

**HOSPITAL ADVISORY COUNCIL  
Special Meeting  
Thursday, November 17, 2016 at 2:30 p.m.**

Location: Oklahoma State Department of Health building  
1000 NE 10<sup>th</sup> Street, Room 307  
Oklahoma City, OK 73117  
Telephone: 405-271-6576

**Meeting Minutes  
Approved January 26, 2017**

The Hospital Advisory Council Meeting Notice for the November 17, 2016 Special meeting was filed with the Oklahoma Secretary of State's (SOS) website located at [www.sos.state.ok.us/meetings.htm](http://www.sos.state.ok.us/meetings.htm) and the Oklahoma State Department of Health's (OSDH) website located at [www.mfs.health.ok.gov](http://www.mfs.health.ok.gov) on Monday, August 15, 2016.

The agenda for this regular meeting was distributed and posted on the OSDH website and the building's front entrance on Tuesday, November 10, 2016.

**I. Call to Order**

Dr. Bell, Chair called the meeting to order at approximately 2:31 p.m.

**II. Roll Call**

Devyn Tillman called roll. The following members were present when roll was called: Stanley Alexander, Heather Bell, DO, Dale Bratzler, DO, Susan Dragoo, Tricia Horn, David Keith and Darin Smith. A quorum was present.

The following members were absent: Jay Gregory, MD and Dave Wallace.

Identified OSDH staff members present were: Lee Martin, Service Director; Timothy Cathey, MD-Medical Director for Protective Health Services; Terri Cook, APM-Facility Services Division; Devyn Tillman, Medical Facilities Service; LaTrina Frazier-Home Services Division; Terri Cook-Facility Services Division; Harriet Cooper, RN-Quality Initiatives and Review; Tanya Cates, RN-HAI Program Coordinator; Hank Hartsell, Jr., Deputy Commissioner of Protective Health Services; Carter Kimble-OSDH.

Identified guests present were: Gayla Middlestead-TME; Chance Flick-American Heart Association; Rita Diehl-OK AWEN; LaWanna Halstead-Oklahoma Hospital Association; Jonathon Rule-Integrus; David Foss-Integrus.

**III. Approval of the August 18, 2016 Special Meeting Minutes**

*A motion was made by David Keith to approve the minutes. The motion was seconded by Stanley Alexander. Motion carried.*

<i>Ayes: 5</i>	<i>Nays: 0</i>	<i>Abstain: 2</i>	<i>Absent: 2</i>	<i>Motion Carried: Yes</i>
Stanley Alexander	Aye	Tricia Horn	Abstain	
Heather Bell, DO	Aye	David Keith	Aye	
Dale Bratzler, DO	Abstain	Darin Smith	Aye	
Susan Dragoo	Aye	Dave Wallace	Absent	
Jay Gregory, DO	Absent			

**IV. Reports and Updates:****a. Legislative Update – Carter Kimble**

Carter Kimble, Director of the Office of State and Federal Policy, provided the council an update on the results of the recent state election. He reported there were forty-five (45) new legislators elected of the one hundred forty-five (145) legislators. This results in a thirty-two (32) percent change for the upcoming legislative session. Charles McCall of Atoka is the new Speaker of the House. Mike Schultz of Altus is the new President Pro Tempore of the Senate.

State agencies are facing a \$600-\$800 million budget shortfall this year. As a result of this shortfall, the OSDH is preparing to amend statutory fees for licensure in several areas of Protective Health Services:

- Updating statutory fees for all providers in Protective Health Services
- Restructuring Fees for certain license inspections, i.e., conducting a second full survey for a restaurant licenses for an additional fee. The OSDH has been, for some time, subsidizing regulatory program activities with state funds.

**V. Presentations****a. Health Associated Infection Information – Tanya Cates**

Tanya Cates reported on the current HAI reporting requirements of acute care hospitals in Oklahoma for the upcoming year. The Hospital inpatient reporting requirements via National Healthcare Safety Network (NHSN) have been adopted by the Oklahoma State Department of Health. Correspondence has been mailed to all acute care hospitals in Oklahoma notifying them of the following reporting requirements: Central Line-associated bloodstream Infections (CLABSI), Catheter-associated Urinary Tract Infections (CAUTI), Surgical Site Infections (SSI), Methicillin-Resistant Staphylococcus aureus (MRSA), Clostridium Difficile Infections (CDI) and Healthcare Personnel Influenza Vaccination.

The HAI Prevention Coordinator of the OSDH will be conducting external validation processes of selected facilities in the upcoming year. The selected facilities will receive letters for the line listing and medical records requests (secure file transfer only). These facilities will receive a written report of the audit findings and necessary follow-up guidance from the Department.

For additional information presented, a copy of the Ms. Cates report is attached below for your information.

**VI. Continued Discussion of Hospital Advisory Council priorities for 2017**

Brandon Bowen, Assistant Director of Medical Facilities was asked to help facilitate the strategic planning for the Council for 2017. This Modernization Act cut down on the number of members and Advisory Councils. This Act consolidated two Councils from a total of thirty-six (36) members down to no more than seven (7) people. Which brought forward the question how is the best way to utilize our time. We proposed to this council how you would like to best focus? It is entirely up to this Council how you would best like to proceed

**a. Infrastructure Within Which the Council Works to Include Resources****b. Communication and Process By Which Issues are Vetted and presented to the Council****c. Past and Current Issues Dealt With, or Being Dealt By the Council****d. Relationship With Other Councils Within the Health Department and How Partnering Occurs on Specific Issues**

**e. Data Available for the Three Areas of Responsibility**

- i. Rules**
- ii. Licensure Activities**
- iii. Quality indicators**

Brandon Bowen, Assistant Director of Medical Facilities Service, reiterated to the members the Council's area of responsibility is to make non-binding recommendations to the Oklahoma State Board of Health.

- Historically over the years the agenda for this Council have been set by the Department. Those issues needing to be recommended to the Board of Health were reviewed by this Council, ex. gathering the public comments for the proposed rule changes that were presented to the Council.
- The Hospital Association and others, over the years, have brought issues that they felt needed to be address to this Council.
- The group discussed possibly reviewing the Oklahoma Administrative Code, Chapter 667 to determine if these rules are in line with the current federal regulations and professional guidelines currently being used.
- There may be certain rules that need to be updated in accordance with current guidelines.
- Dr. Hartsell commented there is currently a workgroup meeting in conjunction with a number of hospital representatives, OSDH staff members as well as the Hospital Association reviewing the Plan Review process as defined in Chapter 667.

**VII. Review and Approval/Recommendation of the Proposed Oklahoma Statute Amendments:**

- a. OS Title 63-1-704 Licenses-Fees Duration-Posting [AMENDED]**
- b. OS Title 63-1-707-Rules and Standards [AMENDED]**

See comment below.

**VIII. Review and Approval of the Proposed Oklahoma Administrative Code Title 310: Chapter 667 Amendments:**

- a. OAC 310:667-1-3. Licensure [AMENDED]**
- b. OAC 310:667-41-1. General [AMENDED]**
- c. OAC 310:667-47-1 Submission of plans and specifications and related requests for services [AMENDED]**

There was no recommendation to approve Agenda items VII & VIII at this meeting. The Council will take more time to read through these changes and will vote at the next meeting of this council after the final version of this rule change has been reviewed; and public comment has been received and distributed in the Rule Change Executive Summary Document.

Dr. Hank Hartsell, Deputy Commissioner of Protective Health Services informed the Council the final rule documents will be presented at the next council meeting for this council to review and to possibly recommend their approval to send these forward to the Board of Health meeting in February.

**IX. Approval of the CY 2017 Future Meeting Dates**

- Thursday, February 16, 2017 @ 2:30 p.m. in Room 1102
- Thursday, May 18, 2017 @ 2:30 p.m. in Room 1102
- Thursday, August 17, 2017 @ 2:30 p.m. in Room 1102
- Thursday, November 16, 2017 @ 2:30 p.m. in Room 1102

*A motion was made by Darin Smith to approve the CY 2017 meeting dates. The motion was seconded by Susan Dragoo. Motion carried.*

<i>Ayes: 7</i>	<i>Nays: 0</i>	<i>Abstain: 0</i>	<i>Absent: 2</i>	<i>Motion Carried: Yes</i>
Stanley Alexander	Aye	Tricia Horn	Aye	
Heather Bell, DO	Aye	David Keith	Aye	
Dale Bratzler, DO	Aye	Darin Smith	Aye	
Susan Dragoo	Aye	Dave Wallace	Absent	
Jay Gregory, DO	Absent			

**X. Public Comment**

Mr. David Foss commented regarding the fee changes being proposed. He hopes these changes are done fairly and in the appropriate manner. He questioned whether the increase in fees is really going to benefit the hospitals and will provide additional benefit to the hospitals.

**XI. Adjourn**

Meeting adjourned at approximately 4:59 p.m.

Approved on Thursday, January 26, 2017 by:

  
\_\_\_\_\_  
Chairperson



# Healthcare-Associated Infection (HAI) Program Update

Tanya Cates, BSN, RN, CPC  
HAI Prevention Coordinator  
Hospital Advisory Council Meeting  
November 17, 2016



Oklahoma  
State  
Department  
of Health

# OUTLINE

- Current HAI Reporting Requirements
- External Validation Process
- HAI Progress Reports



# Reporting Requirements

**Hospital Inpatient Reporting Requirements via NHSN  
according to the Centers for Medicare & Medicaid Services (CMS) Guidelines  
and adopted by the Oklahoma State Department of Health**

**Central Line-associated Bloodstream Infection (CLASBI) in the following areas:  
Adult, Pediatric, and Neonatal ICUs; Adult & Pediatric Medical, Surgical, and  
Medical/Surgical Wards**

**Catheter-associated Urinary Tract Infection (CAUTI) in the following areas:  
Adult and Pediatric ICUs; Adult & Pediatric Medical, Surgical, and  
Medical/Surgical Wards**

**Surgical Site Infections (SSI)-Colon Surgery and Abdominal Hysterectomy**

**Methicillin-Resistant Staphylococcus aureus (MRSA) Bacteremia Infections**

**Clostridium Difficile Infections (CDI)**

**Healthcare Personnel Influenza Vaccination**



# External Validation Process

- ❖ NHSN External Validation Guidance and Toolkit 2015
  - 2015 data
  - Provides guidance and tools for validation of six HAI metrics (CLASBI, CAUTI, SSI-Colon and Abdominal Hysterectomy procedures, MRSA, and CDI)
  - Provides a standard approach for nationwide data quality
  
- ❖ Targeted sampling method for facilities and medical records
  - Recommend minimum number of facilities for each HAI: Larger states with 150 or more facilities should select at least 21 targeted facilities plus a 5% random sample of remaining facilities (Oklahoma currently has 151 licensed hospitals)
  - Facilities listed in a 2015 Standardized Infection Ratio (SIR) In-Plan report will undergo a sorting process from highest to lowest based upon the predicted number of events (1<sup>st</sup> step) and SIR rates until the top 33% are determined- can be repeated up to 3 times if necessary to reach desired number. All unselected facilities remaining are then subject to a 5% random sample.





