STATE BOARD OF HEALTH
OKLAHOMA STATE DEPARTMENT OF HEALTH
Canadian County Health Department
100 S. Rock Island
El Reno, Oklahoma 73036

December 11, 2018

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

Timothy Starkey, President of the Oklahoma State Board of Health, called the regular meeting of the Oklahoma State Board of Health to order on Tuesday, December 11, 2018 at 11:00 a.m. The final agenda was posted at 9:52 a.m. on the OSDH website on December 10, 2018, and at 9:35 a.m. at the building entrance on December 10, 2018.

Members in Attendance: Jenny Alexopulos, D.O.; Terry R. Gerard II, D.O.; Charles W. Grim, D.D.S.; Edward A. Legako, M.D.; Ronald D. Osterhout; Becky Payton; Timothy E. Starkey, M.B.A.

Absent: R. Murali Krishna, M.D.; Chuck Skillings

Central Staff Present: Tom Bates, Interim Commissioner; Brian Downs, Chief of Staff, Kim Bailey, Chief Operating Officer and Chief General Counsel; Buffy Heater, Chief Data, Public Policy & Promotion Officer; Gloria Hudson, Chief Financial Officer; Jennifer Reeves, Deputy Chief Operating Officer and Deputy Chief Financial Officer; Tina Johnson, Deputy Commissioner, Family Health Services; Dr. Edd Rhoades, Chief Medical Officer; Laurence Burnsed, Interim State Epidemiologist and Deputy Commissioner for Prevention and Preparedness Services; Keith Reed, Deputy Commissioner, Community Health Services; Gunnar McFadden, Assistant Deputy Commissioner, Community Health Services; Rocky McElvany, Deputy Commissioner, Protective Health Services; James Joslin, Assistant Deputy Commissioner, Protective Health Services; Mike Cook, Director, Long Term Care, Protective Health Services; Ashley Scott, Legislative Liaison; Tony Sellars, Director, Office of Communications; Nicole Nash, Staff Attorney, Office of the General Counsel; Adrienne Rollins, Director, Health Policy, Planning & Partnerships; Audie Hamman, Interim Director, Internal Audit; and Diane Hanley, Executive Assistant, Commissioner's Office.

Visitors in attendance:
Gary Cox, Executive Director, Oklahoma City-County Health Department; Dr. Keith Weldon, Calumet Public Schools; Andrew Skidmore, Canadian County Emergency Management; Sherry Murray, County Clerk; Jennifer Boyle and Fenton Rood, Oklahoma Department of Environmental Quality; Stephen Grigan, INTEGRIS; Nick Barton, Executive Director of Health, Cheyenne & Arapaho Tribes; Will Griffin, BRIDGES; Jay Smith, Former Regional Director, OSDH Staff; Jan Fox, Regional Director, Canadian County Health Department; Stacy Maroney, Tahzeeba Frisby, John Morton, Tressa Tatro, Chris Jarko, Phylana Kelsey, and Saundra Main, Canadian County Health Department; Bret Buganski and Chris Lee, KOCO 5 News; and Tyler Talley, eCapitol.

REVIEW, DISCUSSION AND APPROVAL OF MINUTES

Mr. Starkey directed attention toward approval of the Minutes for the September 14, 2018 and October 2, 2018 regular meetings.

Mr. Osterhout moved Board approval of the September 14 and October 2, 2018 regular meeting minutes as presented. Second Dr. Alexopulos. Motion Carried.

AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey
ABSENT: Krishna, Skillings

CONSIDERATION, POSSIBLE ACTION AND VOTE ON PROPOSED 2019 BOARD OF HEALTH REGULAR MEETING SCHEDULE.

Mr. Starkey presented the proposed 2019 Board of Health regular meeting schedule. These meetings will move to a quarterly schedule and all meetings will begin at 1:00pm. The location for these meetings will be at the Oklahoma State Department of Health (OSDH), 1000 NE 10th Street, Oklahoma City, Oklahoma. Dates are the

following:

Tuesday, February 12, 2019
Tuesday, April 9, 2019
Tuesday, August 13, 2019
Tuesday, October 1, 2019

Mrs. Payton moved Board approval of the 2019 Board of Health regular meeting schedule as presented. Second Mr. Osterhout. Motion Carried.

AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey
ABSENT: Krishna, Skillings

CONSIDERATION, POSSIBLE ACTION AND VOTE ON CHANGES TO THE OSDH ORGANIZATIONAL CHART.

Tom Bates, Interim Commissioner, highlighted some recent changes to the OSDH organizational chart. First, Dr. Edd Rhoades has been named the new Chief Medical Officer. Next, under the Chief Operating Officer (COO), Mrs. Jennifer Reeves has been added as the Deputy Chief Operating Officer. She also serves as the Deputy Chief Financial Officer so her name appears twice on the organizational chart. Mrs. Reeves will split her time approximately 80% in finance and 20% in operations. Also under the COO, Ms. Becki Moore, Director, Informatics, has been added and Don Smalling has been named the Director, Building Management, Safety & Security. Mr. Smalling also currently serves as the Interim Director, Office of Accountability Systems. Finally, Injury Prevention Service has moved from Protective Health Services to Prevention & Preparedness Services.
See Attachment A

Dr. Alexopulos moved Board approval of the changes to the OSDH Organizational Chart as presented. Second Dr. Legako. Motion Carried.

AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey
ABSENT: Krishna, Skillings

CONSIDERATION, POSSIBLE ACTION AND VOTE ON POLICY STATEMENT PROPOSED BY THE TRI-BOARDS OF HEALTH.

Mrs. Buffy Heater, Chief Data, Public Policy and Promotion Officer, shared that the members of the Tri-Board, which consists of the Oklahoma State Board of Health, The Oklahoma-City County Board of Health (OCCBH), and the Tulsa-City County Board of Health (TCCBH), met on October 2, 2018 to identify key policy priorities for the upcoming legislative session. The top three policy topics identified were Tobacco Use, Access to Healthcare, and Reducing Poverty Rates. Mrs. Heater stated the proposed policy statement up for consideration has already been adopted by the OCCBH and TCCBH.
See Attachment B

Mr. Osterhout moved Board approval of the Tri-Boards of Health policy statement as presented. Second Dr. Grim. Motion Carried.

AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey
ABSENT: Krishna, Skillings

CONSIDERATION, POSSIBLE ACTION AND VOTE TO OPEN EMERGENCY RULEMAKING AND PROMULGATE PROPOSED NEW EMERGENCY RULES 310:681-5-8.1, CONTAINING FOOD SAFETY STANDARDS, PROPOSED BY THE OKLAHOMA MEDICAL MARIJUANA AUTHORITY'S FOOD SAFETY STANDARDS BOARD.

Mrs. Heater explained that State Question 788 required the OSDH to create the Food Safety Standards Board (FSSB). It is a 12-member board appointed by the Commissioner of Health. The state question also required a set of food safety standards be available within 60 days of the passage of the state question. This FSSB board

met in August 2018 to create food safety standards specific to licensed processors and the preparation of edible marijuana products. Those standards were posted online and made publicly available on August 27, 2018. *See Attachment C*

Dr. Legako moved Board approval to adopt new emergency rules 310:681-5-8.1 as presented. Second Osterhout. Motion Carried.

AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey
ABSENT: Krishna, Skillings

CONSIDERATION, POSSIBLE ACTION AND VOTE TO OPEN EMERGENCY RULEMAKING FOR AMENDMENTS TO THE DEFINITIONS' SECTION IN 310:681-1-4 OF THE CURRENT EMERGENCY RULES AS PROPOSED BY THE OKLAHOMA MEDICAL MARIJUANA AUTHORITY'S FOOD SAFETY STANDARDS BOARD.

Mrs. Heater shared that the Food Safety Standards Board adopted standards included amendments to the definitions' section in 310:681-1-4 of the current Oklahoma Medical Marijuana Authority emergency rules. *See Attachment C*

Mrs. Payton moved Board approval for amendments to the definitions' section in 310:681-1-4 as presented. Second Alexopulos. Motion Carried.

AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey
ABSENT: Krishna, Skillings

CANADIAN COUNTY HEALTH DEPARTMENT PRESENTATION

Jan Fox, Regional Director, provided an update on Canadian county health outcomes, local health department services, and recent community activities. El Reno is the county seat for Canadian County and has more than 115,000 residents. According to the latest county health rankings report published by the Robert Wood Johnson Foundation in 2018, Canadian county ranked third highest in health outcomes compared to all other Oklahoma counties. Mrs. Fox touched on many of the services provided at the Canadian County Health Department including immunizations, STD screenings, WIC appointments, family planning and child guidance services. The health educator is involved in a wide range of outreach opportunities such as HIV/STD education in schools and providing trainings in mental health first aid, safe sleep and the dangers of vaping. The county health department collaborates with many local partners to host a variety of community events and activities that benefit the needs of local residents while also encouraging physical activity and healthy snacks. *See Attachment D*

PROGRAM PRESENTATION-PREVENTION & PREPAREDNESS SERVICES

Laurence Burnsed, Interim State Epidemiologist and Deputy Commissioner for Prevention & Preparedness Services, presented an overview of the influenza surveillance process in Oklahoma. Influenza is very unpredictable but trends are helpful in understanding its progress. The health department works with healthcare facilities, labs, and healthcare providers across the state collecting data to describe the spread and intensity of influenza and other respiratory pathogens. This data is shared with federal partners at the Centers for Disease Control (CDC) and contributes to the national picture of the types of influenza strains circulating throughout the season. Weekly influenza updates are available on OK FluView found on the OSDH website. Mr. Burnsed also mentioned an article recently published in the *American Journal of Public Health Perspectives* that highlighted an Oklahoma public health exercise where the OSDH Immunization Service and the Strategic National Stockpile team worked with the Oklahoma Highway Patrol to quickly transport 11,000 flu vaccines for statewide distribution. This success story demonstrated innovative thinking and the value of collaboration internally as well as with external partners in solving public health response challenges. *See Attachment E*

PROGRAM PRESENTATION-LONG TERM CARE SERVICE

Mike Cook, Director, Long Term Care Service, provided an update on Long Term Care (LTC) activities. He explained that LTC provides regulatory oversight for nursing homes, intermediate care facilities, residential

care facilities, adult day care centers, and assisted living centers. In looking at all the facility types since 2014, there has not been a significant change in the number of beds available to Oklahoma residents. In regard to facility inspections, Mr. Cook shared since 2014 there have been 758 fewer inspections conducted. Complaint inspections have decreased 21% since 2014 and revisits have also decreased by 26%. In 2018, LTC staff faced some challenges when the Centers for Medicare and Medicaid (CMS) came out with new nursing home regulations as well as a new long term care survey process. The LTC staffing turnover rate is about 10% which is a remarkably good number. At 10%, LTC loses about one to two surveyors a month. New surveyors go through a lengthy training process. Mr. Cook mentioned that LTC participated in a couple of successful OSDH hiring events and were able to hire some LPNs.

