STATE BOARD OF HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH
Roman Nose State Park Lodge
Watonga, Oklahoma

August 16-18, 2013

R. Murali Krishna, President of the Oklahoma State Board of Health, called the 382nd special meeting of the Oklahoma State Board of Health to order on Friday, August 16th, 2013, at 7:01 p.m. The final agenda was posted at 10:57 a.m. on the OSDH website on August 15, 2013; at 10:55 a.m. on the OSDH building entrance on August 15, 2013; and at 1:00 p.m. on the Roman Nose State Park Lodge Building entrance on August 15, 2013.

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley, Janice Hiner.

Visitors in attendance: See list

Call to Order and Opening Remarks

Dr. Krishna called the meeting to order. He thanked all distinguished guests and staff for their attendance. He acknowledged special guests Senator Patrick Anderson; Senator Ron Justice; Representative Harold Wright; Tracey Strader, the Executive Director of the Tobacco Settlement Endowment Trust; and Dr. George Foster, Vice-Chair of the Tobacco Settlement Endowment Trust.

Dr. Krishna 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 2013 retreat objectives:
To orient OSDH and TSET Board members to each organization, their integrated strategic priorities and programs to improve wellness; Review of Strategic Planning Framework: Mission, Vision, Values; and Develop Recommendations for Legislative Priorities.

Dr. Krishna extended a special thanks to Department staff and Dr. Cline for their continued quality improvement efforts and thanked Board members for their commitment to public health.

ADJOURNMENT

Ms. Wolfe moved to adjourn. Second Dr. Alexopulos. Motion carried.

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

The meeting adjourned at 7:29 p.m.

Saturday, August 17, 2013

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley, Janice Hiner.

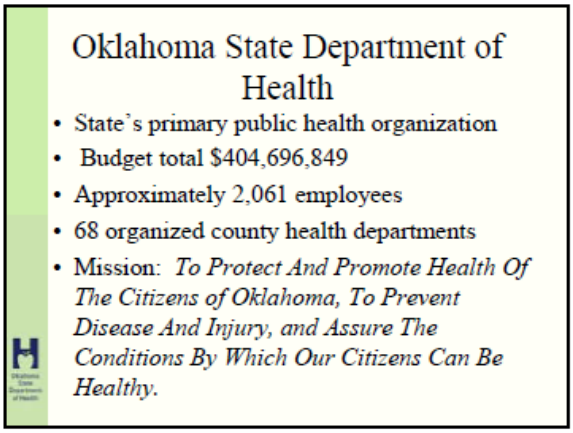
Visitors in attendance: See list

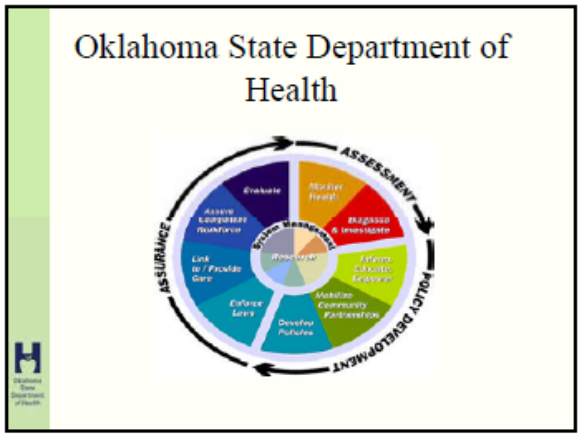
Call to Order and Opening Remarks

Dr. Krishna called the meeting to order at 8:35 a.m. and welcomed those in attendance. He acknowledged special guests Gary Cox, Director 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; Pam Rask of the Tulsa Health Department; and Brent Wilborn of the Oklahoma Primary Care Association.

WELLNESS INTEGRATED STRATEGIC PLAN

Julie Cox-Kain, M.P.A., Chief Operating Officer; Tracey Strader, M.S.W., Executive Director, Tobacco Settlement Endowment Trust; Keith Reed, outgoing Director for the Center for the Advancement of Wellness.





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Oklahoma Tobacco Settlement Endowment Trust

TRACEY STRADER, MSW, EXECUTIVE DIRECTOR

About TSET

- Created by a constitutional amendment approved by voters 69% to 31% in 2000.
- 75% of Master Tobacco Settlement Agreement payments are invested through an endowment, and **only the earnings** are spent for programs to improve health.
- Governed by a seven-member, bipartisan, Board of Directors to fund and oversee programs. A separate five-member Board of Investors manages the endowment funds.

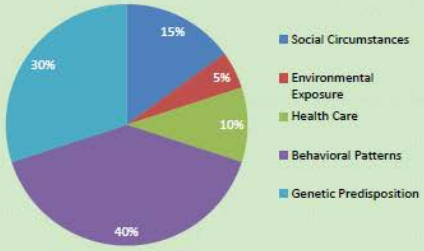
TSET - BETTER LIVES THROUGH BETTER HEALTH

About TSET

- **Our mission**: To improve the health and quality of life of all Oklahomans by addressing the hazards of tobacco use and other health issues.
- **Our strategic plan** focuses on addressing the leading causes of preventable death – cancer and cardiovascular disease – by targeting tobacco use and physical activity and nutrition.
- **What we fund:**
  - Prevention
  - Research
  - Emerging Opportunities
- **Guided by** evidence of effectiveness and evaluation

TSET - BETTER LIVES THROUGH BETTER HEALTH

Determinants of Health and Their Contribution to Premature Death



TSET - BETTER LIVES THROUGH BETTER HEALTH

TSET – OSDH Partnership

- Shared goals in tobacco control and obesity
- Strategies defined together, playing on the strengths of each organization
- Strategies based on state plans and available evidence, and tailored to Oklahoma culture.
- TSET focus on grant making - what is funded, who is funded, and how the grants are funded. Monitoring measures of progress and assuring technical assistance, consultation, and training are available to support grantees.
- OSDH focus on providing expert resources and consultation to entire state. Specific focus on providing the technical assistance, consultation, and training for TSET-funded grants in illness.

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - TOBACCO CONTROL

Communities of Excellence in Tobacco Control

34 grantees · 51 counties · 1 tribal nation · 85% of state's population

TSET - BETTER LIVES THROUGH BETTER HEALTH

2
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PROGRAMS FUNDED - TOBACCO CONTROL

Oklahoma Tobacco Helpline

- funded by TSET in partnership with Department of Health, Health Care Authority, and Employees Group Insurance Division
- served over 250,000 since 2003
- quit coaching™ significantly increases quit rates (approx. 35%)
- patches, gum, or lozenges sent via mail order
- estimated savings of $67 million annually for direct medical cost from smokers who have quit
- ranked second in the nation in reach
  - over 60% with incomes of $20,000 or less
  - 6,971 callers from Oklahoma Co., FY12
  - 1,902 callers from Cleveland Co.
  - 801 callers from Canadian Co.

Oklahoma Tobacco Helpline 1 800 QUIT NOW

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - PHYSICAL ACTIVITY & NUTRITION

Physical Activity & Nutrition

- strategies similar to tobacco prevention
- create comprehensive program over time
- first initiative: community-based programs
- originally funded a three-year pilot project in Tulsa

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - PHYSICAL ACTIVITY & NUTRITION

Communities of Excellence in Physical Activity & Nutrition

15 grantees · 21 counties · 55% of state's population

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - INCENTIVE GRANTS

Healthy Communities & Healthy Schools Incentive Grants

- communities and schools earning basic, merit, or excellence levels of certification under the Certified Healthy Communities program may be eligible for incentive grants
- grant funding may be used on a variety of criteria to promote health in local communities

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - HEALTH SYSTEMS

Health Systems Grants

- **Oklahoma Department of Mental Health and Substance Abuse Services**
- **Oklahoma Health Care Authority**
- **Oklahoma Hospital Association**

Each organization works to support their networks in leading a culture of health improvement, infusing tobacco dependence treatment into their routine care, with active linkages to the Oklahoma Tobacco Helpline. Also promotes physical activity and healthy nutrition through provider organizations and practices.

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - HEALTH COMMUNICATIONS

Health Communications

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PROGRAMS FUNDED - EVALUATION

- University of Oklahoma
  - College of Public Health – Dr. Laura Beebe
- Oklahoma State University
  - Department of Nutritional Sciences – Dr. Deanna Hildebrand

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - RESEARCH CENTERS

Research Centers

- Peggy and Charles Stephenson Cancer Center
  - TSET Cancer Research Program
  - Oklahoma Tobacco Research Center
- Oklahoma Center for Adult Stem Cell Research

Providing research and treatment in cancer and tobacco-related diseases

TSET - BETTER LIVES THROUGH BETTER HEALTH

PROGRAMS FUNDED - UNSOLICITED PROPOSALS

Unsolicited Proposals

- *Oklahoma Afterschool Network*
- *OSU Dining Services*
- *Rescue Social Change Group*
- *Physician Manpower Training Commission*

Addressing any of TSET's Constitutional purposes.

TSET - BETTER LIVES THROUGH BETTER HEALTH

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Creation of the Center for the Advancement of Wellness

- Board of Health Retreat August 2011
- Consolidate obesity programs within the agency
- Leverage knowledge and infrastructure built in tobacco to accelerate obesity efforts
- Utilize evidence-base, strategic and business planning processes to target achievements in Tobacco use and obesity prevention & reduction

Center for the Advancement of Wellness

- **Purpose:** Reduce/prevent tobacco use and obesity
- **Distinctive Competence:** Provide data, best practices, expert consultation
- **Method:** Impact policy, environment, social norms
- Key goals by 2017:
  - Reduce smoking prevalence from 26.1% to 23.1% of adults and from 17.9% to 15.8% of adolescents.
  - Reduce obesity prevalence from 31.1% to 29.6% of adults and from 16.7% to 15.9% of adolescents.

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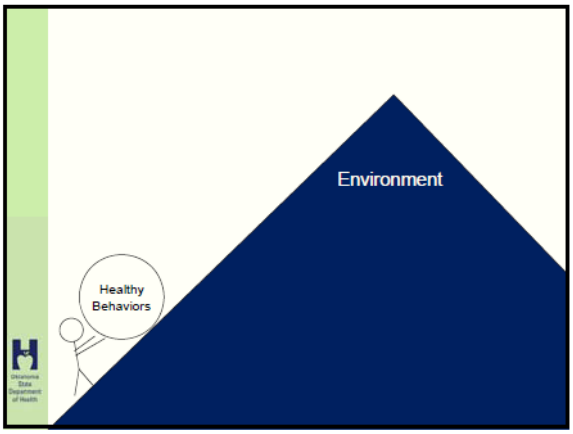
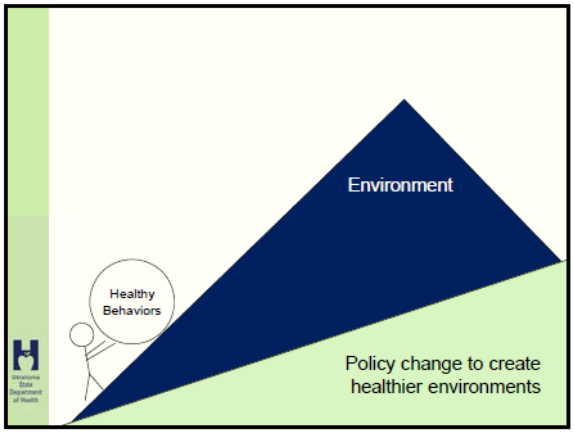
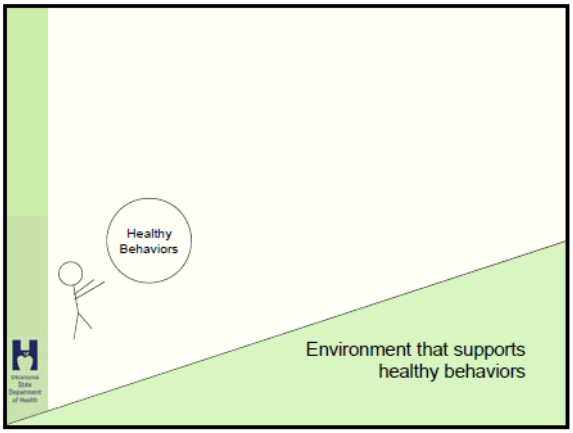
Oklahoma Adults – 2011 BRFSS

- **26.1%** Smoke
- **31.1%** Obese
- **34.4%** Overweight
- **55.2%** Not getting minimal Physical Activity
- **84.5%** Not consuming minimum of 5 fruits and vegetables/day







ASTHO Multistate Collaborative

- ASTHO/United Health Foundation effort to improve health rankings of low ranking states
- Kansas, Georgia, Rhode Island, Arkansas, Oklahoma
- Center partnering with ODMHSAS and Tourism/Recreation on worksite wellness projects
- HealthLead assessment for baseline data to guide improvement areas
- Goal is to create scalable model for worksite wellness in state agencies to impact both employees and agency's target population

Governor's Get Fit Challenge

- Program for before, during or after school designed to get kids moving more and eating better
- Grades 4 through 8
- Pending IRB approval, will evaluate selected schools in the fall
- Includes DVD of warm up and core exercises plus 20 minutes of cardiovascular activity 3 days per week
- Also includes nutrition and physical activity worksheets
- Through the program, help shape healthier school environments for kids

Partnership with TSET

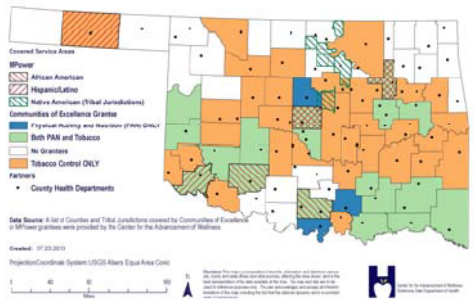
- One of multiple funding sources for Center
- Partners in tobacco, physical activity, and nutrition initiatives
- TSET Communities of Excellence (CX) grants in tobacco and physical activity/nutrition
- Center provides expert consultation to CX grantees, as well as schools, businesses, communities and others around the state