# External Validation Process

- ❖ For each HAI validated, a sample size of 60 medical records/episodes of care per facility is recommended
  - For validation purposes, a medical record is the record of a single facility inpatient admission also referred to as an episode of care.
  - For surgical procedures, the episode of care refers to the procedure and all associated medical encounters documented during the surveillance follow-up window.
  - Samples will include up to 20 reported HAIs and a goal of 40 non-reported candidate/eligible HAIs
  - Targeted medical record selection requires:
    - a securely transmitted line listing of all 2015 positive ICU urine cultures from each facility
    - NHSN line listings of all 2015 Colon and Abdominal Hysterectomy procedures and reported SSIs



# External Validation Process

- ❖ HAI Prevention Coordinator will contact the Infection Preventionist (IP) to discuss the audit process and determine the amount of time estimated to access medical records. HAI Coordinator and IP will consider a mutually agreeable due date for the laboratory line listings, dates for the medical record request, and proposed date(s) for the onsite audit.
  - Selected facilities will also receive letters for the line listing and medical records requests (secure file transfer only)
  
- ❖ Following the validation audit, facilities will receive a report of the audit findings and necessary follow-up guidance
  - Audit discrepancies are referred to CDC for adjudication

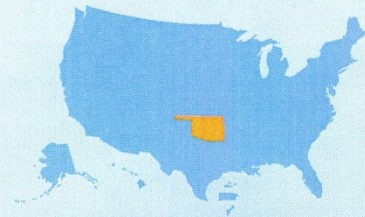




# OKLAHOMA

HEALTHCARE ASSOCIATED INFECTIONS  
PROGRESS

**Healthcare-associated infections (HAIs)** are infections patients can get while receiving medical treatment in a healthcare facility. The **standardized infection ratio (SIR)** is a statistic used to track HAI prevention progress over time; lower SIRs indicate better progress. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). Oklahoma requires hospitals to publicly report at least one HAI to NHSN, and HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## ✓ CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

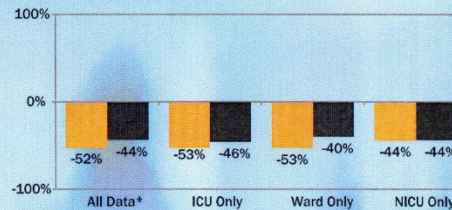
**CLABSIs** ↓ 52% LOWER COMPARED TO NAT'L BASELINE

A **central line** is a tube that a doctor usually places in a large vein of a patient's neck or chest to give important medical treatment. When not put in correctly or kept clean, central lines can become a freeway for germs to enter the body and cause deadly infections in the blood.

Oklahoma hospitals did not report a significant change in CLABSIs between 2011 and 2012.

**7%** 7% of Oklahoma hospitals have an SIR worse than the national SIR of 0.56.

Changes in CLABSI vs. 2008 National Baseline



### LEGEND

- State
- National
- ✓ State examines data and reviews medical charts for this infection to confirm accuracy and completeness
- Q State investigates data for this infection to assess completeness and quality
- \* Statistically significant difference
- v Fewer than 5 facilities reported data

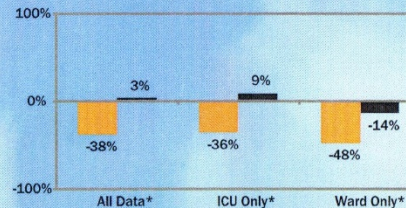
## CAUTIs ↓ 38% LOWER COMPARED TO NAT'L BASELINE

When a urinary catheter is not inserted correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and cause a **catheter-associated urinary tract infection** in the urinary system, which includes the bladder and kidneys.

**3%** 3% of Oklahoma hospitals have an SIR worse than the national SIR of 1.03.

## CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

Changes in CAUTI vs. 2009 National Baseline



## SSIs: COLON SURGERY ↓ 20% LOWER COMPARED TO NAT'L BASELINE

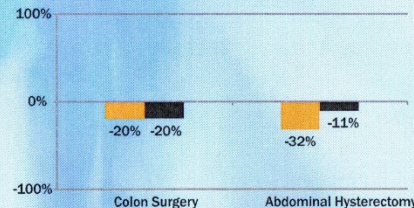
### SURGICAL SITE INFECTIONS: COLON SURGERY AND ABDOMINAL HYSTERECTOMY SURGERY

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve the skin only. Other SSIs can involve tissues under the skin, organs, or implanted material.

**13%** 13% of Oklahoma hospitals have a colon surgery SIR worse than the national SIR of 0.80.

## SSIs: ABDOMINAL HYSTERECTOMY ↓ 32% LOWER COMPARED TO NAT'L BASELINE

Changes in SSI vs. 2008 National Baseline



■ Not enough data to report how many Oklahoma hospitals have an abdominal hysterectomy SIR significantly worse than the national SIR of 0.89.

THIS REPORT IS BASED ON 2012 DATA, PUBLISHED MARCH 2014



HEALTHCARE ASSOCIATED INFECTIONS PROGRESS



# OKLAHOMA

**HEALTHCARE-ASSOCIATED INFECTION (HAI) DATA** gives healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is preventing infections: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For more information:

- 2012 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- Preventing HAIs: [www.cdc.gov/hai](http://www.cdc.gov/hai)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs in Oklahoma: [www.ok.gov/health/Protective\\_Health/Medical\\_Facilities\\_Service/Quality\\_Initiatives/Healthcare-Associated\\_Infections\\_Prevention\\_Program/](http://www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Quality_Initiatives/Healthcare-Associated_Infections_Prevention_Program/)



## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a statistic used to track healthcare-associated infection prevention progress over time. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

- ✓ Q In some cases, states that work to validate, or double check, HAI data may have higher SIRs since they are actively looking for infections.

## WHAT DOES THE STANDARDIZED INFECTION RATIO MEAN?

### IF THE STATE SIR IS:

MORE THAN 1

There were more infections reported in the state in 2012 compared to the national baseline data, **indicating there has been an increase in infections.**

1

There were about the same number of infections reported in the state in 2012 compared to the national baseline data, **indicating no progress has been made.**

LESS THAN 1

There were fewer infections reported in the state in 2012 compared to the national baseline data, **indicating progress has been made in preventing infections.**

## WHAT IS OKLAHOMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Oklahoma has a state mandate to publicly report at least one HAI to NHSN.

Oklahoma has several prevention efforts (known as prevention collaboratives) to reduce specific HAIs, including:

- Central line-associated bloodstream infections
- Catheter-associated urinary tract infections
- Surgical site infections

Oklahoma implemented prevention efforts in dialysis facilities.

<sup>+</sup> Not all hospitals are required to report these infections; some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

### NUMBER OF OKLAHOMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN IN 2012

Total Hospitals: 144\*

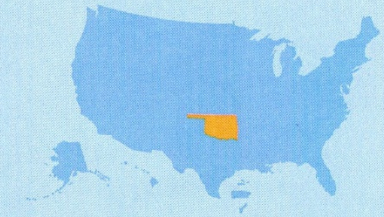
		STATE SIR	NAT'L SIR
<b>CLABSI</b> 55 hospitals	Oklahoma's 2012 state <b>CLABSI</b> SIR is significantly better than the 2012 national SIR.	0.48	0.56
<b>CAUTI</b> 61 hospitals	Oklahoma's 2012 state <b>CAUTI</b> SIR is significantly better than the 2012 national SIR.	0.62	1.03
<b>SSI, Colon Surgery</b> 61 hospitals	Oklahoma's 2012 state <b>Colon Surgery SSI</b> SIR is similar to the 2012 national SIR.	0.80	0.80
<b>SSI, Abdominal Hysterectomy</b> 59 hospitals	Oklahoma's 2012 state <b>Abdominal Hysterectomy SSI</b> SIR is similar to the 2012 national SIR.	0.68	0.89





# OKLAHOMA

Healthcare-associated infections (HAIs) are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are collected through CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website.



## CLABSIs

↓ 61% LOWER COMPARED TO NAT'L BASELINE\*

### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

- Oklahoma hospitals reported no significant change in CLABSIs between 2012 and 2013.
- 4% Among the 27 hospitals in Oklahoma with enough data to calculate an SIR, 4% had an SIR significantly worse than the national SIR of 0.54.

## CAUTIs

↓ 23% LOWER COMPARED TO NAT'L BASELINE\*

### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

- Oklahoma hospitals reported a significant increase in CAUTIs between 2012 and 2013.
- 5% Among the 37 hospitals in Oklahoma with enough data to calculate an SIR, 5% had an SIR significantly worse than the national SIR of 1.06.

## MRSA Bacteremia

↑ 4% HIGHER COMPARED TO NAT'L BASELINE

### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

- 10% Among the 21 hospitals in Oklahoma with enough data to calculate an SIR, 10% had an SIR significantly worse than the national SIR of 0.92.

## SSIs

### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a surgical site infection. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

SSI: Abdominal Hysterectomy ↓ 50% LOWER COMPARED TO NAT'L BASELINE\*

- Oklahoma hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2012 and 2013.
- Not enough data to report how many hospitals had an SIR significantly worse than the national SIR of 0.86.

SSI: Colon Surgery ↑ 15% HIGHER COMPARED TO NAT'L BASELINE

- Oklahoma hospitals reported a significant increase in SSIs related to colon surgery between 2012 and 2013.
- Several changes to the NHSN 2013 SSI protocol likely contributed to an increase in the national and some state-specific colon surgery SIRs compared to 2012.
- 12% Among the 25 hospitals in Oklahoma with enough data to calculate an SIR, 12% had an SIR significantly worse than the national SIR of 0.92.

## C. difficile Infections

↓ 11% LOWER COMPARED TO NAT'L BASELINE\*

### LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

- 9% Among the 70 hospitals in Oklahoma with enough data to calculate an SIR, 9% had an SIR significantly worse than the national SIR of 0.90.



\* Statistically significant.



