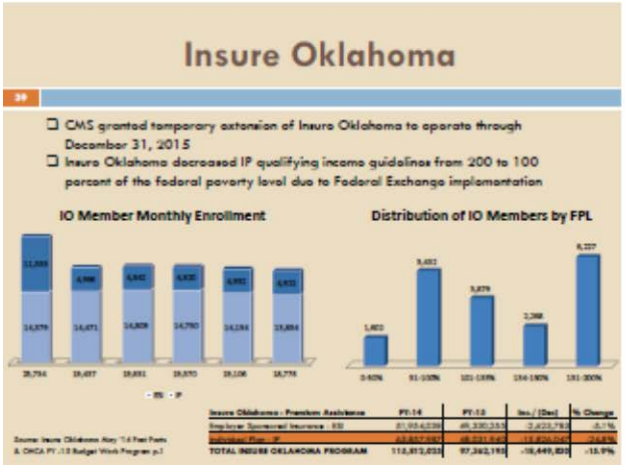
Plan Benefits*	Sample Plans 2013: Plan Option 1*	Sample Plans 2013: Plan Option 2*	Sample Plans 2014: Bronze*	Sample Plans 2014: Silver*
Actuarial Value	62%	69%	60%	70%
Individual Deductible	$2,500	$1,000	$6,000	$3,000
Family Deductible	$7,500	$3,000	$12,700	$9,000
Plan Coinsurance	20% (up to 40% depending on tier)	20% (up to 40% depending on tier)	0%	20%
Out of Pocket Max (n Network/after deductible)	$2,500	$2,500	$6,000 Single / $12,700 Family	$6,350 Single* / $12,700 Family
Inpatient Hospital	20% (up to 40% depending on tier)	20% (up to 40% depending on tier)	0% coinsurance	20% coinsurance
Office Visit Copay: PCP/SCP	$35	$35	$0	$35
Emergency Room/Urgent Care	$100	$100	$0	20% coinsurance
Preventive	$0	$0	$0	$0
Maternity	Optional Benefit	Optional Benefit	$0	$35 per visit/ 20% coinsurance
MH/SA	50% coinsurance	50% coinsurance	$0	$35 per visit/ 20% coinsurance
Prescription Drugs	50% Coinsurance, not subject to deductible	50% Coinsurance, not subject to deductible	$0	Preferred Generic:$10; Non-Preferred Generic:$20; Preferred Brand:$50; Non-Preferred Generic:$100; Specialty:$150; Not subject to the plan deductible.

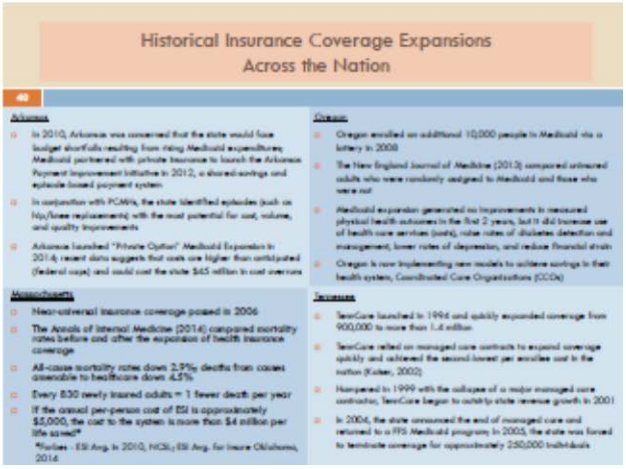
* See Milliman ACA IA OK p. 35 for disclosures

36 Medicaid

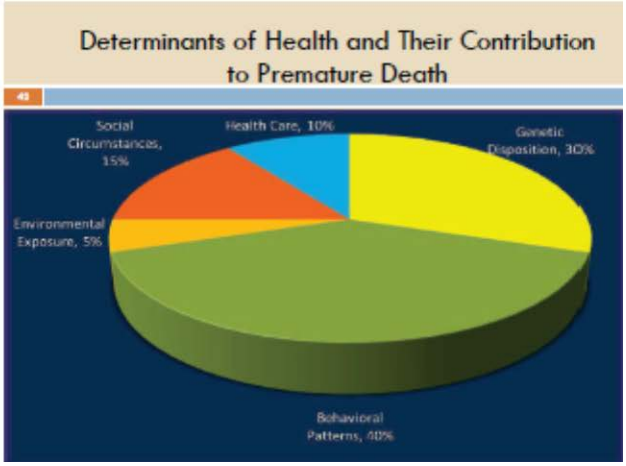

Medicaid Enrollment & Cost Figures
37
Medicaid Total Enrollment Trend
(Potential Partial Woodwork Included)
Distribution of Medicaid Members by FPL
Medicaid Total Expenditures
(In Millions)
FMAP for the Newly Eligible under Medicaid expansion
100% from 2014-2016
95% in 2017
94% in 2018
93% in 2019
90% for 2020 and beyond


OHCA Budget Reductions
38
The OHCA reduced SoonerCare provider payments by 7.75% to an effective rate of 89.25%.
Physician crossover co-insurance claims were reduced from 83.75% to 46.25%.
Emergency Rules Adopted:
Limit FQHCs and RHCs to one encounter per member per day; Limit encounters to a total of four visits per member per month
Eliminate payment for hospital leave to nursing facilities and ICF/IIDs
Reduce/deny payment for preventable readmissions that occur within 30 days from discharge
Permit an increase of copays to the federal maximum
Eliminate the perinatal dental benefit
Require prior authorization for oxygen after three months
Limit glasses for children to two per year
Individuals with creditable health insurance coverage dis-enrolled from SoonerCare Choice
Eligibility criteria now required to receive psychosocial rehabilitation (PSR) services for adults and children


Insure Oklahoma
39
CMS granted temporary extension of Insure Oklahoma to operate through December 31, 2015
Insure Oklahoma decreased IP qualifying income guideline from 200 to 100 percent of the federal poverty level due to Federal Exchange implementation
IO Member Monthly Enrollment
Distribution of IO Members by FPL
TOTAL INSURE OKLAHOMA PROGRAM


Historical Insurance Coverage Expansions Across the Nation
40
Arkansas
Massachusetts
Oregon
Tennessee


41
Oklahoma Health Improvement Plan Framework


Determinants of Health and Their Contribution to Premature Death
42
Social Circumstances, 15%
Health Care, 10%
Genetic Disposition, 30%
Environmental Exposure, 5%
Behavioral Patterns, 40%

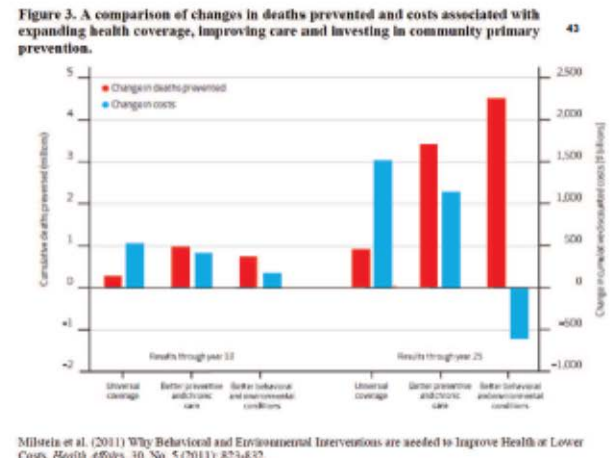
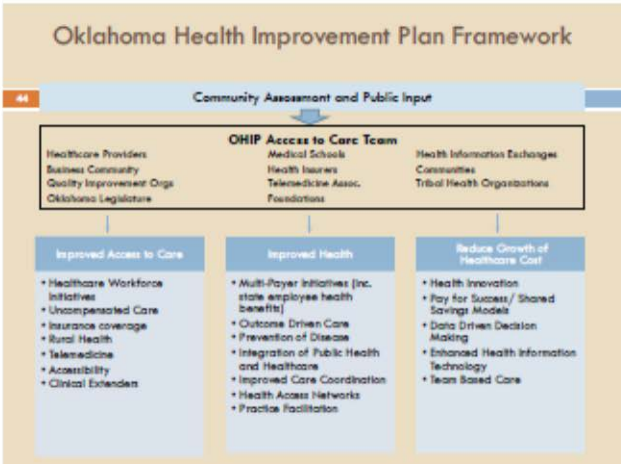
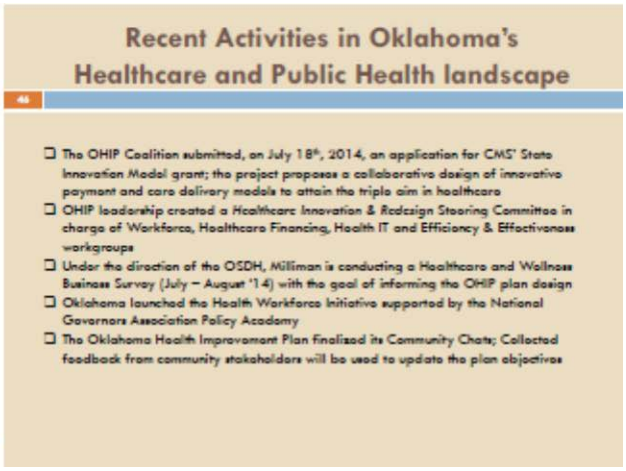
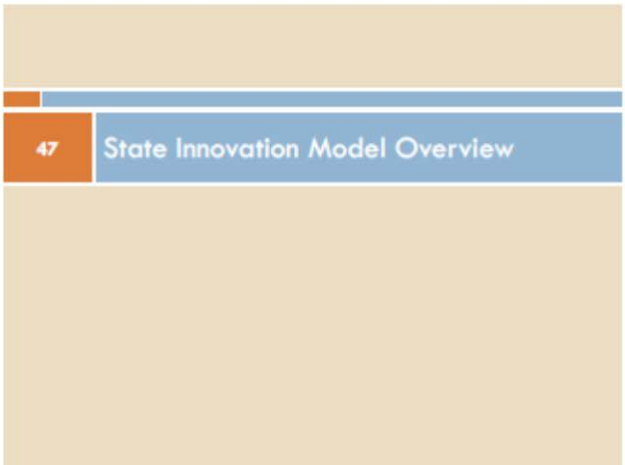