Oklahoma Tobacco Helpline 1 800 QUIT NOW Okhelpline.com

breathe easy

TOBACCO STOPS WITH ME. StopsWithMe.com

Oklahoma Areas Receiving Technical Assistance from the Center for the Advancement of Wellness



Strategic Priorities

Smokefree environments

- Sector-based education about voluntary smokefree/tobacco free policies
  - ✓ Entertainment industry – bars, casinos, restaurants with smoking rooms
  - ✓ Career technical centers
  - ✓ Focus on importance of clean indoor air and voluntary policies to promote health

Strategic Priorities

Registry of smokefree places

- Allows for monitoring/tracking smokefree policies around the state for goal-setting and reporting purposes
- Possible searchable public site to help connect citizens with smokefree places, including housing, bars, entertainment, etc

Strategic Priorities

Cessation

- Cessation through systems change
  - ✓ Assess state agencies and populations served
  - ✓ Work with health care systems, insurance, county health departments, other agencies
- Cessations communications
  - ✓ Mass media campaign (with TSET)
  - ✓ Materials for providers, insurance companies, and others

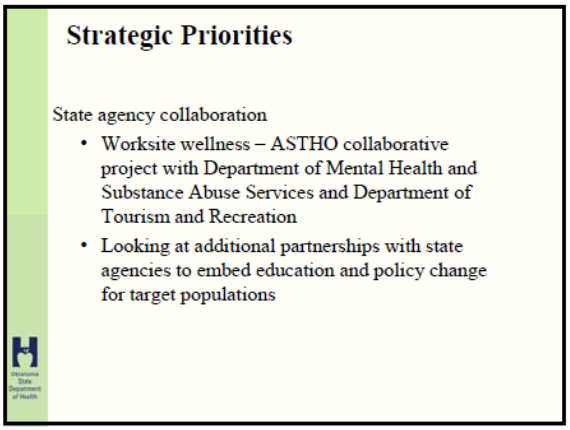
Strategic Priorities

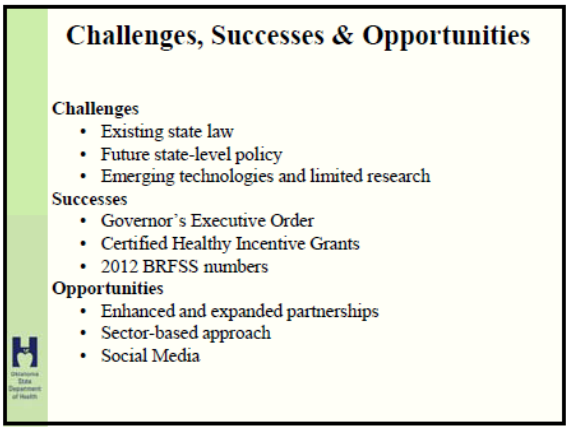
Youth engagement

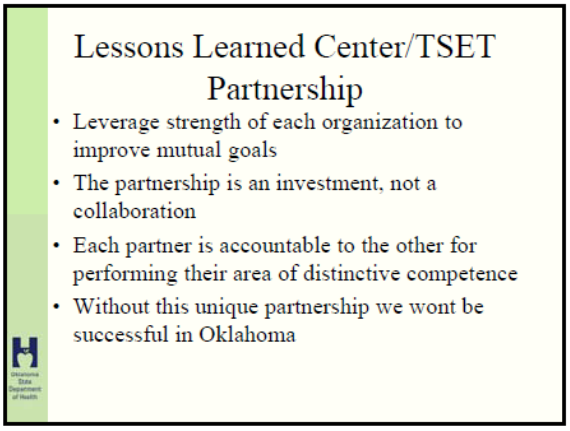
- Tobacco and Physical Activity/Nutrition focus for youth advocacy
- Survey youth, look at available research
- Explore partnerships for training, support

School-based strategies

- Access to fruits and vegetables
- Wellness policies
- 24/7 tobacco free





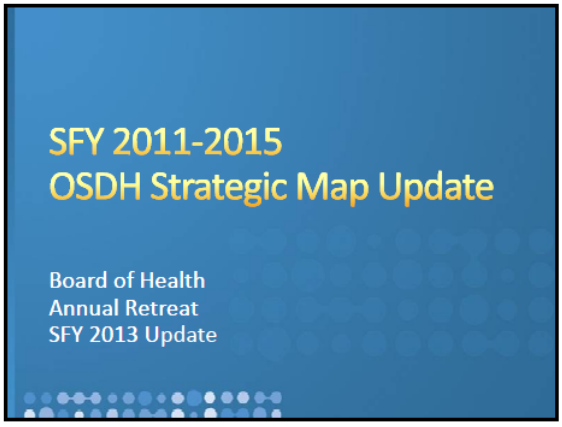


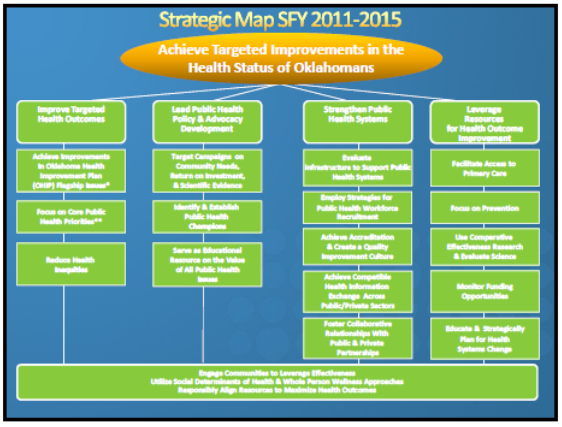
The presentation included a media advertisement about multiunit housing units as an example of media campaigns that have resulted from the collaboration between the OSDH and TSET. See Attachments 1-3.

The presentation concluded.

STRATEGIC PLAN REVIEW

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





Oklahoma Health Improvement Plan (OHIP) Flagship Issues

- Tobacco Use Prevention
- Children's Health Improvement
- Obesity Reduction

Core Public Health Priorities

- Children's Health
  - Infant Mortality
  - Prenatal Care
- Disease & Injury Prevention
  - Immunization
  - Motor Vehicle Crashes
  - Preventable Hospitalizations
- Imperatives
  - All Hazards Preparedness
  - Infectious Disease
  - Mandates
- Strong & Healthy Oklahoma (Wellness)
  - Cardiovascular Health
  - Obesity
  - Tobacco

LSTAT Strategic Planning Priority Area Lead Champions

- **OHIP Flagship & Core Public Health Services**
  - Strong & Healthy Oklahoma /Wellness *(Keith Reed)*
  - Children's Health *(Dr. Edd Rhoades)*
  - Disease & Injury Prevention/Imperatives *(Toni Frioux/Drs. Kristy Bradley & Hank Hartsell)*
  - Health Inequities *(Neil Hann)*
- **Policy & Advocacy** *(Dr. Mark Newman)*
- **Public Health Systems**
  - Infrastructure, Performance Management, & Accreditation *(Joyce Marshall)*
  - Workforce *(Toni Frioux)*
  - Health Information Exchange (HIE) *(Julie Cox-Kain)*
  - Public/Private Partnerships *(Neil Hann)*
- **Resources** *(Julie Cox-Kain)*

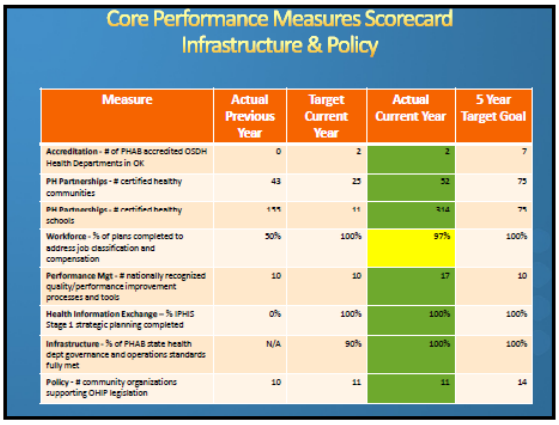
OSDH Performance Management Model: Tying It All Together

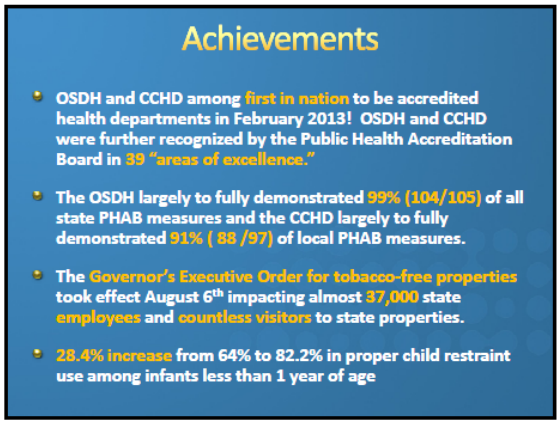
Core Performance Measures Scorecard Public Health Imperatives

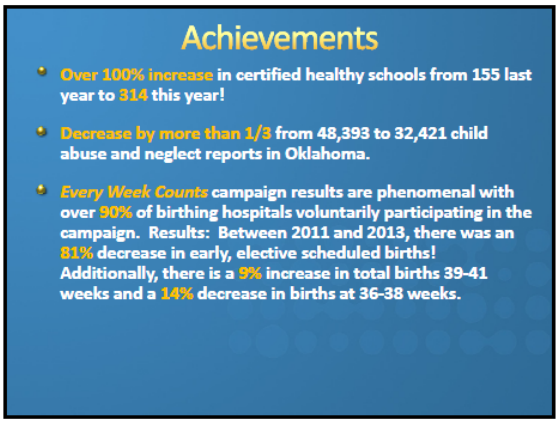
Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Inspection - % state mandated non-complaint activities meet IFMs	92.3%	90%	86%	100%
Inspection - % state mandated complaint activities meet mandates	23.1%	80%	67%	100%
Infectious Disease - % immediately notifiable reports received by phone consultation/investigation initiated in 15 minutes	98%	95%	99%	95%
Infectious Disease - % immediately notifiable reports submitted in PHIDDO/ investigation initiated in 15 minutes	92%	95%	97%	95%
Infectious Disease - Average # reported TB, pertussis, shigellosis, and cryptosporidiosis cases per 100,000 population	14.07	14.1	23.32	13.4
Preparedness - % of CHDs exercising COOP annually	100%	100%	100%	100%

Core Performance Measures Scorecard Public Health Priority Programs

Measure	Actual Previous Year	Target Current Year	Actual Current Year	5 Year Target Goal
Children - # infant deaths per 1000 live births	7.6	7.6	7.6 (provisional)	7.2
Children - % first trimester prenatal care	67.2%	77%	60.8%	78%
Injury - # motor vehicle injuries in infants less than one year of age	121	113	107	97
Prevention - # preventable hospitalizations per 1000 Medicare enrollees	81.8	84.8	81.0	82
Immunization - % immunized (19-35 months)	70.3%	72.5%	77.3%	76.5%
Obesity - % adults who are obese	31.1%	31.1%	32.2%	30.2%
Tobacco - % adults who smoke	26.1%	25.6%	23.3%	24.1%
Cardiovascular - cardiovascular deaths/100,000	292.8	272.6	302.9	236.9



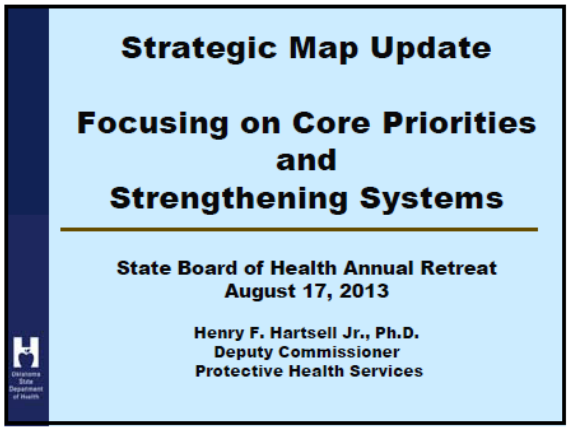


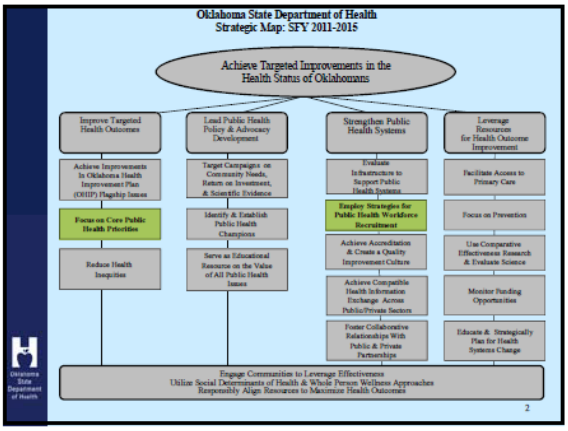


The presentation concluded.

FOCUS ON CORE PRIORITIES & STRENGTHEN SYSTEMS

Henry F. Hartsel, Ph.D., Deputy Commissioner, Protective Health Services





Objectives for Inspection Frequency Mandates

Meet 100% of required time intervals and response deadlines by FY2014 for:

1. State mandated routine inspections
2. State mandated complaint inspections
3. Contract (federal) mandated routine surveys
4. Contract (federal) complaint investigations

(Fifty-two mandates were covered by the four objectives in FY2013.)