In conclusion, Mr. Osterhout stated how difficult yet important long term care work is and reminded everyone of the large number of residents that are impacted now and in the coming years. He said people need to know they have the right to complain and know how to complain. He expressed concern about RN requirements not being met in facilities. Mr. Cook pointed out that the federal law and state law have very different requirements when it comes to staffing but he will look into the matter.
See Attachment F

LEGISLATIVE UPDATE

Ashley Scott, Legislative Liaison, provided a legislative update for board members. Governor Stitt will be coming into office and retaining Republican governance for the state of Oklahoma. He has made a few appointments including Michael Rogers as Secretary of State, Donelle Harder as Deputy Secretary of State, Kenneth Wagoner as Secretary of Energy, and Michael Junk as the Governor's Chief of Staff. The House of Republicans will have 77 Republicans and 24 Democrats. There are 46 new house members and Mrs. Scott mentioned how important it will be to communicate with them on public health related issues. Charles McCall will remain as Speaker of the House. The Senate has 39 Republicans and 9 Democrats with 11 of those being new members. The President Pro Tempore is Greg Treat. OSDH has a governmental affairs team that is reviewing all OSDH program area policy submissions. This team is working collaboratively with legal and fiscal staff to understand the potential impact regulation changes could have on OSDH as well as other partners. Mrs. Scott shared that January 8th is Organizational Day at the legislature, January 14 is the Governor's Inauguration and January 17th will be the day that bill numbers are released.

OSDH FINANCIAL PRESENTATION

Gloria Hudson, Chief Financial Officer, stated that the OSDH did a contract with Ernst & Young for a GAP Analysis. Currently, OSDH uses two financial reporting systems, Fiscal, which is about 20 years old, and PeopleSoft, the statewide accounting System. The GAP analysis provided the OSDH with the following three possible options:

1) Use current State of Oklahoma PeopleSoft Phase 2 implementation
2) Create independent instance of PeopleSoft for OSDH
3) Implement integrated ERP instance for OSDH

A decision has not been made yet on an option. OSDH will be meeting with the Office of Management & Enterprise Services (OMES) to discuss this further. Ms. Hudson shared progress on staffing levels and OSDH is still hiring. She also reported on financial statements.
See Attachment G

PRESIDENT'S REPORT

Mr. Starkey shared that the executive committee met and discussed the changing role of the board from an oversight board to an advisory board effective January 2019. He also mentioned that they are proud of the progress that OSDH has made under the direction of Mr. Bates and would like to see him become the permanent commissioner.

INTERIM COMMISSIONER'S REPORT

Tom Bates, Interim Commissioner, congratulated Dr. Edd Rhoades on receiving the 2018 Ray Heifer MD Award, a national award given annually to a distinguished pediatrician for his contribution to the prevention of child abuse and neglect. Dr. Rhoades was also recently named Chief Medical Officer for OSDH. Mr. Bates thanked Dr. Rhoades for his many years of service. He mentioned a Kudos in-box that is now available for

OSDH staff to recognize a co-worker for a job well done. Mr. Bates reflected on his time at OSDH and recognized and thanked the OSDH leadership team for all their hard work and for rising to the challenge through some difficult times. He stated how important it is to have open lines of communication with the city-county health departments and other key stakeholders. Mr. Bates discussed that while solid science is critical, it is just as important to understand that much of the work in public health is relational in nature. Public health in Oklahoma has some huge challenges and it is going to take partnerships, community engagement and building relationships of trust for long-term improvements.

NEW BUSINESS

No new business.

ADJOURNMENT

Mrs. Payton moved Board approval to Adjourn. Second Legako. No roll call.

The meeting adjourned at 12:31 p.m.

Approved

Timothy E. Starkey, M.B.A.
President, Oklahoma State Board of Health
February 12, 2019

ATTACHMENT A

Oklahoma State Department of Health

Organization Chart | DRAFT as of 12/04/18

BOARD OF HEALTH

OFFICE OF ACCOUNTABILITY SYSTEMS
Don Smalling, Interim Director

INTERIM COMMISSIONER OF HEALTH
Tom Bates, J.D.

INTERNAL AUDIT
Audie Hamman, Interim Director

GRANT ADMINISTRATION & FEDERAL COMPLIANCE
Vacant

CHIEF MEDICAL OFFICER
Dr. Edd Rhoades

CHIEF LEGAL COUNSEL
Kim Bailey, J.D.

CHIEF OF STAFF
Brian Downs

- **OFFICE OF COMMUNICATIONS**
  Tony Sellars
- **LEGISLATIVE LIAISON**
  Ashley Scott

CHIEF OPERATING OFFICER
Kim Bailey, J.D.

Jennifer Reeves
Deputy Chief Operating Officer

- **HUMAN RESOURCES**
  Rosangela Miguel
- **Informatics**
  Becki Moore
- **Vital Records**
  Kelly Baker
- **Building Management, Safety & Security**
  Don Smallng

PREVENTION & PREPAREDNESS SERVICES
Laurence Burnsed, Interim
Deputy Commissioner/ State Epidemiologist

- **Emergency Preparedness & Response**
  Scott Sproat
- **Public Health Laboratory**
  Dr. S. Terry Dunn
- **HIV/STD Prevention Service**
  Kristen Eberly
  Interim Director
- **Acute Disease Service**
  Anthony Lee
  Interim Director
- **Injury Prevention Service**
  Dr. Tracy Wendling

PROTECTIVE HEALTH SERVICES
Rocky McElvany
Deputy Commissioner

James Joslin
Asst. Deputy Commissioner

- **Consumer Health Service**
  Lynnette Jordan
- **Long Term Care Service**
  Mike Cook
- **Medial Facilities**
  Dr. Julie Myers
- **Health Resource Development Service**
  James Joslin

FAMILY HEALTH SERVICES
Tina Johnson
Deputy Commissioner

- **Maternal & Child Health Service**
  Joyce Marshall
- **Dental Health Service**
  Dr. Jana Winfree
- **Nursing Service**
  Ann Benson
- **Screening & Special Services**
  Lisa Caton
- **Family Support & Prevention Service**
  Beth Martin
- **WIC Service**
  Terry Bryce
- **Sooner Start**
  John Corpolongo

COMMUNITY HEALTH SERVICES
Keith Reed
Deputy Commissioner

Gunnar McFadden
Asst. Deputy Commissioner

- **County Health Departments**
- **Community Evaluation & Records Support**
  Dr. Jennifer Han
- **Immunization Service**
  Vacant

CHIEF FINANCIAL OFFICER
Gloria Hudson

Jennifer Reeves
Deputy Chief Finance Officer

- **Budget & Purchasing**
  Vacant
- **Revenue**
  Leigh Newby
- **Grants**
  Lytle Caldwell, CPA
- **A/P & Payroll**
  Mike Truitt

CHIEF DATA, PUBLIC POLICY & PROMOTION OFFICER
Buffy Heater

- **Center for Chronic Disease Prevention & Health Promotion**
  Stephanie U'ren
- **Health Policy, Planning & Partnerships**
  Adrienne Rollins
- **Center for Health Statistics**
  Dr. Derek Pate
- **Oklahoma Medical Marijuana Authority**
  Adrienne Rollins

KEY

Agency Leadership

Public health in Oklahoma continues to be of critical importance. On October 2nd, 2018, the boards of health for the Oklahoma State Department of Health, the Oklahoma City-County Health Department, and the Tulsa Health Department, convened their annual tri-board meeting to, among other things, identify key policy priorities for the upcoming legislative session. In an effort to include information from key stakeholders, the Oklahoma Health Improvement Plan full team policy priority ideas were shared and helped drive the policy priority discussion.

The tri-board has identified three key policy topics to improve public health: Tobacco Control, Access to Healthcare and Reducing Poverty Rates.

The first is tobacco. Tobacco use continues to be the leading cause of preventable death. [1] Oklahoma ranks 39th nationally with 20.1%, or one in five, adults who smoke.[2] Additionally, 12.5% of Oklahoma high school students smoke cigarettes.[3] In order to reduce and prevent tobacco use the tri-board is united in the pursuit of several policies. An additional increase in the tobacco tax by $1.50 within ten years would prevent 28,200 youth from becoming adult smokers as well as to encourage 30,400 adults to quit smoking in addition to saving the state $1.22 billion in future healthcare costs.[4] Other important policy initiatives include advancing the availability of and consumer connection to tobacco cessation aids focusing on low income populations as well as those under the age of 35; and to support comprehensive clean indoor air policies by closing the loopholes, modifying definitions to encompass other methods of inhalation, and addressing inhaled forms of marijuana.

Secondly, the tri-board agrees to address policies that improve access to healthcare. Oklahoma ranks 45th in the nation for the number of Active Primary Care Physicians.[5] Additionally, in 2017 only one state (Texas) had a higher percentage of uninsured than Oklahoma - 14.2% of Oklahomans of all ages are without health insurance.[6] Efforts to address this issue should include improving access to preventative medical and mental health care, as well as improving the availability of affordable health insurance coverage. Policies to improve availability of affordable health insurance include support for subsidized private insurance options via an Insure Oklahoma buy-in and/or Medicaid Expansion programs. The tri-board believes pursuit of these efforts will provide increased value in Oklahomans health, longevity, and quality of life as shown by the success in other states.[7]

Finally, the tri-board will pursue and support poverty reduction strategies through education and advocacy. These efforts are important to help break the cycle of generational poverty which greatly influence the social determinants of health (SDOH).[8] The tri-board aims to assist the incorporation of upstream social supports such as housing and transportation as a way to improve health outcomes. The tri-board also promotes the placement of professionals in public schools such as community health workers, school health nurses, social workers, counselors, and family support specialists. Because education and health are both negatively impacted by contributing factors such as adverse childhood experiences (ACEs), childhood trauma, opioid addiction, overall poor mental health, obesity, and the

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[1] Center for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (2018). Fast fact: smoking and tobacco use. Retrieved from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm on October 12, 2018.

[2] Centers for Disease Control and Prevention. Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2017.

[3] Center for Disease Control and Prevention. Youth Behavior Risk Factor Surveillance System Survey Data. 2016.

[4] Campaign for Tobacco-Free Kids (2018). Factsheet: New revenues, public health benefits and cost savings from a $1.50 cigarette tax increase in Oklahoma.

[5] https://www.aamc.org/download/484580/data/oklahomaprofile.pdf

[6] https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf

[7] Sommers B, Long S, Baicker K. May 6 2014. Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study. Annals of Internal Medicine.

[8] https://www.cdc.gov/socialdeterminants/

availability of school-based programs, addressing these concerns are paramount to the long-term improvement of public health in Oklahoma.

It is also incumbent upon the tri-board to ensure rural areas are being served to the best degree possible. The tri-board recognizes the strides made by the State Department of Health, City-County health departments and local county health departments to pursue local initiatives and grant opportunities that fit the needs of the communities they serve. The tri-board supports continued efforts to promote the autonomy of local county health departments and communities, while simultaneously collaborating with them to identify new resources.

Moving forward, the tri-board agrees to advance a coordinated policy approach supported by a common message that defines public health and why it is critically important to all people of Oklahoma. The tri-board will utilize materials developed by the joint commission on public health to share this information with decision makers. Tri-board members recommend legislative action to address these three policy topics during Oklahoma's 2019 legislative session. The tri-board stands united in support of this agenda and pledges to communicate these policy priorities to legislators, public health stakeholders, OHIP representatives, and the public at large.

Presented to membership of each Board of Health for consideration and possible adoption.