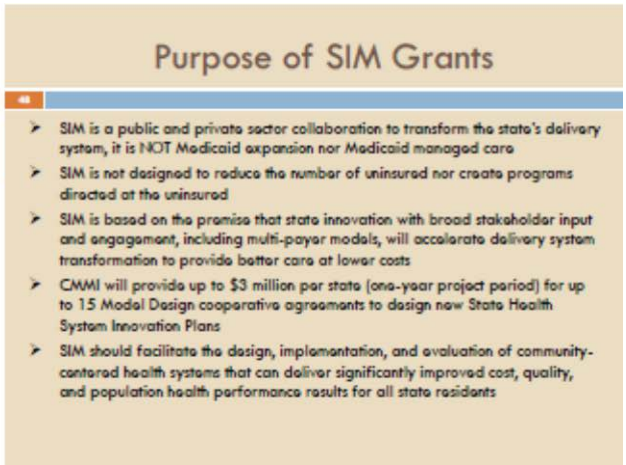
Figure 3. A comparison of changes in deaths prevented and costs associated with expanding health coverage, improving care and investing in community primary prevention.
43
Changes in deaths prevented
Changes in costs
Results through year 10
Results through year 25
Universal coverage
Better preventive and chronic care
Better behavioral and environmental conditions
Universal coverage
Better preventive and chronic care
Better behavioral and environmental conditions
Milstein et al. (2011) Why Behavioral and Environmental Interventions are needed to Improve Health at Lower

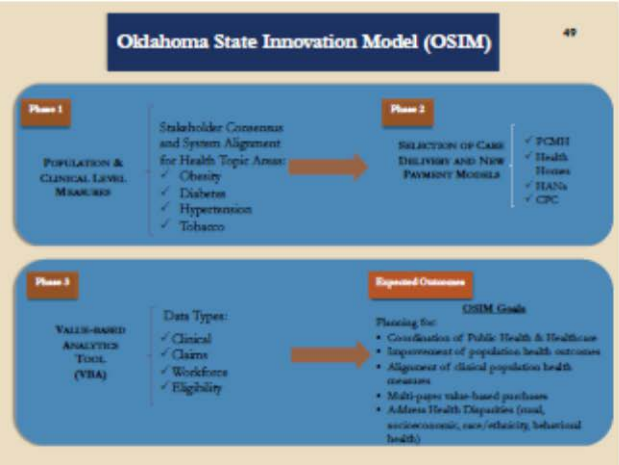

Oklahoma Health Improvement Plan Framework
44
Community Assessment and Public Input
OHIP Access to Care Team
Healthcare Providers
Business Community
Quality Improvement Orgs
Oklahoma Legislature
Medical Schools
Health Insurers
Telemedicine Assoc.
Foundations
Health Information Exchanges
Communities
Tribal Health Organizations
Improved Access to Care
• Healthcare Workforce Initiatives
• Uncompensated Care
• Insurance coverage
• Rural Health
• Telemedicine
• Accessibility
• Clinical Extenders
Improved Health
• Multi-Payer Initiatives (inc. state employee health benefits)
• Outcome Driven Care
• Prevention of Disease
• Integration of Public Health and Healthcare
• Improved Care Coordination
• Health Access Networks
• Practice Facilitation
Reduce Growth of Healthcare Cost
• Health Innovation
• Pay for Success/ Shared Savings Models
• Data Driven Decision Making
• Enhanced Health Information Technology
• Team Based Care

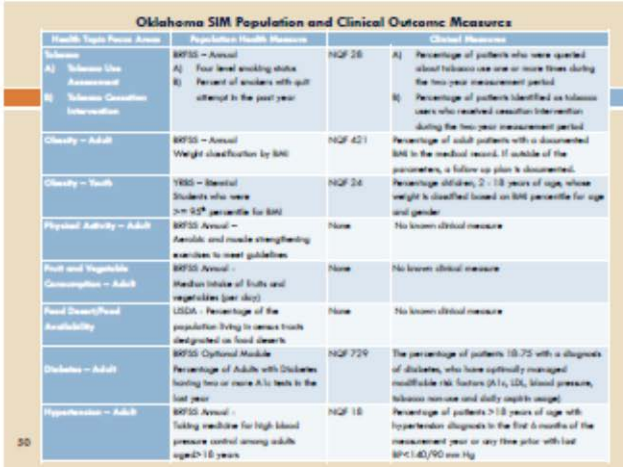

Healthcare Innovation & Redesign
45
Pay for Success
Value-Based Insurance Design
Multi-Payer Initiatives
Integration of PH and Healthcare
Health Access Networks
Prioritization of Outcomes
Chair: Julie Cox-Kain, HHS
Workforce
Vice Chair: Deidre Myers, Commerce
• Coordinated HC Workforce Efforts
• Robust & timely healthcare workforce data
• Pipeline adequate to meet current and future healthcare demand
• Delivery Redesign (Core Team)
Healthcare Financing
Vice Chair: Dr. Joe Cunningham, BCBSOK
• Insurance Coverage
• Uncompensated Care
• State-Purchased Insurance
• Pay for Success (Core Team)
Health IT
Vice Chair: Dr. David Kendrick, OU Chair of Informatics
• Increased adoption of EHR
• Increased attainment of meaningful use
• Interoperability
Efficiency & Effectiveness (Prioritized)
Vice Chair: Becky Pasternik-Ikard, OHCA
• Use of Clinical Preventive Services (prioritized)
• Care Coordination/Team Based Care
• PCMH
• Practice Facilitation (NQF goals – prioritized)
• Outcome Driven Care
Health Disparities (rural, socioeconomic, race/ethnicity, behavioral health, etc.)

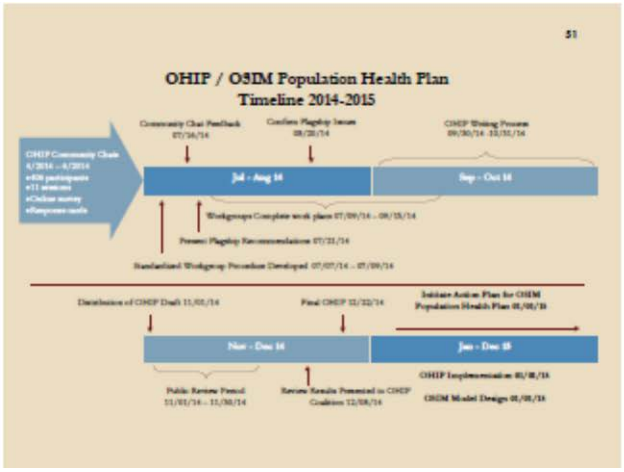

Recent Activities in Oklahoma's Healthcare and Public Health landscape
46
The OHIP Coalition submitted, on July 18th, 2014, an application for CMS' State Innovation Model grant; the project proposes a collaborative design of innovative payment and care delivery models to attain the triple aim in healthcare
OHIP leadership created a Healthcare Innovation & Redesign Steering Committee in charge of Workforce, Healthcare Financing, Health IT and Efficiency & Effectiveness workgroups
Under the direction of the OSDH, Milliman is conducting a Healthcare and Wellness Business Survey (July – August '14) with the goal of informing the OHIP plan design
Oklahoma launched the Health Workforce Initiative supported by the National Governors Association Policy Academy
The Oklahoma Health Improvement Plan finalized its Community Chats; Collected feedback from community stakeholders will be used to update the plan objectives