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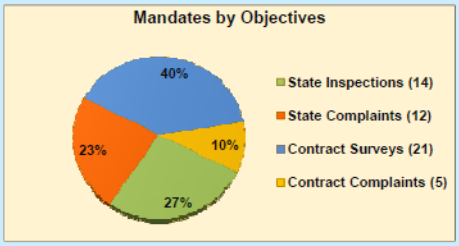
Inspection Frequency Mandates by Performance Objectives 2012 - 2013

Percentage of 52 Total Mandates Covered by the Objectives



Source: OSDH StepUp Performance Management System.

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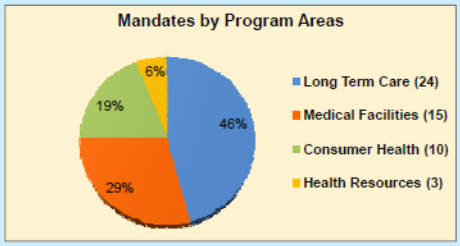
Inspection Frequency Mandates by Program Areas 2012-2013

Percentage of 52 Mandates Administered by Program Areas



Source: OSDH StepUp Performance Management System.

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Highlights for State Fiscal Year 2013

- *All* long term care inspections and investigations current on 6/30/2013
- Home health agency recertification surveys current on 9/30/2012
- Food service establishment, jail, and nurse aide training inspections timely performed for second straight year
- 48 of 52 (92%) mandates brought into compliance as of 6/30/2013

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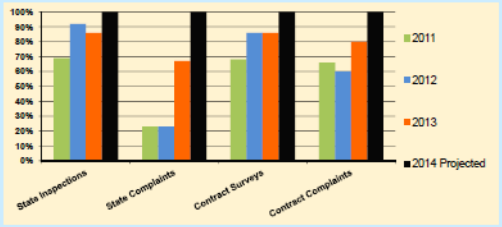
Compliance with Inspection Frequency Mandates Fiscal Years 2011-2014

Percentage of inspections, complaint investigations and surveys conducted by OSDH in accordance with mandated time frames.



Source: OSDH StepUp Performance Management System. "Contract Complaints" are based on the previous federal fiscal year.

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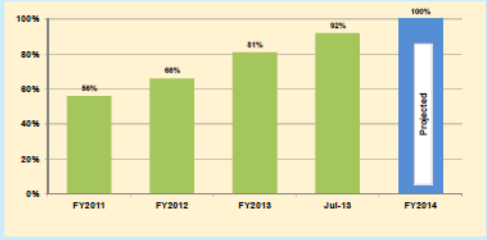
Compliance with Inspection Frequency Mandates Fiscal Years 2011-2014

Percent of Inspection Frequency Mandates in Compliance



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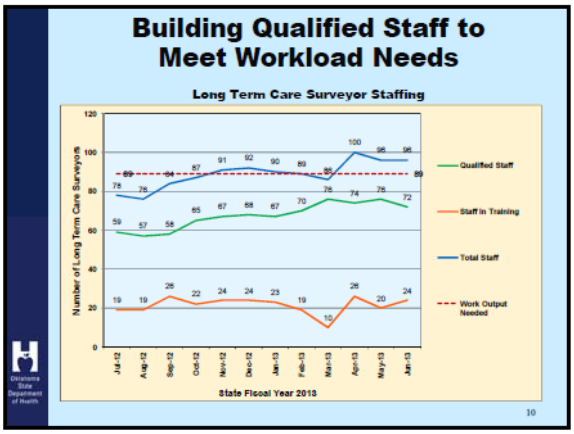
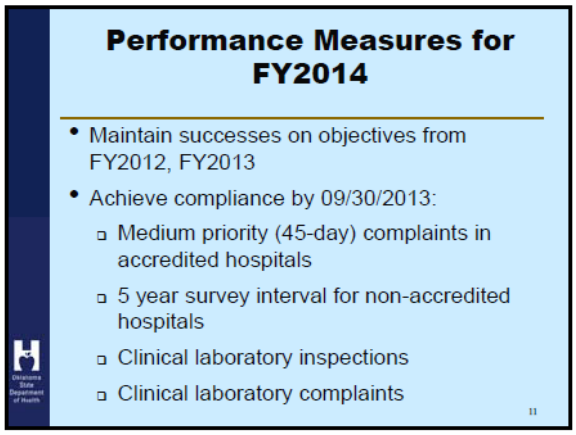
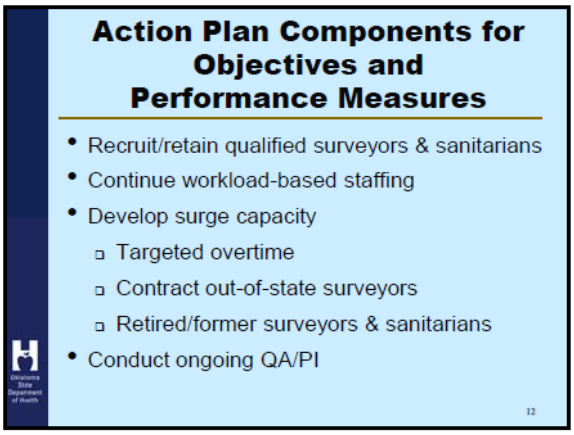
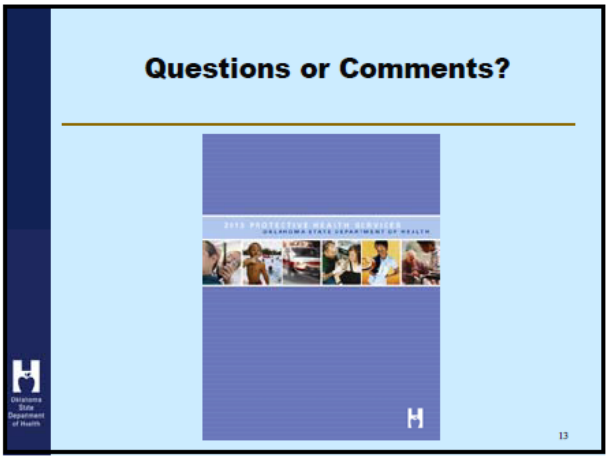




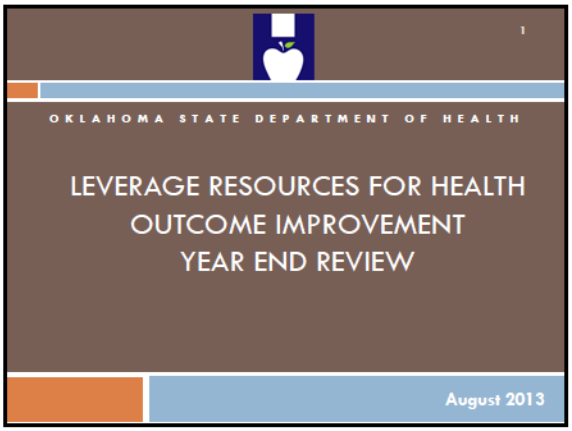


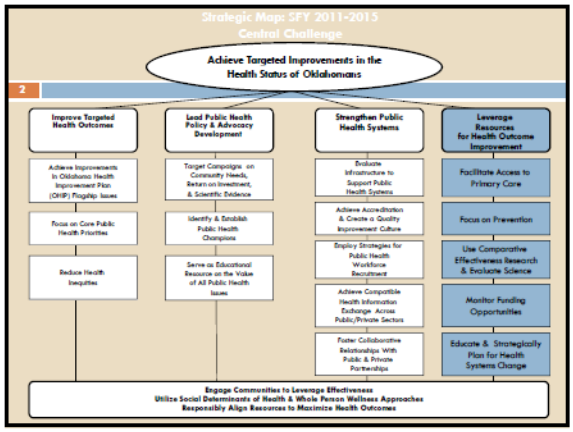


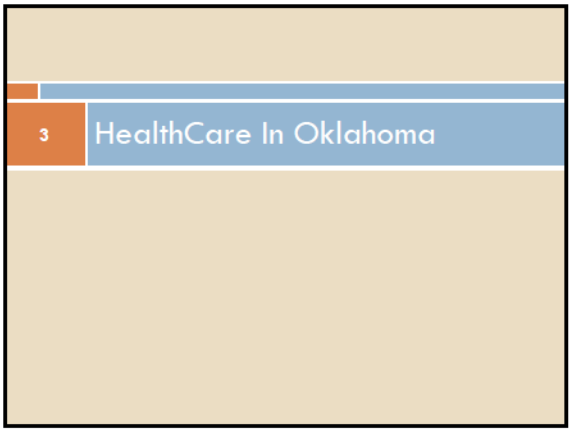
The presentation concluded.

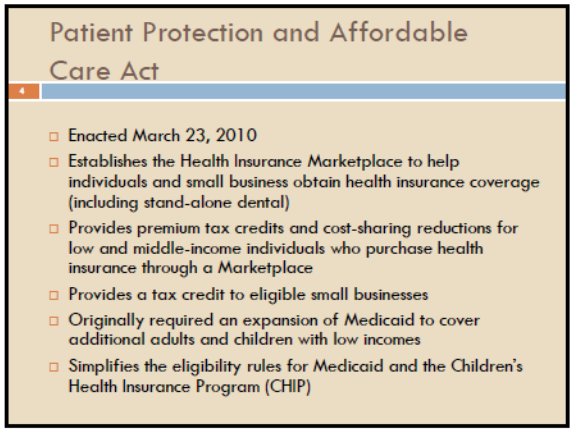
LEVERAGE RESOURCES FOR HEALTH OUTCOMES IMPROVEMENT YEAR END REVIEW

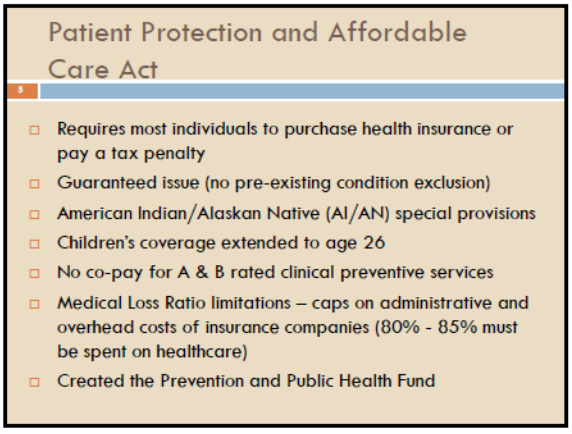
Julie Cox-Kain, M.P.A., Chief Operating Officer

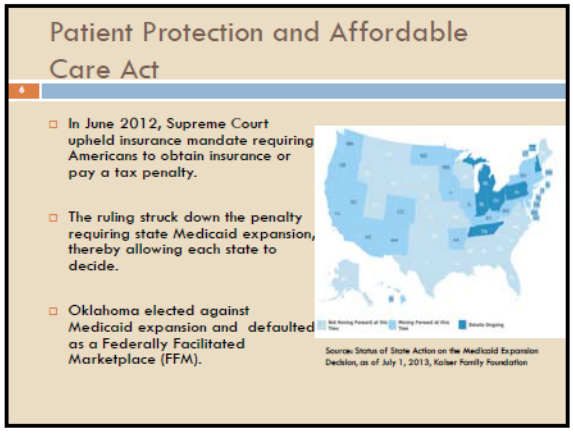








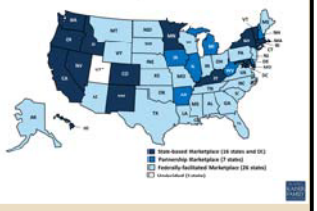




Types of Health Insurance Exchanges

- **State-Based Marketplace**
  - States can create and operate their own marketplace
- **Partnership Marketplace**
  - Hybrid in which the state runs certain functions. A Partnership Exchange allows states to make key decisions and tailor the marketplace to local needs and market conditions
- **Federally-Facilitated Marketplace (FFM)**
  - The Federal government will establish and operate a marketplace in those states that do not establish their own

States Decisions For Creating Health Insurance Marketplaces



Source: "Establishing Health Insurance Marketplaces: An Overview of State Efforts", Kaiser Family Foundation, 2013

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

Category	Percentage of expenses paid by health plan	Percentage of expenses paid by individual
Platinum	90%	10%
Gold	80%	20%
Silver	70%	30%
Bronze	60%	40%

Higher percentage of income used by plan

Lower monthly premium payment

Actuarial Value of Plans Offered in the Exchanges	
"Bronze"	This plan represents the required minimum creditable coverage standard; the actuarial value is 60%
"Silver"	Actuarial value of 70%
"Gold"	Actuarial value of 80%
"Platinum"	Actuarial value of 90%
"Catastrophic"	Provides catastrophic coverage along with some preventative and primary care benefits (only available in the individual market) to young adults (under age 30) and those to whom the individual mandate does not apply due to income reasons

Source: "Health Insurance Marketplace: Agents and Brokers Meeting" presentation, CMS 2013

Individual/Family Tax Credits

Income Level	Premium as a Percent of Income
Up to 133% FPL	2% of income
133-150% FPL	3 – 4% of income
150-200% FPL	4 – 6.3% of income
200-250% FPL	6.3 – 8.05% of income
250-300% FPL	8.05 – 9.5% of income
300-400% FPL	9.5% of income

Source: Summary of Affordable Care Act, Kaiser Family Foundation, 2013

- Beginning in January 2014, new tax credits will be available that will significantly reduce the cost of private health insurance for individuals and families.
- Provides refundable premium credits advanced to eligible individuals and families with incomes between 100-400% FPL to purchase insurance through the Exchanges.
- Requires verification of both income and citizenship status in determining eligibility for the federal premium credits.