TULSA HEALTH Department

Kian Kamas
Chair, Tulsa Health Department

Gary Raskob, PhD
Chair, Oklahoma City-County Health Department

Board of Health

Tim Starkey, MBA
President, Oklahoma State Board of Health

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 681. MEDICAL MARIJUANA CONTROL PROGRAM

SUBCHAPTER 5. COMMERCIAL ESTABLISHMENTS

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310:681-5-8.1. Food Safety Standards for Processors

(a) **Purpose**. This Section sets forth the food safety standards that processors must comply with in the preparation, production, manufacturing, processing, handling, packaging, and labeling of edible marijuana products.

(b) **Existing law**. This Section does not relieve licensed processors of any obligations under existing laws, rules, and regulations, including 63 O.S. § 1-1101 et seq., OAC 310:257, and OAC 310:260, to the extent they are applicable and do not conflict with 63 O.S. § 420A et. seq.

(1) The sale, offer to sell, dispense or release into commerce of any food or confection under a name, label, or brand when the name, label, or brand either precisely or by slang term or popular usage, is the name, label, or brand of marijuana is not prohibited.

(2) Marijuana used in food shall be considered an additive, a component, and/or an edible substance.

(3) Marijuana shall not be considered a deleterious, poisonous, or nonnutritive substance, and the use of marijuana, alone, in food shall not make such food adulterated or misbranded.

(c) **Updated law.** In the event the Oklahoma Board of Health or the Commissioner of Health amends OAC 310:257 or OAC 310:260, adopts new food safety rules, or incorporates into Oklahoma law updated federal food safety standards, including Title 21 of the Code of Federal Regulations, licensed processors shall comply with such rules to the extent they are applicable and do not conflict with 63 O.S. § 420A et seq. or these rules.

(d) **Board Meetings.** The Medical Marijuana Industry Expert Board/Food Safety Standards Board shall meet as regularly as its members deem necessary to review Oklahoma food safety laws and these rules and to take action, including amending and/or adding recommended standards to the Oklahoma Board of Health or the Commissioner of Health.

(e) **Labeling and Packaging**. Labels and packages for food containing marijuana shall comply with all applicable requirements in existing Oklahoma law, rules, and regulations, and any laws incorporated therein by reference, to the extent they do not conflict with 63 O.S. § 420A.

(1) Title 21, part 101 of the Code of Federal Regulations ("CFR"), as of August 22, 2018, is hereby incorporated by reference into this Section to the extent it is applicable and does not conflict with 63 O.S. § 420A et seq.

(2) Existing requirements for principal display panels or information panels include:

(A) Name and address of the business;
(B) Name of the food;
(C) Net quantity or weight of contents;
(D) Ingredients list;

(E) Food allergen information;
(F) Nutrition labeling, if required under 21 CFR § 101.9;

(2) In addition, principal display panels or information panels must contain:
(A) List of cannabis ingredients;
(B) The batch of marijuana;
(C) The strain of marijuana (optional);
(E) THC dosage in milligrams per unit; and
(F) The lot code.

(3) Nutrient content, health, qualified health and structure/function claims must comply with the Food and Drug Administration ("FDA") Food Labeling Guide.

(4) Packaging must contain the statement, "For accidental ingestion call 1-800-222-1222."

(5) All packages and individually-packaged product units, including but not limited to those from bulk packaging, must contain the Oklahoma uniform symbol in clear and plain sight. The Oklahoma uniform symbol must be printed at least one-half inch by one-half inch in size in color.

(6) In order to comply with OAC 310:681-7-1(4) and this Section, a label must contain a warning that states, "Women should not use marijuana or medical marijuana products during pregnancy because of the risk of birth defects or while breastfeeding."

(f) **Recommended HACCP**. A Hazard Analysis and Critical Control Plan ("HACCP"), as set forth under Title 21, Part 120 of the Code of Federal Regulations, shall be recognized as a standardized best practice to ensure that food is suitable for human consumption and that food-packaging materials are safe and suitable. Processors are encouraged to adopt a HACCP to help ensure compliance with existing Oklahoma food safety laws, particularly OAC 310:260-3-6.

(g) **Required Testing Procedures**. In light of the medical nature of marijuana authorized under 63 O.S. § 420A et seq. and to ensure the suitability and safety for human consumption of food products containing medical marijuana, processors are required to test food products containing medical marijuana for microbials, solvent and chemical residue, metals, pesticide residue, potency, and contaminants and filth in accordance with the following standards and thresholds.

(1) **Frequency.** Processors shall on a quarterly basis test one lot of each type of edible medical marijuana product.

(2) **Allowable Thresholds**. Products that fail to meet the thresholds as set forth below must be rejected and/or recalled immediately. In the event of recall, processors shall immediately notify the Department and all commercial establishments to which the recalled product was or may have been sold or transferred of the recall. Upon notification of the recall, the Department should work with dispensaries to notify patients who received the recalled product.

(3) **Retention of Test Results and Records**. Processors shall retain all test results and related records for three (3) years.

(4) **Microbiological testing.**
(A) All products shall be tested for aerobic plate count.
(B) Product test results shall validate that less than one

colony forming unit (CFU) per gram of tested material is present for E. coli or Salmonella species or the product shall be rejected and/or recalled.

(C) Products shall be tested for the presence of yeast and molds. Product test results shall validate less than 104 CFU or the product shall be rejected and/or recalled.

(D) Test reports shall include method reference.

(5) **Solvent and Chemical Residue**.

(A) Food products containing medical marijuana shall be tested for the following solvents to the maximum extent practical:

(i) Acetone < 1,000 ppm
(ii) Benzene < 2 ppm
(iii) Butanes/ Heptanes < 1,000 ppm
(iv) Hexane < 60 ppm
(v) Isopropyl Alcohol < 1,000 ppm
(vi) Pentane < 1,000 ppm
(vii) Propane < 1,000 ppm
(viii) Toluene < 180 ppm
(ix) Total Xylenes (m, p, o-xylenes) < 430 ppm

(B) Test reports shall provide specific data for all listed and detected solvents.

(C) The test report shall list any solvents listed above that could not be tested for.

(D) If the test equipment's Limit of Detection (lowest possible detection limit) is above the specified limit for a solvent, the equipment's Limit of Detection amount will be considered sufficient to exceed safe contamination limits.

(E) If the cannabis concentrate used to make an infused product was tested for solvents and chemical residue and test results indicate the lot was within established limits, then the infused product does not require additional testing for solvents and chemical residue.

(6) **Metals**.

(A) Testing for heavy metals shall include but is not limited to lead, arsenic, cadmium, and mercury.

(B) Test results shall meet the following thresholds:

(i) Lead – max limit < 1 ppm
(ii) Arsenic – max limit < 0.4 ppm
(iii) Cadmium – max limit < 0.44 ppm
(iv) Mercury – max limit < 0.2 ppm

(C) If the cannabis concentrate used to make an infused product was tested for metals and test results indicate the lot was within established limits, then the infused product does not require additional testing for metals.

(7) **Pesticide Residue**.

(A) Processors shall test all product batches for pesticides; 0.1 ppm or a positive result at the Limit of Detection (equipment's lowest possible detection amount) will be considered to exceed safe residue limits.

(B) Pesticide residue testing shall analyze samples for the presence of chlorinated hydrocarbons, organophosphates,

carbamates, pyrethroids, neonicotinoids, acaracides, fungicides, and bactericides to the maximum extent practical.

(C) If the cannabis concentrate used to make an infused product was tested for pesticides and test results indicate the lot was within established limits, then the infused product does not require additional testing for pesticides.

(8) **Potency**. Processors shall test products for and provide results for levels of total THC.

(9) **Contaminants and Filth**. Processors shall inspect all products for contaminants and filth.

(A) Contaminants include any biological or chemical agent, foreign matter, or other substances not intentionally added to products that may compromise food safety or suitability.

(B) Processors shall document allowable thresholds for physical contaminants as part of the product test plan. Inspection requirements should be included in the operation's product test plan for third party testing, if applicable.

(C) Inspection records shall indicate a continual process of physical inspection has taken place for all batches.

(h) **Private Homes; Living or sleeping quarters**.

(1) A private home, a room used as living or sleeping quarters, or an area directly opening into a room used as living or sleeping quarters may not be used for conducting processing operations.

(2) Living or sleeping quarters located on the premises of a processor such as those provided for lodging registration clerks or resident managers shall be separated from rooms and areas used for food establishment operations by complete partitioning and solid self-closing doors.

Definitions to add 310:681-1-4

"Food" has the same meaning as set forth in 63 O.S. § 1-1101 and OAC 310:257-1-3 ("'food' means (1) articles used for food or drink for man, (2) chewing gum, and (3) articles used for components of any such article") and as set forth in OAC 310:250-1-6 ("'food' means any raw, cooked, or processed edible substance, ice, beverage or ingredient used or intended for use or for sale in whole or in part for human consumption").

"Information Panel" has the same definition as set forth in 21 CFR § 101.2 and means "that part of the label immediately contiguous and to the right of the principal display panel as observed by an individual facing the principal display panel."

"Label" carries the same definition as set forth in 63 O.S. § 1-1101 and means a display of written, printed, or graphic matter upon the immediate container of any article; and a requirement made by or under authority of this article that any word, statement, or other information appearing on the label shall not be considered to be complied with unless such word, statement, or other information also appears on the outside container or wrapper, if there be any, of the retail package of such article, or is easily legible through the outside container or wrapper.

"Lot" means the food produced during a period of time indicated by a specific code.

“Oklahoma Uniform Symbol” means the image, established by the Department and made available to commercial licensees, indicating the package contains marijuana and must be printed at least one-half inch in size by one-half inch in size in color.

“Package” or “Packaging” means any container or wrapper that a grower or processor may use for enclosing or containing medical marijuana or medical marijuana products.

“Principal Display Panel” has the same definition as set forth in 21 CFR § 101.1 and “means the part of a label that is most likely to be displayed, presented, shown, or examined under customary conditions of display for retail sale.”

Oklahoma State Department of Health

Board of Health

Presentation

Canadian County Health Department

December 11, 2018

Canadian County

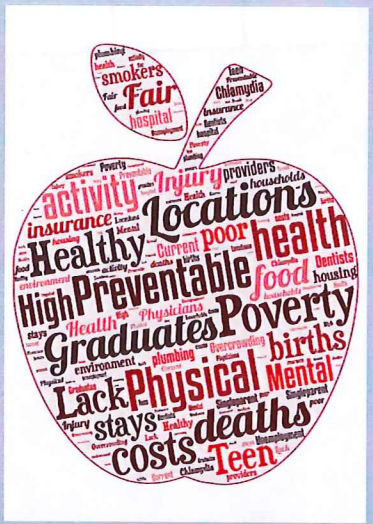
County Health Outcomes Rank

- According to the "Building a Culture of Health, County by County: County Health Rankings & Roadmaps report" published by the Robert Wood Johnson Foundation in 2018, Canadian County ranks 3rd highest in health outcomes compared to all other Oklahoma Counties.