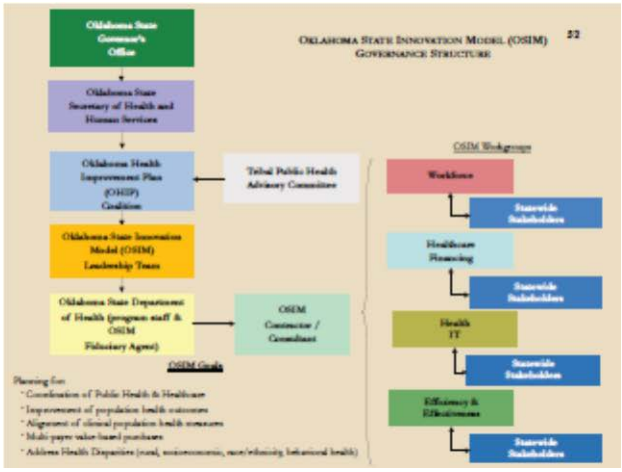

47
State Innovation Model Overview


Purpose of SIM Grants
48
SIM is a public and private sector collaboration to transform the state's delivery system, it is NOT Medicaid expansion nor Medicaid managed care
SIM is not designed to reduce the number of uninsured nor create programs directed at the uninsured
SIM is based on the premise that state innovation with broad stakeholder input and engagement, including multi-payer models, will accelerate delivery system transformation to provide better care at lower costs
CMMI will provide up to $3 million per state (one-year project period) for up to 15 Model Design cooperative agreements to design new State Health System Innovation Plans
SIM should facilitate the design, implementation, and evaluation of community-centered health systems that can deliver significantly improved cost, quality, and population health performance results for all state residents

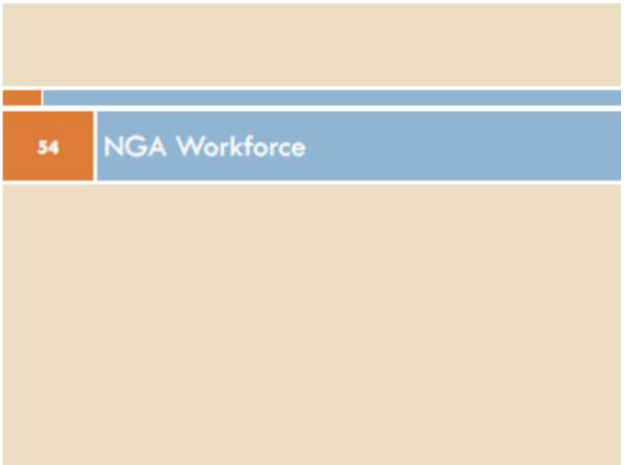

Oklahoma State Innovation Model (OSIM)
49
Phase 1
Population & Clinical Level Measures
Stakeholder Consensus and System Alignment for Health Topic Areas:
✓ Obesity
✓ Diabetes
✓ Hypertension
✓ Tobacco
Phase 2
Selection of Care Delivery and New Payment Models
✓ PCMH
✓ Health Homes
✓ HANs
✓ CPC
Phase 3
Value-based Analytics Tool (VBA)
Data Types:
✓ Clinical
✓ Claims
✓ Workforce
✓ Eligibility
Expected Outcomes
OSIM Goals
Planning for:
• Coordination of Public Health & Healthcare
• Improvement of population health outcomes
• Alignment of clinical population health measures
• Multi-payer value-based purchases
• Address Health Disparities (rural, socioeconomic, race/ethnicity, behavioral health)

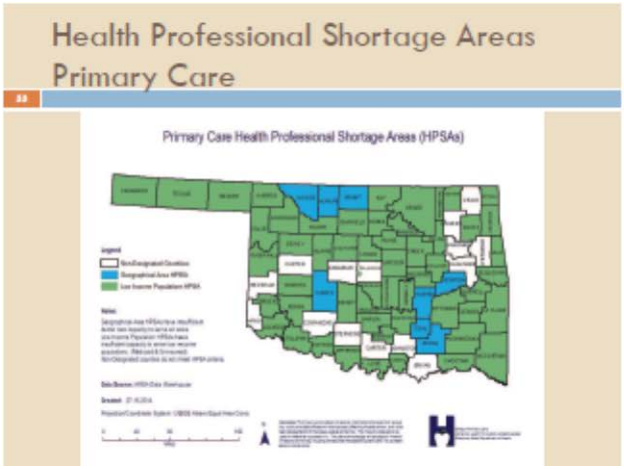

Oklahoma SIM Population and Clinical Outcome Measures
50

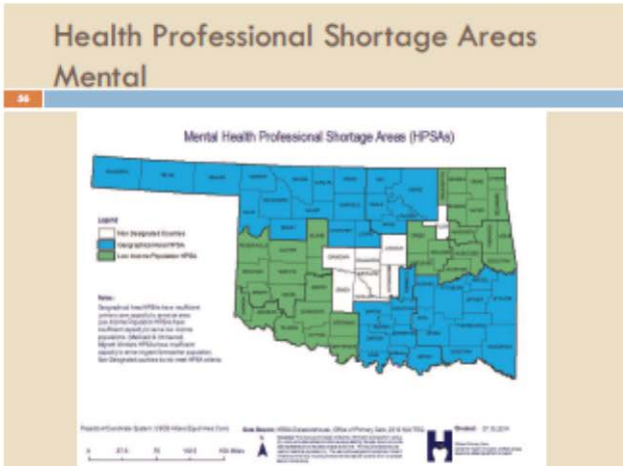

51
OHIP / OSIM Population Health Plan
Timeline 2014-2015
Jul - Aug 14
Sep - Oct 14
Nov - Dec 14
Jan - Dec 15

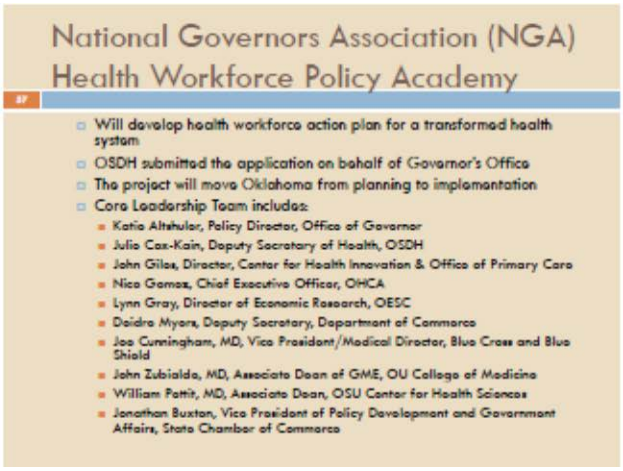

Oklahoma State Governor's Office
Oklahoma State Secretary of Health and Human Services
Oklahoma Health Improvement Plan (OHIP) Coalition
Oklahoma State Innovation Model (OSIM) Leadership Team
Oklahoma State Department of Health (program staff & OSIM Fiduciary Agent)
Tribal Public Health Advisory Committee
OSIM Contractor / Consultant
OSIM Goals
Planning for:
• Coordination of Public Health & Healthcare
• Improvement of population health outcomes
• Alignment of clinical population health measures
• Multi-payer value-based purchases
• Address Health Disparities (rural, socioeconomic, race/ethnicity, behavioral health)
Oklahoma State Innovation Model (OSIM)
Governance Structure
52
OSIM Workgroups
Workforce
Statewide Stakeholders
Healthcare Financing
Statewide Stakeholders
Health IT
Statewide Stakeholders
Efficiency & Effectiveness
Statewide Stakeholders

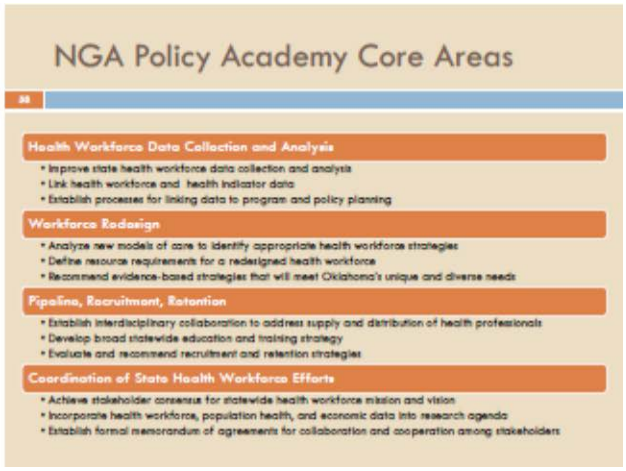

OSIM Partners (36 Total)
53
OSDH & OHCA
Hospital Association
OSMA & OAFP
Tribal Nations (4)
ODMHSAS
Long-term Care
OU & OSU Physicians
BCBSOK & CommunityCare
OK Primary Care Assoc.
OK Employee Group ID
MyHealth & CCO
State Chamber & Dept. of Commerce
Consumer Advocacy
Association of Health Plans
Hospital Systems
Medical Associations
Employers
OU & OSU Medical Centers
OSU Center for Rural Health