Small Business Health Options Program (SHOP)

- Starting in 2014, a SHOP will be available in each State.
- Starting October 1, plans will be available for review and enrollment for coverage starting as soon as January 1, 2014. Rolling monthly enrollments for employers after January 1.
- Once a group is enrolled, its rate is guaranteed for 12 months.

Available to those employers:

- With fewer than 25 full time equivalent employees
- Whose employees' wages average less than $50, 000 per year
- Who contribute at least 50% of employees' premium costs
- Who buy health insurance through the SHOP only, starting in 2014

Is worth:

- Up to 35% of employer's premium contribution (up to 25% for tax-exempt employers) now
- Up to 50% of employer's premium contribution (up to 35% for tax-exempt employers) starting in 2014

Individual Penalties

Do any of the following apply?
- part of a religion opposed to acceptance of benefits from a health insurance policy
- between jobs and without insurance for up to three months
- undocumented immigrant
- incarcerated
- member of an Indian tribe
- family income is below the threshold for filing a tax return ($10,000 for an individual, $20,000 for a family in 2013)
- pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

YES → There is no penalty for being without health insurance.

NO

Were you insured for the whole year through a combination of any of the following sources?
- Medicare
- Medicaid or the Children's Health Insurance Program (CHIP)
- TRICARE (for service members, retirees, and their families)
- Veteran's health program
- Plan offered by an employer
- Insurance bought on your own that is at least at the Bronze level
- Grandfathered health plan in existence before the health reform law was enacted

YES → The requirement to have health insurance is satisfied and no penalty is assessed.

NO →

2014	2015	2016 +
Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.	Penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2.0% of family income, whichever is greater.	Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever

Source: "The Requirement to Buy Coverage Under the Affordable Care Act Beginning in 2014", Kaiser Family Foundation, 2013

Employer Penalties DELAYED

Are you a large employer?
- At least 50 FTE workers including full time (30+ hours per week) and part time workers (prorated)
- Excluding seasonal workers (up to 120 days per year)

YES → Are any of your full time employees in an exchange plan and receiving premium credit?

YES → Do you have more than 30 full time employees?

YES → Do you provide health insurance?

NO (from each) → NO PENALTY

Pay monthly penalty, lessor of:
1/12 x $2,000 x (# of full time employees -30)
OR
1/12 x $3,000 x (# of full time employees who receive credits for exchange coverage)
Delayed until 2015

YES

Pay monthly penalty: 1/12 x $2000 x (# of full time employees -30)
Delayed until 2015

NO

Source: Coverage or Penalty, US Chamber of Commerce

Essential Benefits

13

- Essential Health Benefits (EHB) are a set of healthcare service categories that must be covered by certain plans, starting in 2014.
- Health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, must offer this comprehensive package of items and services; EHBs must include items and services within at least 10 categories.
- Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid State Plans must cover these services by 2014.

- Maternity Care
- Hospitalization
- Rehabilitative & Habilitative Services
- Laboratory Services
- Pediatric Services
- Prescription Drugs
- Mental & Behavioral Health Treatment
- Ambulatory Patient Services
- Preventive & Wellness Services
- Emergency Services

Source: "Health Insurance Marketplace: Agents and Brokers Meeting" presentation, CMS 2013

Premium Rate Setting Factors

14

Age

Plan premium rates can vary within a ratio of 3:1 for adults 21 and older. States also can vary for children under 21 based on actuarial justification.

States can establish age curves or can default to the federal age curve.

Age bands: 0-20; one-year bands between 21-63; 64 and older.

Smoking

Premium rates can vary within 1.5:1 ratio.

Can vary based on age.

Small group plans may only impose a tobacco surcharge in connection with a wellness program allowing participating individuals to avoid the full amount of the surcharge.

Tobacco use defined in terms of regular use and time of last use (i.e., average 4+/week within the last 6 months).

Geography

States are permitted to establish rating areas: Based on Metropolitan Statistical Areas (MSAs)/non-MSAs, 3-digit ZIP codes or counties; and established as of January 1, 2013, no more rating areas than the number of MSAs plus one in the state.

If a state did not establish rating areas, the federal default is one rating area for each MSA and one rating for all non-MSA areas in the state.

Family Size

The total premium for family coverage generally must be determined by summing the premiums for each individual family member. For family members under 21, total premium includes only the premiums for no more than the three oldest covered children.

Tobacco and age rating must apply only to the portion of the premium attributable to applicable covered family member.

Adverse Selection Mitigation Strategies: Risk adjustment, Reinsurance & Risk Corridors

Source: "Health Insurance Marketplace: Agents and Brokers Meeting" presentation, CMS 2013

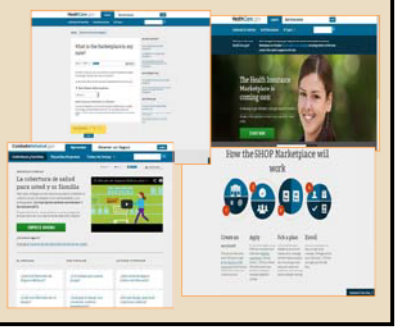
Online Enrollment Portal Healthcare.gov

15

Open Enrollment October 1, 2013 – March 31, 2014

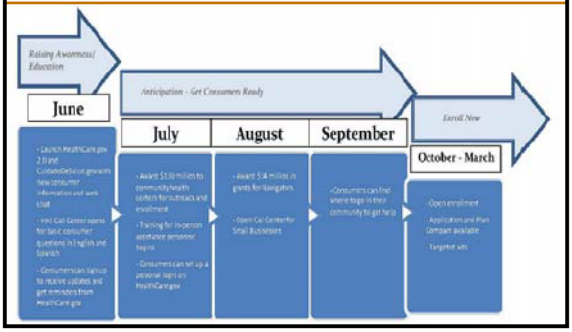
Enroll online or by phone Healthcare.gov 1-800-318-2596

Expected to include links to issuer and agent websites



Centers for Medicare and Medicaid Services Timeline (CMS)

16



Implementation Delays

17

- The Employee Choice provision in FFM-SHOP markets have been officially delayed until 2015 – in 2014 plan year, SHOP enrollees can only choose one Qualified Health Plan (QHP)selected by the employer.
- Guidance and operational/technical details and processes regarding the various provisions have yet to be finalized, including a paper-based verification process for American Indian/Alaska Natives (AI/ANs).
- In June 2013, the Government Accountability Office cited approximately 44% of key activities CMS targeted for completion by March 31, 2013, were behind schedule.
- The federal data hub, expected to power the exchange, remains behind schedule, including final testing with federal and state partners (and data sources).
- Many activities remain incomplete in the core functional areas of eligibility and enrollment, plan management, and consumer assistance.
- Funding awards and development of a training curriculum for a key program that will provide outreach and enrollment assistance to small employers and employees have been delayed by approximately 2 months.

CMS's timelines for the remaining key activities provide a roadmap for completion; however, many activities yet to be completed suggest future challenges

CMS has expressed its confidence that exchanges will be open and functioning in every state by October 1, 2013

PPACA Medicaid Changes

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- Use of the new Modified Gross Adjusted Income (MAGI) to calculate household composition and income to determine Medicaid eligibility
- Elimination of asset tests
- Implementation of passive renewals
- Automation of electronic verifications to determine Medicaid eligibility in real-time
- Streamlined eligibility and connection/hand-off with the Federally Facilitated Marketplace
- Former foster care children under age 26 will be eligible for Medicaid regardless of decisions about expansion, Federally Facilitated Marketplace or current Medicaid programs. According to OHCA rule impact statement, the cost for the second half of FY2014 to cover this group would be $600k

19 Projected Insurance Enrollment

Future Insurance Market Enrollment without Medicaid Expansion

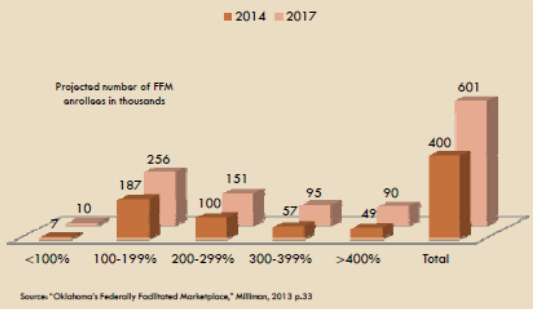
20

Based on 2013 Milliman "Best Estimate" Projections:

Market	2012	2014	2017
Individual	108,677	399,999	601,812
ESI Small Group	353,710	347,489	360,011
ESI Medium Group	181,468	187,651	203,126
ESI Large Group (Fully Insured)	365,467	362,769	376,741
ESI Large Group (Self Insured)	779,768	756,929	768,024
Medicaid/CHIP	524,877	592,935	641,814
Uninsured	644,843	425,088	268,084

Oklahoma Enrollment by Income Level For Individual Market Under Age 65

21



Source: "Oklahoma's Federally Facilitated Marketplace," Milliman, 2013 p.33

22 Recommendations for Medicaid Waivers

Leavitt Partner Recommendations

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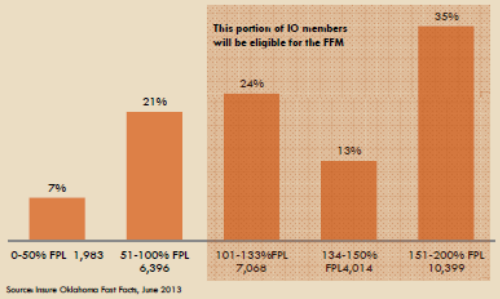
- Negotiate with the Centers for Medicare and Medicaid Services (CMS) to extend Insure Oklahoma (IO) through 2014
  - An extension will provide an estimated would continue insurance for approximately 9,000 individuals between 0-100% FPL
  - Areas of negotiation may be limited due to state and federal statutes and/or rules
  - Based written correspondence cost-sharing provisions and enrollment caps seem to be areas of primary concern for CMS
  - Modification of caps and cost sharing provisions may increase Oklahoma's financial liability

Insure Oklahoma FPL Breakdown of Total Enrollment

24



Source: Insure Oklahoma Fast Facts, June 2013

Leavitt Partner Recommendations

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- Prepare an alternative to PPACA Medicaid expansion through a demonstration waiver:
  - Create a steering committee
  - Leverage Insure Oklahoma (IO) as framework
  - Maintain Employer Sponsored Insurance (ESI) components of IO
  - Support premium assistance of private insurance coverage
  - Integrate public health and behavior health initiatives and infrastructure
  - Streamline Medicaid eligibility
  - Work toward multi-payer models
  - Develop a strong evaluation component
  - Demonstrate cost-effectiveness
  - Leverage current program initiatives

Leavitt Partner Recommendations

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- Demonstration waiver (continued)
  - Projected outcomes
    - Reduce the number of uninsured individuals in Oklahoma
    - Opportunity for innovative approaches to improve health outcomes and slow the increase in healthcare costs
    - Reduce uncompensated care costs for healthcare providers and the State of Oklahoma
    - Protect Oklahoma employers with lower wage workers from shared responsibility payments (*delayed until 2015*)
    - Opportunity to realize program savings and increased tax revenue
  - Costs
    - State of Oklahoma appropriations to match the recommended demonstration proposal estimated at $745 - $939 million over 10 years

Leavitt Partner Recommendations

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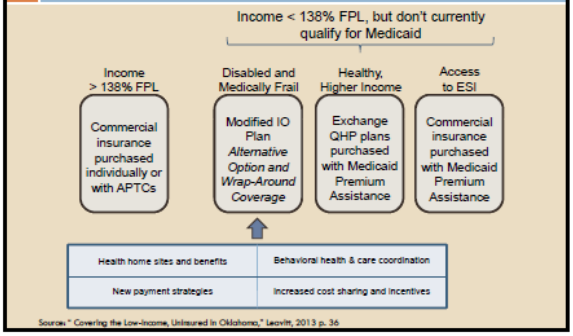

Source: " Covering the Low-Income, Uninsured in Oklahoma," Leavitt, 2013 p. 36

Leavitt Partner Recommendations

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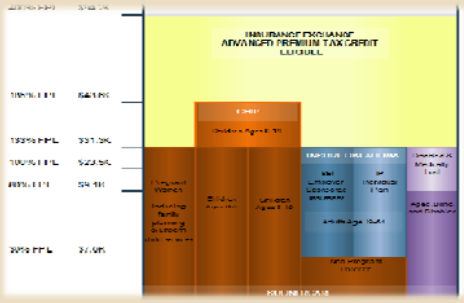

Source: " Covering the Low-Income, Uninsured in Oklahoma," presentation Leavitt, 2013

Leavitt Partner Recommendations Costs and Savings

29

Estimates of Ten Year Financial Cost and Economic Impact of the Proposed Demonstration Program, 2023				
Take-Up	New Enrollees	Total Cost (Federal and State)	Net Cost to State (Surplus)	Total Economic Impact
Low	204,911	$10.5 Billion	($486 Million)	$13.6 Billion
Medium	233,334	$12.0 Billion	($465 Million)	$15.6 Billion
High	257,493	$13.3 Billion	($447 Million)	$17.3 Billion

Source: Leavitt Partners, 2013

Leavitt Partner Recommendations Costs and Savings

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Estimates of Ten Year Net Surplus

Oklahoma's Total Match	OHCA Program Savings	Other State Agency Savings**	Total Increase in Tax Revenue	Net Surplus
$745-$939 million	$211 million	$482 million	$538-$693 million	$447-$486 million

**Other state agency savings (DMHSAS, OSDH, and Corrections) estimated from a high-level review of cost savings and warrant additional analysis