Measures that Contribute to Canadian County's High Ranking

Less: adults reporting fair or poor health; adults who are current smokers; chlamydia cases per 100,000 population; teen births; persons without health insurance; preventable hospital stays for Medicare enrollees; persons unemployed; children living in poverty; children living in single-parent household; deaths due to injury; households with at least one of the following: overcrowding, high housing costs, or lack of kitchen or plumbing facilities

More: persons with leisure-time physical activity; factors that contribute to a healthy food environment; access to locations for physical activity; primary care physicians, dentists, and mental health providers; Medicare enrollees receiving mammography; high school graduates;



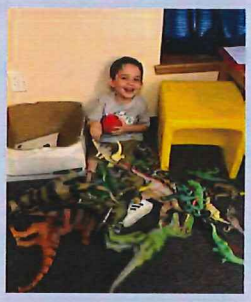
Health Department Services Offered

- **Consumer Protection**
  Retail and Wholesale Food Establishment Inspections
  Training for Food Service Workers
- **HIV/STD**
  HIV Counseling and Testing
  Sexually Transmitted Disease Testing
  Health Awareness Information
- **Health Promotion**
  Injury Prevention
  Tobacco Use Prevention/Education
  Public Health Statistics
  Communications/Media Relations
- **Acute Disease**
  Communicable Disease Investigations
  Identification/Treatment of Tuberculosis (TB)
- **Maternal and Child Health**
  Immunizations
  Child Guidance Services
  Family Planning
  Children's First
  Early Intervention
- **WIC (Women, Infant, Children)**
  Nutrition Education
- **Emergency Preparedness and Response**

Child Guidance Services

- Trauma Focused Therapy
- Parent Child Interaction Therapy
- Hearing Screenings
- Circle of Parents Groups in the school system
- Social Skills groups for children on the Autism Spectrum
- Full evaluations for referrals to the Public School systems
- Autism screenings
- Direct therapies to address behavior, speech issues, parenting, DHS referred cases and much more

Early Foundations

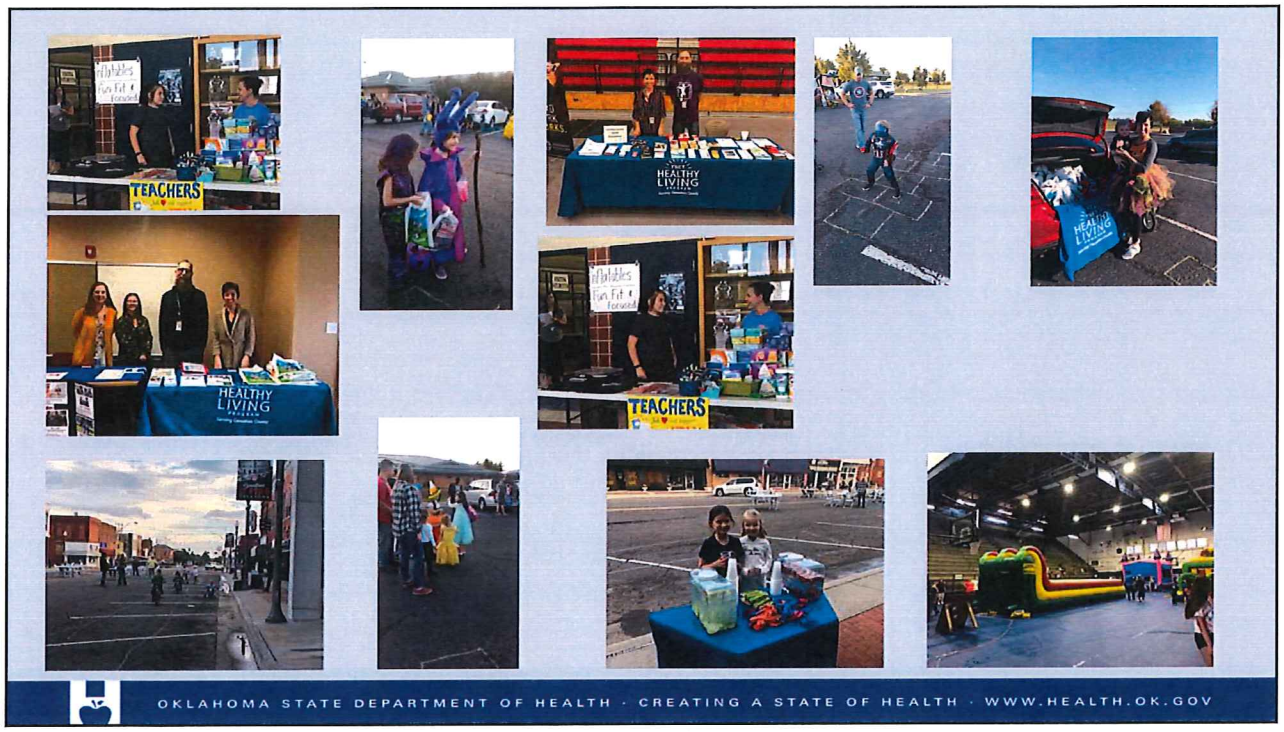


Canadian County

Early Foundations is a research program collaboration between the State Department of Health, The University of Oklahoma, El Reno Public Schools, Yukon Public Schools, and Mustang Public Schools. The purpose is to investigate the best service delivery time for toddlers and preschoolers on the Autism Spectrum.

Recent Health Department Community Activities

- Rock the Block - El Reno community "Open Streets"
- 2nd Annual Fit, Fun, Focused
- Wild Horse Garden and Market Inc. (Community Garden) in Mustang
- Great American Smoke Out at Lucky Star Casino
- Halloween Events:
  - El Reno Spooktacular
  - Youth and Family Trunk or Treat



Questions?

- For more information, please contact:
  - Jan Fox at janf@health.ok.gov or 405-262-0042

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Influenza Surveillance in Oklahoma 2018-2019 Season

Influenza Surveillance Objectives

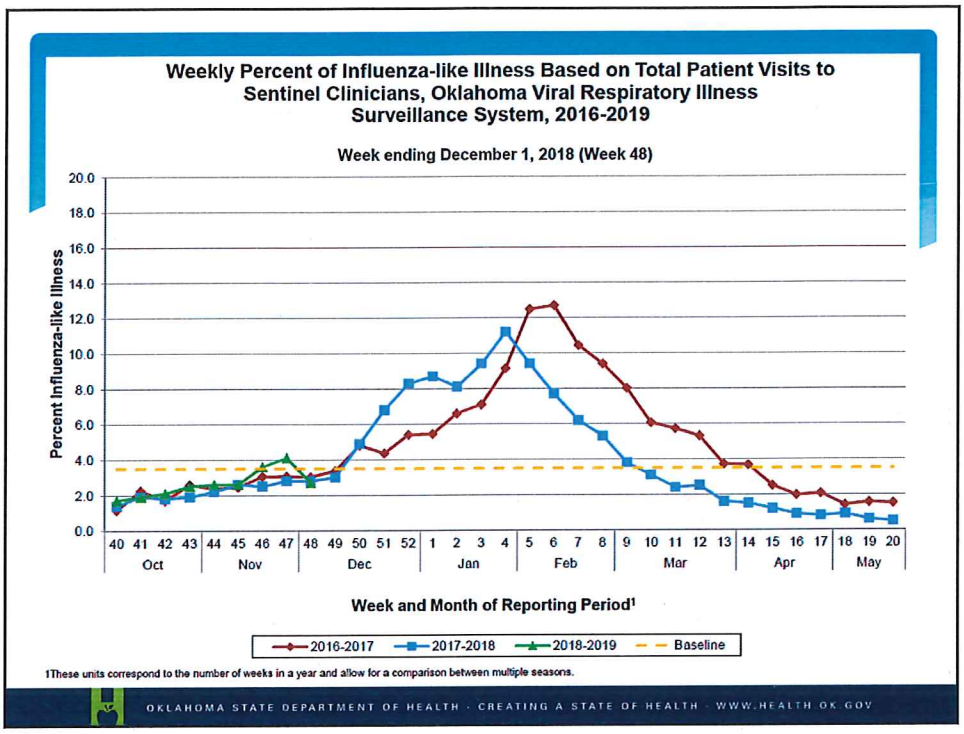
- Describe the spread and intensity of influenza and other viral respiratory pathogens
- Monitor the incidence of severe influenza disease
- Determine circulating influenza strains
- Contribute to the national epidemiology of influenza
  - Sentinel data submitted to federal partners
  - Public Health Lab data and specimens submitted for national virologic surveillance and antigenic characterization

Influenza Surveillance Components

- Sentinel influenza providers and laboratories
  - 24 sentinel providers, 11 laboratories
  - Outpatient visits and lab testing for respiratory pathogens
- Influenza-associated hospitalizations and deaths
  - Notifiable conditions (OAC 310:515)
- Public Health Laboratory viral respiratory results
- Investigate outbreaks and work with partners to implement control measures

Influenza Surveillance Communication

- Health alert network advisory distributed weekly
  - Healthcare providers, public health personnel, tribal partners
- OK FluView updated every Thursday by 10:00 a.m.
- Acute Disease epidemiologist consultations and distribution of resources to providers, institutions, public, etc.


Weekly Percent of Influenza-like Illness Based on Total Patient Visits to Sentinel Clinicians, Oklahoma Viral Respiratory Illness Surveillance System, 2016-2019
Week ending December 1, 2018 (Week 48)
Percent Influenza-like Illness
20.0
18.0
16.0
14.0
12.0
10.0
8.0
6.0
4.0
2.0
0.0
40 41 42 43 44 45 46 47 48 49 50 51 52 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Oct Nov Dec Jan Feb Mar Apr May
Week and Month of Reporting Period1
2016-2017
2017-2018
2018-2019
Baseline
1These units correspond to the number of weeks in a year and allow for a comparison between multiple seasons.
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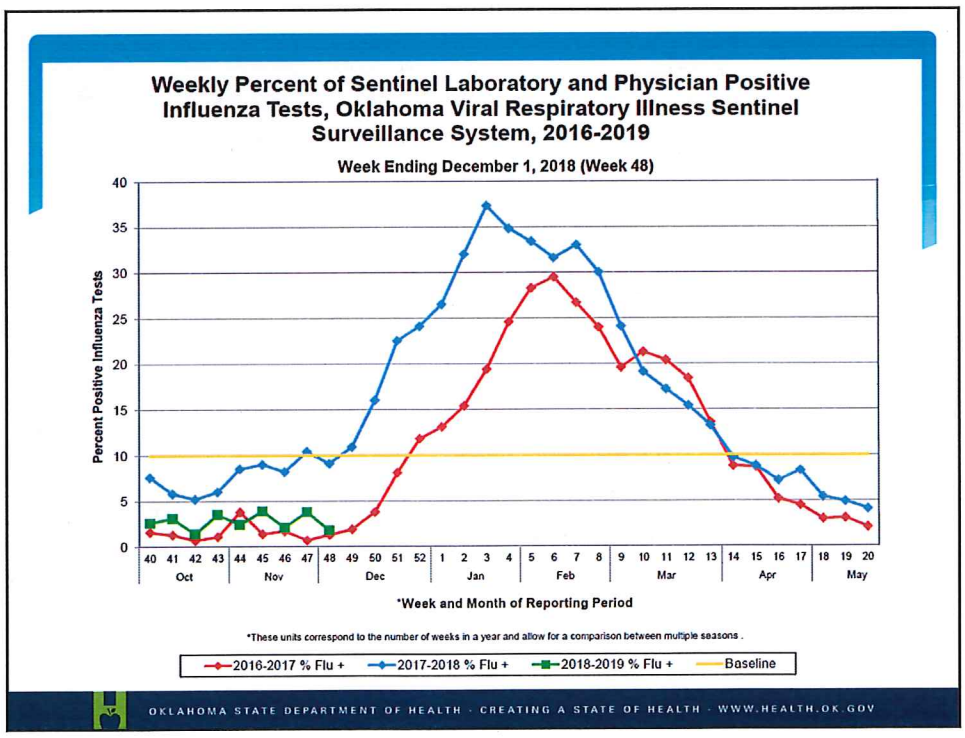
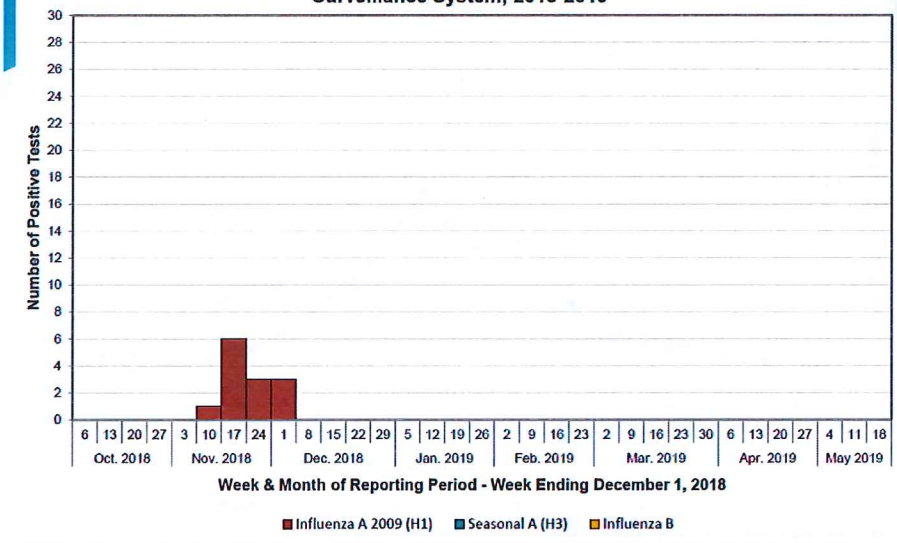

