

**Regular Meeting of the Oklahoma State Board of Health**  
**Tuesday, February 12, 2019, 1:00 PM**  
Posted at [www.health.ok.gov](http://www.health.ok.gov)  
**Oklahoma State Department of Health**  
**1000 NE 10<sup>th</sup> Street, 11<sup>th</sup> Floor, Room 1102**  
**Oklahoma City, OK 73117**

**AGENDA**

- I. Call to Order, Roll Call, and confirmation of a Quorum
- II. Review, discussion and approval of Minutes for:
  - a) December 11, 2018 Regular Meeting
- III. OSDH Financial Presentation - Gloria Hudson, Chief Financial Officer
  - a. Overview of SFY 2020 budget request and December 2018 financial statements
- IV. Community Health Services Presentation - Keith Reed, Deputy Commissioner
  - a. Review of data platform to forecast county level budget and staffing
- V. Family Health Services Presentation - Tina Johnson, Deputy Commissioner
  - a. Update on recent activities for Screening and Special Services
- VI. Prevention & Preparedness Services Presentation - Laurence Burnsed, Interim Deputy Commissioner/State Epidemiologist
  - a. Update on Acute Disease Service, HIV/STD Service and recent inspection summary on OSDH Public Health Laboratory
- VII. Protective Health Services Presentation - Rocky McElvany, Deputy Commissioner
  - a. Elevating care in nursing homes through the reinvestment of civil monetary penalties in Oklahoma
- BREAK
- VIII. Chief Medical Officer Report – Dr. Edd Rhoades, Chief Medical Officer
  - a. Overview of role and responsibilities of Chief Medical Officer
- IX. Legislative and Policy Update - Ashley Scott, Legislative Liaison and Buffy Heater, Chief Data, Public Policy & Promotion Officer
  - a. Discuss agency legislation and upcoming dates
  - b. Discuss agency policy development process, recent rule promulgation activities, and upcoming key dates
- X. President’s Report – Tim Starkey, MBA, Board President
  - a. Update and possible discussion on executive committee discussion and board activity since last regular Board of Health meeting

- XI. Interim Commissioner Report – Tom Bates, J.D., Interim Commissioner
  - a. Update and possible discussion on agency progress and program activity since last regular Board of Health meeting
  
- XII. Discussion of potential recommendations on agenda items for 2019 Board of Health meetings – Board of Health members and Interim Commissioner
  
- XIII. Adjournment

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 Alexopoulos, 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. Alexopoulos. Motion Carried.**

**AYE: Alexopoulos, 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 10<sup>th</sup> Street, Oklahoma City, Oklahoma. Dates are the

1 following:

- 2 Tuesday, February 12, 2019
- 3 Tuesday, April 9, 2019
- 4 Tuesday, August 13, 2019
- 5 Tuesday, October 1, 2019

6  
7 **Mrs. Payton moved Board approval of the 2019 Board of Health regular meeting schedule as presented.**  
8 **Second Mr. Osterhout. Motion Carried.**

9  
10 **AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey**  
11 **ABSENT: Krishna, Skillings**

12  
13 **CONSIDERATION, POSSIBLE ACTION AND VOTE ON CHANGES TO THE OSDH**  
14 **ORGANIZATIONAL CHART.**

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

24 *See Attachment A*

25  
26 **Dr. Alexopulos moved Board approval of the changes to the OSDH Organizational Chart as presented.**  
27 **Second Dr. Legako. Motion Carried.**

28  
29 **AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey**  
30 **ABSENT: Krishna, Skillings**

31  
32 **CONSIDERATION, POSSIBLE ACTION AND VOTE ON POLICY STATEMENT PROPOSED BY**  
33 **THE TRI-BOARDS OF HEALTH.**

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

40 *See Attachment B*

41  
42 **Mr. Osterhout moved Board approval of the Tri-Boards of Health policy statement as presented. Second**  
43 **Dr. Grim. Motion Carried.**

44  
45 **AYE: Alexopulos, Gerard, Grim, Legako, Osterhout, Payton, Starkey**  
46 **ABSENT: Krishna, Skillings**

47  
48 **CONSIDERATION, POSSIBLE ACTION AND VOTE TO OPEN EMERGENCY RULEMAKING**  
49 **AND PROMULGATE PROPOSED NEW EMERGENCY RULES 310:681-5-8.1, CONTAINING**  
50 **FOOD SAFETY STANDARDS, PROPOSED BY THE OKLAHOMA MEDICAL MARIJUANA**  
51 **AUTHORITY'S FOOD SAFETY STANDARDS BOARD.**

52 Mrs. Heater explained that State Question 788 required the OSDH to create the Food Safety Standards Board  
53 (FSSB). It is a 12-member board appointed by the Commissioner of Health. The state question also required a  
54 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

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

10  
11 In conclusion, Mr. Osterhout stated how difficult yet important long term care work is and reminded everyone  
12 of the large number of residents that are impacted now and in the coming years. He said people need to know  
13 they have the right to complain and know how to complain. He expressed concern about RN requirements not  
14 being met in facilities. Mr. Cook pointed out that the federal law and state law have very different  
15 requirements when it comes to staffing but he will look into the matter.  
16 *See Attachment F*

17  
18 **LEGISLATIVE UPDATE**

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

31  
32 **OSDH FINANCIAL PRESENTATION**

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

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

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

44  
45 **PRESIDENT’S REPORT**

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

50  
51 **INTERIM COMMISSIONER’S REPORT**

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

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

8  
9 **NEW BUSINESS**

10 No new business.

11  
12 **ADJOURNMENT**

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

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15 The meeting adjourned at 12:31 p.m.