1
2
3
4
5
6

Leavitt Partner Recommendations

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- Develop complementary proposals to reduce uncompensated care costs for Native Americans seeking healthcare services at tribal and IHS facilities:
  - Limited federal resources make it difficult for IHS, Tribal, and Urban Indian (I/T/U) healthcare facilities to meet demand; this burdens private contract healthcare providers with uncompensated care costs
  - Uncompensated care waivers provide an opportunity for the federal government to meet their obligation to provide healthcare to Native Americans in Oklahoma
  - Allows the State of Oklahoma to mitigate costs associated with uncompensated care and improve health outcomes through greater healthcare access
  - Federal share of healthcare costs for AI/AN is 100%
  - Uncompensated care waivers are not a substitute for comprehensive insurance coverage

Leavitt Partner Recommendations

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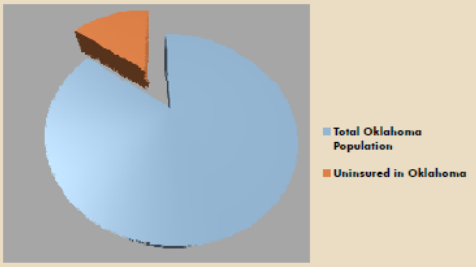
- Provide full reimbursement for current Medicaid program eligibility (pregnant women, family planning, and breast and cervical cancer) to reduce the potential for an increase in uncompensated care for I/T/Us
- Identify specific issues significantly impacting healthcare in Oklahoma, define quality measures and metrics, and implement new payment strategies that focus on provider incentives and shares savings with the I/T/U

33 The Uninsured and Uncompensated Care in Oklahoma

The Uninsured in Oklahoma

34

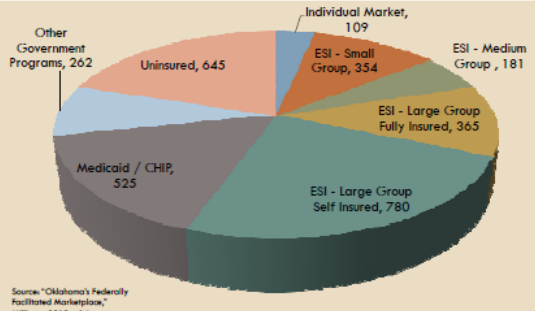
644, 843 or 17% of Oklahoma's population is uninsured



Source: Milliman's 2013 report, "Oklahoma Federally Facilitated Marketplace":

Oklahoma Population Under Age 65 by Type of Insurance in Thousands

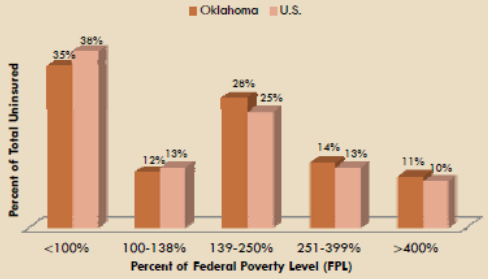
35



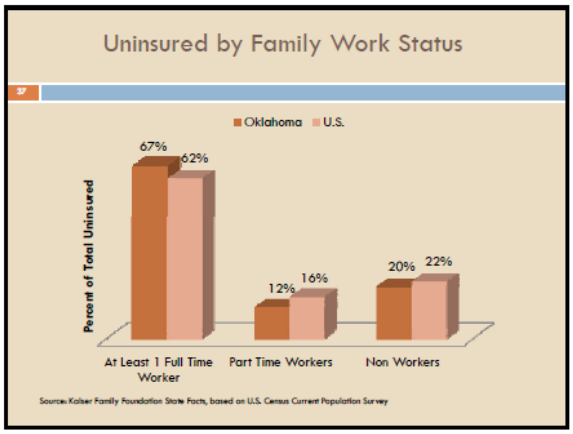
Source: "Oklahoma's Federally Facilitated Marketplace," Milliman, 2013 p.14

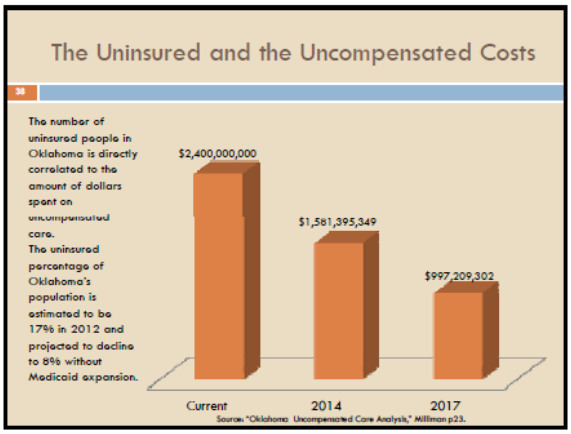
Uninsured by Income Level, 2011

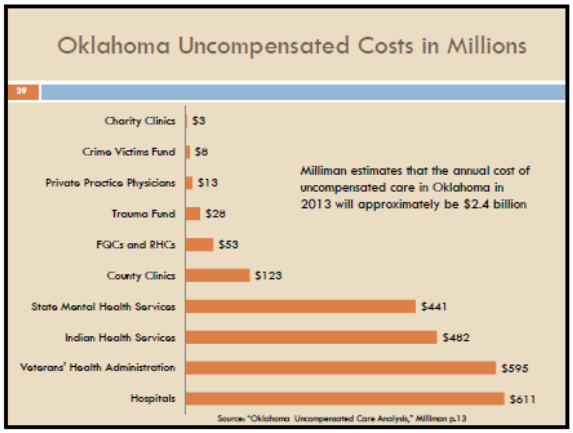
36

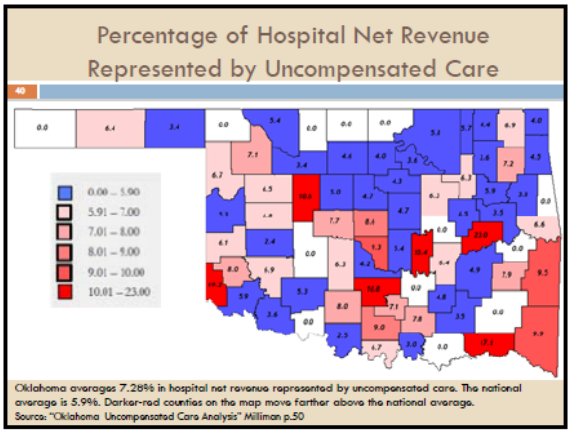


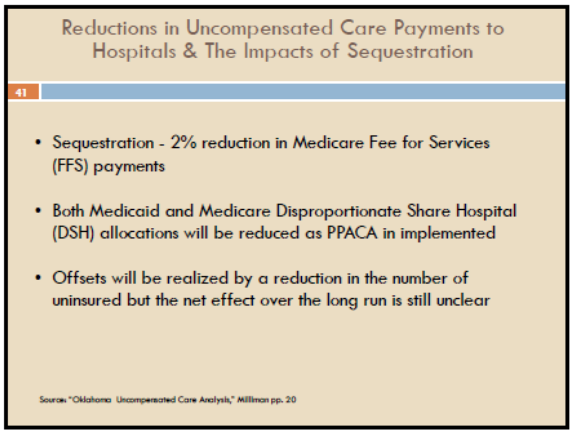
Source: Kaiser Family Foundation State Facts

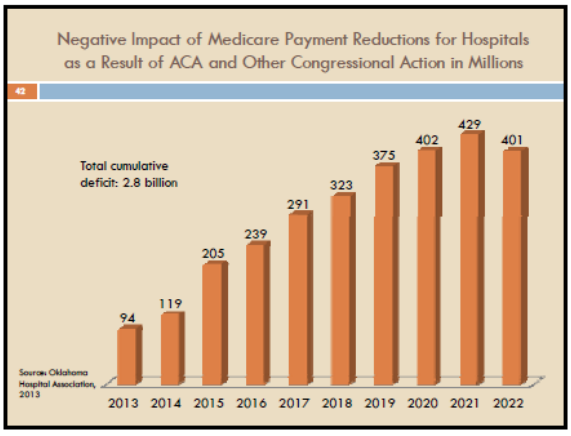

Uninsured by Family Work Status
37
Oklahoma
U.S.
Percent of Total Uninsured
67%
62%
12%
16%
20%
22%
At Least 1 Full Time Worker
Part Time Workers
Non Workers
Source: Kaiser Family Foundation State Facts, based on U.S. Census Current Population Survey

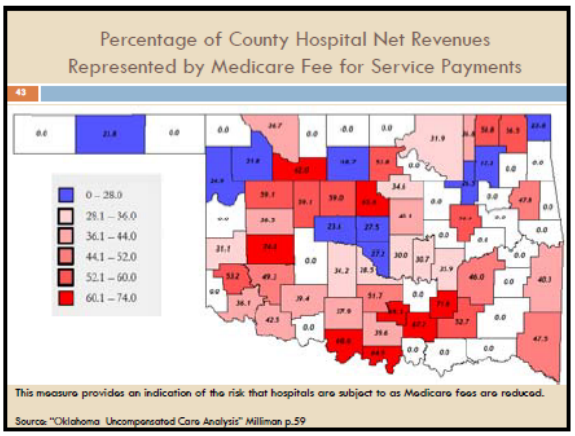

The Uninsured and the Uncompensated Costs
38
The number of uninsured people in Oklahoma is directly correlated to the amount of dollars spent on uncompensated care.
The uninsured percentage of Oklahoma's population is estimated to be 17% in 2012 and projected to decline to 8% without Medicaid expansion.
$2,400,000,000
$1,581,395,349
$997,209,302
Current
2014
2017
Source: "Oklahoma Uncompensated Care Analysis," Milliman p23.

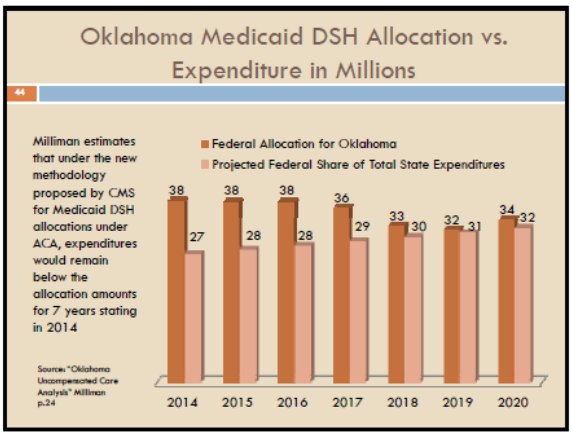

Oklahoma Uncompensated Costs in Millions
39
Charity Clinics $3
Crime Victims Fund $8
Private Practice Physicians $13
Trauma Fund $28
FQCs and RHCs $53
County Clinics $123
State Mental Health Services $441
Indian Health Services $482
Veterans' Health Administration $595
Hospitals $611
Milliman estimates that the annual cost of uncompensated care in Oklahoma in 2013 will approximately be $2.4 billion
Source: "Oklahoma Uncompensated Care Analysis," Milliman p.13


Percentage of Hospital Net Revenue Represented by Uncompensated Care
40
0.00 – 5.90
5.91 – 7.00
7.01 – 8.00
8.01 – 9.00
9.01 – 10.00
10.01 – 23.00
Oklahoma averages 7.28% in hospital net revenue represented by uncompensated care. The national average is 5.9%. Darker-red counties on the map move farther above the national average.
Source: "Oklahoma Uncompensated Care Analysis" Milliman p.50

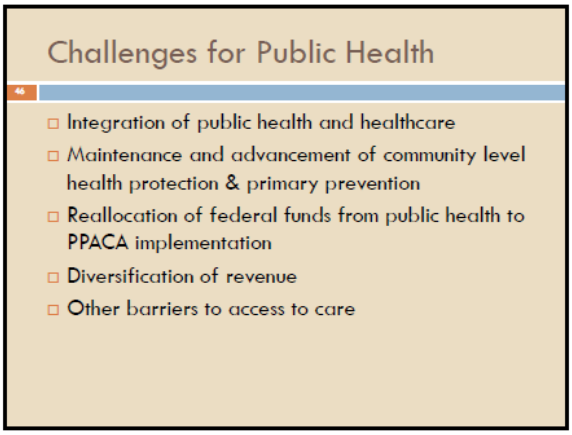

Reductions in Uncompensated Care Payments to Hospitals & The Impacts of Sequestration
41
• Sequestration - 2% reduction in Medicare Fee for Services (FFS) payments
• Both Medicaid and Medicare Disproportionate Share Hospital (DSH) allocations will be reduced as PPACA in implemented
• Offsets will be realized by a reduction in the number of uninsured but the net effect over the long run is still unclear
Source: "Oklahoma Uncompensated Care Analysis," Milliman pp. 20

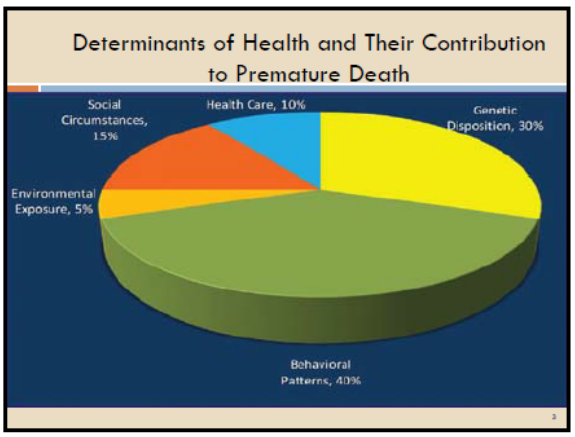

Negative Impact of Medicare Payment Reductions for Hospitals as a Result of ACA and Other Congressional Action in Millions
42
Total cumulative deficit: 2.8 billion
94
119
205
239
291
323
375
402
429
401
Source: Oklahoma Hospital Association, 2013
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022