Weekly Percent of Sentinel Laboratory and Physician Positive Influenza Tests, Oklahoma Viral Respiratory Illness Sentinel Surveillance System, 2016-2019
Week Ending December 1, 2018 (Week 48)
Percent Positive Influenza Tests
40
35
30
25
20
15
10
5
0
40 41 42 43 44 45 46 47 48 49 50 51 52 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20
Oct Nov Dec Jan Feb Mar Apr May
*Week and Month of Reporting Period
*These units correspond to the number of weeks in a year and allow for a comparison between multiple seasons .
2016-2017 % Flu +
2017-2018 % Flu +
2018-2019 % Flu +
Baseline
OKLAHOMA STATE DEPARTMENT OF HEALTH · CREATING A STATE OF HEALTH · WWW.HEALTH.OK.GOV

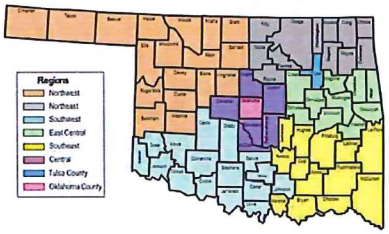
Number and Type of Polymerase Chain Reaction (PCR) Positive Influenza Tests by Date of Collection at Oklahoma State Department of Health Public Health Laboratory, Oklahoma Viral Respiratory Illness Sentinel Surveillance System, 2018-2019



Influenza-Associated Hospitalizations and Deaths by Region, Oklahoma, September 1, 2018 - December 1, 2018

Region	Influenza Hospitalizations Total (Rate per 100,000)	Influenza Deaths Total (Rate per 100,000)
Northwest	4 (1.6)	0 (0)
Northeast	23 (4.7)	4 (0.8)
Southwest	4 (0.9)	1 (0.2)
East Central	25 (6.1)	0 (0)
Southeast	16 (5)	0 (0)
Central	19 (3.2)	0 (0)
Tulsa Co.	33 (5.2)	1 (0)
Oklahoma Co.	10 (1.3)	0 (0)
Total	134 (3.4)	6 (0.1)

Data Source: Acute Disease Service, Oklahoma State Department of Health.



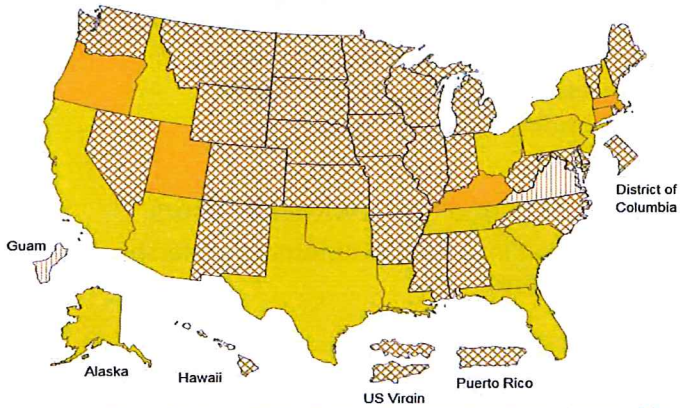
Influenza-Associated Hospitalizations and Deaths by Age Group
Oklahoma, September 1, 2018 - December 1, 2018

	Influenza Hospitalizations	Influenza Deaths
Age Group, Years	Total (Rate per 100,000)	Total (Rate per 100,000)
00-04	17 (6.3)	0 (0)
05-17	5 (0.7)	0 (0)
18-49	27 (1.7)	0 (0)
50-64	23 (3.1)	1 (0.1)
65+	62 (10.8)	5 (0.9)
Total	134 (3.4)	6 (0.2)
Age Range (Median)	0 - 99 yrs (63 yrs)	(81 yrs.)

Data Source: Acute Disease Service, Oklahoma State Department of Health.

Influenza Activity Level Map

Week Ending Nov 24, 2018 - Week 47



Influenza Activity Estimates
- No Activity
- Sporadic
- Local Activity
- Regional
- Widespread
- No Report

*This map indicates geographic spread and does not measure the severity of influenza activity.

Medical Countermeasure Response Exercise Recognition

- American Journal of Public Health, September 2018 supplement
  - Highlighted medical countermeasures management for preparedness and response
- Case studies of highlighted states innovative approach to point of dispensing (POD) sites
  - Oklahoma's September 2016 mass influenza vaccination campaign as part of a full-scale exercise highlighted

Medical Countermeasure Response Recognition

- Key partners: OSDH Emergency Preparedness, Immunization Service, and local county health departments; Oklahoma highway patrol
- Enable distribution of 11,960 doses within 24 hours
  - Illustrated the value of internal and external partnerships for successful rapid response

Source: Use of Medical Countermeasures in Small-Scale Emergency Responses. *Am J Public Health.* 2018;108:S196-S201. doi:10.2105/AJPH 2018.304491

Use of Medical Countermeasures in Small-Scale Emergency Responses

It is well documented that long-standing focus on public health emergency preparedness medical countermeasures (MCMs) distribution and mass dispensing capabilities for mitigation of bioterrorism incidents and a lack of real-world opportunities to test national preparedness for large-scale emergencies has hindered development of a body of evidence-based practices in the United States.

To encourage jurisdictions seeking innovative opportunities for continuous improvement, we describe instances when the MCM capabilities were used to address smaller-scale, more-frequent public health emergencies such as disease outbreaks, natural disasters, or routine influenza vaccination. We argue that small-scale events represent a critical opportunity that state, local, tribal, and territorial entities can utilize for greater gains in MCM operational readiness than through exercises or planned reviews.

By using and evaluating MCM capabilities during a real response, jurisdictions can advance preparedness science and support the translation of research into practice, thereby increasing their capacity to scale up for larger, rarer, higher-consequence emergencies. (*Am J Public Health*. 2018;108: S196–S201. doi:10.2105/AJPH.2018.304491)

Ijeoma A. Perry, MS, MPH, Rebecca S. Noe, MN, MPH, FNP-BC, and Amy Stewart, MPH

To respond effectively to a large-scale, rare, but high-consequence emergency such as an aerosolized anthrax attack, US communities will rely on the use of points of dispensing (PODs) as sites where the affected public can receive potentially lifesaving medical countermeasures (MCMs) deployed from the Centers for Disease Control and Prevention's (CDC's) Strategic National Stockpile.[1–4] For 15 years, CDC, through the Public Health Emergency Preparedness (PHEP) cooperative agreements and Cities Readiness Initiative funding stream, has provided significant support ($12.5 billion annually) for state and local public health departments to develop, test, and maintain MCM dispensing and administration plans and infrastructure.[1] A significant focus on funding bioterrorism preparedness followed the 2001 anthrax attacks.[3] As a consequence, efforts to develop the nation's capability to dispense, manage, and distribute MCMs, as part of the PHEP cooperative agreements, have experienced fewer budget cuts than other preparedness activities.[1]

While jurisdictions report increased levels of MCM distribution and dispensing capability,[1] studies have consistently found challenges in demonstration of MCM operational readiness despite the existence of developed plans.[1,5,6] With the rarity of large-scale bioterrorism emergencies and the rising frequency of natural disasters and international public health emergencies,[7] jurisdictions have progressively used exercises and rare, large-scale responses to infectious disease emergencies (e.g., H1N1 influenza pandemic response, Table 1 and Table A, available as a supplement to the online version of this article at http://www.ajph.org) to validate their MCM plans and, thereby, cultivate awareness of gaps and potential solutions.[4,6,8,9,12–15]

It is noteworthy that limited evidence in the literature suggests that some jurisdictions are capitalizing on the use of the MCM capabilities to respond to more frequent smaller-scale responses.[2,10,11,16,–17] Specifically, using MCM capabilities in real-world responses operationalizes the MCM plan, which can (1) improve the response, (2) reveal gaps in the plan that are not apparent in exercises, and (3) promote evidence-based practices. To illustrate these points, and demonstrate the range of innovative responses, we identified examples through personal communications to CDC and a targeted search for evaluations of real-world responses using PODs within the published literature, which we present in table and narrative form. The use of MCM capabilities in a routine event—an annual vaccination campaign—and an emergent response are presented as case studies to demonstrate two disparate types of events that are addressed with MCM capabilities.

MASS DISPENSING IN SMALL-SCALE RESPONSES

Our case studies and the tabulated examples highlight jurisdictions' use of the MCM capabilities and POD infrastructure to support dispensing or administration of MCMs in a variety of responses. Often situated in community centers or centralized large buildings, PODs may be accessible to the public (open PODs) or designed to exclusively serve pre-identified groups within locations such as schools, businesses, or hospitals (closed PODs).[4,8,12] Both open and closed PODs may be medical or nonmedical—the former staffed by clinicians capable of performing individual medical assessments in tandem with vaccine administration or dispensing MCMs, the latter staffed by lay personnel who are limited to dispensing MCMs.

ABOUT THE AUTHORS

All of the authors are with Centers for Disease Control and Prevention, Office of Public Health Preparedness and Response, Atlanta, GA.