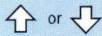
HEALTHCARE ASSOCIATED INFECTIONS  
PROGRESS



LEGEND



2013 state SIR is significantly lower (better) than comparison group in column header



Change in 2013 state SIR compared to group in column header is not statistically significant



2013 state SIR is significantly higher (worse) than comparison group in column header



2013 state SIR cannot be calculated

# OKLAHOMA

**HEALTHCARE-ASSOCIATED INFECTION (HAI) DATA** give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

- 2013 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Oklahoma: [www.ok.gov/health/Protective\\_Health/Medical\\_Facilities\\_Service/Quality\\_Initiatives/Healthcare-Associated\\_Infections\\_Prevention\\_Program/](http://www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Quality_Initiatives/Healthcare-Associated_Infections_Prevention_Program/)
- Oklahoma validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)



HAI TYPE	# OF OKLAHOMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2013 Total Hospitals in State: 144 <sup>†</sup>	2013 STATE SIR vs. 2012 State SIR <sup>‡</sup>	2013 STATE SIR vs. 2013 Nat'l SIR	2013 STATE SIR vs. Nat'l Baseline <sup>‡</sup>	2013 STATE SIR	2013 NAT'L SIR
<b>CLABSI</b> Nat'l Baseline: 2008	53	↓ 18%	↓ 27%	↓ 61%	0.39	0.54
<b>CAUTI</b> Nat'l Baseline: 2009	58	↑ 24%	↓ 28%	↓ 23%	0.77	1.06
<b>SSI, Abdominal Hysterectomy</b> Nat'l Baseline: 2008	62	↓ 27%	↓ 43%	↓ 50%	0.50	0.86
<b>SSI, Colon Surgery</b> Nat'l Baseline: 2008	56	↑ 39%	↑ 25%	↑ 15%	1.15	0.92
<b>MRSA Bacteremia</b> Nat'l Baseline: 2011	91	2012 SIR not available	↑ 14%	↑ 4%	1.05	0.92
<b>C. difficile Infections</b> Nat'l Baseline: 2011	91	2012 SIR not available	↓ 1%	↓ 11%	0.89	0.90

<sup>†</sup>Not all hospitals are required to report these infections; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

<sup>‡</sup>The state's 2012 SIR can be found in the data tables of this report.

<sup>‡</sup>Nat'l baseline time period varies by infection type. See first column of this table for specifics.

## WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

## WHAT IS OKLAHOMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

Oklahoma has a state mandate to publicly report at least one HAI to NHSN.

Prevention efforts to reduce specific HAIs:

- Catheter-associated urinary tract infections

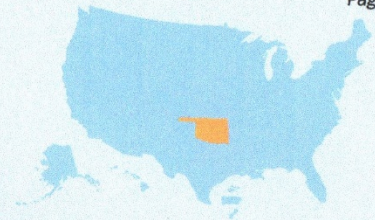


Oklahoma State Department of Health



# OKLAHOMA

## ACUTE CARE HOSPITALS



**Healthcare-associated infections (HAIs)** are infections patients can get while receiving medical treatment in a healthcare facility. Working toward the elimination of HAIs is a CDC priority. The standardized infection ratio (SIR) is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The infection data are reported to CDC's National Healthcare Safety Network (NHSN). HAI data for nearly all U.S. hospitals are published on the Hospital Compare website. This report is based on 2014 data, published in 2016.

### CLABSIs

↓ 57% LOWER COMPARED TO NAT'L BASELINE\*

#### CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTIONS

When a tube is placed in a large vein and not put in correctly or kept clean, it can become a way for germs to enter the body and cause deadly infections in the blood.

Oklahoma hospitals reported no significant change in CLABSIs between 2013 and 2014.

**11%** Among the 27 hospitals in Oklahoma with enough data to calculate an SIR, 11% had an SIR significantly higher (worse) than 0.50, the value of the national SIR.

### CAUTIs

↓ 15% LOWER COMPARED TO NAT'L BASELINE\*

#### CATHETER-ASSOCIATED URINARY TRACT INFECTIONS

When a urinary catheter is not put in correctly, not kept clean, or left in a patient for too long, germs can travel through the catheter and infect the bladder and kidneys.

Oklahoma hospitals reported no significant change in CAUTIs between 2013 and 2014.

**5%** Among the 37 hospitals in Oklahoma with enough data to calculate an SIR, 5% had an SIR significantly higher (worse) than 1.00, the value of the national SIR.

### MRSA Bacteremia

↑ 8% HIGHER COMPARED TO NAT'L BASELINE\*

#### LABORATORY IDENTIFIED HOSPITAL-ONSET BLOODSTREAM INFECTIONS

Methicillin-resistant *Staphylococcus aureus* (MRSA) is bacteria usually spread by contaminated hands. In a healthcare setting, such as a hospital, MRSA can cause serious bloodstream infections.

Oklahoma hospitals reported no significant change in MRSA bacteremia between 2013 and 2014.

**16%** Among the 19 hospitals in Oklahoma with enough data to calculate an SIR, 16% had an SIR significantly higher (worse) than 0.87, the value of the national SIR.

### SSIs

#### SURGICAL SITE INFECTIONS

When germs get into an area where surgery is or was performed, patients can get a **surgical site infection**. Sometimes these infections involve only the skin. Other SSIs can involve tissues under the skin, organs, or implanted material.

SSI: Abdominal Hysterectomy ↓ 46% LOWER COMPARED TO NAT'L BASELINE\*

Oklahoma hospitals reported no significant change in SSIs related to abdominal hysterectomy surgery between 2013 and 2014.

**Not enough data** to report how many hospitals had an SIR significantly higher (worse) than 0.83, the value of the national SIR.

SSI: Colon Surgery ↓ 15% LOWER COMPARED TO NAT'L BASELINE\*

Oklahoma hospitals reported a significant decrease in SSIs related to colon surgery between 2013 and 2014.

**3%** Among the 29 hospitals in Oklahoma with enough data to calculate an SIR, 3% had an SIR significantly higher (worse) than 0.98, the value of the national SIR.

### C. difficile Infections

↓ 6% LOWER COMPARED TO NAT'L BASELINE\*

#### LABORATORY IDENTIFIED HOSPITAL-ONSET C. DIFFICILE INFECTIONS

When a person takes antibiotics, good bacteria that protect against infection are destroyed for several months. During this time, patients can get sick from *Clostridium difficile* (*C. difficile*), bacteria that cause potentially deadly diarrhea, which can be spread in healthcare settings.

Oklahoma hospitals reported no significant change in *C. difficile* infections between 2013 and 2014.

**15%** Among the 68 hospitals in Oklahoma with enough data to calculate an SIR, 15% had an SIR significantly higher (worse) than 0.92, the value of the national SIR.

\* Statistically significant



Oklahoma State Department of Health





# OKLAHOMA

## ACUTE CARE HOSPITALS

Healthcare-associated infection (HAI) data give healthcare facilities and public health agencies knowledge to design, implement, and evaluate HAI prevention efforts.

Learn how your hospital is performing: [www.medicare.gov/hospitalcompare](http://www.medicare.gov/hospitalcompare)  
For additional information:

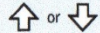


- 2014 HAI Progress Report: [www.cdc.gov/hai/progress-report/](http://www.cdc.gov/hai/progress-report/)
- NHSN: [www.cdc.gov/nhsn](http://www.cdc.gov/nhsn)
- HAIs and prevention activities in Oklahoma: [www.ok.gov/health/Protective\\_Health/Medical\\_Facilities\\_Service/Quality\\_Initiatives/Healthcare-Associated\\_Infections\\_Prevention\\_Program/](http://www.ok.gov/health/Protective_Health/Medical_Facilities_Service/Quality_Initiatives/Healthcare-Associated_Infections_Prevention_Program/)
- Oklahoma validation efforts: [www.cdc.gov/hai/pdfs/state-progress-landscape.pdf](http://www.cdc.gov/hai/pdfs/state-progress-landscape.pdf)

### LEGEND



2014 state SIR is significantly lower (better) than comparison group in column header



Change in 2014 state SIR compared to group in column header is not statistically significant



2014 state SIR is significantly higher (worse) than comparison group in column header



2014 state SIR cannot be calculated

HAI TYPE	# OF OKLAHOMA HOSPITALS THAT REPORTED DATA TO CDC'S NHSN, 2014 <sup>†</sup> Total Hospitals in Oklahoma: 143	2014 STATE SIR vs. 2013 State SIR	2014 STATE SIR vs. 2014 Nat'l SIR	2014 STATE SIR vs. Nat'l Baseline <sup>‡</sup>	2014 STATE SIR	2014 NAT'L SIR
<b>CLABSI</b> Nat'l Baseline: 2008	58	↑ 16%	↓ 13%	↓ 57%	0.43	0.50
<b>CAUTI</b> Nat'l Baseline: 2009	62	↑ 10%	↓ 16%	↓ 15%	0.85	1.00
<b>SSI, Abdominal Hysterectomy</b> Nat'l Baseline: 2008	63	↑ 7%	↓ 35%	↓ 46%	0.54	0.83
<b>SSI, Colon Surgery</b> Nat'l Baseline: 2008	57	↓ 27%	↓ 13%	↓ 15%	0.85	0.98
<b>MRSA Bacteremia</b> Nat'l Baseline: 2011	91	↑ 2%	↑ 24%	↑ 8%	1.08	0.87
<b>C. difficile Infections</b> Nat'l Baseline: 2011	90	↑ 4%	↑ 2%	↓ 6%	0.94	0.92

<sup>†</sup>The number of hospitals that reported to NHSN and are included in the SIR calculation. This number may vary across HAI types; for example, some hospitals do not use central lines or urinary catheters, or do not perform colon or abdominal hysterectomy surgeries.

For additional data points, refer to the technical data tables.

<sup>‡</sup>Nat'l baseline time period varies by HAI type. See first column of this table for specifics.

### WHAT IS THE STANDARDIZED INFECTION RATIO?

The **standardized infection ratio (SIR)** is a summary statistic that can be used to track HAI prevention progress over time; lower SIRs are better. The SIR for a facility or state is adjusted to account for factors that might cause infection rates to be higher or lower, such as hospital size, teaching status, the type of patients a hospital serves, and surgery and patient characteristics.