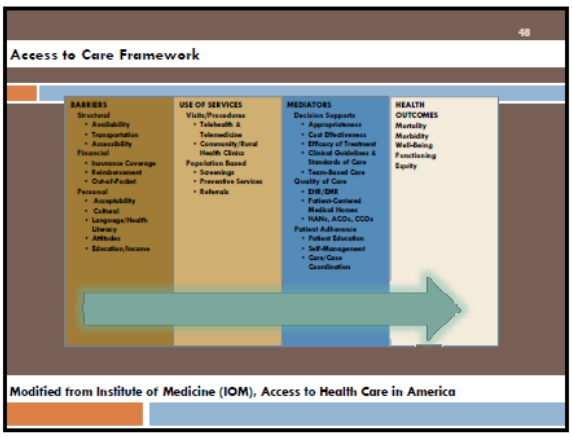

Percentage of County Hospital Net Revenues Represented by Medicare Fee for Service Payments
43
0 – 28.0
28.1 – 36.0
36.1 – 44.0
44.1 – 52.0
52.1 – 60.0
60.1 – 74.0
This measure provides an indication of the risk that hospitals are subject to as Medicare fees are reduced.
Source: "Oklahoma Uncompensated Care Analysis" Milliman p.59

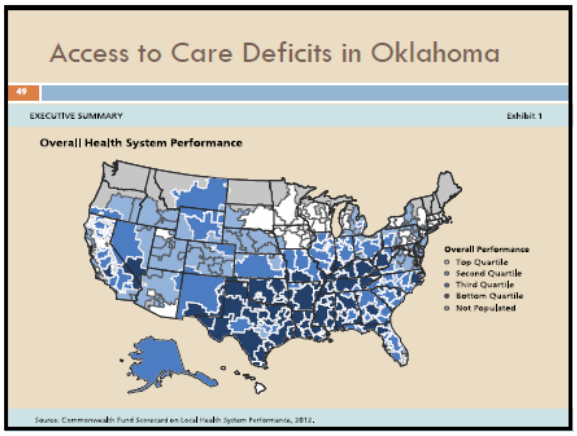

Oklahoma Medicaid DSH Allocation vs. Expenditure in Millions
44
Milliman estimates that under the new methodology proposed by CMS for Medicaid DSH allocations under ACA, expenditures would remain below the allocation amounts for 7 years stating in 2014
Federal Allocation for Oklahoma
Projected Federal Share of Total State Expenditures
38 27
38 28
38 28
36 29
33 30
32 31
34 32
2014 2015 2016 2017 2018 2019 2020
Source: "Oklahoma Uncompensated Care Analysis" Milliman p.24

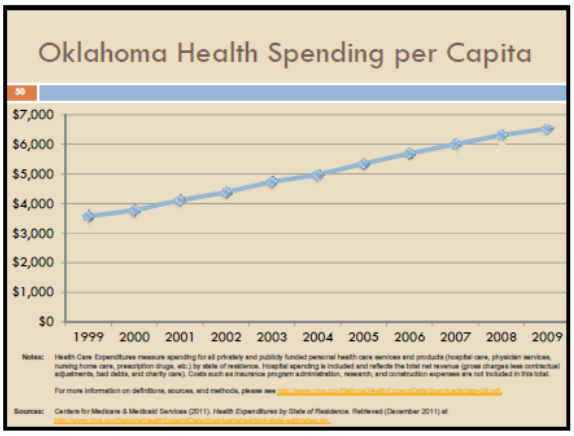

45
Challenges and Opportunities for Public Health

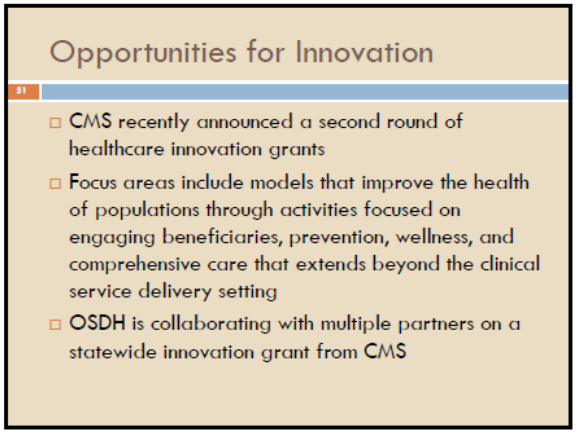

Challenges for Public Health
46
Integration of public health and healthcare
Maintenance and advancement of community level health protection & primary prevention
Reallocation of federal funds from public health to PPACA implementation
Diversification of revenue
Other barriers to access to care


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


48
Access to Care Framework
BARRIERS
USE OF SERVICES
MEDIATORS
HEALTH OUTCOMES
Modified from Institute of Medicine (IOM), Access to Health Care in America







Dr. Cline and the Board acknowledged Chris Bruehl, Director of Appointments for Governor Mary Fallin, for taking time from his schedule to thank the Board of Health for their efforts as he passed through the retreat facility.

Dr. Cline and the Board thanked Representative Jeff Hickman for the time he spent addressing the Board as well as advocacy efforts in public health. Representative Hickman thanked the Board for using their expertise in healthcare to improve public health and encouraged members to contact their local legislators and advocate for public health policy that will make a difference.

The presentation concluded.

MISSION, VISION, VALUES
Arnold Baciagalupo, Ph.D.

Dr. Baciagalupo briefly described the importance of an organization's Mission, Vision, and Values statements. He emphasized that intermittent review of these statements is critical to the continued alignment of an organization. He drew Board attention to the handout in the packet which outlined the process used by the Department for the review of the current Mission, Vision, and Values statements.

The recommended Mission Statement is as follows: *To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy.*

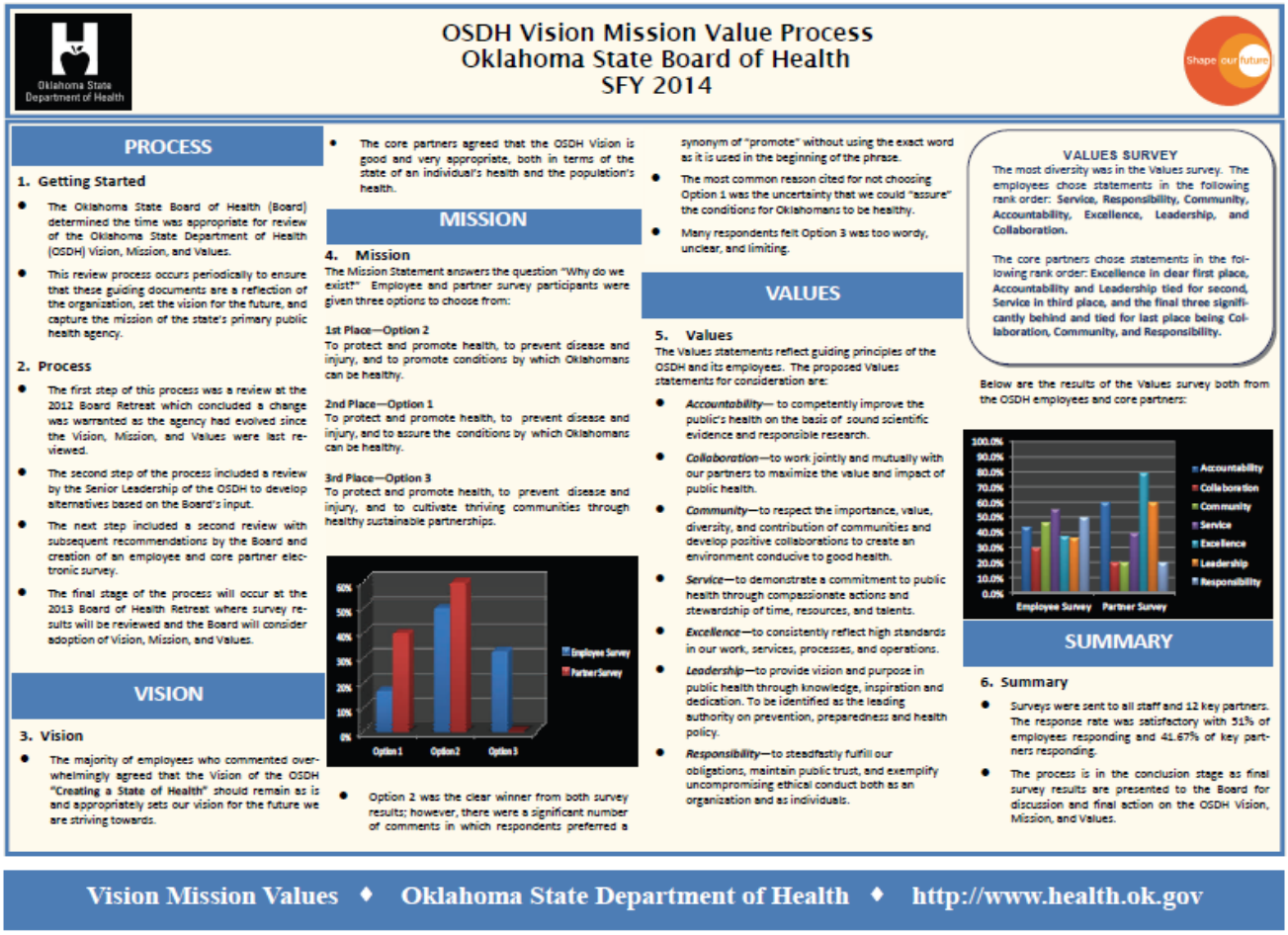
Ms. Wolfe moved Board approval to adopt the Mission Statement as presented. Second Dr. Alexopulos. Motion carried.

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

There were no modifications to the current Vision Statement.

Mr. Starkey moved Board approval to table action on the values statements until August 18, 2013. Mr. Starkey moved Board approval to appoint an Ad Hoc Committee consisting of Ms. Burger, Dr. Stewart, and Dr. Alexopulos for the purpose of modifying the proposed values Statements, based on Board comments, and presenting recommendations back to the Board on August 18, 2013. Second Ms. Wolfe. Motion carried.

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



The presentation concluded.

2013 LEGISLATIVE AGENDA BREAKOUT

Mark Newman, Ph.D., Director, Office of State and Federal Policy

The Board discussed potential policy and legislative issues they would like to support during the upcoming legislative session.

Ms. Wolfe moved Board approval to explore and develop language to transfer hearing aid dealers and fitters to the Board of Examiners of Speech Language Pathologists and Audiologists; Workplace Drug and Alcohol Testing Program to the Department of Labor; and Certified Workplans and HMO's to the State Department of Insurance. Second Ms. Burger. Motion carried.

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

Ms. Burger moved Board approval to explore and develop language prohibit the sale of ecigarettes to minors. Second Dr. Alexopulos. Motion carried.

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

Dr. Gerard moved Board approval to explore and develop language to propose a tax credit for the construction of tornado shelters or sales tax-free materials when constructing a tornado shelter. Second Ms. Wolfe. Motion carried.

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

Dr. Grim moved Board approval to explore and develop language to support smoking policy disclosure of multiunit housing. Second Dr. Stewart. Motion carried.

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

ADJOURNMENT

Dr. Krishna advised the Board and Department staff that the proposed Executive Session on August 18, 2013 would need to be moved to the first item on the agenda in order to allow Dr. Alexopulos to attend. A motion would be made the morning of August 18, 2013.

Ms. Wolfe moved to adjourn. Second Dr. Stewart. Motion carried.

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

The meeting adjourned at 4:37 p.m.

Sunday, August 18, 2013

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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; VaLauna Grissom, Secretary to the State Board of Health; Commissioner's Office: Diane Hanley, Janice Hiner.

Visitors in attendance: See list

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

Ms. Burger moved Board approval to move the Proposed Executive Session to the first item on the agenda. Second Ms. Wolfe. Motion carried.

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

PROPOSED EXECUTIVE SESSION
Dr. Grim moved Board approval to move into Executive Session at 8:32 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.

- Conflict of Interest discussion

Second Alexopulos. Motion carried.

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

Dr. Alexopulos moved Board approval to come out of Executive Session at 9:19 a.m. and open regular meeting. Second Dr. Gerard. Motion carried.

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

No action taken as a result of Executive Session

Dr. Baciagalupo thanked the Board and Department staff for their commitment and participation throughout the meeting. He asked the Board if their expectations of him were met. 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.

COMMUNITY RELATIONS/INVOLVEMENT
Arnold Baciagalupo, Ph.D.

Dr. Baciagalupo asked Board member to briefly provide an overview of local health issues from their respective communities. Each Board member discussed outreach opportunities as a result of the previous year President's Challenge in which Dr. Krishna challenged each Board member to develop an individual Board member action plan. Board members also highlighted opportunities for collaboration and partnerships within their communities as well as the barriers faced by some communities such as access to care, impacts of natural disasters, poverty, and increases in domestic violence.