16  
17 Approved

18  
19  
20  
21 

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



**BOARD OF HEALTH**

**INTERIM COMMISSIONER OF HEALTH**  
 Tom Bates, J.D.

**OFFICE OF ACCOUNTABILITY SYSTEMS**  
 Don Smalling, Interim Director

**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.

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

**PROTECTIVE HEALTH SERVICES**  
 Rocky McElvany, Deputy Commissioner

**FAMILY HEALTH SERVICES**  
 Tina Johnson, Deputy Commissioner

**COMMUNITY HEALTH SERVICES**  
 Keith Reed, Deputy Commissioner

**CHIEF FINANCIAL OFFICER**  
 Gloria Hudson

**CHIEF DATA, PUBLIC POLICY & PROMOTION OFFICER**  
 Buffy Heater

Jennifer Reeves  
 Deputy Chief Operating Officer

**HUMAN RESOURCES**  
 Rosangela Miguel

**Informatics**  
 Becki Moore

**Vital Records**  
 Kelly Baker

**Building Management, Safety & Security**  
 Don Smalling

**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

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

**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

Gunnar McFadden  
 Asst. Deputy Commissioner

**County Health Departments**

**Community Evaluation & Records Support**  
 Dr. Jennifer Han

**Immunization Service**  
 Vacant

Jennifer Reeves  
 Deputy Chief Finance Officer

**Budget & Purchasing**  
 Vacant

**Revenue**  
 Leigh Newby

**Grants**  
 Lytle Caldwell, CPA

**A/P & Payroll**  
 Mike Truitt

**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

Public health in Oklahoma continues to be of critical importance. On October 2<sup>nd</sup>, 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.<sup>1</sup> Oklahoma ranks 39<sup>th</sup> nationally with 20.1%, or one in five, adults who smoke.<sup>2</sup> Additionally, 12.5% of Oklahoma high school students smoke cigarettes.<sup>3</sup> 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.<sup>4</sup> 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 45<sup>th</sup> in the nation for the number of Active Primary Care Physicians.<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>

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).<sup>8</sup> 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

<sup>1</sup> 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](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/index.htm) on October 12, 2018.

<sup>2</sup> 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.

<sup>3</sup> Center for Disease Control and Prevention. Youth Behavior Risk Factor Surveillance System Survey Data. 2016.

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

<sup>5</sup> <https://www.aamc.org/download/484580/data/oklahomaprofile.pdf>

<sup>6</sup> <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf>

<sup>7</sup> 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*.

<sup>8</sup> <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.

A handwritten signature in black ink, appearing to read "Kian Kamas".

Kian Kamas  
Chair, Tulsa Health Department

A handwritten signature in black ink, appearing to read "Gary Raskob".

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

A handwritten signature in black ink, appearing to read "Tim Starkey".

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**

...

**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**



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**Canadian County**



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## 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.



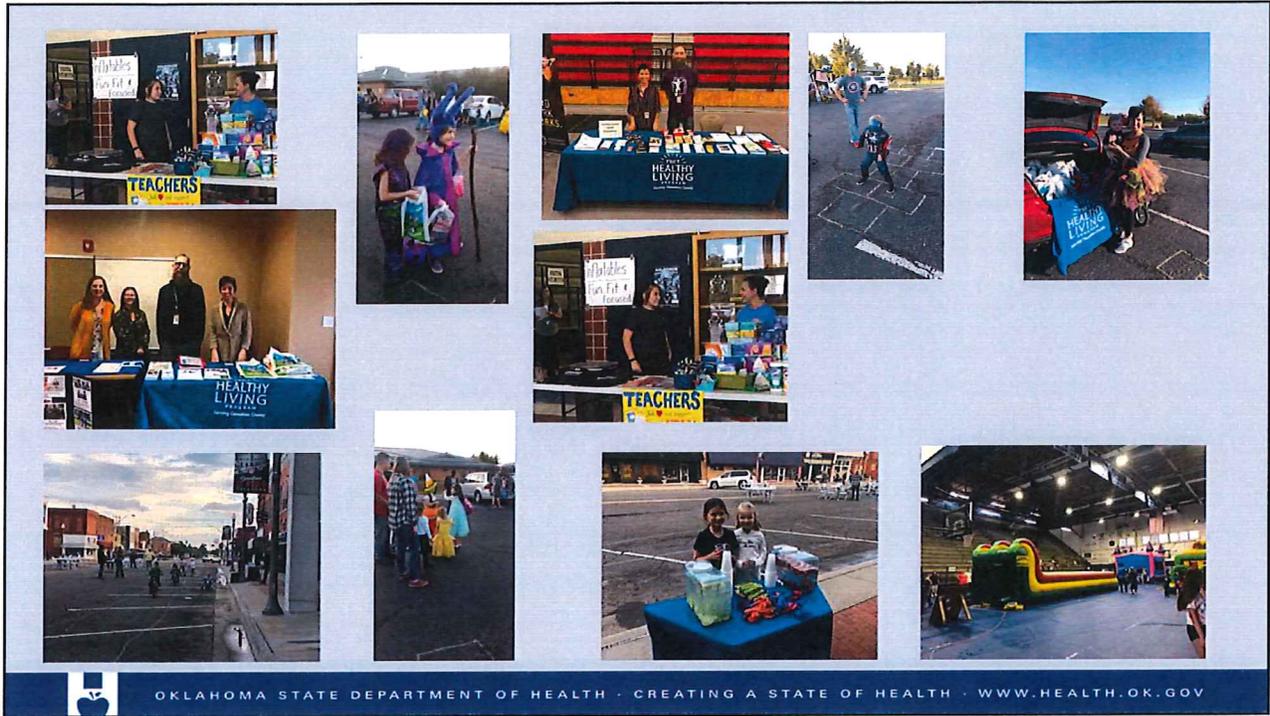
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## Recent Health Department Community Activities

- Rock the Block - El Reno community "Open Streets"
- 2<sup>nd</sup> 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



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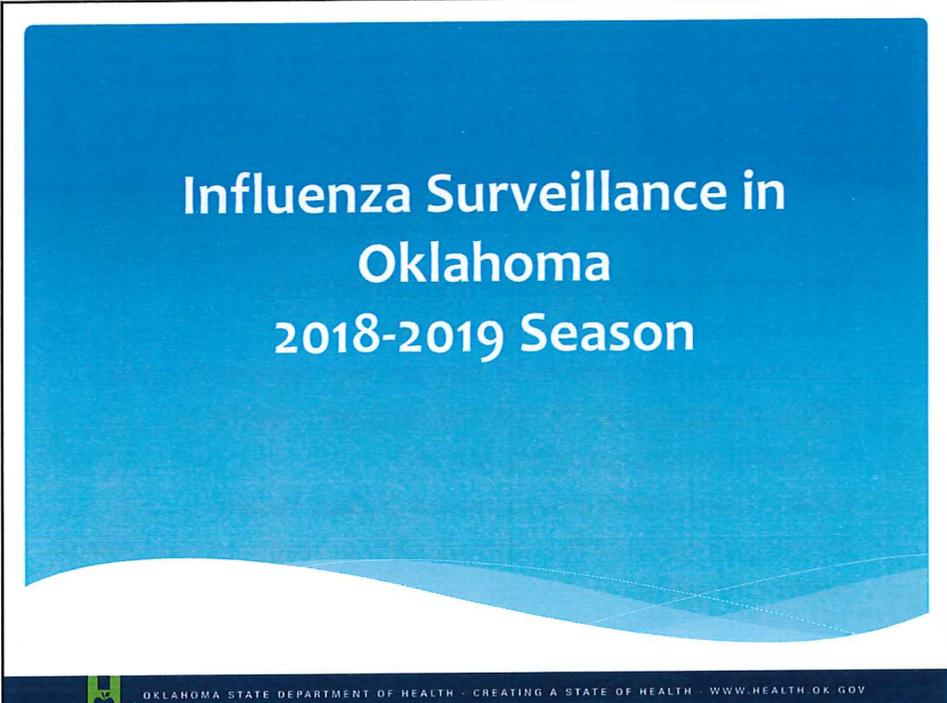