### WHAT IS OKLAHOMA DOING TO PREVENT HEALTHCARE-ASSOCIATED INFECTIONS?

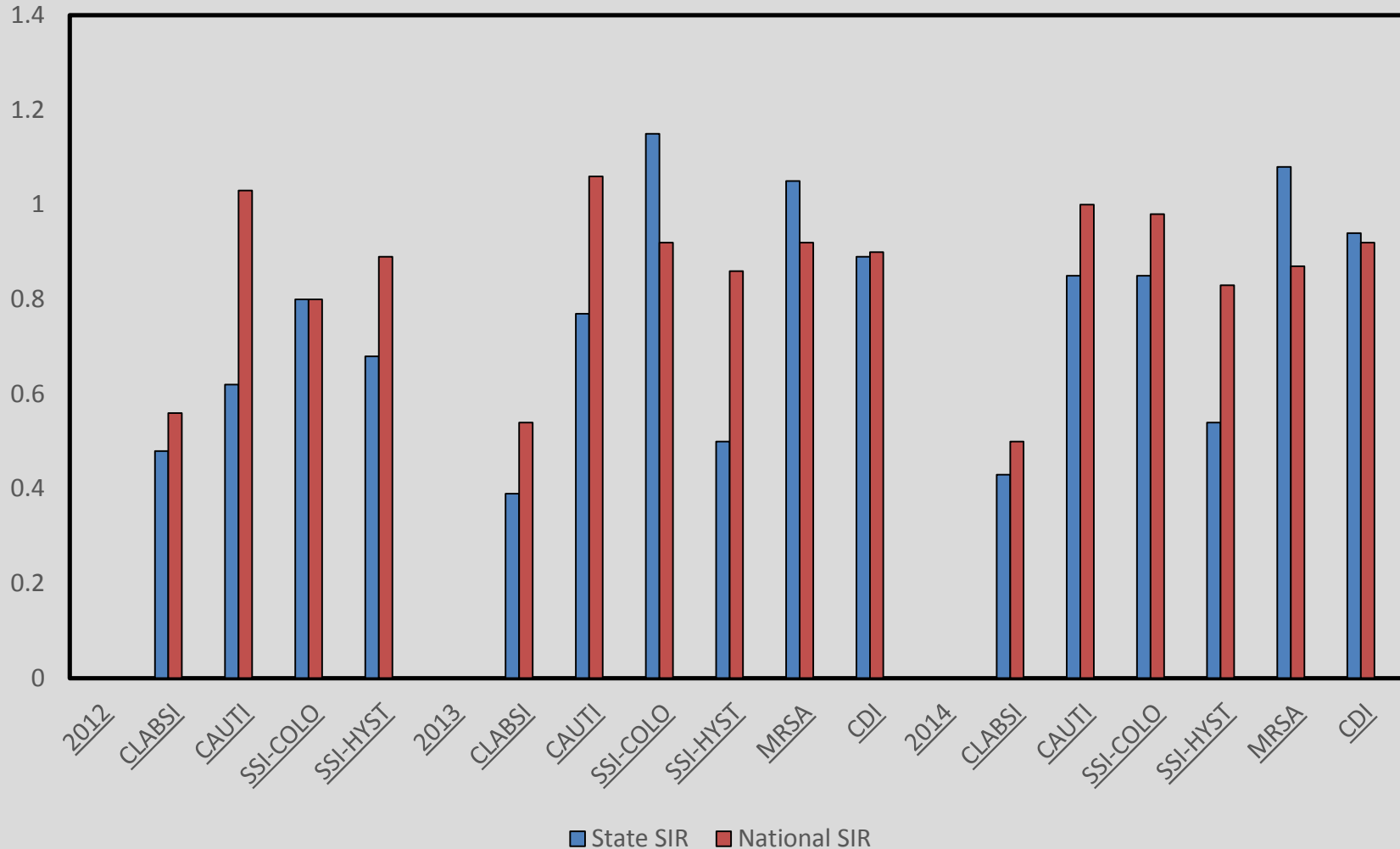
Oklahoma has a state mandate to publicly report at least one HAI to NHSN.



Oklahoma State Department of Health



# State and National SIR Trends



Oklahoma  
State  
Department  
of Health

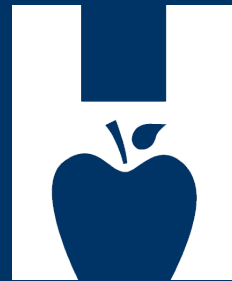
# Thank You!



Oklahoma  
State  
Department  
of Health

# Budget Priorities

OKLAHOMA STATE DEPARTMENT OF HEALTH · OCTOBER 2016



Terry Cline, Ph.D.  
Commissioner of Health  
Secretary of Health and Human Services

# Public Health Core Services

## Community and Family Health Services

- County Health Depts.
- Early Childhood Programs
- Maternal and Child Health
- Dental Health

## Office of the State Epidemiologist

- Public Health Laboratory
- Infectious Disease & Immunization Services
- Emergency Preparedness and Response

## Protective Health Services

- Long-Term Care
- Medical Facilities
- Consumer Health
  - Restaurants -
  - Hotels -
  - Tattoo & Body Piercings
- Injury Prevention

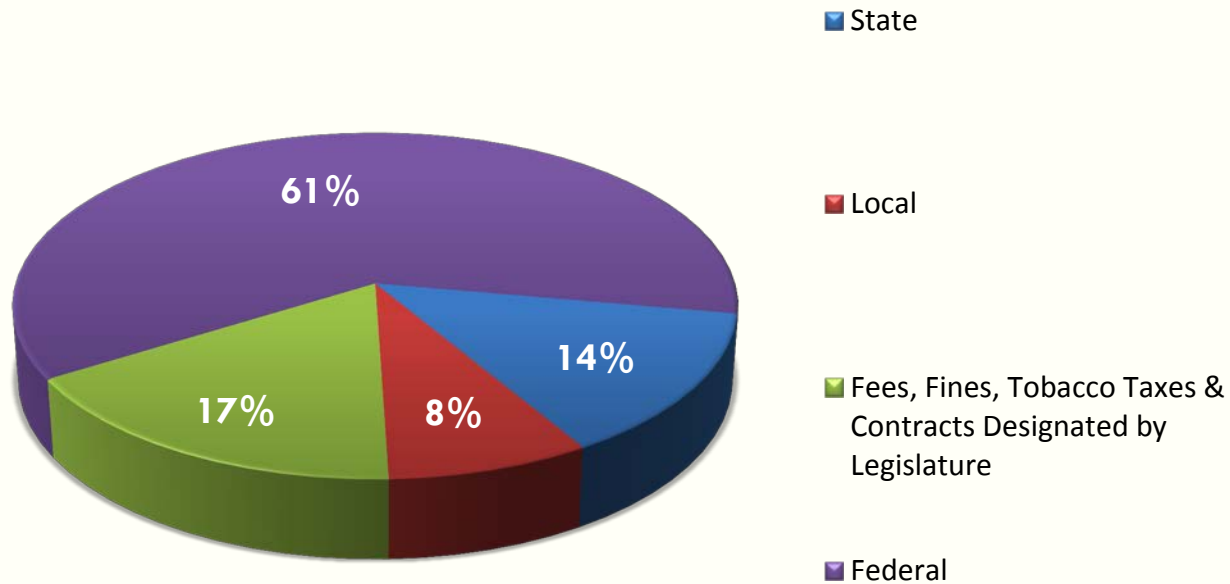
## Health Improvement Services

- Tobacco Use Prevention & Cessation
- Obesity Reduction & Prevention
- Primary Care and Rural Health Development
- Health Care Information