2014 BUDGET / BUSINESS PLAN
Julie Cox-Kain, M.P.A., Chief Operating Officer

OKLAHOMA STATE DEPARTMENT OF HEALTH

BUDGET AND BUSINESS PLAN OVERVIEW
STATE FISCAL YEAR 2014

OSDH SFY 2013 -2014 Budget Summary Comparison

Revenue Source	2013 Budget	2013 % of Budget	2014 Budget	2014 % of Budget
Federal	$231,869,055	56.46%	$222,622,449	55.01%
Revolving (Includes Local Millage)	$117,055,977	28.50%	$119,090,718	29.43%
State	$ 61,783,682	15.04%	$62,983,682	15.56%
Total	$410,708,714	100%	$404,696,849	100%

Expenditure Category	2013 Budget	2013 % of Budget	2014 Budget	2014 % of Budget
Personnel	$148,827,862	36.24%	$144,029,554	35.59%
Professional Services	$55,172,567	13.43%	$65,739,335	16.24%
Travel	$5,334,795	1.30%	$5,382,438	1.33%
Equipment	$2,659,321	0.65%	$1,761,527	0.44%
Local Government Subdivisions	$16,435,559	4.00%	$14,664,362	3.62%
Trauma Distribution	$28,324,000	6.90%	$28,001,600	6.92%
WIC Food Costs	$66,748,068	16.25%	$65,550,000	16.20%
Other Expenditures	$87,206,542	21.23%	$79,568,033	19.66%

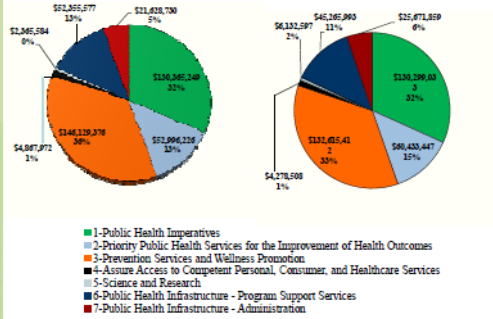
2014 Funding Public Health Priority

1 - Public Health Imperatives	$130,299,033
2 - Priority Public Health Services for the Improvement of Health Outcomes	$60,433,447
3 - Prevention Services and Wellness Promotion	$132,615,412
4 - Assure Access to Competent Personal, Consumer, and Healthcare Services	$4,278,508
5 - Science and Research	$6,132,597
6 - Public Health Infrastructure - Program Support Services	$45,265,993
7 - Public Health Infrastructure - Administration	$25,671,859
Total	$404,696,849

OSDH SFY 2014 BUDGET BY PUBLIC HEALTH PRIORITY

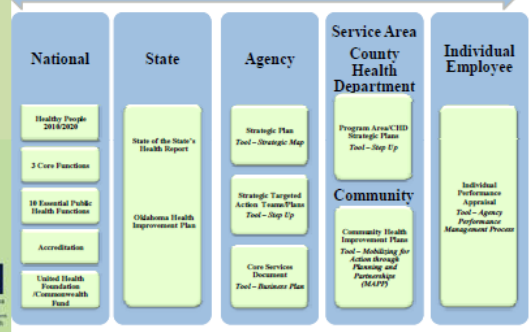
2013 Budget $410,708,714

2014 Budget $404,696,849



BUSINESS PLAN UPDATE

OKLAHOMA STATE DEPARTMENT OF HEALTH
STRATEGIC PLANNING MODEL



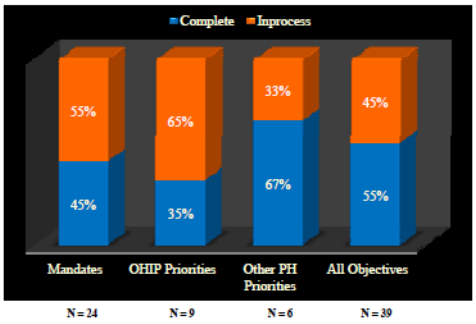
Core Public Health Priorities

Mandates
- Mandates
- Emergency Preparedness & Response
- Infectious Disease Control

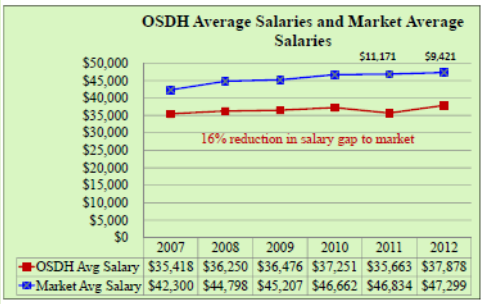
OHIP Priorities
- Tobacco
- Obesity
- Children's Health

Other Public Health Priorities
- Preventable Hospitalizations
- Immunization
- Motor Vehicle Crash Death

Business Plan 2013 Update

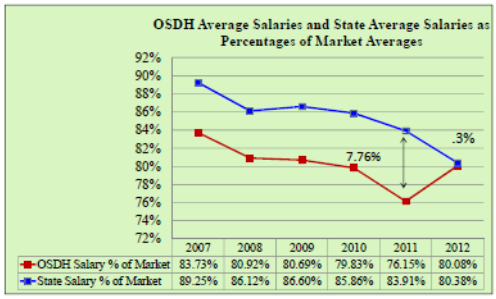


BUSINESS PLAN EXAMPLE



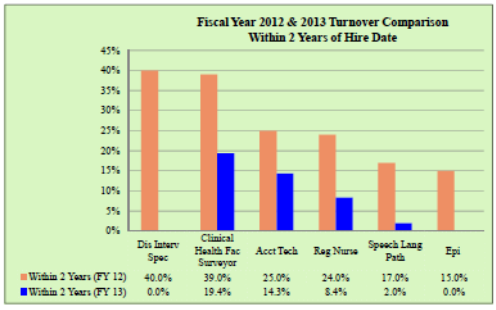
	2007	2008	2009	2010	2011	2012
OSDH Avg Salary	$35,418	$36,250	$36,476	$37,251	$35,663	$37,878
Market Avg Salary	$42,300	$44,798	$45,207	$46,662	$46,834	$47,299

Human Resources



	2007	2008	2009	2010	2011	2012
OSDH Salary % of Market	83.73%	80.92%	80.69%	79.83%	76.15%	80.08%
State Salary % of Market	89.25%	86.12%	86.60%	85.86%	83.91%	80.38%

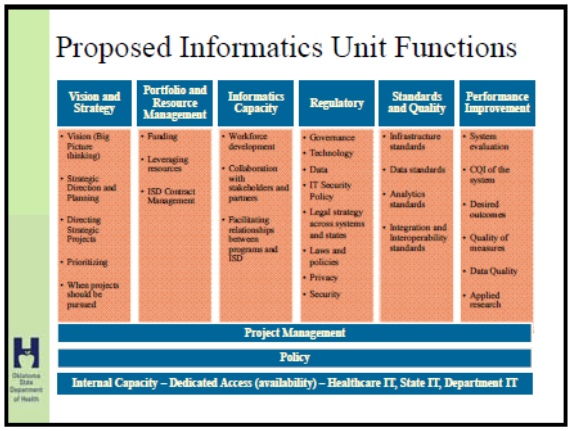
Human Resources

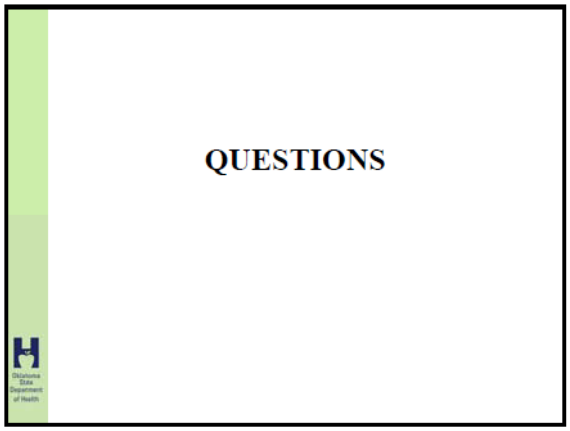


	Dis Interv Spec	Clinical Health Fac Surveyor	Acct Tech	Reg Nurse	Speech Lang Path	Epi
Within 2 Years (FY 12)	40.0%	39.0%	25.0%	24.0%	17.0%	15.0%
Within 2 Years (FY 13)	0.0%	19.4%	14.3%	8.4%	2.0%	0.0%

2014 Key Focus Area

- Develop additional health informatics capacity
- Necessary to create data architecture and govern the use and exchange of public health information:
  - Between public health registries and programs
  - Between Health and Human Service agencies
  - Between the OSDH and medical providers
- The deadlines for Meaningful Use Stage 2 are intensifying focus on the following:
  - Public health Meaningful Use activities
  - Public Health Information Network (PHIN) Activities
    - Interoperable Public Health Information System (IPHIS)
    - Laboratory Information Management System (LIMS)
    - Oklahoma State Immunization Information System (OSIIS)
    - Case Management Client Information System (CMCIS)
  - Privacy & Security
  - Other agency registries and systems
- IT consolidation process has complicated efforts
- All state public health agencies are dealing with these issues currently





The presentation concluded.

OFFICE OF ACCOUNTABILITY SYSTEMS POLICIES AND PROCEDURES
Terry L. Cline, Ph.D., Commissioner of Health

Dr. Cline presented the Office of Accountability Systems Policy with highlighted additions for approval to the Board of Health. He briefly discussed the controls built into the policy to ensure consistent and fair review and the creation of the Coordinating Complaint Council, which will serve to maximize the resources of the Board and Department and eliminate the duplication of investigations.

Office of Accountability Systems

Background

The Office of Accountability Systems (OAS) was created pursuant to Title 63 of the Oklahoma Statutes, Section 1-105f (63 O.S. § 105f) by the Oklahoma Legislature in 2006. Pursuant to statute, there is a Director for OAS who reports directly to and under the direct supervision of the Board of Health, but is also under the general supervision of the Commissioner of Health, 63 O.S. § 105f (B)(2). The duties of the OAS are established at 63 O.S. § 105f (A) & (B) as:

1. Coordinate audits and investigations and make reports to the State Board of Health and State Commissioner of Health within the State Department of Health and State Health Officer relating to the administration of programs and operations of the State Department of Health, see, 63 O.S. § 105f (A) (1);

2. Except as otherwise prohibited by current law, access all records, reports, audits, reviews, documents, papers, recommendations, or other material which relate to programs and operations with respect to which the Director of the Office of Accountability Systems has responsibilities, see, 63 O.S. § 105f (A) (2);

3. Request assistance from other state, federal and local government agencies, see, 63 O.S. § 105f (A) (3);

4. Issue administrative subpoenas for the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence, see, 63 O.S. § 105f (A) (4);

5. Administer to or take from any current or former employee of the State Department of Health an oath, affirmation, or affidavit, see, 63 O.S. § 105f (A) (5);

6. Receive and investigate complaints or information from an employee of the Department, service recipient or member of the public concerning the possible existence of an activity within the State Department of Health constituting a violation of law, rules or regulations, mismanagement, gross waste of funds, abuse of authority or a substantial and specific danger to the public health and safety, see, 63 O.S. § 105f (A) (6);

7. Cause to be issued on behalf of OAS credentials, including an identification card with the State Seal, see, 63 O.S. § 105f (A) (7);

8. Keep confidential all actions and records relating to OAS complaints, see, 63 O.S. § 105f (A) (8);

9. Keep the State Board of Health and the State Commissioner of Health fully informed of matters relating to fraud, abuses, deficiencies and other serious problems of which the Director is aware relating to the administration of programs and operations within the State Department of Health. Further, the Director shall recommend corrective action concerning such matters and report to the State Board of Health and the State Commissioner of Health on the progress of the corrective matters, see, 63 O.S. § 105f (B) (1); and

10. Report expeditiously to the appropriate law enforcement entity whenever the Director has reasonable grounds to believe that there has been a felonious violation of state or federal criminal law, see, 63 O.S. § 105f (B) (3).

Policy Statement

In adopting this Policy Statement, the Board of Health has reviewed and takes into account certain programs and policies of the OSDH, including the OSDH Personnel Advisory Committee, the Civil Rights Administrator for the OSDH, the Internal Audit Unit of the OSDH and OSDH Administrative Procedure 1-30a. OSDH Administrative Procedure 1-30a establishes a process for the handling and referral of complaints and other inquiries received by OAS, which includes when OAS receives a complaint or inquiry concerning the President of the Board of Health, any current member of the Board of Health, the Commissioner of Health, a member of Senior Leadership of the OSDH, (for the purposes of this policy "Senior Leadership of the OSDH" is defined as a Deputy Commissioner for the OSDH, the Chief Operating Officer for the OSDH, the Director of State and Federal Policy for the OSDH, and the Executive Assistant/Senior Advisor for the Commissioner of Health) any individual who directly reports to the Board of Health, (including the Director of OAS, the Secretary of the Board of Health and the Director of Internal Audit) and any other complaint or inquiry received by OAS, as follows:

A. If the complaint involves the President of the Board of Health, the OAS Director will inform the Commissioner of Health and the Chair of the Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and nature of the complaint and after consultation with the Commissioner and Committee Chair, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

B. If the complaint involves a current member of the Board of Health, who is not the President, the OAS Director will inform the Commissioner of Health, the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee concerning the receipt and nature of the complaint and after consultation with the Commissioner and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

C. If the complaint involves the Board of Health in total, the OAS Director will inform the Commissioner of Health concerning the receipt and nature of the complaint. After consultation with the Commissioner of Health, if an investigation is required, the Director of OAS will follow the procedures set forth in OSHD Administrative Procedure 1-30a;

D. If the complaint involves the Commissioner of Health, the OAS Director will inform the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and nature of the complaint and after consultation with the Committee Chair and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

E. If the complaint involves a current member of Senior Leadership of the OSDH, the OAS Director will inform the Commissioner of Health, the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and nature of the complaint and after consultation with the Committee Chair, Commissioner of Health and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

F. If the complaint involves a person in a position that directly reports to the Board of Health, the OAS Director will inform the Commissioner of Health, the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee concerning the receipt and nature of the complaint and after consultation with the Commissioner of Health and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a; and

G. If the complaint does not fall within any of the categories listed above, The OAS Director will convene a meeting of the OSDH Coordinating Complaint Council and after consultation with the Council follow the procedures set forth in OSDH Administrative Procedure 1-30a.