54
NGA Workforce







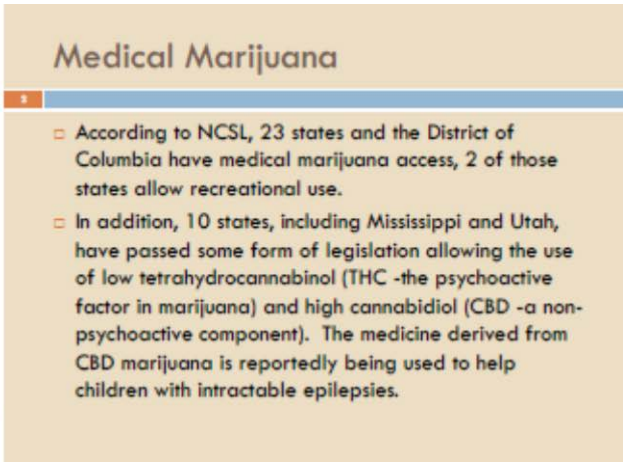


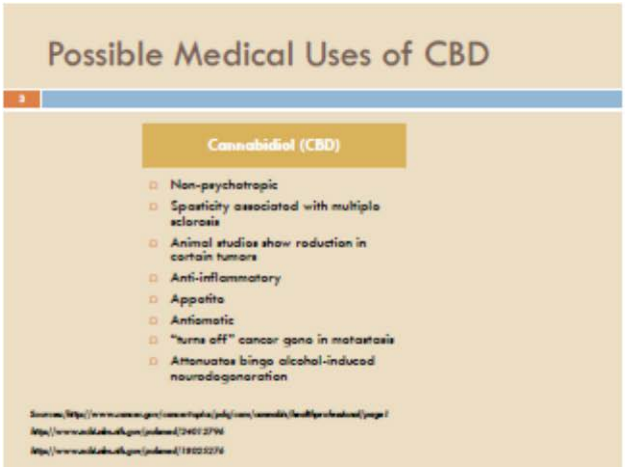
Activity	Date(s)
Establish Action Plan Core Areas and Goals	**June 30, 2014**
Finalize Draft Strategies for Action Plan	August 31, 2014
Engage Stakeholders	May-December 2014
Conduct In-State Technical Assistance	September-November 2014
Submit 1st Draft Action Plan	**January 12, 2015**
Begin Implementing Action Plan	February-October 2015
Conduct In-State Technical Assistance	February-May 2015
Submit 2nd Draft Action Plan	**June 30, 2015**
Attend Policy Academy Closing Meeting	October, 2015
Submit Final Action Plan and Preliminary Results Signed by Governor	**October, 2015**
Monthly Calls	June-October 2015
Quarterly Webinars	Aug., Nov. 2014; Mar., Jun., Sept. 2015
Request Ad-Hoc TA	May-October 2015

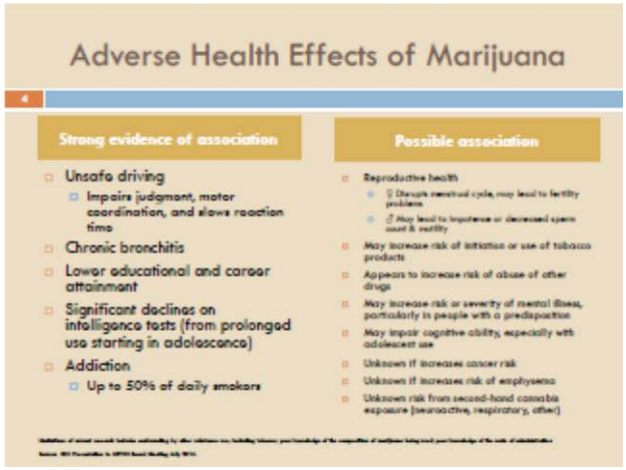
The presentation concluded.

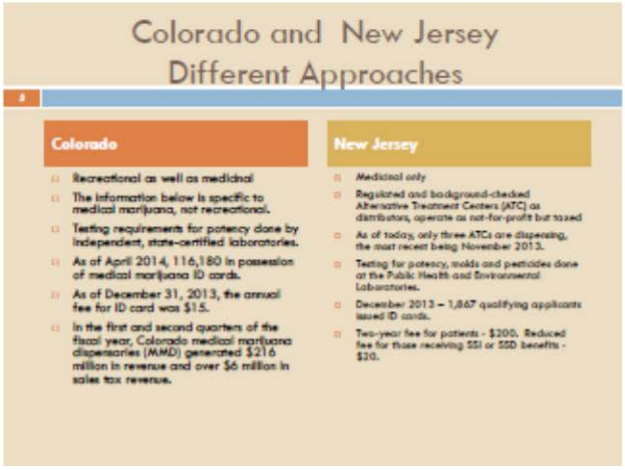
FUTURE LEGISLATIVE AGENDA AND PUBLIC HEALTH LABORATORY BREAKOUT

Mark Newman, Ph.D., Director, Office of State and Federal Policy; Toni D. Frioux, MS, APRN-CNP, Deputy Commissioner for Prevention and Preparedness Services









Governor Fallin's Smoke-free Indoors Initiative Petition

7

Employees of the Department who support the petition may, during *nonworking* hours:

- Sign the petition
- Promote the petition
- Other activities in support of the petition

At *all* times, employees are allowed to educate the interested public about the dangers of secondhand smoke and the facts about the petition.

Surgeon General's report on the Health Consequences of Smoking – 50 years

8

- Estimated 20 million deaths caused by smoking or related illnesses since 1965
- Smoking among adults in the US has gone from 42% of the population in 1965 to 18% in 2012 (23.3% in OK)
- The vast majority of smokers begin by age 26 (98%)
- Patterns of use are changing – intermittent use of combustibles and an increase in the use of other nicotine delivery methods

Surgeon General's report – Increasing revenue collection and minimize tax avoidance

9

- The Surgeon General's report indicates that implementing a high-tech cigarette tax stamp, improving tobacco licensure management and making stamps harder to counterfeit are possible methods of increasing revenue and holding tobacco product producers accountable.
- This could be done through a track-and-trace system, similar to the MITS (Marijuana Inventory Tracking Solution) system for marijuana instituted by Colorado. This is an RFID (Radio Frequency Identification) system to allow for tracking goods all along a supply chain, ensuring taxes are paid at every required stop along the way.

Surgeon General's report – Current and End-game Strategies

10

Current

- Increase the price point (including establishing minimum packaging in order to raise retail price*)
- Smokefree indoor polices
- Media campaigns
- Full access to cessation programs
- Funding of statewide tobacco control programs

End Game

- Reduce the amount of nicotine in tobacco products
- Greater restrictions on sales, up to and including bans on entire product categories

* Increased quantity means an increased price, reducing attractiveness and availability to minors and younger smokers

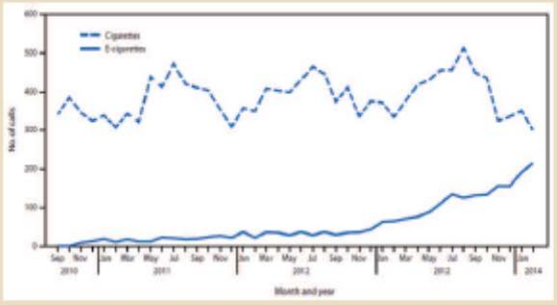
11 Non combustibles – E-cigarettes

Liquid nicotine – unregulated

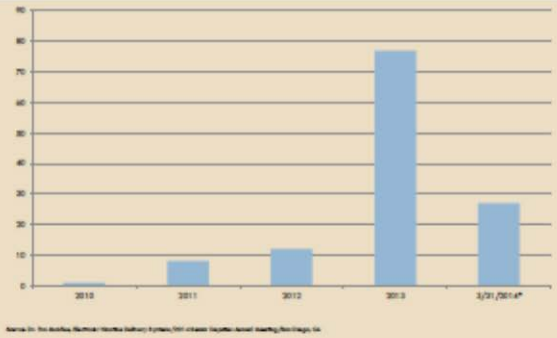
Spike in calls to Poison Control Centers

Number of calls to poison centers for cigarette and e-cigarette exposures in the United States, by month. September 2010- February 2014

13



Number of Calls to Oklahoma Poison Control
Human Exposure (Poisonings) to E-juice/Liquid Nicotine
January 2010- March 31, 2014



Liquid Nicotine Poisoning

- American Association of Poison Control Centers issued a warning to parents about the use of e-cigarettes and liquid nicotine around children, especially as the potential poison can be brightly colored or highly flavored, and there is no regulation concerning what ingredients are utilized in the mixture.
- In 2013, the AAPCC reported 1,471 exposures to e-cigarettes or liquid nicotine with slightly more than half of those exposed being children under six. So far in 2014, the AAPCC reports 1,932 such calls.
- No deaths, but nausea and vomiting reported, in some cases severe enough to warrant emergency room visits.
- FDA is currently considering rules requiring warning labels, as well as e-cigarette companies having to register with FDA and disclose their liquid nicotine ingredients.