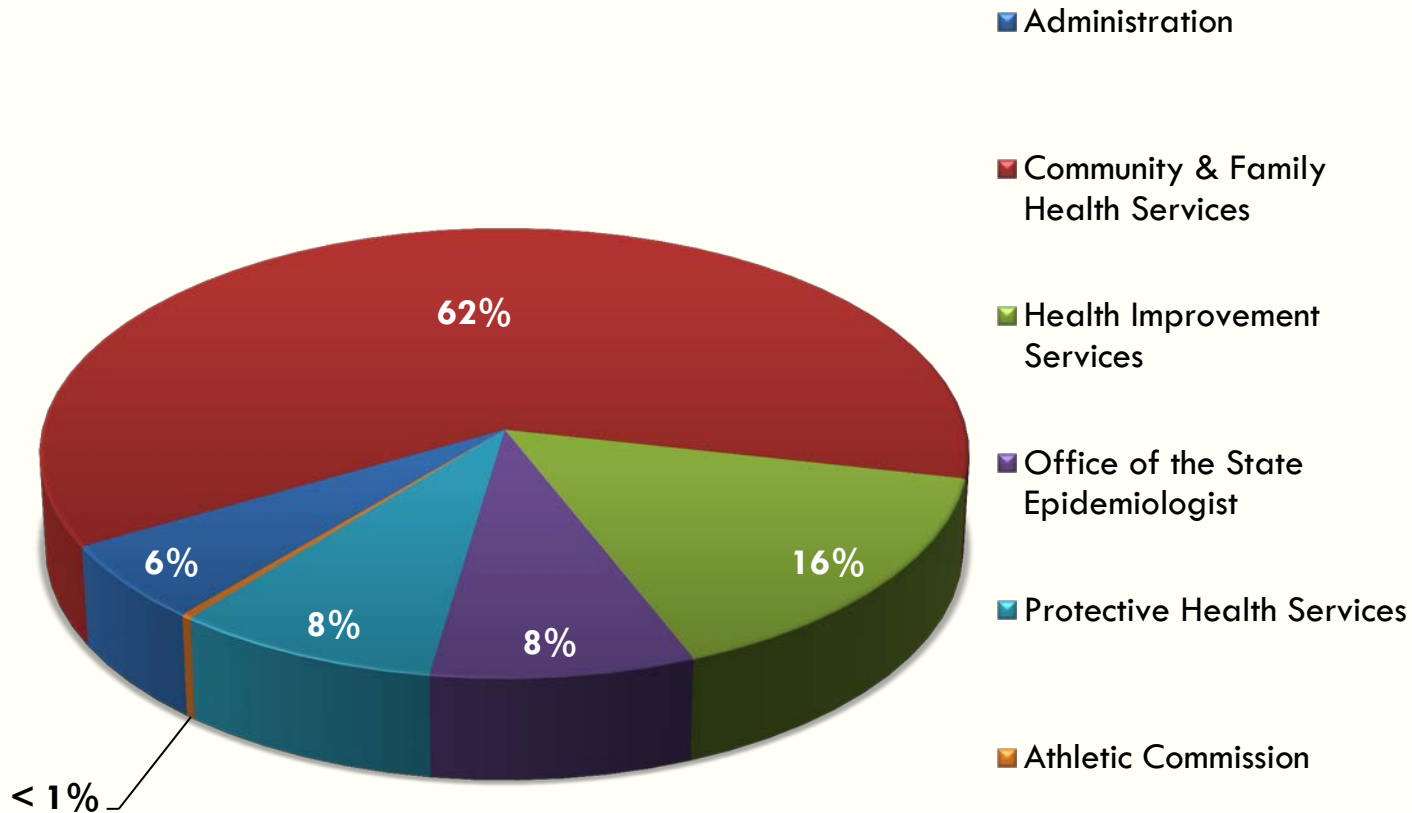


# OSDH SFY 2017 Total Budget by Revenue Source

## \$394,310,277



# OSDH SFY 2017 State Appropriation by Program

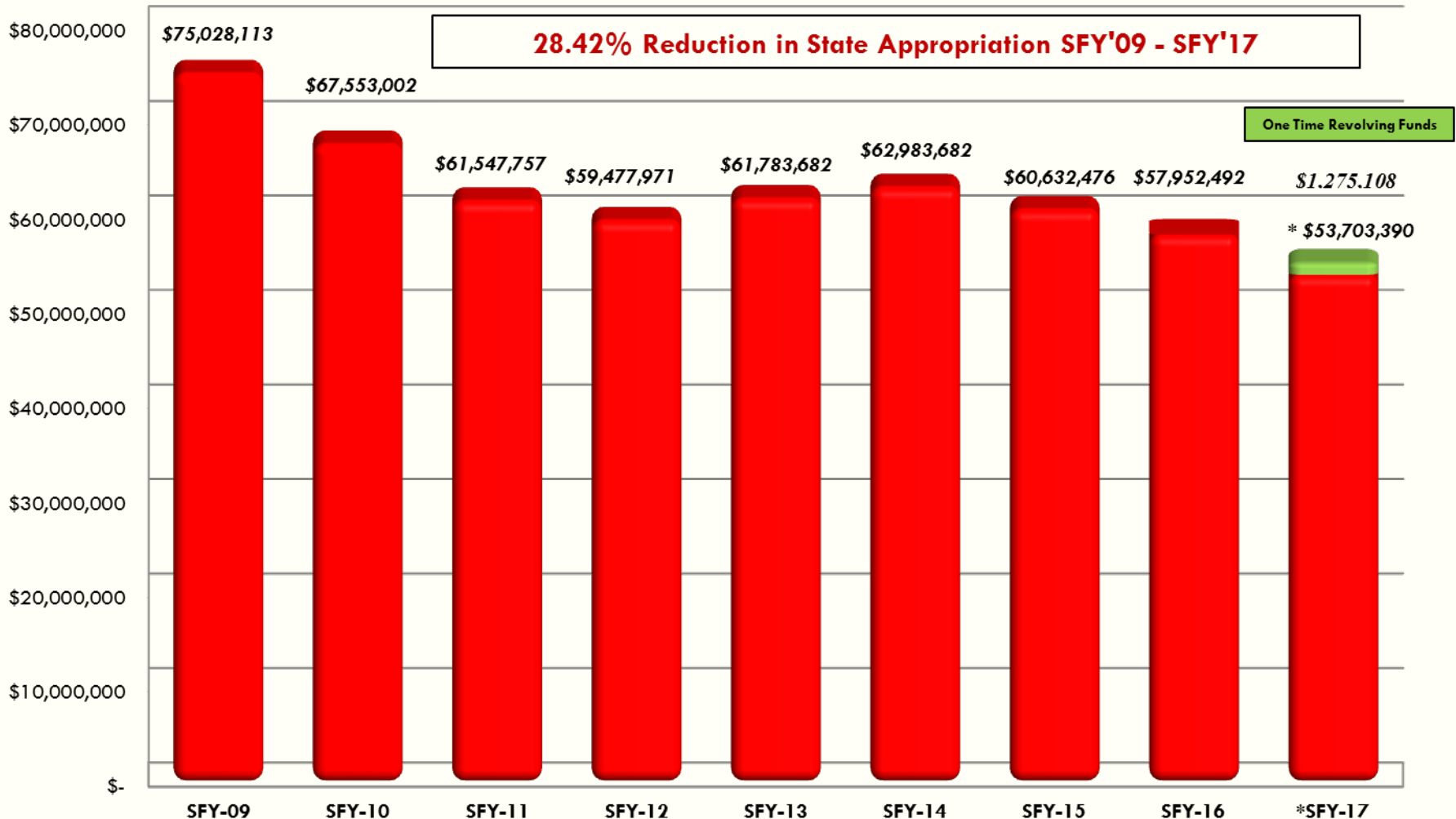


*OSDH Represents 0.75% of Oklahoma State Appropriated Budget*



# OSDH State Appropriation History

## SFY 2009 – SFY 2017



# SFY 2016, 2017 & Potential 2018 State Reductions

<b>SFY-16 Revenue Failure* - 7%</b>	
OSDH Infrastructure	\$ 1,242,691
Federally Qualified Health Centers (FQHC) Start Up Funding (Elimination)	\$ 319,531
Federally Qualified Health Centers (FQHC) Uncompensated Care (Reduction)	\$ 741,051
Cord Blood Bank (Elimination)	\$ 500,000
Strategic Planning (STEP-UP) Software Purchase (Elimination)	\$ 220,000
Dental Health Education Services (Elimination)	\$ 220,000
Colorectal Cancer Screening (Reduction)	\$ 200,000
Ryan White Part B Program	\$ 786,000
Oklahoma Athletic Commission (Reduction)	\$ 14,000
<b>Total</b>	<b>\$ 4,243,273*</b>

<b>SFY-17 Appropriation Reduction – 2.5%</b>	
OSDH Infrastructure (VOBO State Savings)	\$ 914,566
Federally Qualified Health Centers (FQHC) Uncompensated Care	\$ 237,891
Oklahoma Child Abuse Prevention Services	\$ 252,933
Oklahoma Athletic Commission	\$ 4,315
<b>Total SFY '17</b>	<b>\$ 1,409,705</b>
Reduction to Health Improvement Services	\$ 1,275,108
<b>Potential Reduction Beginning SFY '18</b>	<b>\$ 1,275,108</b>

**\* SFY 16 General Appropriations Refund of Revenue Failure \$1,564,289.95**

- 1) OSDH restored \$67,264 to FQHC uncompensated care for SFY-16 unpaid invoices
- 2) Balance to SFY'16 unpaid expenses



# Federal Funding Reductions SFY 2011 - SFY 2017

Federal Funding	% Reduced
Hospital Preparedness	44%
Public Health Emergency Preparedness	13%
MIECHV	32%
Immunization	31%
Comprehensive Cancer	13%
Tobacco	34%
Tuberculosis Elimination	18%



# Services Rendered SFY 2016

## County Health Departments

County Health Department Services	2,877,398
County Health Department Clients	372,324
County Health Department Visits	689,803

## Inspections

Health Inspections	28,489
--------------------	--------

## Birth and Death Certificates Issued

Birth Certificates	175,386
Death Certificates	215,190

## Infectious Disease

Infectious Disease Reports	10,856
OSDH Hours of Infectious Disease Investigations	17,517



# Public Health Laboratory

Test Volumes for 2015

Total Specimens

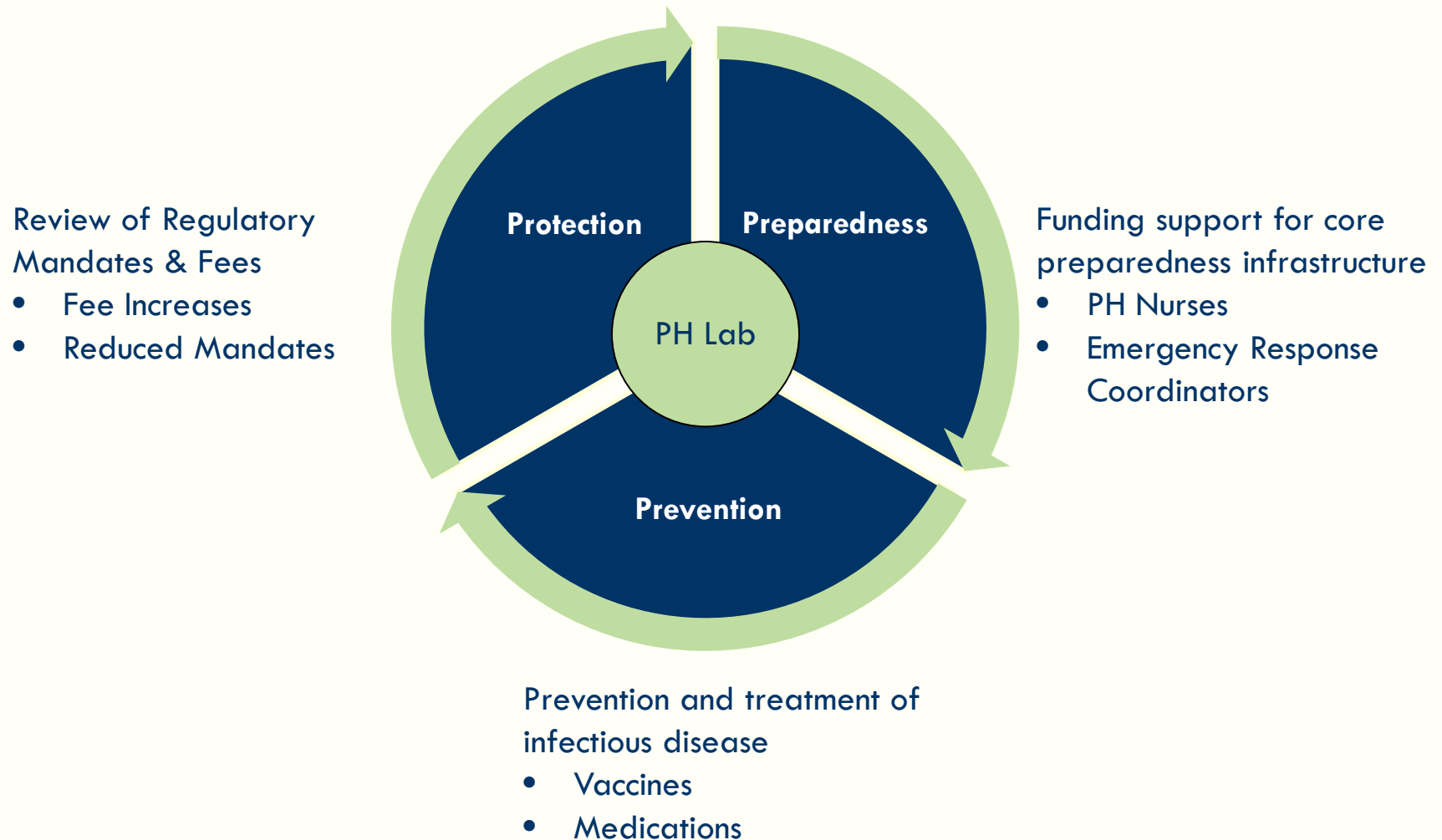
**177,555**

Total Tests

**709,840**



# SFY 2018 Budget Request



# OSDH Budget Request SFY 2018

<b>Program</b>	<b>Amount</b>
Public Health Lab	\$7,587,146 (60.07%)
Immunization	\$1,537,296 (12.17%)
FMAP Reductions	\$1,281,368 (10.14%)
Restore One Time Funding	\$1,275,108 (10.10%)
Infectious Disease	\$602,642 (4.77%)
<u>Childhood Lead Exposure</u>	<u>\$346,750 (2.75%)</u>
<b>TOTAL STATE</b>	<b>\$12,630,310</b>
<b>State Fees</b>	<b>Amount</b>
Adult Day Care/Residential Care/ Nursing	Per bed up to program cost
Health Facility Plan Review	Per plan up to program cost
Sanitarians and Environmental Specialist	Per license and renewal up to program cost

Public Health Collaborative  
Budget Request  
Consumer Protection Fees

<b>Program</b>	<b>Fees</b>
Food Licensure	Simplified, risk based fee structure Temporary License Eliminate plan review fee Re-inspection fee
Hotel/Motel	Per room block up to program cost
Swimming Pools/Public Bathing Places	Per pool/spa up to program cost

# Questions



**Oklahoma Statutes Citationized**  
**Title 63. Public Health and Safety**  
**Chapter 1 - Oklahoma Public Health Code**

**A. Licensing and Regulations**

**Article 7 - Hospitals and Related Institutions**

**Section 1-704 - Licenses - Fees - Duration - Posting**

A. 1. The application by any person for a license to operate a hospital within the meaning of this article shall be accompanied by a fee to be determined by the number of beds available for patients, to be established by the State Board of Health, but not to exceed ~~Ten Dollars (\$10.00)~~ Twenty-Five Dollars (\$25.00) for each bed included in the maximum bed capacity at such facility.