OSDH Administrative Procedure 1-30a establishes the Coordinating Complaint Council, the Council members and the Council duties. It is the intent of the Board of Health that all OAS staff comply with the requirements of OSDH Administrative Procedure 1-30a. This Board of Health Policy Statement is written to provide a framework for the interaction between the OAS and the OSDH, and to maximize the limited resources of the Board of Health and the OSDH.

H. Effective this date, the Director of OAS may exercise the duties listed in paragraphs (3), (4) and (10), above with the written approval of the President of the Board of Health and/or the Commissioner of Health.

I. Effective this date, the Identification Cards issued by the OSDH meet the requirements of paragraph (7) above.

J. Effective this date, the Director of OAS may exercise the duties listed in paragraphs (1), (2), (5), (6), (8) and (9), above, when a complaint is received by OAS concerning any member of the Board of Health, the Commissioner of Health, a member of Senior Leadership of the OSDH or a complaint alleging that an employee of the OSDH has committed a fraud or has abused his/her authority to the community regulated by the OSDH or to the general public who is not an employee of the OSDH, in the performance of his/her job duties.

The presentation concluded.

Ms. Wolfe moved Board approval to approve the Office of Accountability Systems Policies and Procedures as presented. Second Dr. Woodson. Motion carried.

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

AD HOC COMMITTEE REPORT FOR PROPOSED VALUES STATEMENTS

Robert S. Stewart, M.D.; Martha A. Burger, M.B.A.; Jenny Alexopulos, D.O.

Dr Stewart presented five (5) Values Statements proposed by the Ad Hoc committee. The committee felt these statements were representative of the feedback provided by the Board, Department employees, and Public Health Partners. The Board discussed possible modifications as well as the ordering of the Values Statements. The Board agreed that Leadership should lead the statements but did not have a preference for the ordering of the remaining statements.

1. ***Leadership*** - To provide vision and purpose in public health through knowledge, inspiration and dedication. To be identified as the leading authority on prevention, preparedness and health policy.
2. ***Integrity*** - To steadfastly fulfill our obligations, maintain public trust, and exemplify excellence and ethical conduct in our work ,services, processes, and operations.
3. ***Community*** - To respect the importance, diversity, and contribution of individuals and community partners.
4. ***Service*** - To demonstrate a commitment to public health through compassionate actions and stewardship of time, resources, and talents.
5. ***Accountability*** – To competently improve the public's health on the basis of sound scientific evidence and responsible research.

Ms. Burger moved Board approval to approve the values statements as presented giving the Department Senior Leadership the flexibility to wordsmith. Second Dr. Stewart. Motion carried.

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

ADJOURNMENT

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

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

The meeting adjourned at 11:17 a.m.

Approved

R. Murali Krishna M.D

R. Murali Krishna, M.D.
President, Oklahoma State Board of Health

October 9, 2013

LITTLE CIGARS AND PACK LIMITS

Description

Little cigars are almost identical to cigarettes in shape and size. They generally have filters like cigarettes, but are wrapped with either a tobacco leaf or a substance containing tobacco, and not solely paper, as is the case with cigarettes. Little cigars are often sold individually.

Health Harms

- Regular cigar smoking causes cancer, heart disease, and chronic obstructive pulmonary disease (COPD).[1]
- Cigar smoke contains the same toxins as cigarette smoke. Any difference in risks between cigars and cigarettes is likely attributable to differences in frequency of use and the fact that not all cigar smokers inhale.
- Little cigars and cigarillos are more like cigarettes and therefore are more easily smoked and inhaled like cigarettes.
- Another use of cigars, known as "blunting," involves a cigar that is hollowed out and filled with marijuana.[2]

Youth Access

- Between 2001 and 2008, the sale of cigars increased by 87%. Little cigars contributed to that growth at a rate of 158%.[3]
- Nationally, high school students are about twice as likely as adults (13.1 percent vs. 6.6 percent) to report smoking a cigar in the past month.[4] Nationally, high school students are about twice as likely as adults (13.1 percent vs. 6.6 percent) to report smoking a cigar in the past month.[5]
- In Oklahoma, 13% of high school students reported current use of cigars (10.6% of females and 15.9% of females). [6] Almost two-thirds (63.5%) of high schools students who smoke cigars usually or always smoke flavored cigars (females: 58.4%, males: 67.3%).[7]
- Tax increases have not affected all tobacco products equally. Although cigarettes and little cigars are similar products, little cigars can be purchased for substantially less than cigarettes, making them more attractive to price-sensitive populations.[8]
- The state excise tax on little cigars is 3.6 cents each. A pack of 5 little cigars would result in 18 cents state excise tax and 25 cents federal (43 cents total).[9]
- Cheap, sweet cigars can serve as an entry product for kids to a lifetime of smoking.[10]
- Minimum pack size requirements would make the products less accessible by youth, since the prices would be higher.
- Most cigars are sold in convenience stores rather than in cigar shops.[11]

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[1] National Cancer Institute**.** Cigars: Health Effects and Trends. Smoking and Tobacco Control Monograph No. 9. 1998
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[3] Campaign for Tobacco Free Kids. Not Your Grandfathers Cigar. March 2013
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[5] U.S. Centers for Disease Control and Prevention (CDC), "Youth Risk Behavior Surveillance—United States, 2011," *Morbidity and Mortality Weekly Report (MMWR)* 61(SS-4), June 8, 2012.
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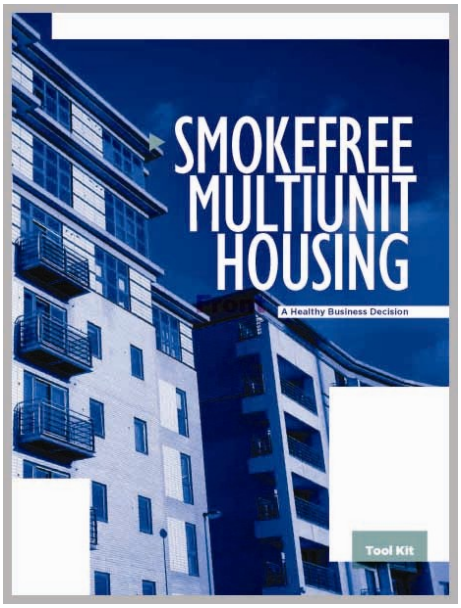
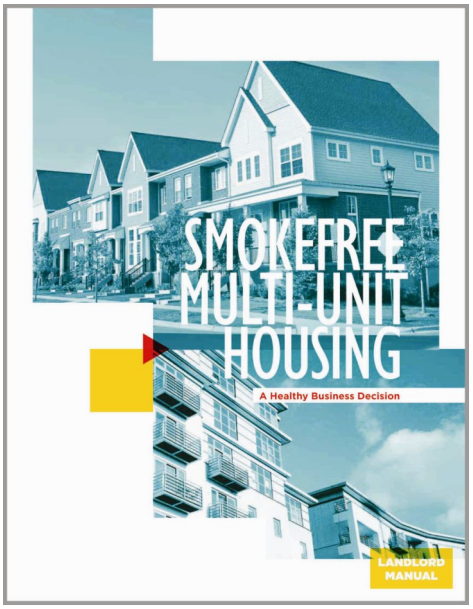
[7] Youth Tobacco Survey 2011
[8] Tobacco Control Legal Consortium. Regulatory Options for Little Cigars
[9] Oklahoma Tax Commission: Oklahoma tax rates
[10] Campaign for Tobacco Free Kids. Not your Grandfathers Cigar. March 2013
[11] Zid, LA, "Savor the Flavor," *Convenience Store/Petroleum* magazine, October 2010.





Multiunit Housing Smoking Policy Disclosure

- About 10% of Oklahoma's housing units are in multiunit housing (5 units or more).
- 80% of Oklahoma apartment residents live in buildings that have no policy on smoking.*
- State smoking laws protect hallways, offices and other areas that are indoor workplaces. Private residential areas are not protected by these laws.
- When smoking is allowed in one area, smoke can and will spread to other areas within the building.
- A majority of Oklahoma nonsmoking apartment residents report they have experienced smoke infiltration into their apartments.*
- 60% of Oklahoma apartment residents would prefer to be in an entirely nonsmoking building.*
- Secondhand tobacco smoke causes disease and premature death in nonsmokers. There is no safe level of exposure.**
- OSDH and the OHIP recommend smokefree homes, including multiunit housing.
- Consideration should be given to nonsmoking zones outside of entrances, open windows and patio doorways, especially in multiunit housing, to prevent smoke entering homes.
- Oklahoma's Commissioner of Health has issued a public health warning advising persons with heart disease or at elevated risk for heart disease not to enter places where smoking is allowed.***
- [l·yŘ2ℕŘă ăK2dzfŘ ʎyŦ2ℕY Y˙dzfűʎunit housing residents and prospective residents ǿKŜűKŜℕ ăY˙2ʅʎyƎ ʎă l·ff2ǿŜŘΣ l·yŘ ʎŦ ă2Σ ǿKŜℕŜ¢

Footnotes from front (sources)

* 2011 survey of Oklahoma multiunit housing residents by Spears School of Business, Oklahoma State University

** 2006 US Surgeon General's Report.

*** April 2004 public health warning accessible at www.breatheeasyok.com.

E-Cigarettes

What is an e-cigarette?

- A battery-powered device that heats a liquid solution to produce a vapor for inhalation.
- Some look similar to cigarettes and even have a tip that lights up when the user inhales. Other vapor products look less like cigarettes but serve the same purpose. Some are refillable and rechargeable, while others are disposable.
- The liquid solution comes in various flavors and nicotine levels, including a 0% nicotine option.
- Use of an e-cigarette is often referred to as “vaping” rather than “smoking.”

Are they safe? Are they regulated?

- As e-cigarettes are a relatively new product, there is limited research about them.
- E-cigarettes don’t contain traditional tobacco, but they do contain nicotine, which is a tobacco-derived product. As a result, a federal court has determined they can be regulated as a tobacco product, and the FDA has announced its intent to regulate e-cigarettes.
- Because the products are not currently regulated and many are produced outside the United States, there is no oversight of manufacturer’s claims or independent reseller’s claims regarding ingredients, nicotine content, safety, or possible use as a cessation aid.
- The liquid nicotine solution can be dangerous to children or pets if ingested.
- Even with limited research, there is reason to believe that these products can cause harm. Certain metals have been found to be present in e-cigarettes which could be harmful if inhaled. Additionally, there have been incidents of the battery exploding or causing fire.
- Research on the health effects of secondhand vapor is limited. At one time in history, smoking in buildings and vehicles was considered a safe practice, but years of research have proved otherwise. Research on e-cigarettes is new and evolving, and it may be some time before we know the total health effects of these products to users and those exposed to secondhand vapor.

Where can e-cigarettes legally be used? Who can buy them?

- Because state clean indoor air laws were written before e-cigarettes, the law is silent on their indoor use. Organizations may pass voluntary policies that prohibit indoor use of e-cigarettes.
- The law does not prohibit the sale of e-cigarettes to minors, however, most stores have voluntary policies requiring a customer be 18 to purchase an e-cigarette product.

What other concerns exist about e-cigarettes?

- Kid-friendly flavors such as cherry and chocolate are banned by the FDA for cigarettes because of their potential to appeal to children; that is not the case with e-cigarettes. E-cigarettes come in many flavors, which may increase the appeal for youth.
- Because many e-cigarettes look like traditional cigarettes and emit a vapor that looks like traditional cigarette smoke, e-cigarettes also have the potential to impact social norms and public perception of smoking prevalence that the tobacco control community has worked so hard to change.

- Laws that restrict cigarette advertising do not include e-cigarettes, so ads are appearing in magazines, on television, and in other public places, which also impacts the social norm regarding these products and potentially social norms about smoking overall.
- Even if future research finds that harm to the individual could be reduced, there could be increased harm to the *public* if 1) people who would have otherwise quit tobacco use e-cigarettes instead, and 2) people who would have otherwise not used a tobacco product take up e-cigarettes or other tobacco products.

Are e-cigarettes a proven cessation aide?

- There is limited research on the effectiveness of e-cigarettes as a cessation aide and their long-term safety is unstudied. However, there are multiple FDA-approved nicotine replacement therapy products available for individuals who wish to quit. These approved products, which have been studied for effectiveness and side effects, are available for free by calling 1-800-QUIT-NOW.
- Some people who have no intention of quitting traditional tobacco products may use e-cigarettes to get nicotine throughout the day and still comply with bans on traditional cigarette smoking in public. This is a form of "dual use" and has the potential to increase overall tobacco use, though more research is needed on this topic.
- Many people have shared anecdotal stories about switching from cigarettes to e-cigarettes; however, it is not clear in most cases if those individuals have quit using cigarettes but continue to use e-cigarettes, or if they have quit nicotine use entirely.

What action should we take related to e-cigarettes?

Note: These are possible actions if e-cigarettes are an area of focus relevant to your community and your organization's work at this time. It is not required that you take any action.

- To protect other customers and employees who choose not to be exposed to chemicals, businesses should adopt policies that prohibit the use of e-cigarettes on their property as part of a comprehensive tobacco-free policy.
    - If local organizations have voluntary tobacco-free policies, revise those policies to include e-cigarettes.
    - If no voluntary policy exists, work toward passing a comprehensive tobacco-free policy that includes e-cigarettes.
- Although e-cigarettes are a popular topic right now because of their novelty, it's important to continue working on evidence-based best practices for overall reduction in tobacco use. While it is important for us to address this new concern in tobacco control, we cannot lose sight of the still large problem of tobacco use, which kills about 6,200 people per year in Oklahoma. We have the 4th highest smoking rate in the country. Sales of e-cigarettes in the U.S. last year reached $500 million, but e-cigarettes are still a small fraction (0.5%) of the total tobacco market in the U.S. (Source: New York Times)