1
2
3
4

15 Prescription Monitoring Program

How it can Work

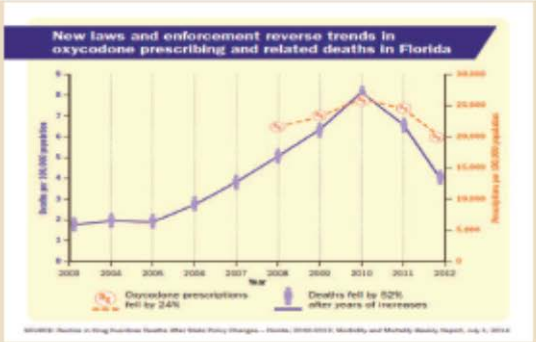
Long Term Goals

PMP- Successes

- According to the CDC, Oklahoma has one of the highest rates in the nation of painkiller prescriptions per 100 people, at 128.
- New York implemented a PMP in 2012, and in one year saw a 75% drop in patients using multiple prescribers to receive the same drug.
- Tennessee, which had a prescription rate of 143 per 100, has seen a 36% drop in patients attempting to use multiple prescribers to receive the same drug.
- Both New York's and Tennessee's PMP require patient look up before the patient can receive prescription.

5
6
7
8

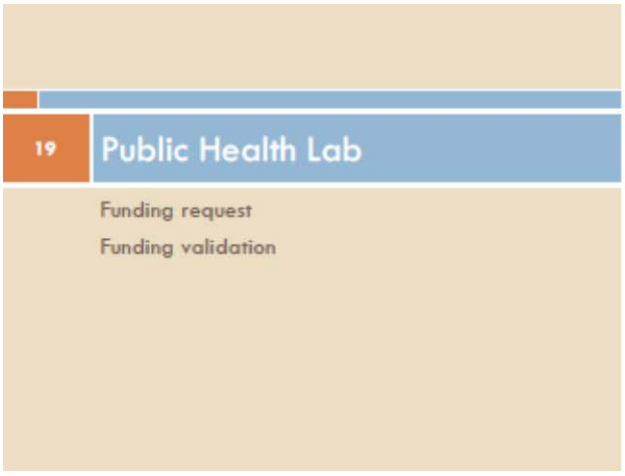
PMP- Successes

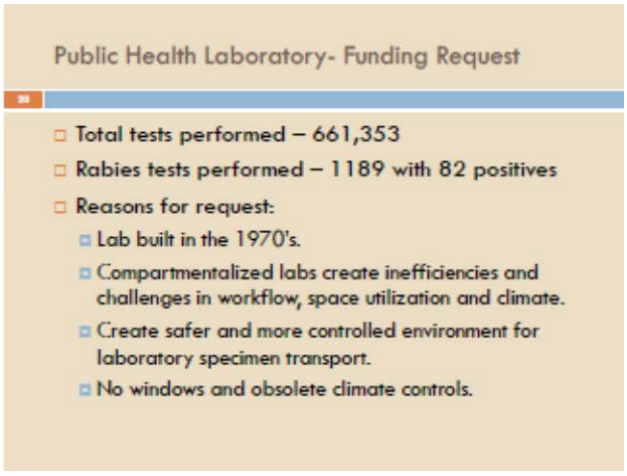


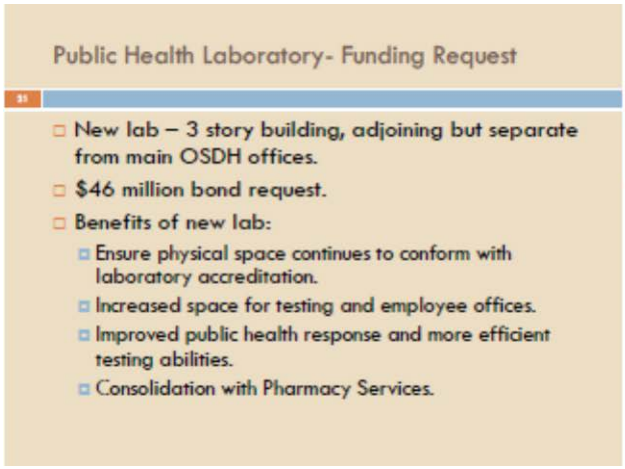
PMP – Long-term goals

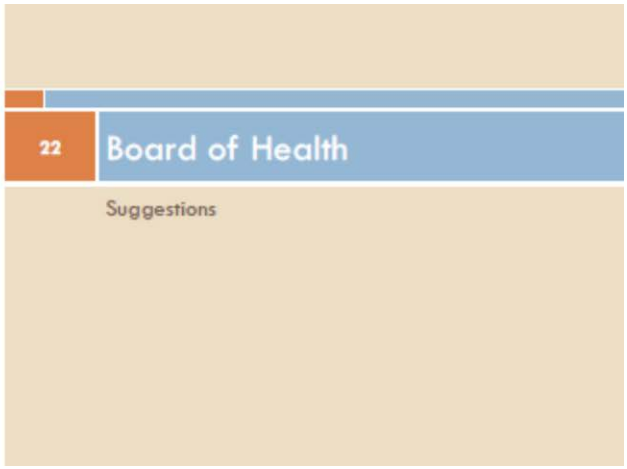
- Interoperability – easing the ability for physicians to utilize the PMP by allowing exchange of data and use of data analytics.
- Marked reduction in prescription painkiller abuse and deaths.
- Reduction in the number of patients able to acquire multiple doses of the same narcotic drug from more than one source.
- Increase in quality of care received.

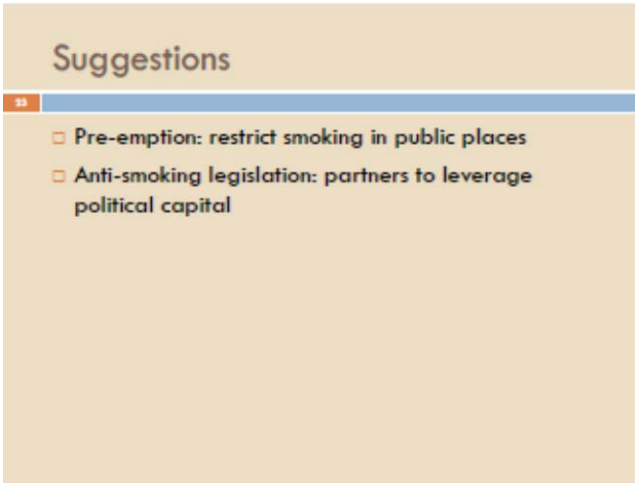
9
10
11
12











Dr. Newman asked for discussion or recommended policy initiatives. Members of the Board discussed pre-emption as a possibility but felt it may be a distraction should the Governor choose to move forward with an Initiative Petition. Members of the Board agreed the Department should be prepared to take a stance on the use of medical Marijuana should legislation be introduced in the upcoming legislative session. Board

members also supported possible comprehensive safety packaging legislation in response to the lack of regulations in the vaping industry. All members of the Board supported a new Public Health Laboratory. Members supported charging the Long Term Care Advisory Committee with making policy recommendations regarding Long Term Care improvements. Board members were supportive of prescription monitoring program (PMP) legislation.

The presentation concluded.

The meeting adjourned at 3:59 p.m.

Sunday, August 17, 2014

ROLL CALL

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

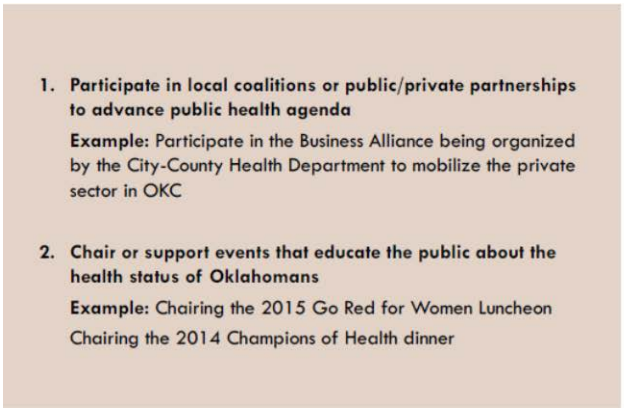
Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of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

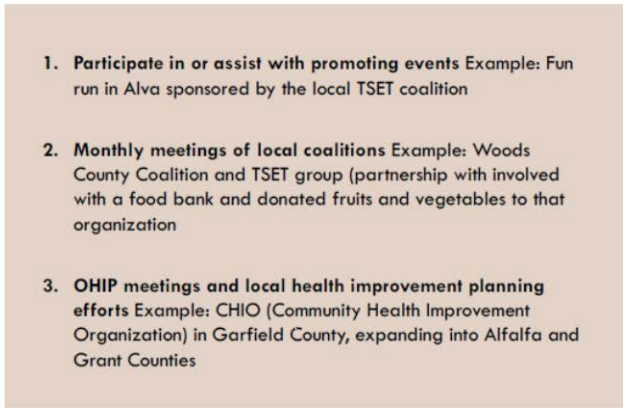
Visitors in attendance: See list

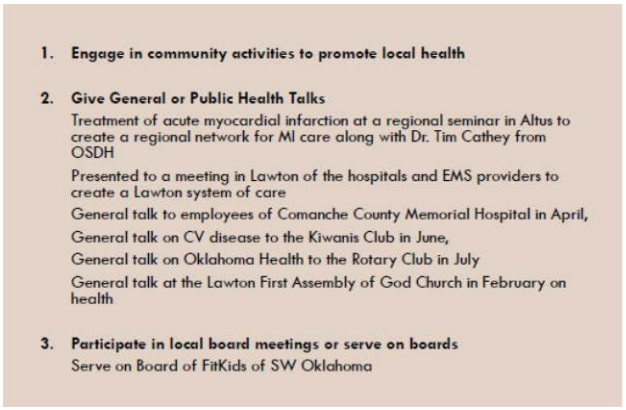
Call to Order and Opening Remarks
Dr. Woodson called the meeting to order at 8:30 a.m.