2. For the purpose of determining the fee, the total number of beds shall include cribs and bassinets.

B. No such fee shall be refunded unless licensure is refused. All licenses shall be for a period of ~~twelve (12)~~ thirty-six (36) months from the date of issue. ~~Provided that licenses may be issued for a period of more than twelve (12) months, but not more than twenty-four (24) months, for the license period immediately following the enactment of this provision in order to permit an equitable distribution of license expiration dates to all months of the year.~~

C. Fees for ~~such extended~~ the licensure period shall be calculated per year of issuance or renewal ~~prorated according to the total months to be licensed, with such amounts to be calculated to the nearest dollar.~~

D. All licenses:

1. Shall be on a form prescribed by the State Commissioner of Health, shall not be transferable or assignable;
2. Shall be issued only for the premises named in the application;
3. Shall be posted in a conspicuous place on the licensed premises; and
4. May be renewed for twelve-month ~~thirty-six (36)~~ month periods upon application, investigation and payment of license fee, as in the case of procurement of an original license.

***Historical Data***

Laws 1963, SB 26, c. 325, art. 7, § 704, emerg. eff. July 1, 1963; Amended by Laws 1978, SB 366, c. 286, § 1, eff. January 1, 1979; Amended by Laws 1993, HB 1830, c. 269, § 13, eff. September 1, 1993; Amended by Laws 1999, HB 1184, c. 93, § 3, eff. November 1, 1999 ([superseded document available](#)).

**Section 1-707 - Rules and Standards**

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

1. Construction plans and location, including:
  - a. fees Fees not to exceed Two Thousand Dollars (\$2,000.00) for related Department services, including professional consultations, courtesy or final on-site construction inspections, and reviews of applications for self-certification of compliance; and
  - b. Fees not to exceed fifteen one-hundredths percent (0.15%) of the cost of design and construction of the project, for submission or resubmission of architectural and building plans functional programs and design and construction plans and specifications,



and procedures to ensure the timely review of such plans by the State Department of Health.

c. Said assessed ~~fee~~ fees shall be used solely for the purposes of processing approval of construction plans and location and providing related services by the State Department of Health;

2. Physical plant and facilities;
  3. Fire protection and safety;
  4. Food service;
  5. Reports and records;
  6. Staffing and personal service;
  7. Surgical facilities and equipment;
  8. Maternity facilities and equipment;
  9. Control of communicable disease;
  10. Sanitation;
  11. Laboratory services;
  12. Nursing facilities and equipment; and
  13. Other items as may be deemed necessary to carry out the purposes of this article.
- B. 1. The State Board of Health, upon the recommendation of the State Commissioner of Health and with the advice of the Oklahoma Hospital Advisory Council and the State Board of Pharmacy, shall promulgate rules and standards as it deems to be in the public interest with respect to the storage and dispensing of drugs and medications for hospital patients.
2. The State Board of Pharmacy shall be empowered to inspect drug facilities in licensed hospitals and shall report violations of applicable statutes and rules to the State Department of Health for action and reply.
- C. 1. The Commissioner shall appoint an Oklahoma Hospital Advisory Council to advise the Board, the Commissioner and the Department regarding hospital operations and to recommend actions to improve patient care.
2. The Advisory Council shall have the duty and authority to:
- a. review and approve in its advisory capacity rules and standards for hospital licensure,
  - b. evaluate, review and make recommendations regarding Department licensure activities, provided however, the Advisory Council shall not make recommendations regarding scope of practice for any health care providers or practitioners regulated pursuant to Title 59 of the Oklahoma Statutes, and
  - c. recommend and approve:
    - (1) quality indicators and data submission requirements for hospitals, to include:
      - (a) Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators Available as part of the standard inpatient discharge data set, and
      - (b) for acute care intensive care unit patients, ventilator-associated ~~pneumonia~~ event and device-related blood stream infections, and
    - (2) the indicators and data to be used by the Department to monitor compliance with licensure requirements, and
  - d. to publish an annual report of hospital performance to include the facility specific quality indicators required by this section.
- D. 1. The Advisory Council shall be composed of nine (9) members appointed by the Commissioner with the advice and consent of the Board. The membership of the Advisory Council shall be as follows:

- a. two members shall be hospital administrators of licensed hospitals,
  - b. two members shall be licensed physicians or practitioners who have current privileges to provide services in hospitals,
  - c. two members shall be hospital employees, and
  - d. three members shall be citizens representing the public who:
    - (1) are not hospital employees,
    - (2) do not hold hospital staff appointments, and
    - (3) are not members of hospital governing boards.
2. a. Advisory Council members shall be appointed for three-year terms except the initial terms after November 1, 1999, of one hospital administrator, one licensed physician or practitioner, one hospital employee, and one public member shall be one (1) year. The initial terms after the effective date of this act of one hospital administrator, one licensed physician or practitioner, one hospital employee, and one public member shall be two (2) years. The initial terms of all other members shall be three (3) years. After initial appointments to the Council, members shall be appointed to three-year terms.
- b. Members of the Advisory Council may be removed by the Commissioner for cause.
- E. The Advisory Council shall meet on a quarterly basis and shall annually elect from among its members a chairperson. Members of the Council shall serve without compensation but shall be reimbursed by the Department for travel expenses related to their service as authorized by the State Travel Reimbursement Act.

***Historical Data***

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

**Title 310 - Oklahoma State Department of Health  
Chapter 667 - Hospital Standards**

**Subchapter 1 - General Provisions**

**310:667-1-3. Licensure [AMENDED]**

(a) **Application for licensure.**

(1) No person or entity shall operate a hospital without first obtaining a license from the Department. The license is not transferable or assignable.

(2) The applicant shall file a licensure application in a timely manner. The application shall be on forms provided by the Department, with a ~~check fee~~ fee of ~~\$10.00~~ twenty-two dollars (\$22.00) for each census bed, crib and bassinet, payable to the Oklahoma State Department of Health.

(3) The entity responsible for operation of the hospital and appointment of the medical staff shall be considered the applicant for the license. This entity may be a lessee if the hospital is leased and the lessee is the operating entity. For the purposes of licensure, a company providing administrative management of a hospital, which functions by contract with the governing body of the hospital, shall not be considered the entity responsible for operation.

(4) An application is not considered to be filed unless it is accompanied by the application fee.

(b) **Application filing.** An initial license application or renewal application shall be filed as follows:

(1) The application for an initial license for a new hospital shall be filed prior to or at the time final drawings for construction are submitted to the Department for review which shall be at least thirty (30) days before a hospital begins operation.

(2) The application for an initial license for a change of ownership or operation, shall be filed at least thirty (30) days before the transfer. The sale of stock of a corporate licensee, where a majority of the governing body does not change, is not considered a change of ownership or operation. The sale or merger of a corporation that owns an operating corporation that is the licensed entity shall not be considered a change of ownership unless a majority of the governing body is replaced.

(3) The application for renewal of a license of an existing hospital shall be filed ~~at least thirty (30) days~~ before the expiration date of the current license.

(c) **Where to file.** The application and the license fee shall be delivered or sent to the Department. The effective date shall be the date the application and fee are received.

(d) **Forms.** The applicant for a license shall file application forms as follows:

(1) For an initial license of a new hospital, or for an existing hospital following a change in ownership or operation, the applicant shall file these forms: Application for License to Operate a Hospital or Related Institution; Board of Directors Information Sheet; and Designation of Licensed Beds Form.

(2) For renewal of a current license, the applicant shall file the Application for License to Operate a Hospital or Related Institution; Board of Directors Information Sheet; Designation of Licensed Beds Form; and a Fire Inspection Report For Hospitals.

(e) **Description of forms.** The forms used to apply for a hospital license are the following:

(1) The Application For License to Operate Hospital or Related Institution (Form 920) requests: identification of the type of license requested; the name and address of the hospital;

the name and address of the operating entity; the number of beds and bassinets; the ownership of the building and grounds; the applicant's name; the chief executive officer/administrator's name; attachment for credentialed staff; and an affidavit attesting the signature of the applicant.

(2) The Board of Directors Information Form (Form AGH-2) requests: The names and addresses of the Board of Directors for the hospital.

(3) The Designation of Licensed Beds Form (Form 920-A) requests: A listing of the types of beds operated by the hospital and a total of the beds.

(4) The Fire Inspection Report for Hospitals (Form 928) requests: a check list of the annual inspection conducted by the local fire marshall.

(f) **Eligibility for license.**

(1) Hospitals making appropriate application that have been determined to be compliant with these standards are eligible for a license.

(2) A hospital may operate inpatient and outpatient facilities under one (1) license as a hospital campus as long as the following requirements are met:

(A) The facilities shall be separated by no more than fifty (50) miles. This requirement may be waived if the services of the facilities are totally integrated through telecommunication or by other means.

(B) The facilities are operated by the same governing body with one administrator.

(C) The medical staff for all facilities is totally integrated so that any practitioner's privileges extend to all facilities operated under the common license.

(3) An outpatient facility located at a different address from a hospital is eligible to be licensed as part of the hospital but is not required to be licensed.

(4) Each hospital shall participate in a functioning regional system of providing twenty-four (24) hour emergency hospital care approved by the Commissioner of Health in consultation with the Oklahoma Trauma Systems Improvement and Development Advisory Council. Participation in a regional system may include active participation of the hospital in the provision of emergency services based upon the system plan, participation of the hospital's medical staff in the provision of emergency services at other hospitals in the system based on the system plan, or payment into a fund to reimburse hospitals providing emergency services in the system.

(5) If an area of the state fails to develop a functioning regional system of providing twenty-four (24) hour emergency hospital care necessary to meet the state's needs for trauma and emergency care as established by the state-wide trauma and emergency services plan, the Commissioner of Health, in consultation with the Oklahoma Emergency Response Systems Development Advisory Council, shall develop a system for the area. Each hospital located in the area shall participate as specified by the system plan for that region.

(g) **Regional system of emergency hospital care.**

(1) In counties and their contiguous communities with populations of 300,000 or more, a functioning regional system of providing twenty-four (24) hour emergency hospital care shall include definitive emergency care for all clinical categories specified in OAC 310:667-59-7. In these regions, a functioning system shall only transfer emergent patients out of the system when treatment or diagnostic services are at capacity unless the patient has a special treatment need not normally provided by the system. Transfers out of the system may occur based upon the patient or the patient's legal representative's request or based upon a special circumstance for the transfer.

(2) In counties and communities with populations of less than 300,000, a functioning regional system of providing twenty-four (24) hour emergency hospital care shall include definitive care based upon the classification of hospital's emergency services in the region as specified in OAC 310:667-59-7. Transfers out of the regional system may be based upon lack of diagnostic or treatment capability or capacity. A functioning system shall not permit emergent patient transfers out of the system if the system has the capability and capacity to provide care unless the patient or patient's legal representative requests the transfer.