## Questions?

- For more information, please contact:

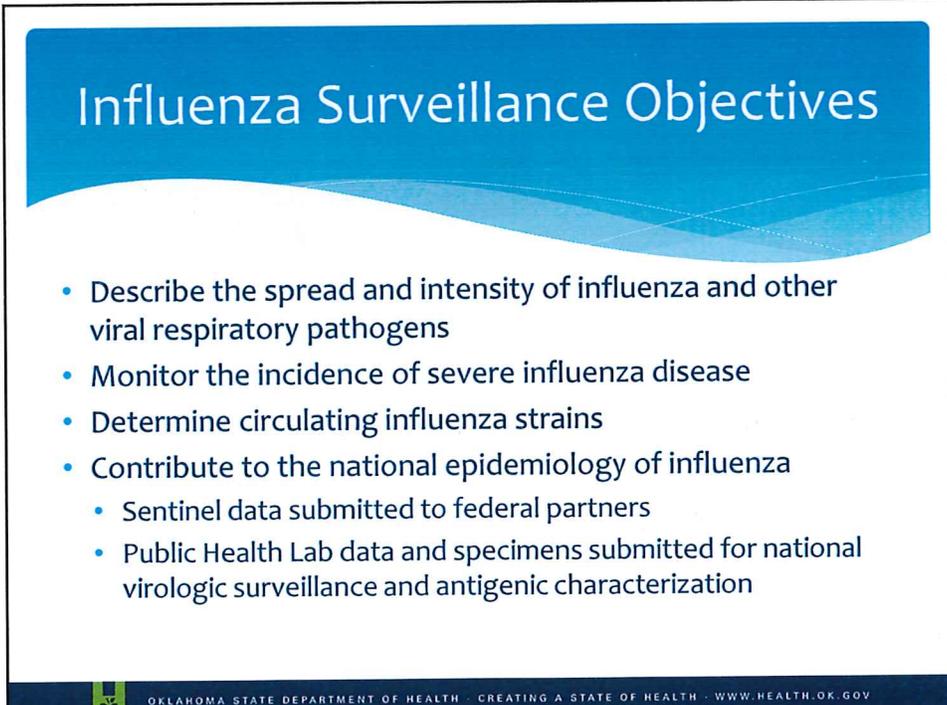
– Jan Fox at [janf@health.ok.gov](mailto:janf@health.ok.gov) or 405-262-0042





# Influenza Surveillance in Oklahoma 2018-2019 Season

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## 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

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## 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