Correspondence should be sent to Ijeoma Perry, 1600 Clifton Rd, Atlanta, GA 30329 (e-mail: iez5@cdc.gov). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This article was accepted April 15, 2018.

Note. *The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.*

doi: 10.2105/AJPH.2018.304491

TABLE 1—The Impact and Lessons Learned Following the Use of Medical Countermeasures in Small-Scale Emergency Responses: United States, 2009–2017

Response and State (Year)	Activity/Impact	Lessons Learned
Disaster response		
Yellowstone River oil spill—Montana (2015)[a]	During January 2015, a pipeline breach spilled 50 000 gallons of oil into the Yellowstone River. This river is the drinking water source for approximately 6000 residents of Dawson County, Montana. The water system was promptly shut down, and the LHD activated its MCM plan and a POD site. Within 1 day, a community center POD received pallets of water and dispensed drinking water to the residents. Public health employees and volunteers from the oil pipeline company provided the majority of the manpower and unloaded the first shipment of more than 15 pallets of water at the POD. A daily gallon of water per person and pet were distributed from the POD over 5 days. Most residents reported receiving their allocated amounts of water within 5–10 min of arriving at the POD. The rapid throughput was a result of changes made to initial POD traffic flow, the use of a donated forklift, and parking enforcement by Department of Transportation officers. Volunteers provided daily home delivery of bottled water to people with functional and access needs. A total of 80 000 gallons of water were distributed throughout the response and 40 000 gallons were stored at the end of the operation.	Access to multiple POD locations in the local MCM plan proved critical because the third option (community center with semi docks) had to be used. The MCM plan incorrectly identified that volunteer management support would be available from national volunteer disaster response organization(s). Media management was problematic as the event was national news, and some news media organizations did not follow media protocols. Reporters entered unsafe areas where forklifts were in operation and increased the potential for injuries. The new engagement with the Department of Transportation filled an unexpected need for traffic management expertise (e.g., changed traffic flow) and enforcement (e.g., ability to ticket) to protect the safety of the pedestrians walking into the facility.
Pandemic influenza outbreak response		
H1N1 response—Los Angeles, CA (2009–2010)[8,9]	During the 2009 H1N1 influenza pandemic response, the LACDPH used 109 POD sites in Los Angeles to provide almost 200 000 doses of monovalent influenza A (H1N1)pdm09 (pH1N1) vaccine over 46 d. A study of 101 POD vaccination events from 60 sites examined the effectiveness of POD operations. The average number of doses administered each hour at the 60 sites was 239 (range = 40–427) and an average of 247 persons (range = 7–1614) waited in line to be vaccinated. The 109 POD locations were located across Los Angeles County to facilitate access by diverse high-risk populations. Marked POD underutilization among the African American community persisted despite targeted community outreach (e.g., culturally appropriate health education materials, public service announcements, and use of faith-based organizations). A total of 446 outreach events were implemented at a variety of locations including WIC offices, senior centers, and faith-based organizations. Other racial and ethnic groups were successfully vaccinated in the PODs. The response emphasized that the evident social and economic barriers should be addressed and from this experience LACDPH developed the Los Angeles County Community Disaster Resilience coalition (http://www.laresilience.org/about.php). This vaccination campaign was one of the largest POD-based efforts during the 2009–2010 H1N1 response.	The inclusion of race/ethnicity in scheduled reports of vaccine utilization enabled identification of racial disparities among groups. Countermessaging opposition to 2009 monovalent H1N1 vaccine within the African American community led to an ongoing need for extensive and varied approaches in communication and engagement activities. The response emphasized a need to strengthen relationships with other health department programs that partner with minority communities. Coverage and representation of racial and ethnic minorities was accomplished by establishing POD sites within a high concentration of the target population. POD throughput efficiency could have been improved by increasing the ratio of nonmedical staff to medical staff.

Continued

The primary benefit of utilizing PODs is the high throughput at which mass prophylaxis and vaccination of large populations can be accomplished in contrast to an alternative method such as the use of health care sites, which have limited access and capacity.[4,8,18,19] Although the use of PODs can facilitate provision of MCMs to a large number of people, the decision to use PODs in an emergency response depends on several factors, including, but not limited

TABLE 1—*Continued*

Response and State (Year)	Activity/Impact	Lessons Learned
Non-influenza infectious disease outbreak response		
Largest botulism outbreak in 40 years in United States—Ohio (2015)[b]	In 2015, CDC's DSNS deployed 50 doses of heptavalent botulinum antitoxin to Ohio in support of the largest botulism outbreak in 40 y in the United States. The antitoxin was delivered to the state within less than 10 h of the federal decision to deploy. The ODH received the shipment into its centralized vaccine storage location and divided the doses on the basis of requests from 7 different health care facilities in the Columbus area. By midnight, the OSHP transported the initial botulinum antitoxin delivery from the state storage location to the health care facility that first alerted authorities about diagnosed patients. Of 29 people hospitalized at various facilities, 25 (86%) received botulinum antitoxin and 11 (38%) were intubated. After a week, 18 (62%) were discharged. The DSNS demonstrated its ability to rapidly deploy a large amount of botulinum antitoxin and transport this lifesaving MCM directly to a state receiving location. The state MCM distribution plans facilitated the pre-positioning of OSHP units and the opening of a vaccine warehouse that offered access to cold-storage repackaging and shipping supplies. These capabilities ensured the rapid (< 2 h) botulinum antitoxin processing and shipment to the medical center with critical patients. An LHD managed the transport of the other 6 requests by using nonemergency vehicles that were effective during this ongoing event.	Increased awareness and compliance of state botulinum antitoxin protocol among health care providers and health department programs to ensure a coordinated and prompt request to CDC was needed. The manufacturer's quick-thaw instructions were not written in plain language, which led ODH to develop a supplemental "1-pager" that guided uptake of the correct procedure at the individual facilities. The opportunity to use OSHP in the future for transport of small quantities of time-sensitive life-saving medications from state warehouses to health care facilities was recognized. It was determined that better communication with health care facilities is needed regarding storage and handling of the product on site. For instance, some facilities refroze botulinum antitoxin, which damaged some of it.
Opioid epidemic response		
Statewide distribution of naloxone—North Carolina (2017)[c]	In 2017, North Carolina's PHP&R supported the DMH's efforts to rapidly and effectively distribute nearly 40 000 units of naloxone (worth $3 million) over a 2-week period in October. Access to naloxone is a focus area of the North Carolina Opioid Action Plan. The product arrived at a state warehouse and the state's PHP&R staff quickly used CDC's Inventory Management and Tracking System software to generate chain-of-custody forms and packing slips. Accurate and timely release of product was coordinated with more than 70 partner agencies and organizations that came from across the state to pick up their allotment for their communities.	The state's PHP&R successfully used a component of its MCM plan by using their inventory software to provide necessary paperwork for the ad hoc distribution. The state's MCM receiving and dispensing capability was not fully leveraged for this event because of 3 key factors: (1) a lack of awareness of the capability of PHP&R across the state health department, (2) time constraints placed on the DMH to distribute the product, and (3) competing priorities. It is possible that North Carolina will purchase more naloxone in the future and lessons learned from this distribution will allow for better coordination and communication and the ability to incorporate a future distribution into a statewide exercise to help strengthen this capability.

Note. CDC = Centers for Disease Control and Prevention; DMH = Division of Mental Health; DSNS = Division of Strategic National Stockpile; LACDPH = Los Angeles County Department of Public Health; LHD = local health department; MCM = medical countermeasures; ODH = Ohio Department of Health; OSHP = Ohio State Highway Patrol; PHP&R = Public Health Preparedness and Response; POD = point of dispensing; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. Table 1 is an abridged version of Table A, which presents a wider range of response activities and corresponding lessons learned and is available as a supplement to the online version of this article at www.ajph.org.

[a]Activities/impacts and lessons learned from the Yellowstone River oil spill were provided by J. Fladager (e-mail communication, December 12, 2017). For more information, see the CDC *Public Health Preparedness 2016 Snapshot*.[3]

[b]Activities/impacts and lessons learned from the largest botulism outbreak in 40 years in United States—Ohio were provided by T. McBride (e-mail communication, December 5, 2017). For more information, see McCarty et al.[10]

[c]Activities/impacts and lessons learned from the statewide distribution of naloxone—North Carolina were provided by A. Williford (e-mail communication, December 4, 2017). For more information, see North Carolina Office of the Governor.[11]

to, the availability of MCMs, scope of the response, capacity of the existing health care system, the ability of law enforcement to provide security, and an adequate number of trained volunteers to staff the POD.[8,18] The examples presented in Table 1 and Table A (available as a supplement to the online version of this article at www.ajph.org) highlight multiple responses in which using MCM plans and PODs increased timeliness and effectiveness of the response and garnered critical lessons learned that likely would not have been realized following exercises (e.g., race/ethnicity reporting to identify disparities, preidentifying a school contact with decision-making authority).

CASE STUDIES

In the following two case studies, innovative thinking enabled jurisdictions to solve response challenges considering advantages typically produced by the use of PODs.

Oklahoma Influenza Vaccination Campaign

In September 2016, the immunization program at the Oklahoma State Department of Health (OSDH) urgently needed assistance to distribute seasonal influenza vaccine throughout the state for its annual mass vaccination campaign.[20] The event was logistically unworkable because of a delay that prevented timely distribution of the vaccine by the state-contracted courier service to the local health departments (LHDs) that planned the community campaigns. Without distribution capability, the immunization campaign was to be cancelled. Aware of the situation, the Oklahoma state epidemiologist encouraged a collaboration between the state immunization program and OSDH Strategic National Stockpile team. The opportunity to solve a real-world public health problem, while testing their MCM plans, was evident.

By chance, concurrent with the intended vaccination campaign, the OSDH Strategic National Stockpile team planned to conduct a full-scale MCM exercise. The planned exercise was a means to test the team's ability to move materials to predetermined locations throughout the state while maintaining cold-chain integrity (maintaining appropriate cold temperature standards), a noted deficiency in a previous exercise. Because of collaboration between the state immunization program and the OSDH Strategic National Stockpile team, within two days of the planned cold-chain exercise, vaccine distribution to support the annual vaccination campaign was incorporated into the team's planned exercise.

In addition to promoting interdependency between these two state agencies, the incorporation of influenza vaccine distribution into the MCM exercise required maintenance of cold-chain integrity during transport of the vaccines. This collaboration enabled the distribution of 11 960 influenza vaccine doses to eight LHDs within 24 hours (which allowed them to be used in the planned vaccination campaign). In addition, the Oklahoma State Highway Patrol, which was interested in testing a new geographic information system or global positioning system, used the exercise to track the vehicles delivering the vaccine in real time and offered to provide this service in the event of future OSDH Strategic National Stockpile team distribution activities.

Lessons learned. The OSDH Strategic National Stockpile coordinator attributed his team's success to the team's quarterly, PHEP-funded drills. Oklahoma demonstrated the remarkable flexibility of the MCM capability in that, within short notice, by using complex logistics, they identified and quickly engaged key partners with whom they effectively distributed vaccines while maintaining the cold chain as evidenced by temperature readings that were collected and analyzed. An important lesson learned was that the OSDH Strategic National Stockpile data loggers used to monitor vaccine temperatures required quick tutorials in the field to interpret the temperature instrument's gauge correctly. As a consequence, screen shots of the gauge are now included in the OSDH Strategic National Stockpile distribution training to support staff's ability to correctly read and record the temperature gauge (Mark Schultz, written communications, November 14, 2017).