(3) A functioning regional system of providing twenty-four (24) hour emergency hospital care shall demonstrate compliance with OAC 310:667-1-3(g)(1) or (2) through system continuous quality improvement activities. Activities shall include monitoring of patient transfers and corrective actions when inappropriate transfers are identified. Special circumstance patient transfers shall be identified and reviewed through continuous quality improvement activities.

(h) **Quality indicators.** The Department, with the recommendation and approval of the Hospital Advisory Council, shall establish quality indicators to monitor and evaluate the quality of care provided by licensed hospitals in the state.

(1) The quality indicators shall focus on the following measurement areas:

- (A) Acute myocardial infarction (including coronary artery disease);
- (B) Heart failure;
- (C) Community acquired pneumonia;
- (D) Pregnancy and related conditions (including newborn and maternal care);
- (E) Surgical procedures and complications;
- (F) Patient perception measures such as satisfaction surveys; and
- (G) Ventilator-associated pneumonia and device-related blood stream infections for certain intensive care unit patients in acute care hospital settings.

(2) The quality indicators in use shall be periodically evaluated and revised as health care quality issues are identified and others are resolved.

(i) **Data submission requirements.**

(1) The Department shall define the parameters and scope of each quality indicator, the beginning and ending dates of the period when each indicator will be in effect, how the indicator will be measured, any inclusionary or exclusionary criteria, and the frequency and format of how the data shall be reported.

(2) Each hospital shall report applicable data related to these indicators to the Department in the specified format and within required time frames.

[Source: Added at 12 Ok Reg 1555, eff 4-12-95 (emergency); Added at 12 Ok Reg 2429, eff 6-26-95; Amended at 21 Ok Reg 573, eff 1-12-04 (emergency); Amended at 21 Ok Reg 2785, eff 7-12-04; Amended at 21 Ok Reg 2437, eff 7-11-05; Amended at 24 Ok Reg 2018, eff 6-25-07]

## **Subchapter 41 - General Construction Provisions**

### **310:667-41-1. General [AMENDED]**

~~(a) These requirements are intended as minimum standards for constructing and equipping hospital and specialized hospital projects. For brevity and convenience these standards are presented in "code language". Use of words such as "shall" is mandatory. Insofar as practical, these standards relate to desired performance or results or both. Details of construction and engineering are assumed to be part of good design practice and local building regulations.~~

~~Design and construction shall conform to the requirements of these standards. Requirements set forth in these standards shall be considered as minimum. For aspects of design and construction not included, local governing building codes shall apply. Where there is no local governing building code, the prevailing model code used within the geographic area is hereby specified for all requirements not otherwise specified in these standards. (See OAC 310:667-41-4(b) for wind and seismic local requirements.) Where American Society of Civil Engineers (ASCE 9-72) is referenced, similar provisions in the model building code are considered substantially equivalent.~~

~~(b) These standards are not intended to restrict innovations and improvements in design or construction techniques. Accordingly, the Department may approve plans and specifications which contain deviations if it is determined that the respective intent or objective has been met.~~

~~(c) Some projects may be subject to the regulations of several different programs, including those of other state agencies, local agencies, and federal authorities. While every effort has been made for coordination, individual project requirements shall be verified, as appropriate.~~

~~(d) The Centers for Medicare & Medicaid Services (CMS), which is responsible for Medicare and Medicaid reimbursement, has adopted the National Fire Protection Association 101 Life Safety Code (NFPA 101). To ensure non-conflicting requirements, the 2000 version of this code is hereby adopted by the Department and all new construction shall comply with that code. Existing construction may continue to comply with the version of NFPA 101 for which construction was approved.~~

~~(e) The health care provider shall supply for each project a functional program for the facility that describes the purpose of the project, the projected demand or utilization, staffing patterns, departmental relationships, space requirements, and other basic information relating to fulfillment of the institution's objectives. This program shall include a description of each function or service; the operational space required for each function; the quantity of staff or other occupants of the various spaces; the numbers, types, and areas (in net square feet) of all spaces; the special design features; the systems of operation; and the interrelationships of various functions and spaces. The functional program shall include a description of those services necessary for the complete operation of the facility and shall also include the Infection Control Risk Assessment (ICRA). Services available elsewhere in the institution or community need not be duplicated in the facility. The functional program shall also address the potential future expansion of essential services which may be needed to accommodate increased demand. The approved functional program shall be available for use in the development of project design and construction documents.~~

~~(f) An ICRA is a determination of the potential risk of transmission of various agents in the facility. This continuous process is an essential component of a facility functional or master program to provide a safe environment of care. The ICRA shall be conducted by a panel with expertise in infection control, risk management, facility design, construction, ventilation, safety, and epidemiology. The design professional shall incorporate the specific, construction related requirements of the ICRA in the contract documents. The contract documents shall require the contractor to implement these specific requirements during construction. The ICRA is initiated in design and planning and continues through construction and renovation. After considering the facility's patient population and programs, The ICRA shall address but not be limited to the following key elements:~~

- ~~(1) The impact of disrupting essential services to patients and employees;~~
- ~~(2) Patient placement or relocation;~~

~~(3) Placement of effective barriers to protect susceptible patients from airborne contaminants such as Aspergillus sp.~~

~~(4) Air handling and ventilation needs in surgical services, airborne infection isolation and protective environment rooms, laboratories, local exhaust systems for hazardous agents, and other special areas;~~

~~(5) Determination of additional numbers of airborne infection isolation or protective environment room requirements;~~

~~(6) Consideration of the domestic water system to limit Legionella sp. and waterborne opportunistic pathogens.~~

(a) The following national standards are incorporated by reference:

(1) Facility Guidelines Institute (FGI): Guidelines for Design and Construction of Hospitals and Outpatient Facilities, 2014 Edition; and

(2) National Fire Protection Association (NFPA) 101: Life Safety Code, 2012 Edition, adopted in 81 Federal Register 26871 by the Centers for Medicare & Medicaid Services on July 5, 2016.

(b) Oklahoma statutes prevail if there is conflict between the FGI Guidelines and Oklahoma statutes. For Medicare-certified hospitals, the Life Safety Code adopted by the Centers for Medicare & Medicaid Services prevails if there is a conflict between the Life Safety Code and this Chapter.

(c) A hospital may submit a request for exception or temporary waiver if the FGI Guidelines create an unreasonable hardship, or if the design and construction for the hospital property offers improved or compensating features with equivalent outcomes to the FGI Guidelines.

(d) The Department may permit exceptions and temporary waivers of the FGI Guidelines if the Department determines that such exceptions or temporary waivers comply with the requirements of 63 O.S. Section 1-701 et seq., this Chapter, and the following:

(1) Any hospital requesting an exception or temporary waiver shall apply in writing on a form provided by the Department. The form shall include:

(i) The FGI Guidelines section(s) for which the exception or temporary waiver is requested;

(ii) Reason(s) for requesting an exception or temporary waiver;

(iii) The specific relief requested; and

(iv) Any documentation which supports the application for exception.

(2) In consideration of a request for exception or temporary waiver, the Department shall consider the following:

(i) Compliance with 63 O.S. Section 1-701 et seq.;

(ii) The level of care provided;

(iii) The impact of an exception on care provided;

(iv) Alternative policies or procedures proposed; and

(v) Compliance history with provisions of the FGI Guidelines, Life Safety Code and this Chapter.

(3) The Department shall permit or disallow the exception or waiver in writing within forty-five (45) calendar days after receipt of the request.

(4) If the Department finds that a request is incomplete, the Department shall advise the hospital in writing and offer an opportunity to submit additional or clarifying information. The applicant shall have thirty (30) calendar days after receipt of notification to submit

additional or clarifying information in writing to the Department of Health, or the request shall be considered withdrawn.

(5) A hospital which disagrees with the Department's decision regarding the exception or temporary waiver may file a written petition requesting relief through an individual proceeding pursuant to OAC 310:2 (relating to Procedures of the State Department of Health).

(6) The Department may revoke an exception or temporary waiver through an administrative proceeding in accordance with OAC 310:2 and the Oklahoma Administrative Procedures Act upon finding the hospital is operating in violation of the exception or temporary waiver, or the exception or temporary waiver jeopardizes patient care and safety or constitutes a distinct hazard to life.

### **Subchapter 47 - Submittal Requirements**

#### **310:667-47-1. Submission of plans and specifications and related requests for services [AMENDED]**

(a) Before construction is begun, plans and specifications, covering the construction of new buildings or major alterations to existing buildings, shall be submitted to the Department for review ~~and approval~~.

(b) Each construction project submission shall be accompanied by a check for the appropriate review fee based on the cost of design and construction of the project. ~~Review fees~~ Fees for plan and specification reviews and related Department services are as follows:

(1) ~~Project cost less than \$10,000.00: \$250.00 Fee~~ Functional programs and design and construction plans and specifications fee: twelve one-hundredths percent (0.12%) of the cost of design and construction of the project;

(2) ~~Project cost \$10,000.00 to \$50,000.00: \$500.00 Fee~~ Request for exception to or temporary waiver of FGI Guidelines fee: Five Hundred Dollars (\$500.00);

(3) ~~Project cost \$50,000.00 to \$250,000.00: \$1000.00 Fee~~ Application for self-certification fee: Two Hundred Fifty Dollars (\$250.00);

(4) ~~Project cost \$250,000.00 to \$1,000,000.00: \$1500.00 Fee~~ Courtesy or final construction inspection fee: Five Hundred Dollars (\$500.00);

(5) ~~Project cost greater than \$1,000,000.00: \$2000.00 Fee~~ Professional consultation or technical assistance fee: Fifty Dollars (\$50.00) for each staff hour or fraction thereof. For technical assistance requiring travel, the fee may be increased to include the Department's costs for travel.

(c) The ~~review~~ fee for review of functional programs and design and construction plans and specifications shall cover the cost of review for up to two (2) stage one and two (2) stage two submittals. If a stage one or stage two submittal is not approved after two (2) submissions, another review fee based on fifty percent (50%) of the cost of the project shall be required with the third submittal. Fast-track projects shall be allowed two reviews for each package submitted. If a fast-track stage package is not approved after the second submittal, another review fee based on fifty percent (50%) of the cost of the project shall be required with the third submittal of the package.



(d) ~~All construction project submittals~~ **Review process.** Design and construction plans and specifications shall be reviewed within 45 calendar days of receipt by the Department in accordance with the following process.

(1) **Administrative completeness review.** Unless otherwise provided in this Subchapter, the Department shall have ten (10) calendar days in which to initially determine if the filed application is administratively complete

(i) **Not complete.** Upon determining that the application is not administratively complete, the Department shall immediately notify the applicant in writing and shall indicate with reasonable specificity the inadequacies and measures necessary to complete the application. Such notification shall not require nor preclude further review of the application and further requests for specific information. If the Department fails to notify the applicant as specified in this Paragraph, the period for technical review shall begin at the close of the administrative completeness review period. Upon submission of correction of inadequacies, the Department shall have an additional 15 calendar days to review the application for completeness.