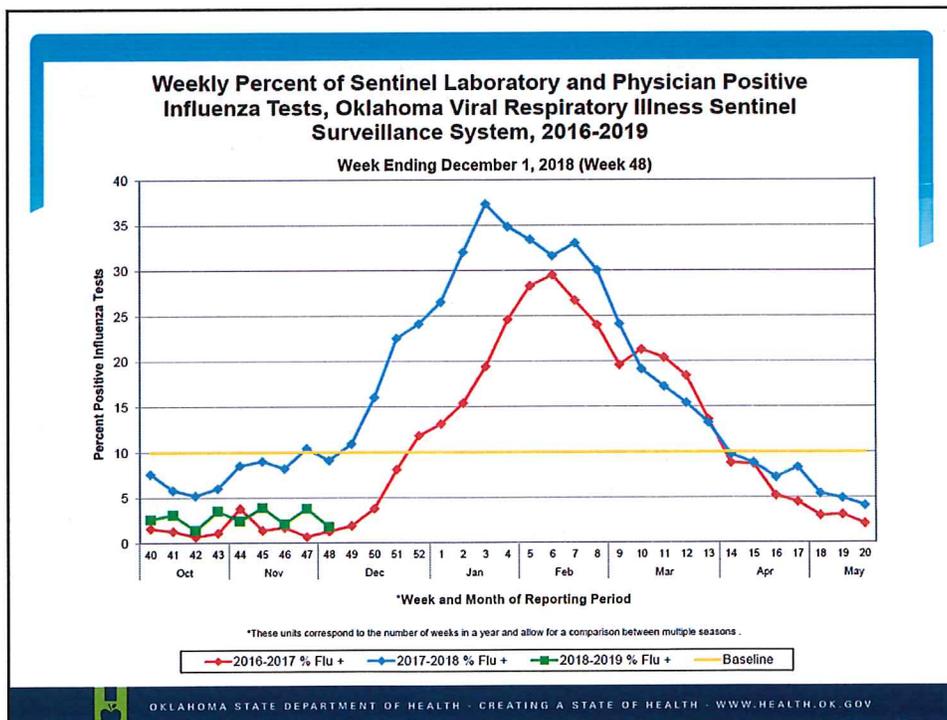
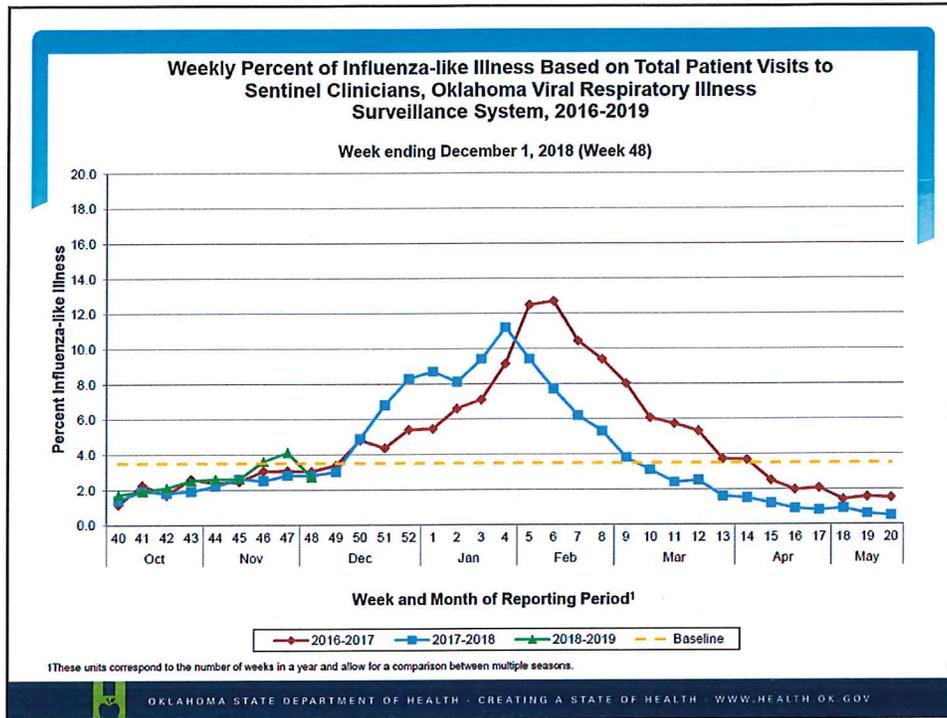
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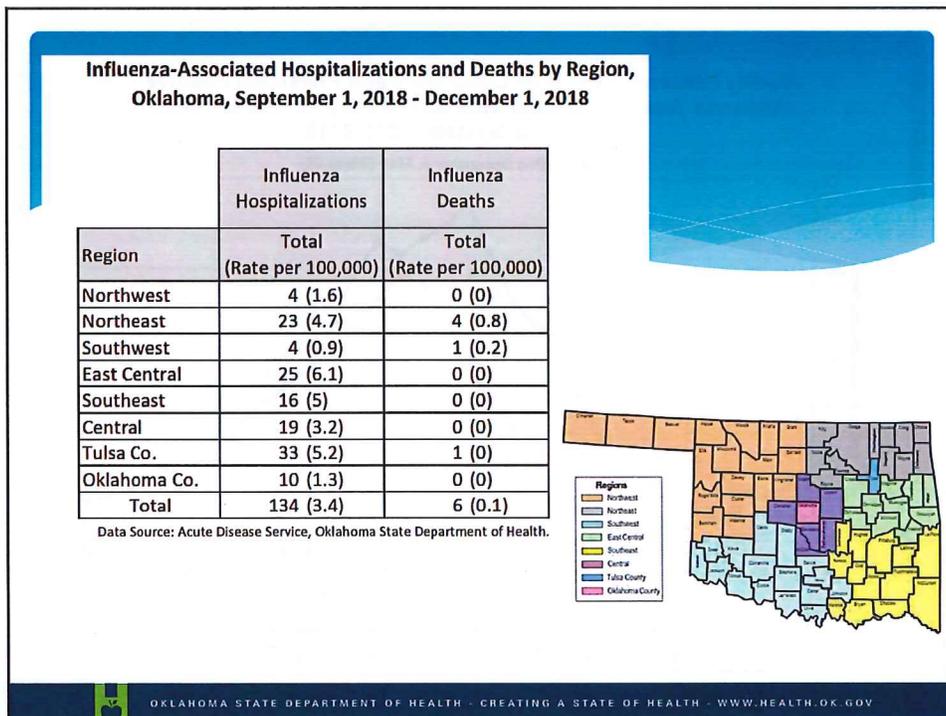
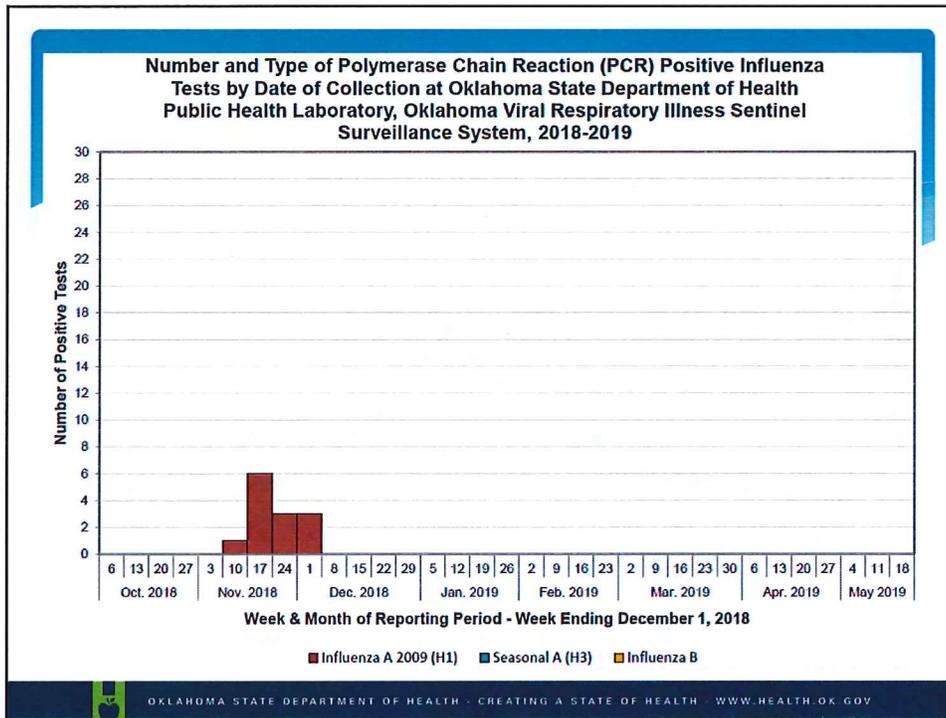
## Influenza Surveillance Communication

- 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.