Impact. This collaboration was crucial to a statewide vaccination campaign to protect the Oklahoma community from seasonal influenza. Furthermore, the enhanced collaboration among different components within the state and LHDs, and crosstalk with the Oklahoma State Highway Patrol, strengthened planning for future mass vaccination campaigns. Also, the combination of resources to perform the annual campaign and cold-chain exercise in tandem enabled economies of scale regarding staff time and led to a cost avoidance of $500 from not using the courier distribution service. In future years, additional cost avoidances will be realized because the OSDH Strategic National Stockpile agreed to continue distribution support for future annual immunization campaigns (Mark Schultz, e-mail communication, November 20, 2017). This case emphasized the value of partnership between the state's immunization and Strategic National Stockpile programs as they leveraged the MCM capabilities to support a local public health function and strengthen MCM capability.[21]

2015 Rhode Island Meningitis Response

On February 5, 2015, the Rhode Island Department of Health (RIDOH) declared an outbreak of meningitis at Providence College after two cases were identified among the student population. The cause was identified as a rare serogroup B meningococcal bacterial strain.[16] In response, RIDOH facilitated Providence College's acquisition of postexposure antibiotic prophylaxis for 71 students and mass vaccination with a newly licensed serogroup B meningococcal vaccine, on the basis of consultation with CDC and available guidelines.[16,22]

To expedite vaccination of 3745 eligible students, RIDOH leveraged and activated its incident command system and elements of their state's Medical Emergency Distribution System and warehouse plans, including MCM (antibiotic and vaccine) procurement, distribution, and vaccine administration using a closed POD (Brittan Bates-Manni, e-mail communication, December 8, 2017). Three entities (Providence College, RIDOH, and the Rhode Island Medical Reserve Corps) coordinated closely on all elements related to POD planning and execution. On February 8, only three days after the outbreak was

declared, these three entities cooperatively operated a mass vaccination POD in nine hours within the college's 45 000-square-foot recreation center to immunize 3061 students with the first dose of serogroup B meningococcal vaccine (Brittan Bates-Manni, e-mail communication, December 8, 2017). The Rhode Island Medical Reserve Corps provided the vaccinators. This was the largest number of people vaccinated in one day in a single location in Rhode Island. The college held a follow-up vaccination clinic on February 11 for the remaining unvaccinated students and supported a meningococcal carriage evaluation with CDC to measure the new vaccine's impact on carriage of the bacteria.[16,17]

Lessons learned. Communication was a central theme among lessons learned from the meningitis outbreak response (Brittan Bates-Manni, e-mail communication, December 8, 2017). First, engaging the college's emergency manager was integral to the establishment and operation of the POD on the campus and promoted similar relationships throughout the state's higher-learning institutions. Second, coordination of POD messaging, set-up, and throughput among the college, RIDOH, and Rhode Island Medical Reserve Corps proved challenging because of the lack of joint conference calls or colocated planners during the rapidly evolving response, which emphasized the need to establish a more effective tactical planning approach. Third, RIDOH provided 800-megahertz Rhode Island Statewide Communication Network radios for tactical communications, which did not work in all areas of the recreation center and were not programmed to overlap with channels used by RIDOH and Rhode Island Medical Reserve Corps staff. Thus, the need to test the available communications systems before POD activation was highlighted.

Furthermore, the new vaccine was shipped in prefilled syringes without needles despite verbal confirmations by the pharmaceutical representative that the needles would be included (which underscored a need for the RIDOH and other health departments to ensure visual inspection of the expected supplies before shipment). Also, development of an incident-specific medical history form and an algorithm for form reviewers helped to increase POD throughput. In addition, POD planners should have identified the entity responsible for submitting completed Vaccine Adverse Events Reporting System forms to CDC and the Food and Drug Administration in a timely manner. Finally, suboptimal planning for demobilization of unused vaccine resulted in the acquisition of refrigerators that were not designed for vaccine storage for the follow-up clinic. Appropriate refrigerators were secured, but this expense could have been avoided with full partner participation in the demobilization planning.

Impact. The provision of antibiotic prophylaxis to those exposed and rapid vaccination of 94% (3525 of 3745) of the eligible students with the first dose of serogroup B meningococcal vaccine helped to control the Providence College meningitis outbreak.[16] In addition, the POD supported an important rapid mass vaccination effort that permitted the RIDOH and CDC to evaluate the impact of serogroup B meningococcal vaccine on meningococcal carriage within this college student population.[16,17]

CONCLUSIONS

These examples illustrate that smaller-scale responses have been effectively used to validate state and local public health emergency MCM operational capabilities. The empirical evidence gained by using the MCM distribution and dispensing capabilities in real responses drive continuous improvement and are a major experiential supplement to discoveries made under simulated conditions during exercises.[6,18] The following observations are drawn from the examples presented in the case studies, Table 1, and Table A.

First, experience gained either from previous exercises or from real responses instilled confidence in the jurisdiction's ability to operationalize the MCM capabilities in a real event. Access to critical resources, strategic relationships, and response plans enabled rapid decisions. Utilizing MCM capabilities during real events provided additional experience and magnified opportunities for improvement without the aforementioned limitations posed by scenario-based exercises.[7]

Second, responding to a real event compelled participants to further characterize, prioritize, and solve outstanding gaps. For example, the meningitis outbreak case emphasized the value of partnership between the RIDOH and college emergency managers. As a consequence, the response increased RIDOH's connectivity with Rhode Island colleges to ensure a framework for stronger coordination during future public health responses on college campuses.

Third, communication and ongoing partnership development enabled successful responses. In the two cases, participants benefitted from real opportunities to utilize MCM capabilities and forge partnerships with epidemiologists, emergency managers, logisticians, surveillance staff, and others with whom they seldom interact as a result of compartmentalized working spheres. The impact of these critical partnerships is a philosophical shift from dependence on a single contingency model of dispensing to a dynamic and integrative system that is more readily adapted to meet the needs of the community served.

Fourth, the formal rigors of evaluation are necessary after a response. This point is emphasized by the tabulated examples, which illustrate significant gaps in evaluation strategies with respect to response efficiency and effectiveness.[4,9,12,13,15,23] An evaluation of 26 North Carolina LHDs found that "most LHDs had no clear or common process to assess POD success or impact following a 2009 H1N1 pandemic influenza school-based vaccination campaign."[15] One approach to addressing this challenge would be to engage partners across the health departments or academic institutions who can augment the capacity for operational research.[4,8,9,13–15] Postresponse evaluation is critical to distinguishing what types of small-scale emergencies lend themselves to the use of PODs and identifying specific improvements required.[2,6] Furthermore, evaluation results can demonstrate that a jurisdiction has met the criteria for advanced MCM readiness status on the basis of the CDC Operational Readiness Review that is required of PHEP recipients. Ultimately, evaluation is vital to identifying how the lessons learned from the use of MCM capabilities in small-scale responses can be scaled to apply to rare, catastrophic emergencies.[6,7]

NEXT STEPS

The examples presented should encourage state and local entities to consider leveraging their MCM capabilities during responses to disasters, outbreaks, and vaccination campaigns to strengthen their capability to operationalize in large-scale events. Accordingly, health departments may consider the following to strengthen their MCM capabilities: (1) understand ways that MCM plans, especially those addressing PODs, have been and could be used to support non-anthrax events (especially events requiring vaccines given the additional logistical considerations); (2) document and publish an evidence base to foster continuous improvement; and (3) review evaluation strategies to identify opportunities for improvement. Accomplishing these three goals may be challenging because the documented observations resulting from exercises and incidents are typically decentralized in after-action reports and are of wide-ranging quality and accessibility to outside partners, which limits their usefulness to advance preparedness science.[6] Nevertheless, there are repositories that facilitate broad sharing of best practices among PHEP recipients. For example, a peer-exchange platform such as the Online-Technical Resource and Assistance Center (https://www.cdc.gov/phpr/readiness/on-trac.htm) provides a forum in which to share practices and is managed by the CDC Division of State and Local Readiness Capacity Building Branch. Part of the mission of the Capacity Building Branch is to develop, curate, and disseminate resources beneficial throughout the nation. The tools and approaches described in this article are intended to encourage state and local entities to consider utilizing their MCM capabilities for a wide variety of responses to strengthen their capability to operationalize across an array of threats. AJPH

CONTRIBUTORS

I. A. Perry led analysis and authorship of the commentary. R. S. Noe provided research and editorial support. A. Stewart provided research guidance as the senior author.

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Long Term Care Update
OSDH Board of Health
December 11, 2018

Michael Cook
Director, Long Term Care Service
Oklahoma State Department of Health

Long Term Care Facility Types

						2014 vs 2018
Facility Type	**2014**	**2015**	**2016**	**2017**	**2018**	+/-
Nursing Homes (M/M)	313	309	310	305	306	-7
Nursing Homes (PP)	2	2	1	2	2	0
Nursing Homes (VA)	7	7	7	7	7	0
Intermediate Care Facilities	88	88	86	87	89	1
Residential Care Facilities	75	68	55	51	47	-28
Adult Day Care Centers	38	41	38	41	41	3
Assisted Living Centers	160	167	175	183	183	23
Total	683	682	672	676	675	-8

Long Term Care Inspections
(by Facility Type)

Health & Life Safety Code						2014 vs 2018	
Facility Type	**2014**	**2015**	**2016**	**2017**	**2018**	+/-	+/-
Nursing Homes (M/M)	2812	2573	2551	2189	2279	-533	- 7
Nursing Homes (PP)	1	1	2	5	3	2	
Nursing Homes (VA)	28	60	37	41	22	-6	
Intermediate Care Facilities	359	388	413	390	350	-9	
Residential Care Facilities	311	270	173	179	126	-185	- 28
Adult Day Care Centers	52	70	71	76	59	7	
Assisted Living Centers	494	537	529	457	460	-34	+ 23
Total	4057	3899	3776	3337	3299	-758	- 8

Long Term Care Inspections
(by Survey Type)

Health & Life Safety Code						2014 vs 2018	
Survey Type	**2014**	**2015**	**2016**	**2017**	**2018**	+/-	
ReCertification	1021	1045	1047	1009	982	-39	
Initial	39	31	42	35	35	-4	
Complaints	1483	1286	1316	1046	1167	-316	**-21%**
Revisits	1514	1537	1371	1247	1115	-399	**-26%**
Total	4057	3899	3776	3337	3299	-758	

Long Term Care
Inspection Frequency Mandates

INSPECTION FREQUENCY MANDATES	SFY14	SFY15	SFY16	SFY17	SFY18
Number of inspection mandates	24	24	24	24	24
Inspections not meeting mandates	101	45	3	2	14
Inspections meeting mandates	3025	2785	3146	2357	2080
Inspections required	3126	2830	3149	2359	2094
Percent of inspections met	96.8%	98.4%	99.9%	99.9%	99.3%

Long Term Care Challenges
SFY 2018

- Centers for Medicare and Medicaid Services
  - State Operations Manual Appendix PP – deficiency F tags
  - State Operations Manual Appendix Z – Emergency Preparedness
  - Long Term Care Survey Process
- Staffing (Hiring and Retention)
  - May Hiring Event
  - October Hiring Event
  - RNs and LPNs
  - 10% Turnover Rate (Hospital 18.2%, Cost $49,500, Source NSI)
- Quality Improvement Projects
  - Complaint Report Writing
  - Quality Measures
  - Long Term Care Survey Process Writing

Long Term Care
SFY 2019

THANK YOU!