COMMUNITY RELATIONS/INVOLVEMENT
Martha Burger, Vice-President, Oklahoma State Board of Health

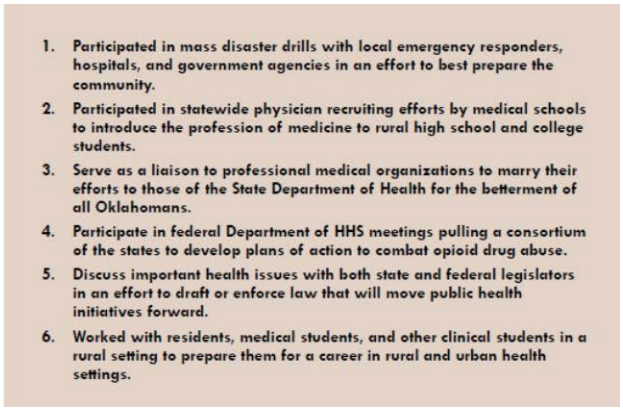
Martha Burger provided a brief sampling of opportunities for community collaboration and partnership provided by Board members.







1. **Engage in community activities to promote local health**
2. **Give General or Public Health Talks**
   Treatment of acute myocardial infarction at a regional seminar in Altus to create a regional network for MI care along with Dr. Tim Cathey from OSDH
   Presented to a meeting in Lawton of the hospitals and EMS providers to create a Lawton system of care
   General talk to employees of Comanche County Memorial Hospital in April,
   General talk on CV disease to the Kiwanis Club in June,
   General talk on Oklahoma Health to the Rotary Club in July
   General talk at the Lawton First Assembly of God Church in February on health
3. **Participate in local board meetings or serve on boards**
   Serve on Board of FitKids of SW Oklahoma



1. **Participated in mass disaster drills with local emergency responders, hospitals, and government agencies in an effort to best prepare the community.**
2. **Participated in statewide physician recruiting efforts by medical schools to introduce the profession of medicine to rural high school and college students.**
3. **Serve as a liaison to professional medical organizations to marry their efforts to those of the State Department of Health for the betterment of all Oklahomans.**
4. **Participate in federal Department of HHS meetings pulling a consortium of the states to develop plans of action to combat opioid drug abuse.**
5. **Discuss important health issues with both state and federal legislators in an effort to draft or enforce law that will move public health initiatives forward.**
6. **Worked with residents, medical students, and other clinical students in a rural setting to prepare them for a career in rural and urban health settings.**

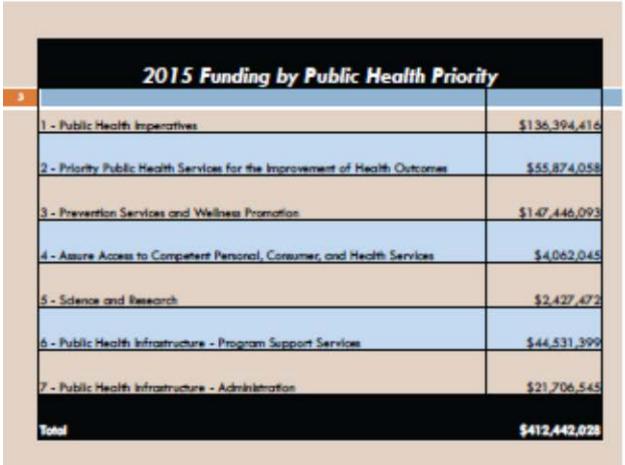
Each member briefly discussed successes and barriers faced in their respective communities. Board members asked for the Department to develop the following: canned 20 minute presentations and talking points around current public health policy issues; speaker's bureau; State of the State's Health and Oklahoma Health Improvement Plan presentations; opportunities to push public health issues through social media; and a site to host the materials. Board members are also interested in another tour of the Public Health Laboratory.

The presentation concluded.

2014 BUDGET / BUSINESS PLAN

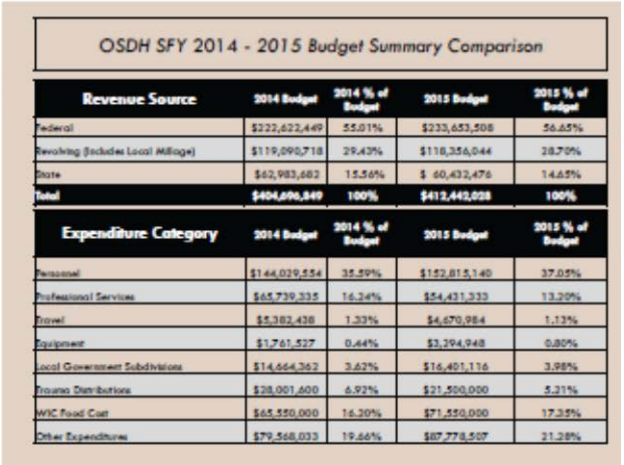
Julie Cox-Kain, M.P.A., Senior Deputy Commissioner; Debbie Boyer, Director, Human Resources

Julie Cox-Kain presented a year end update on the 2015 Budget and Business Plan. Debbie Boyer presented an update on employee engagement and workforce initiatives.



2015 Funding by Public Health Priority

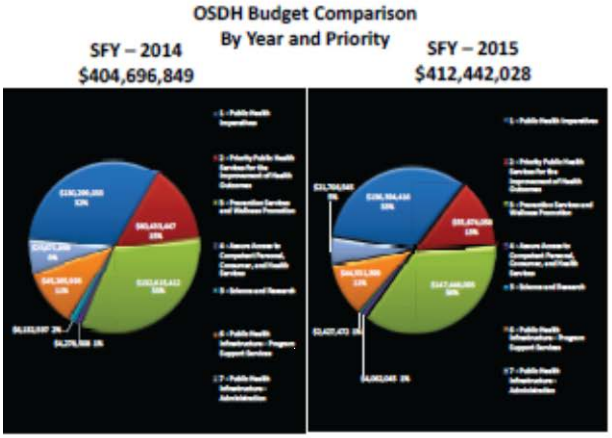
1 - Public Health Imperatives	$136,394,416
2 - Priority Public Health Services for the Improvement of Health Outcomes	$55,874,058
3 - Prevention Services and Wellness Promotion	$147,446,093
4 - Assure Access to Competent Personal, Consumer, and Health Services	$4,062,045
5 - Science and Research	$2,427,472
6 - Public Health Infrastructure - Program Support Services	$44,531,399
7 - Public Health Infrastructure - Administration	$21,706,545
Total	**$412,442,028**



OSDH SFY 2014 - 2015 Budget Summary Comparison

Revenue Source	2014 Budget	2014 % of Budget	2015 Budget	2015 % of Budget
Federal	$222,622,449	55.01%	$233,653,508	56.65%
Revolving (Includes Local Millage)	$119,090,718	29.43%	$118,356,044	28.70%
State	$62,983,682	15.56%	$ 60,432,476	14.65%
Total	**$404,696,849**	**100%**	**$412,442,028**	**100%**

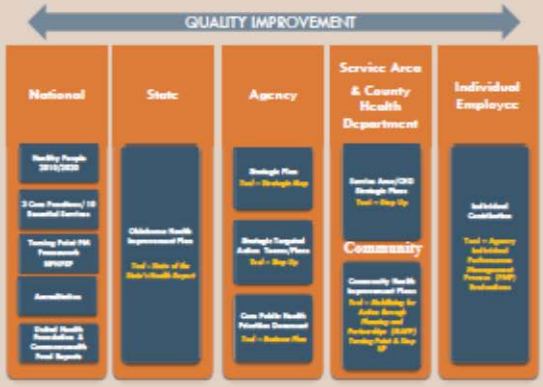
Expenditure Category	2014 Budget	2014 % of Budget	2015 Budget	2015 % of Budget
Personnel	$144,029,554	35.59%	$152,815,140	37.05%
Professional Services	$65,739,335	16.24%	$54,431,333	13.20%
Travel	$5,382,438	1.33%	$4,670,984	1.13%
Equipment	$1,761,527	0.44%	$3,294,948	0.80%
Local Government Subdivisions	$14,664,362	3.62%	$16,401,116	3.98%
Trauma Distributions	$28,001,600	6.92%	$21,500,000	5.21%
WIC Food Cost	$65,550,000	16.20%	$71,550,000	17.35%
Other Expenditures	$79,568,033	19.66%	$87,778,507	21.28%