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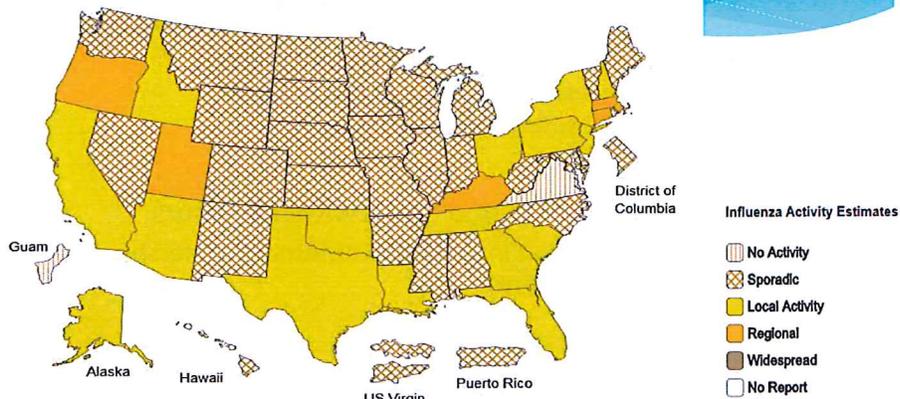
### Influenza-Associated Hospitalizations and Deaths by Age Group Oklahoma, September 1, 2018 - December 1, 2018

Age Group, Years	Influenza Hospitalizations	Influenza Deaths
	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)
<b>Total</b>	<b>134 (3.4)</b>	<b>6 (0.2)</b>
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



\*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



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## 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



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# 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.<sup>1–4</sup> 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.<sup>1</sup> A significant focus on funding bioterrorism preparedness followed the 2001 anthrax attacks.<sup>3</sup> 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.<sup>1</sup>

While jurisdictions report increased levels of MCM distribution and dispensing capability,<sup>1</sup> studies have consistently found challenges in demonstration of MCM operational readiness despite the existence of developed plans.<sup>1,5,6</sup> With the rarity of large-scale bioterrorism emergencies and the rising frequency of natural disasters and

international public health emergencies,<sup>7</sup> 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.<sup>4,6,8,9,12–15</sup>

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.<sup>2,10,11,16–17</sup> 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).<sup>4,8,12</sup> 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

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*Correspondence should be sent to Ijeoma Perry, 1600 Clifton Rd, Atlanta, GA 30329 (e-mail: [iejz5@cdc.gov](mailto:iejz5@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
<b>Disaster response</b>		
Yellowstone River oil spill—Montana (2015) <sup>3</sup>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>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.</p> <p>The MCM plan incorrectly identified that volunteer management support would be available from national volunteer disaster response organization(s).</p> <p>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.</p> <p>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.</p>
<b>Pandemic influenza outbreak response</b>		
H1N1 response—Los Angeles, CA (2009–2010) <sup>8,9</sup>	<p>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.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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 (<a href="http://www.laresilience.org/about.php">http://www.laresilience.org/about.php</a>).</p> <p>This vaccination campaign was one of the largest POD-based efforts during the 2009–2010 H1N1 response.</p>	<p>The inclusion of race/ethnicity in scheduled reports of vaccine utilization enabled identification of racial disparities among groups.</p> <p>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.</p> <p>The response emphasized a need to strengthen relationships with other health department programs that partner with minority communities.</p> <p>Coverage and representation of racial and ethnic minorities was accomplished by establishing POD sites within a high concentration of the target population.</p> <p>POD throughput efficiency could have been improved by increasing the ratio of nonmedical staff to medical staff.</p>

*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.<sup>4,8,18,19</sup> 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) <sup>b</sup>	<p>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.</p> <p>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.</p> <p>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.</p> <p>Of 29 people hospitalized at various facilities, 25 (86%) received botulinum antitoxin and 11 (38%) were intubated. After a week, 18 (62%) were discharged.</p> <p>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.</p> <p>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 (&lt;2 h) botulinum antitoxin processing and shipment to the medical center with critical patients.</p> <p>An LHD managed the transport of the other 6 requests by using nonemergency vehicles that were effective during this ongoing event.</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
Opioid epidemic response Statewide distribution of naloxone—North Carolina (2017) <sup>c</sup>	<p>In 2017, North Carolina's PHP&amp;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.</p> <p>Access to naloxone is a focus area of the North Carolina Opioid Action Plan.</p> <p>The product arrived at a state warehouse and the state's PHP&amp;R staff quickly used CDC's Inventory Management and Tracking System software to generate chain-of-custody forms and packing slips.</p> <p>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.</p>	<p>The state's PHP&amp;R successfully used a component of its MCM plan by using their inventory software to provide necessary paperwork for the ad hoc distribution.</p> <p>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&amp;R across the state health department, (2) time constraints placed on the DMH to distribute the product, and (3) competing priorities.</p> <p>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.</p>

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](http://www.ajph.org).

<sup>a</sup>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*.<sup>3</sup>

<sup>b</sup>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.<sup>10</sup>

<sup>c</sup>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.<sup>11</sup>

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.<sup>8,18</sup> The examples presented in Table 1 and Table A (available as a supplement to the online version of this article at [www.ajph.org](http://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, pre-identifying 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.<sup>20</sup> 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.<sup>21</sup>

### 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.<sup>16</sup> 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.<sup>16,22</sup>

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.<sup>16,17</sup>

**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.<sup>16</sup> 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.<sup>16,17</sup>

## 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.<sup>6,18</sup> 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.<sup>7</sup>

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.<sup>4,9,12,13,15,23</sup> 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."<sup>15</sup> 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.<sup>4,8,9,13-15</sup> Postresponse evaluation is critical to distinguishing what types of small-scale emergencies lend themselves to the use of PODs and identifying specific improvements required.<sup>2,6</sup> 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.<sup>6,7</sup>

## 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.<sup>6</sup> 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

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### Long Term Care Facility Types

Facility Type	2014	2015	2016	2017	2018	2014 vs 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
<b>Total</b>	<b>683</b>	<b>682</b>	<b>672</b>	<b>676</b>	<b>675</b>	<b>-8</b>

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## Long Term Care Inspections (by Facility Type)

Health & Life Safety Code Facility Type	2014	2015	2016	2017	2018	2014 vs 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



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## Long Term Care Inspections (by Survey Type)

Health & Life Safety Code Survey Type	2014	2015	2016	2017	2018	2014 vs 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	



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## 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%



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## 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



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# Long Term Care SFY 2019



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# THANK YOU!