(ii) **Complete.** Upon determination that the application is administratively complete, the Department shall immediately notify the applicant in writing. The period for technical review begins.

(2) **Technical review.** The Department shall have forty-five (45) calendar days from the date a completed application is filed to review each application for technical compliance with the relevant regulations and reach a final determination.

(i) **When times are tolled.** The time period for technical review is tolled (the clock stops) when the Department has asked for supplemental information and advised the applicant that the time period is tolled pending receipt.

(ii) **Supplements.** To make up for time lost in reviewing inadequate materials, a request for supplemental information may specify that up to 30 additional calendar days may be added to the deadline for technical review, unless the request for supplemental information is a second or later request that identifies new deficiencies not previously identified

(iii) **Delays.** Failure by an applicant to supplement an application within 90 days after the request shall be deemed to be withdrawn unless the time is extended by agreement for good cause.

(iv) **Extensions.** Extensions may be made as provided by law.

### **310:667-47-10. Self-certification of plans [NEW]**

(a) The Department shall make available consultation and technical assistance services covering the requirements of this section to a hospital considering self-certification of plans. The consultation and technical assistance is subject to the fees specified in OAC 310:667-47-1(b). The consultation is optional and not a prerequisite for filing a request through the self-certification review process.

(a) The hospital and the project architect may elect to request approval of design and construction plans through a self-certification review process. The hospital and the project architect submit a self-certification request on a form provided by the Department, along with the review fee specified in OAC 310:667-47-1(b)(7). The form shall be signed by the hospital and the project architect attesting that the plans and specifications are based upon and comply with the requirements of this Chapter.

- (b) To be eligible for self-certification, projects must comply with the following requirements:
- (1) The project involves any portion of the hospital where patients are intended to be examined or treated and the total cost is fifteen million dollars (\$15,000,000) or less; or
  - (2) The project involves only portions of the hospital where patients are not intended to be examined or treated; and
  - (3) The project architect attesting the application has held a license to practice architecture or engineering for at least five (5) years prior to the submittal of the application, is licensed to practice in Oklahoma; and
  - (4) The hospital owner/operator acknowledges that the Department retains the authority to:
    - (i) Perform audits of the self-certification review program and select projects at random for review;
    - (ii) Review final construction documents;
    - (iii) Conduct on-site inspections of the project;
    - (iv) Withdraw approval based on the failure of the hospital or project architect to comply with the requirements of this Chapter; and
  - (5) The hospital agrees to make changes required by the Department to bring the construction project into compliance with this Chapter.
- (c) Within twenty-one (21) days after receipt of a complete application, the Department shall approve or deny the application for self-certification and send notification to the hospital. If the application is denied, the hospital shall have thirty (30) days to submit additional or supplemental information demonstrating that the application complies with the requirements for self-certification of plans and specifications. The Department shall have fourteen (14) days after receipt of supplemental information to reconsider the initial denial and issue a final approval or denial of the self-certification request.
- (d) After denial of the application for self-certification and prior to the start of construction, the hospital shall pay the applicable fee for plan review specified in OAC 310:667-47-1(b)(1) through (5). Upon receipt of the plan review fee, the Department shall review the hospital's plans in accordance with the process in OAC 310:667-41-1(d).



Health Facility Plan Review Fees

Comparison of Plan Review Fee Scenarios for Hospitals, Ambulatory Surgical Centers and Hospice Facilities, and Long Term Care Facilities											
Fee Scenario	Hospitals, ASC and Hospice Plan Fees	Long Term Care Plan Fees	Consult Fees (\$50/Hour)	Site Visit Fees (\$500 per Visit)	Self Certification Fees (\$250 per review)	Total Revenue	15% OSDH Admin Cost	Available Revenue: Total Rev. Less Admin. Cost	Projected Appropriation Needed to Supplement Fees FY17	Scenario's Dollar Reduction in Appropriation Needed	Scenario's Percent Reduction in Appropriation Needed
FY2016 Experience	\$160,958	\$2,000	\$0	\$0	\$0	\$162,958	\$24,444	\$138,514	\$330,835	\$0	0.0%
LTC Fees Same as Hospitals	\$160,958	\$33,500	\$0	\$0	\$0	\$194,458	\$29,169	\$165,289	\$304,060	\$26,775	8.1%
Texas Fee Schedule	\$180,000	\$26,300	\$0	\$0	\$0	\$206,300	\$30,945	\$175,355	\$293,994	\$36,841	11.1%
0.10 % of project cost	\$290,416	\$82,864	\$25,000	\$115,000	\$3,750	\$517,031	\$77,555	\$439,476	\$29,873	\$300,962	91.0%
0.12% of project cost	\$348,500	\$99,437	\$25,000	\$115,000	\$3,750	\$591,687	\$88,753	\$502,934	-\$33,585	\$364,420	110.2%
0.13% of project cost	\$377,541	\$107,724	\$25,000	\$115,000	\$3,750	\$629,015	\$94,352	\$534,663	-\$65,314	\$396,149	119.7%
0.14% of project cost	\$406,583	\$116,010	\$25,000	\$115,000	\$3,750	\$666,343	\$99,951	\$566,391	-\$97,042	\$427,877	129.3%
0.15% of project cost	\$435,624.43	\$124,296	\$25,000	\$115,000	\$3,750	\$703,671	\$105,551	\$598,120	-\$128,771	\$459,606	138.9%

<b>Health Facility Plan Review Projected Expenses (FY17) and Revenues (FY16)</b>	
<b><u>Personnel Detail</u></b>	
Administrative Programs Manager @ 1 FTE	\$ 107,931
Architect @ 1 FTE	\$ 95,175
Architect @ 1 FTE	\$ 95,175
Administrative Assistant @ 1FTE	\$ 54,834
Clinical Reviewer @ .5 FTE	\$ 47,367
Clinical Reviewer @ .5 FTE	\$ 47,367
	<b><u>FY17 Planned Expenditures</u></b>
Payroll (Salary and Fringes)	\$ 447,849
Motorpool (state issued car)	\$ 6,000
Communications	\$ 1,000
Supplies	\$ 2,000
Data Costs @\$2500/FTE	\$ 12,500
<b>Total</b>	<b>\$ 469,349</b>
	<b><u>FY16 Actual Revenues</u></b>
Total Revenue from Fees	\$ 162,958
Less 15% OSDH Administrative Costs	\$ 24,444
Revenue Available for Plan Reviews	<b>\$ 138,514</b>
<b>Variance</b>	<b>\$ (330,835)</b>

**PROTECTIVE**  
**HEALTH**  
**SERVICES**



**Oklahoma State Department of Health**  
Protective Health Services – 0505  
Medical Facilities  
1000 NE 10<sup>th</sup> Street  
Oklahoma City, OK 73117-1299  
Telephone: (405) 271-6785  
FAX: (405)271-1738

**HOSPITAL SELF-CERTIFICATION SUBMITTAL FORM**

*INSTRUCTIONS*

- I. The form has been developed to allow facility representatives the option of using self-certification review process when it is not feasible to wait for the full plan review process by the Oklahoma State Department of Health. The self-certification process is not limited to a specific type of project or estimated project cost.
- II. Read carefully and complete all portions of the form. Please type.
- III. Plan review submittal form, fees and all plans are still required to be submitted in accordance with the submittal form in order for the application for self-certification to be approved.
- IV. If the application for self-certification is not approved, a denial letter will be issued and the plan review process will proceed as if the plans were submitted for a full review.

**ARCHITECT CERTIFICATION**

**1. Name of Facility** \_\_\_\_\_

Tel. No. (    ) \_\_\_\_\_ - \_\_\_\_\_      Fax No. (    ) \_\_\_\_\_ - \_\_\_\_\_

DBA \_\_\_\_\_

**2. Mailing Address** \_\_\_\_\_

(Number, Street, City, State, Zip)

**3. Name of Project** \_\_\_\_\_

**4. The undersigned architect hereby certifies:**

- They have created the architectural plans and specifications attached hereto regarding new building, new addition, renovation, alteration, modification, or conversion of an existing building in the referenced project;
- The plans have been reviewed for compliance with Oklahoma State Department of Health (OSDH) Hospital Standards (Title 310 Oklahoma Administrative Code , Chapter 667)
- To the undersigned's knowledge, information and belief, the plans meet the requirements of the licensing rules in all material aspects

Architectural Firm Name: \_\_\_\_\_

Name of Licensed Architect: \_\_\_\_\_

Tel. No. (     ) \_\_\_\_\_ - \_\_\_\_\_ Fax No. (     ) \_\_\_\_\_ - \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Architect's Stamp:

5. The undersigned applicant understands and agrees that, notwithstanding this architectural certification the OSDH shall have continuing authority to (a) review the plans submitted herewith and/or inspect the work with regard thereto, and (b) withdraw its approval thereto. The applicant shall have a continuing obligation to make any changes required by the OSDH to comply with the applicable codes and regulations, whether or not physical plant construction or alterations have been completed.

Authorized Signature for Applicant: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

<b>Comparison of License Fee Scenarios for Hospitals</b>						
Fee Scenario	Hospital License Fees	15% OSDH Admin Cost	Available Revenue: Total Rev. Less Admin. Cost	Projected Appropriation Needed to Supplement Fees FY17	Scenario's Dollar Reduction in Appropriation Needed	Scenario's Percent Reduction in Appropriation Needed
\$10 per bed	\$176,666	\$26,500	\$150,166	\$172,122	\$0	0.0%
\$20 per bed	\$353,332	\$53,000	\$300,332	\$21,956	\$150,166	87.2%
\$22 per bed	\$388,665	\$58,300	\$330,365	-\$8,077	\$180,199.32	104.7%
\$25 per bed	\$441,665	\$66,250	\$375,415	-\$53,127	\$225,249.15	130.9%



Hospital Licensure Program Fees

<b>Hospital Licensure Program Expenses (FY17) and Revenues (FY16)</b>	
<b><u>Personnel Detail</u></b>	
Clinical Health Facility Surveyor III @ 3 FTE	\$ 255,330
Clinical Health Facility Surveyor IV @.2 FTE	\$ 18,947
Administrative Assistant II @.5 FTE	\$ 25,731
	<b><u>FY17 Planned Expenditures</u></b>
Payroll (Salary and Fringes)	\$ 300,008
Motorpool (state issued car)	\$ 11,280
Communications	\$ 1,000
Supplies	\$ 750
Data Costs @\$2500/FTE	\$ 9,250
<b>Total</b>	<b>\$ 322,288</b>
	<b><u>FY16 Actual Revenues</u></b>
	\$ 176,666
Less 15% OSDH Administrative Costs	\$ 26,500
Total Ambulatory Surgical Revenue	<b>\$ 150,166</b>
<b>Variance</b>	<b>\$ (172,122)</b>