BUSINESS PLAN UPDATE

6 Oklahoma State Department of Health

OKLAHOMA STATE DEPARTMENT OF HEALTH
PERFORMANCE MANAGEMENT MODEL



AGENCY PRIORITIES

- Innovations
  - Mandates
  - Emergency Preparedness & Response
  - Infectious Disease Control
- Oklahoma Health Improvement Plan
  - Tobacco
  - Obesity
  - Children's Health
- Other Public Health Priorities
  - Preventable Hospitalizations
  - Immunizations
  - Motor Vehicle Crash Deaths
  - Rx Drug Deaths (Added in 2013 as a Core Priority)

8 Oklahoma State Department of Health

BUSINESS PLAN CATEGORIES

- Legal
- Policy
- Information Technology
- Human Resources
- Financial Resources
- Communication
- Building & Internal Services
- Performance Management
- Data Collection & Analysis

9 Oklahoma State Department of Health

2014 BUSINESS PLAN UPDATE

Mandates – 45% SFY '13 Completion Update
OHP – 35% PH Priorities – 67% All – 55%

SFY 2014 ACCOMPLISHMENTS

- Completed network transition/upgrade
- Completed classification/compensation process
- Career progression reauthorized
- Awarded and implementing LIMS
- Negotiated enterprise service bus (with eMPI) as a statewide contract to enable shared service
- Signed contracts with private insurers and established private billing contract (BC/BS & Community Care)
- Finalized Repair and Renewal plans for majority of central office in August 2014

11 Oklahoma State Department of Health

SFY2015 BUSINESS PLAN PRIORITIES

- Complete mechanical backbone upgrade
- New Public Health Laboratory
- Implement ESB/eMPI in OSDH and as an HHS shared service
- Finalize OSIIS and Electronic Billing Projects
- Requirements for PH EHR (possible shared services)
- Integrate OMES DRP to OSDH COOP
- Fully optimize network and plan to connect to state fiber
- Develop and implement strategies to address recruitment, retention, workforce development, and employee wellness with an emphasis on data collection and analyses, customer satisfaction, and enhanced communication

13 Oklahoma State Department of Health

EMPLOYEE ENGAGEMENT

14 Oklahoma State Department of Health

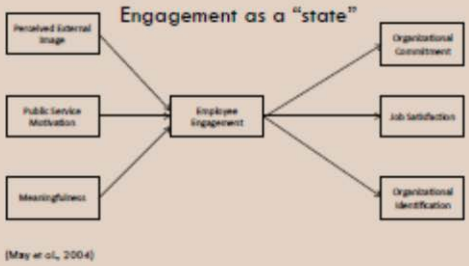
EMPLOYEE ENGAGEMENT SURVEY

- Survey conducted by Durand Crosby, COO of ODMHSAS as part of a research project for dissertation
- Compared OSDH with other state agencies and a non-profit organization
- Survey measured employee engagement and related variables including the following:
  - Public service motivation
  - Perceived organizational image
  - Organizational commitment
  - Organization identification
  - Meaningfulness of work
  - Job satisfaction

15 Oklahoma State Department of Health

RESEARCH MODEL

16

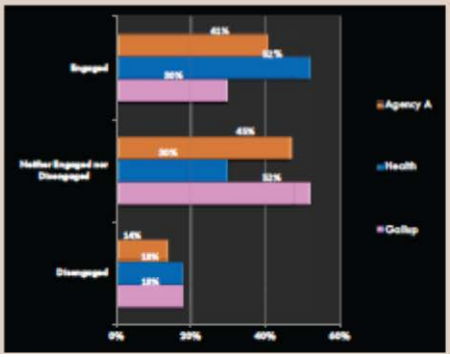


RESULTS - ENGAGEMENT

OSDH Engagement Compared to Agency A & Gallup Survey (2012)

17

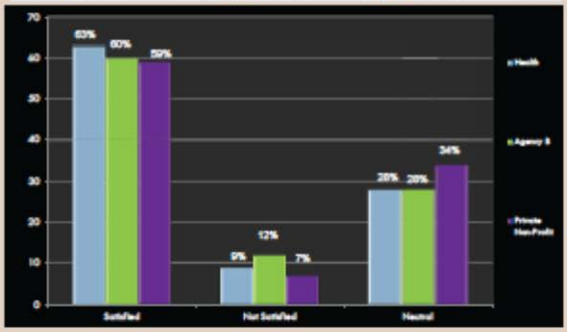
Employee engagement is described as the degree to which an individual is attentive and absorbed in the performance of his or her job (Bakker, 2011).



RESULTS – JOB SATISFACTION

18

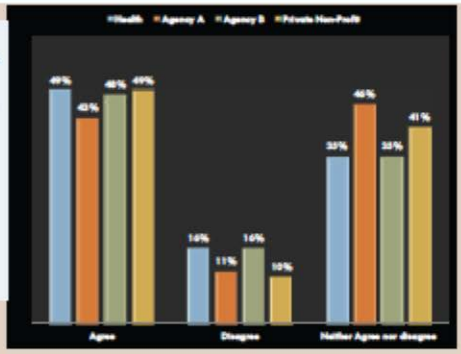
Job Satisfaction is defined as the extent to which a persons hope, desires and expectations about the employment he/she is engaged in are fulfilled.



RESULTS – ORGANIZATIONAL IDENTIFICATION

19

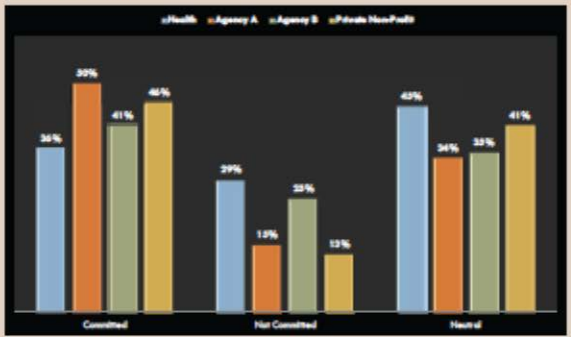
Organizational identification is the extent to which a person identifies themselves with the organization: a possessing or sharing of organizational values.



RESULTS - ORGANIZATIONAL COMMITTMENT

20

Organizational commitment is a persons psychological attachment to the organization.



RESULTS - OVERVIEW

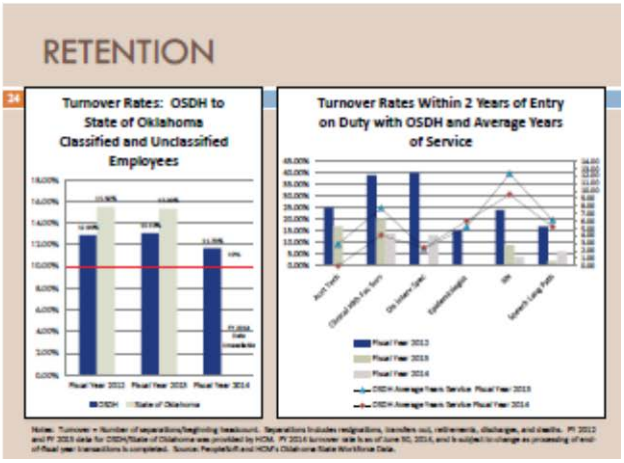
- OSDH scores for several important variables (e.g., engagement, public service motivation (PSM), and job satisfaction) are above normed averages
- All tested variables (PSM, image, and meaningfulness) predicted engagement
- Engagement predicted commitment, identification, and job satisfaction
- OSDH scored high for job satisfaction
- OSDH scored highest on perceived reputation among state agencies tested
- OSDH scored highest (tied) for PSM among entities tested
- OSDH scored well-above norm for engagement (second highest)
- OSDH scored surprising low for commitment (36%)