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# 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
3/2/2018	Last Day for RIF Employees	1872	-146
11/30/18	Ending Baseline	1702	-170
	<b>NET CHANGE</b>		<b>-401</b>



**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	%
<b>Revenues:</b>					
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%
<b>Total Revenue</b>	<b>\$ 374,651,914</b>	<b>\$ 124,883,971</b>	<b>\$ 113,992,179</b>	<b>\$ 10,891,792</b>	<b>-9%</b>
<b>Expenditures:</b>					
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	Forecasted Collections	Surplus/(Deficit)
19901	GRF Duties	\$ 54,874,700	\$ 18,291,568	\$ 36,583,136	\$ 4
20300	Genetic Counseling Licens. 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	CMAA 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	Forecasted 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



# Oklahoma State Department of Health State Fiscal Year 2019 Financial Update

Chief Financial Officer  
February 12, 2019



# 2020 Budget Requests

Operating Request	FY 2020 Request	Ongoing?
County Health Department Funding	\$780,000	Y
Finance System	\$2,000,000	Y
Immunization Vaccines for Children and Adolescents	\$1,516,493	Y
Childhood Lead Screening Program	\$260,150	Y
Infectious Disease Prevention	\$830,525	Y
State Health Laboratory	\$4,500,000	Y
Pathfinder/Defined Benefit Plan Costs Not Allowable – Federal Grants	\$3,500,00	Y
Online Application System	\$1,533,435	Y
<b>FY 2020 request total:</b>	<b>\$14,920,603</b>	



## **1. County Health Department Funding**

Funding will ensure each county health department can provide a core level of public health services to the local population for which it is responsible. Savings and efficiencies will be attained through decreased travel expense/time as staff are continually being redirected to various counties trying to provide minimum coverage. Further, this will help re-stabilize the county staff and return some remaining CHD sites to being open five days a week.

## **2. Finance System**

The funding change will allow OSDH to obtain a new financial system to become compliant with Federal and State Financial System requirements.

## **3. Immunization Vaccines for Children and Adolescents**

This funding will allow the OSDH to provide necessary vaccines through county health department regional hubs to increase Oklahoma child immunization rates.

## **4. Childhood Lead Screening Program**

Increased provider education is needed to improve screening rates of children, and to protect Oklahoma's children from adverse health effects of lead exposure. In addition, a provision of screening through county health department clinics coordinated with primary care providers will provide safety net services.



## **5. Infectious Disease Prevention**

This funding will allow the OSDH to provide medications and other prevention efforts through county health departments necessary to prevent the spread of TB and STDs.

## **6. State Health Laboratory**

The new lab will improve current physical limitations, outdated mechanical systems, outdated air handling units and deterioration of current location which has decreased the lab's efficiency to optimize and validate new testing methodologies required by national accrediting agencies, College of American Pathology and Centers for Medicare and Medicaid Services. In 2017, the Department of Health was authorized to build this new health lab with the bond funds, although they have not started this project yet. This funding change will be used to pay for principal and interest on the 20-year bond.

## **7. Pathfinder/Defined Benefit Plan Costs Not Allowable – Federal Grants**

A portion on the Pathfinder/Defined Contribution retirement costs are not allowable for grants to pay. With OSDH being approximately 60% grant funded, this places an extra burden on the agency to have to expend State or Revolving dollars to pick up these expenses. With the hiring of so many new State employees, this burden will only continue to grow.

## **8. Online Application System**

The increase in funding is to purchase an online system which will allow easier access for public online licensure and payment and will streamline administrative licensing and inspection processes.



**Oklahoma State Department of Health  
Statement of Revenues and Expenditures  
SFY 19, For the Six Month Period Ended December 31, 2018**

Description	Annual Budget	YTD Budget	YTD Actuals	Variance	%
<b>Revenues:</b>					
State Appropriations	\$ 54,874,700	\$ 27,437,350	\$ 27,437,352	\$ (2)	0%
Licenses, Certificates and Fees	36,395,160	18,197,580	22,559,008	(4,361,428)	24%
Genetic Counseling License Revenue	25,000	12,500	12,200	300	-2%
Hotel & Restaurant License	5,964,470	2,982,235	3,401,693	(419,459)	14%
Physicians Laboratory Fee	2,300,043	1,150,021	1,865,741	(715,720)	62%
Public Health Special Fund-Other	5,497,825	2,748,913	1,449,558	1,299,354	-47%
Home Health Care Revolving Fund	150,000	75,000	151,980	(76,980)	103%
Ok Natnl Background Check Revolving Fund	1,250,000	625,000	687,718	(62,718)	10%
Trauma Care Assistance Revolving Fund	6,639,785	3,319,892	3,648,226	(328,334)	10%
Birth & Death Certificates	6,913,604	3,456,802	3,440,634	16,168	0%
OMMA	7,400,233	3,700,117	7,809,434	(4,109,317)	111%
OK State Athletic Commission Revolving Fund	254,200	127,100	91,823	35,277	-28%
Tobacco Tax	15,599,550	7,799,775	6,840,488	959,287	-12%
Cigarette Tax	11,163,773	5,581,886	3,916,804	1,665,082	-30%
Tobacco Products Tax	2,588,399	1,294,200	1,399,786	(105,586)	8%
Tribal Compact InLieu Tax Pmts	1,847,378	923,689	1,523,898	(600,209)	65%
WIC Rebate Program	55,000,000	27,500,000	23,777,839	3,722,161	-14%
Federal Funds	153,321,111	76,660,556	59,666,780	16,993,776	-22%
Ryan White	25,344,242	12,672,121	9,889,194	2,782,927	-22%
Other	127,976,869	63,988,435	49,777,586	14,210,848	-22%
FY 18 Cash Utilization	28,160,849	28,160,849	28,160,849	0	0%
Reimbursement for Personnel Services	29,453,583	14,726,792	12,426,981	2,299,810	-16%
Other	19,647,890	9,823,945	8,310,907	1,513,038	-15%
<b>Total Revenue</b>	<b>\$ 392,452,843</b>	<b>\$ 210,306,846</b>	<b>\$ 189,180,205</b>	<b>\$ 34,718,276</b>	<b>-17%</b>



**Oklahoma State Department of Health  
Statement of Revenues and Expenditures-Continued  
SFY 19, For the Six Month Period Ended December 31, 2018**

Description	Annual Budget	YTD Budget	YTD Actuals	Variance	%
<b>Expenditures:</b>					
Payroll	\$ 148,764,171	\$ 74,382,085	\$ 58,150,415	\$ 16,231,670	-22%
Travel	2,840,473	\$ 1,420,236	606,778	813,459	-57%
Other Professional Services	65,026,534	\$ 32,513,267	10,411,754	22,101,513	-68%
Telecommunications/Printing Services	10,552,832	\$ 5,276,416	1,209,592	4,066,824	-77%
Rent	3,149,601	\$ 1,574,801	1,411,196	163,604	-10%
Maintenance and Repair	4,091,029	\$ 2,045,515	880,645	1,164,869	-57%
Laboratory & Medical Supplies and Materials	14,911,754	\$ 7,455,877	5,534,618	1,921,259	-26%
Office/Safety Supplies	1,991,091	\$ 995,545	198,840	796,706	-80%
WIC Program	57,795,899	\$ 28,897,950	22,312,237	6,585,712	-23%
Program Reimbursements	45,063,110	\$ 22,531,555	7,929,775	14,601,780	-65%
Payments- Health & Social Services	34,700,259	\$ 17,350,130	7,052,576	10,297,553	-59%
Miscellaneous	3,566,092	\$ 1,783,046	251,226	1,531,820	-86%
<b>Total Expenditures</b>	<b>\$ 392,452,843</b>	<b>\$ 196,226,422</b>	<b>\$ 115,949,653</b>	<b>\$ 80,276,768</b>	<b>-41%</b>
Revenues Over/(Under) Expense	\$ (0)	\$ 14,080,425	\$ 73,230,551		