Michael Cook
Director, Long Term Care Service
Oklahoma State Department of Health
mikec@health.ok.gov

Oklahoma State Department of Health State Fiscal Year 2019 Financial Update

Chief Financial Officer

December 11, 2018

GAP Analysis

Ernst and Young provided three options to OSDH

- **Option 1**
- Use current State of Oklahoma PeopleSoft Phase 2 implementation
- **Pros** No changes to current state support
  Decommission FISCAL
  Decommission Access and .Net SQL databases
  Streamline reporting
  Reduce reconciliation between OSDH systems and applications
- **Cons** OMES version of PS does not have current PS code base and functionality
  OSDH cannot control software maintenance schedule
  Phase 2 not used by all agencies– 4 agencies use it
  Will require outside assistance
  Not as complex as OSDH
  Gaps in OMES knowledge regarding unused modules- AR, Budgeting, Travel & Expense
- **Option 2**
- Create independent instance of PeopleSoft for OSDH
- **Pros** OSDH PeopleSoft instance would contain current PS codebase and functionality
  OSDH PS system will contain values and processes that align to specialized OSDH requirements
  OSDH has ability to control the maintenance activity schedules
  Decommission FISCAL
  Decommission Access and .Net SQL databases
  Streamlining reporting
  Reduce reconciliation between OSDH systems and applications
  Add unused PeopleSoft modules to address functional gaps
- **Cons** OSDH & OMES PS instances will synchronize data daily; master data and transactional data
  Reporting will have to be performed in 2 instances – complex reconciliation
  Gaps in OMES knowledge regarding unused modules – AR, Budgeting, Travel & Expense
  May need to utilize contractor for technical and functional support

- **Option 3**
- Implement integrated ERP instance for OSDH
- **Pros** Integrate LEP system with OSDH ERP instance
  OSDH controls the new Financial Management system
  OSDH system will contain values and processes that align to specialized OSDH requirements
  Decommission FISCAL
  Decommission Access and .Net SQL databases
  OSDH can control software maintenance schedule
  May have capability to meet all of OSDH needs including AIR, integration & Reporting tool
  Standardization of county accounting systems
- **Cons** OSDH & OMES PS instances will synchronize data daily; master data and transactional data
  OSDH will continue to pay charge back fees to OMES for PeopleSoft
  Extensive integration points for OMES PS
  Duplication of Commitment Control processes and data with OMES PeopleSoft
  Dual reporting processes – some in new ERP and others in OMES PeopleSoft to support statewide reporting complicates reporting due to separate ERP solutions for OSDH and OMES

Staffing Levels

SFY 18/19 Staffing Changes

Date	Event	Staff Number	Change
6/30/2017	Beg. Baseline	2103	
9/27/2017	Furlough Announced	2070	-33
12/8/2017	RIF Posted	2018	-52
3/2/3018	Last Day for RIF Employees	1872	-146
11/30/18	Ending Baseline	1702	-170
	NET CHANGE		**-401**

Oklahoma State Department of Health
Statement of Revenues and Expenditures
SFY 19, For the Four Month Period Ended October 31, 2018

Description	Annual Budget	YTD Budget	YTD Actuals	Variance	%
Revenues:					
State Appropriations	54,874,700	18,291,567	18,291,568	(1)	0%
Licenses, Certificates and Fees	29,336,586	9,778,862	11,499,835	(1,720,973)	18%
Tobacco Tax	15,599,550	5,199,850	4,435,594	764,256	-15%
WIC Rebate Program	55,000,000	18,333,333	16,329,434	2,003,899	-11%
Federal Funds	143,873,822	47,957,941	45,532,105	2,425,836	-5%
FY 18 Cash Utilization	26,865,783	8,955,261	8,955,261	(0)	0%
Reimbursement for Personnel Services	29,453,583	9,817,861	7,564,591	2,253,270	-23%
Other	19,647,890	6,549,297	1,383,790	5,165,506	-79%
Total Revenue	$ 374,651,914	$ 124,883,971	$ 113,992,179	$ 10,891,792	-9%
Expenditures:					
Salaries	145,509,909	48,503,303	34,330,458	14,172,845	-29%
Travel	2,498,123	832,708	342,605	490,103	-59%
Other Professional Services	55,945,448	18,648,483	4,307,409	14,341,074	-77%
Telecommunications/Printing Services	10,544,018	3,514,673	88,266	3,426,407	-97%
Rent	3,149,601	1,049,867	767,204	282,663	-27%
Maintenance and Repair	4,091,029	1,363,676	541,911	821,766	-60%
Laboratory & Medical Supplies and Materials	8,692,450	2,897,483	2,803,463	94,020	-3%
Office/Safety Supplies	7,030,593	2,343,531	689,970	1,653,561	-71%
WIC Program	57,795,899	19,265,300	13,443,276	5,822,023	-30%
Program Reimbursements- EPRS	13,297,476	4,432,492	1,151,459	3,281,033	-74%
Payments- Health & Social Services	38,545,899	12,848,633	4,206,243	8,642,390	-67%
Miscellaneous	27,551,469	9,183,823	2,184,120	6,999,703	-76%
	374,651,914	124,883,971	64,856,383	60,027,588	-48%
Revenues Over/(Under) Expense	0	0	49,135,796	(49,135,796)	

Oklahoma State Department of Health
Forecasted SFY 19 Collections by Fund
Based upon the Four Month Period Ended October 31, 2018

Fund	Fund Description	SFY19 Original BWP	Collections	Forcasted Collections	Surplus/(Deficit)
19901	GRF Duties	$ 54,874,700	$ 18,291,568	$ 36,583,136	$ 4
20300	Genetic Counseling Licen. Rev	15,000.00	7,900.00	15,800.00	8,700.00
20400	Tobacco Prevntn & Cessatn Fnd	1,330,594.87	358,579.23	717,158.46	(254,857.18)
21000	Public Health Special Fund	62,465,528.13	23,611,301.12	47,222,602.24	8,368,375.23
21100	Nursing Facility Adm Penalties	23,550.73	-	-	(23,550.73)
21200	Home Health Care Revolving Fd	151,000.00	141,505.00	283,010.00	273,515.00
21600	Ok Natl Background Check Revol	1,250,000.00	482,980.00	965,960.00	198,940.00
22000	Civil Monetary Penalty Revl Fd	1,575,000.00	773,145.56	1,546,291.12	744,436.68
22200	Oklahoma Organ Donor Education	145,000.00	20,958.00	41,916.00	(82,126.00)
22500	Breast Cancer Act Revolving Fd	15,000.00	5,120.00	10,240.00	360.00
22600	Ok Sports Eye Safety Prog Revl	150.00	-	-	(150.00)
23300	OK Pre Birth Def, Pre Birth &	160.00	40.00	80.00	(40.00)
23500	Oklahoma Lupus Revolving Fund	165.00	2.00	4.00	(159.00)
23600	Trauma Care Assistance Revolv	24,323,612.66	7,829,804.45	15,659,608.90	(834,199.31)
24200	Pancreatic Can Res Lic Plt Rev	1,500.00	200.00	400.00	(900.00)
26500	Child Abuse Prevention Fund	47,145.00	16,705.00	33,410.00	2,970.00
26700	EMP Death Benefit Revolv Fund	2,800.00	800.00	1,600.00	(400.00)
26800	Okla Emerg Resp Syst Stab & Im	1,787,765.00	493,071.41	986,142.82	(308,550.77)
28400	Dental Loan Repayment Revolvin	463,670.00	114,968.84	229,937.68	(118,763.48)
29500	Ok State Ath Comm Revolving Fd	250,000.00	60,216.89	120,433.78	(69,349.33)
34000	CMIA Programs Disbursing Fund	55,000,000.00	16,329,434.47	32,658,868.94	(6,011,696.59)
40000	Federal Funds	118,719,548.00	31,147,138.18	62,294,276.36	(25,278,133.46)
41000	Federal Funds - Ryan White	8,438,135.00	1,351,268.18	2,702,536.36	(4,384,330.46)
41100	Federal Funds - Ryan White	16,906,107.00	4,000,211.49	8,000,422.98	(4,905,472.53)
Total OSDH		$ 347,786,131	$ 105,036,918	$ 210,073,836	$ (32,675,378)

Forecasted Collections over (under) Budget (32,675,378)

Oklahoma State Department of Health
Forecasted SFY 19 Expenditures by Fund
Based upon the Four Month Period Ended October 31, 2018

Fund	Fund Description	SFY19 Original BWP	Expenditures	Encumbrances	Forcasted Expenditures	Surplus/(Deficit)
198	2018 State Appropriations	$ 4,702,107	$ 94,737	$ 1,670,100	$ 189,473	$ 2,747,797
199	2019 State Appropriations	54,874,700	9,481,096	14,437,469	18,962,193	11,993,941
203	Genetic Counseling Licen. Rev	2,318	3,074	1,869	6,147	(8,772)
204	Tobacco Prevntn & Cessatn Fnd	2,466,056	44,482	1,177,872	88,963	1,154,740
207	Alternatives Services Revolving Fund	17,951	-	-	-	17,951
210	Public Health Special Fund	66,591,474	12,426,471	16,906,188	24,852,942	12,405,872
212	Home Health Care Revolving Fund	177,488	24,782	50	49,564	103,092
216	National Background Check	2,350,188	448,733	1,488,063	897,466	(484,074)
220	Civil Monetary Penalty	6,586,173	541,307	3,638,908	1,082,613	1,323,345
222	Organ Donor Awareness Fund	130,000	-	-	-	130,000
225	Breast Cancer Act Revolving Fund	130,094	14,280	-	28,559	87,255
228	Ok Leukemia and Lymphoma Rvl	50,000	-	-	-	50,000
236	Trauma Care Assistance Revolving Fund	22,972,415	410,921	430,060	821,841	21,309,593
265	Child Abuse Prevention Revolving Fund	120,000	2,520	29,305	5,039	83,136
267	EMT Death Benefit Revolving Fund	20,000	-	-	-	20,000
268	Rural EMS Revolving Fund	1,787,765	-	1,737,513	-	50,252
284	Dental Loan Repayment Revolving Fund	463,670	112,490	-	224,980	126,200
295	Oklahoma Athletic Commission	285,057	52,399	5,100	104,798	122,760
340	CMIA - WIC FOOD	55,395,899	13,443,276	0	26,886,553	15,066,070
400	Federal Fund	130,184,406	23,453,069	49,275,052	46,906,138	10,550,147
410	Ryan White Grant	8,438,047	1,231,008	1,187,043	2,462,015	3,557,981
411	Ryan White Rebate	16,906,107	3,069,131	12,244,895	6,138,263	(4,546,182)
		$ 374,651,914	$ 64,853,774	$ 104,229,488	$ 129,707,548	$ 75,861,103
Forecasted Expenditures Under/(Over) Budget						$ 75,861,103