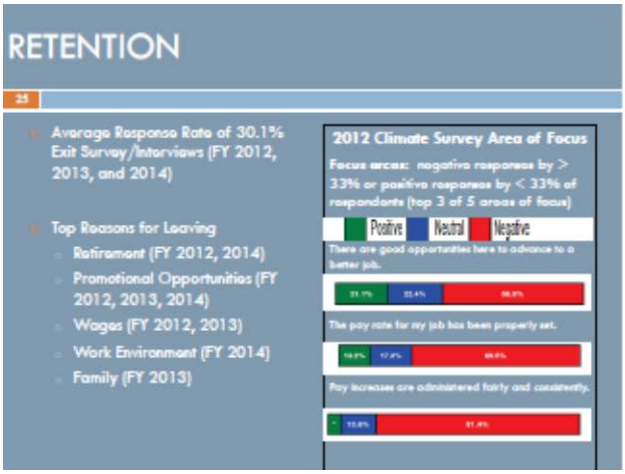
21 Oklahoma State Department of Health

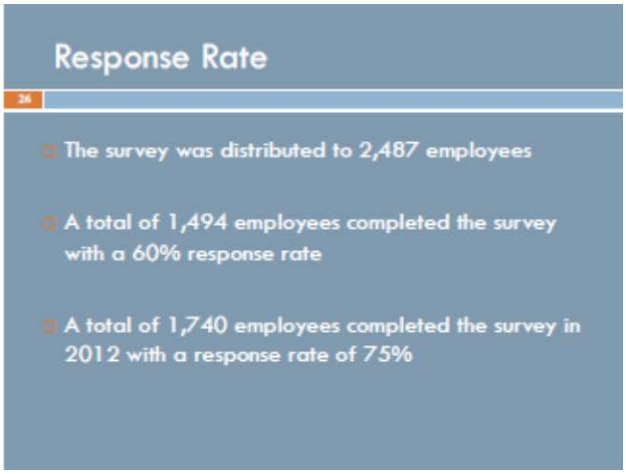
WORKFORCE DEVELOPMENT AND SUPPORT

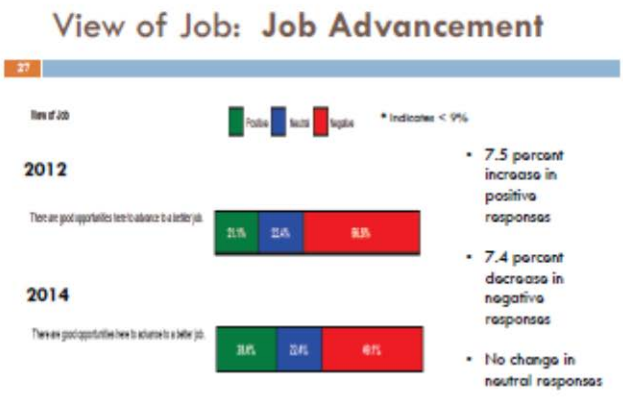
22 Oklahoma State Department of Health

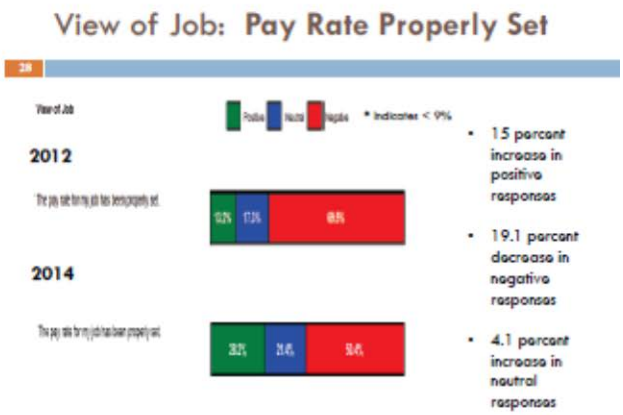

RECRUITMENT
Recruitment materials and booth display
Quarterly advertisements in the Oklahoma Nurse
Visual Imaging contract
Alerts when job openings are posted
Job postings on agency approved social media outlets
Path Forward . . .
Online Recruiter "Talent Toolkit"
Online Applicant Resource Center
Electronic Application
Applicant Tracking and Demographics
Career Maps
23
Oklahoma State Department of Health

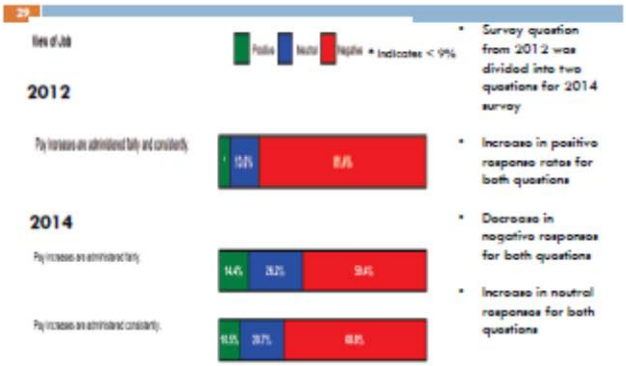

RETENTION
24
Turnover Rates: OSDH to State of Oklahoma Classified and Unclassified Employees
Turnover Rates Within 2 Years of Entry on Duty with OSDH and Average Years of Service

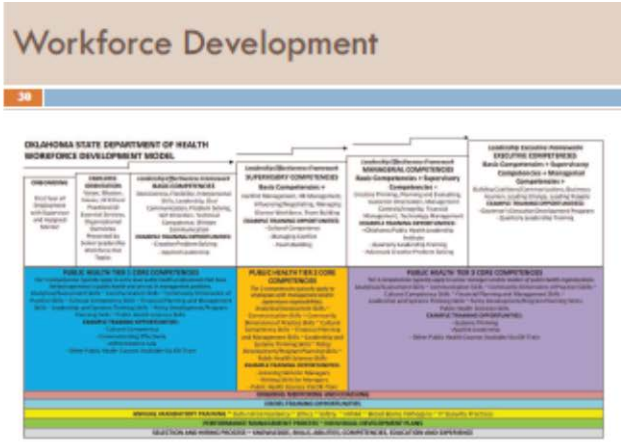

RETENTION
25
Average Response Rate of 30.1% Exit Survey/Interviews (FY 2012, 2013, and 2014)
Top Reasons for Leaving
Retirement (FY 2012, 2014)
Promotional Opportunities (FY 2012, 2013, 2014)
Wages (FY 2012, 2013)
Work Environment (FY 2014)
Family (FY 2013)
2012 Climate Survey Area of Focus
Positive
Neutral
Negative

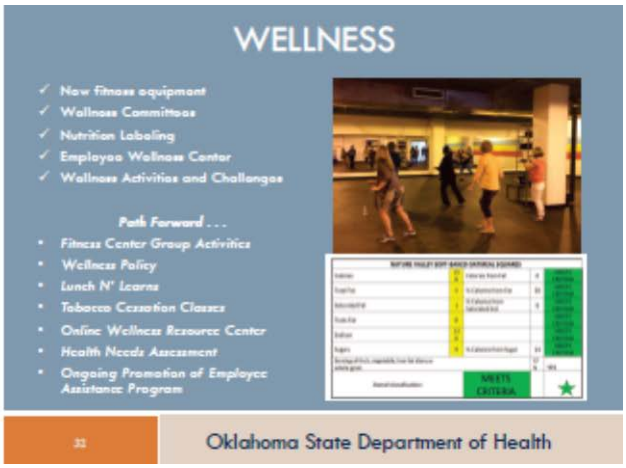

Response Rate
26
The survey was distributed to 2,487 employees
A total of 1,494 employees completed the survey with a 60% response rate
A total of 1,740 employees completed the survey in 2012 with a response rate of 75%

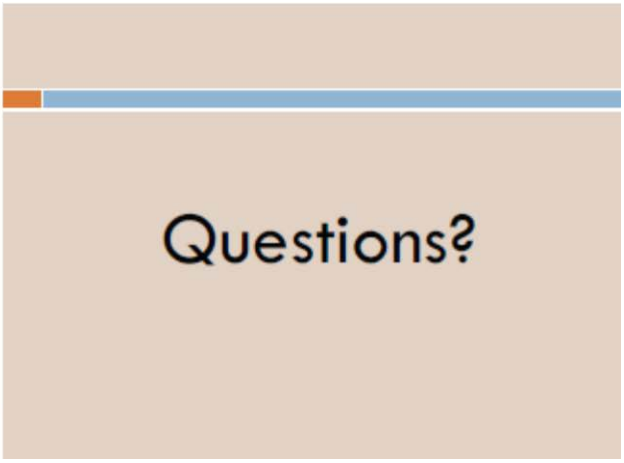

View of Job: Job Advancement
27
2012
2014
7.5 percent increase in positive responses
7.4 percent decrease in negative responses
No change in neutral responses


View of Job: Pay Rate Properly Set
28
2012
2014
1.5 percent increase in positive responses
19.1 percent decrease in negative responses
4.1 percent increase in neutral responses









The presentation concluded.

Dr. Bacigalupo thanked the Board and Department staff for their commitment and participation throughout the meeting. He also encouraged them to provide feedback as to his performance after they have had an opportunity to reflect on the outcomes of the retreat.

PROPOSED EXECUTIVE SESSION

Mrs. Burger moved Board approval to move into Executive Session at 10:39 a.m. pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

- Presentation concerning possible litigation regarding last legislative session.

Second Ms. Hart-Wolfe. Motion carried.

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

Dr. Grim moved Board approval to come out of Executive Session at 11:40 a.m. and open regular meeting. Second Mr. Starkey. Motion carried.

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

No action taken as a result of Executive Session

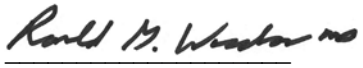
ADJOURNMENT

Dr. Woodson moved to adjourn. Second Mr. Starkey. Motion carried.

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

The meeting adjourned at 11:41a.m.

Approved



Ronald Woodson, M.D.
President, Oklahoma State Board of Health
October 7, 2014