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

Fund	Fund Description	SFY19 Current BWP	Collections	Forecasted Collections	Surplus/(Deficit)
19901	GRF Duties	\$ 54,874,700.00	\$ 27,437,352.00	\$ 27,437,352.00	\$ 4.00
20300	Genetic Counseling Licens. Rev	25,000.00	12,200.00	12,200.00	(600.00)
20400	Tobacco Prevntn & Cessatn Fnd	1,330,594.87	553,012.51	553,012.51	(224,569.85)
21000	Public Health Special Fund	69,509,902.19	35,800,695.91	35,800,695.91	2,091,489.63
21100	Nursing Facility Adm Penalties	23,550.73	-	-	(23,550.73)
21200	Home Health Care Revolving Fd	151,000.00	152,480.00	152,480.00	153,960.00
21600	Ok Natl Background Check Revol	1,250,000.00	687,718.00	687,718.00	125,436.00
22000	Civil Monetary Penalty Revl Fd	1,575,000.00	773,145.56	773,145.56	(28,708.88)
22200	Oklahoma Organ Donor Education	145,000.00	42,356.78	42,356.78	(60,286.44)
22500	Breast Cancer Act Revolving Fd	15,000.00	8,420.00	8,420.00	1,840.00
22600	Ok Sports Eye Safety Prog Revl	150.00	-	-	(150.00)
23300	OK Pre Birth Def, Pre Birth &	160.00	60.00	60.00	(40.00)
23500	Oklahoma Lupus Revolving Fund	165.00	2.00	2.00	(161.00)
23600	Trauma Care Assistance Revolv	24,323,612.66	11,134,599.65	11,134,599.65	(2,054,413.36)
24200	Pancreatic Can Res Lic Plt Rev	1,500.00	420.00	420.00	(660.00)
24800	OMMA Tax Collections	-	1,343.09	1,343.09	2,686.18
26500	Child Abuse Prevention Fund	47,145.00	23,305.00	23,305.00	(535.00)
26700	EMP Death Benefit Revolv Fund	2,800.00	1,220.00	1,220.00	(360.00)
26800	Okla Emerg Resp Syst Stab & Im	1,787,765.00	735,934.45	735,934.45	(315,896.10)
28400	Dental Loan Repayment Revolvin	463,670.00	114,968.84	114,968.84	(233,732.32)
29500	Ok State Ath Comm Revolving Fd	254,200.00	91,822.88	91,822.88	(70,554.24)
34000	CMIA Programs Disbursing Fund	55,000,000.00	23,777,839.11	23,777,839.11	(7,444,321.78)
40000	Federal Funds	128,166,837.00	49,781,266.37	49,781,266.37	(28,604,304.26)
41000	Federal Funds - Ryan White	8,438,135.00	1,495,840.73	1,495,840.73	(5,446,453.54)
41100	Federal Funds - Ryan White	16,906,107.00	8,393,353.13	8,393,353.13	(119,400.74)
Total OSDH		\$ 364,291,994.45	\$ 161,019,356.01	\$ 161,019,356.01	\$ (42,253,282.43)
Forecasted Collections Over (Under) Budget					\$ (42,253,282.43)



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

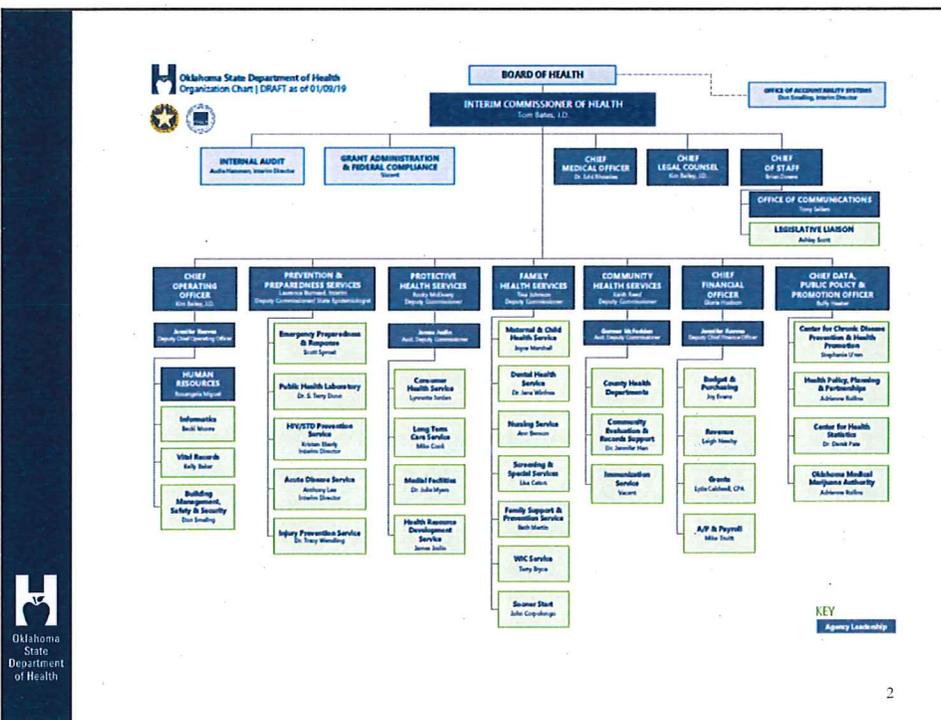
Fund	Division Description	SFY19 Current BWP	Expenditures	Encumbrances	Forecasted Expenditures	Surplus/(Deficit)
198	2018 State Appropriations	\$ 5,602,107.00	\$ 82,569.04	\$ 871,522.61	\$ 85,862.10	\$ 4,562,153.25
199	2019 State Appropriations	54,874,699.69	16,871,103.21	11,261,711.31	13,344,368.35	13,397,516.82
203	Genetic Counseling Licensure Revolving Fund	16,380.00	5,513.16	1,596.00	5,402.88	3,867.96
204	Tobacco Prevention and Cessation Revolving Fund	2,466,056.31	76,540.99	1,036,107.38	53,641.56	1,299,766.38
207	Alternatives-to-Abortion Services Revolving Fund	17,951.00	-	-	-	17,951.00
210	Public Health Special Fund	74,026,852.15	23,393,725.75	13,250,664.15	20,023,332.06	17,359,130.19
212	Home Health Care Revolving Fund	177,487.98	42,855.44	43.03	46,086.01	88,503.50
216	National Background Check	2,350,188.26	742,923.48	677,646.99	32,297.61	897,320.18
220	Civil Monetary Penalty	6,586,172.93	1,003,612.88	1,581,047.84	20,619.50	3,980,892.71
222	Organ Donor Awareness Fund	130,000.00	-	90,000.00	-	40,000.00
225	Breast Cancer Act Revolving Fund	130,093.83	16,529.53	3,689.00	17,815.26	92,060.04
228	Oklahoma Leukemia and Lymphoma Revolving Fund	50,000.00	-	-	-	50,000.00
236	Trauma Care Assistance Revolving Fund	22,972,414.80	4,961,497.86	424,681.83	16,714,939.08	871,296.03
265	Child Abuse Prevention Revolving Fund	120,000.00	8,381.91	26,990.37	-	84,627.72
267	EMT Death Benefit Revolving Fund	20,000.00	-	-	-	20,000.00
268	Rural EMS Revolving Fund	1,787,765.00	252,254.50	1,387,590.43	-	147,920.07
284	Dental Loan Repayment Revolving Fund	463,670.00	183,356.00	-	183,356.00	96,958.00
295	Oklahoma Athletic Commission Revolving Fund	289,256.92	86,750.38	5,102.50	92,726.36	104,677.68
340	CMIA - WIC FOOD	55,395,899.00	21,011,668.00	0.01	-	34,384,230.99
400	Federal Fund	139,631,694.62	41,637,045.86	36,601,182.25	30,303,230.91	31,090,235.60
410	Ryan White Grant	8,438,046.71	1,231,007.71	1,081,205.77	149,478.06	5,976,355.17
411	Ryan White Rebate	16,906,107.00	4,342,317.64	11,493,179.99	183,519.98	887,089.39
						-
Total OSDH		\$ 392,452,843.20	\$ 115,949,653.34	\$ 79,793,961.46	\$ 81,256,675.72	\$ 115,452,552.68
	Forecasted Expenditures (Over) Under Budget					\$ 115,452,552.68



# Oklahoma State Board of Health

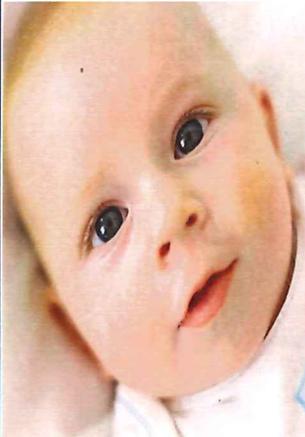
## Family Health Services Update Screening & Special Services

Tina R Johnson, MPH, RN  
Deputy Commissioner  
February 12, 2019



## Screening and Special Services

Director, Lisa Caton, RN, MS



- Newborn Screening Program
- Newborn Hearing Screening Program
- Oklahoma Childhood Lead Poisoning Prevention Program
- Oklahoma Birth Defects Registry
- Genetics Program



3

## Newborn Screening

- ❖ Every baby born in Oklahoma is required to have a blood test in the first week of life
- ❖ The newborn screen tests for 54 hidden conditions: proposed rule changes to add 4 more conditions-Pompe, MPS I, SMA & X-ALD
  - Estimated Number of Children Identified with:
    - SMA 5-9 children annually
    - X-ALD 1-2 children annually
    - MPS I 1 child every other year
    - Pompe 1 child annually
- ❖ Healthcare provider and family notified of abnormal results
- ❖ Case management until the child is either determined not to be affected or diagnosed by a specialist & placed on treatment
- ❖ Telemedicine for Infants identified with Metabolic illness
- ❖ Newborn Screening Results available 24 hours a day, 7 days a week



4

## Newborn Screening Data for CY 2016

- 52,607 births (OK2Share)
- 2,797 newborn with out-of-range newborn screen results which required follow-up activities
- 121 infants diagnosed



5

## Newborn Hearing Screening Program

- ❖ Every baby born in Oklahoma is required to have their hearing checked before leaving the hospital
- ❖ Healthcare provider and family notified of abnormal results
- ❖ Case management until the child is either determined to not have hearing loss or diagnosed with hearing loss by a pediatric audiologist & placed in early intervention services
- ❖ Provides equipment to birthing hospitals to perform initial newborn hearing screening
- ❖ Provides equipment for SoonerStart, Child Guidance & county health departments for follow-up hearing screening for children birth to 13 years of age.
- ❖ Work with partners across the state such as the Oklahoma Family Network



6

## Newborn Hearing Screening Data for CY 2016

- 52,607 births (OK2Share)
- 7,500 required follow-up activity (did not pass their initial hearing screen, not screened at birth or had a risk factor for late onset hearing loss)
- 110 diagnosed with hearing loss



7

## Oklahoma Birth Defects Registry

- ❖ Active surveillance system that monitors over 1,000 different birth defects
- ❖ Collaborates with birthing hospitals across the state to identify children who meet case definition
- ❖ OBDR staff looks through thousands of medical records to identify & abstract pertinent information for the approximately 1800 children born each year with a birth defect
- ❖ Provides families with information about available resources (support groups, early intervention, etc.)
- ❖ Provides birth defect prevention education across the state
- ❖ Provides multivitamins with folic acid to county health departments for distribution to women of child bearing age



8

## Oklahoma Birth Defects Registry Preliminary Data for CY 2016

- 52,607 births (OK2Share)
- 1,778 children identified with a birth defect and included in the registry



9

## Oklahoma Childhood Lead Poisoning Prevention Program

- ❖ All Oklahoma Children are required to have a blood lead screening at 12 & 24 months of age or any child up to 6 that hasn't been tested
- ❖ All blood lead test results are to be reported to OSDH
- ❖ Conducts surveillance of elevated childhood lead levels
- ❖ Provides case management for children 6-72 months of age who have an elevated blood lead level
- ❖ Performs environmental investigations to identify the source of lead exposure for children who are identified with significantly elevated blood lead levels
  - Identify steps to take to reduce the lead level & associated adverse outcomes
- ❖ Works with county health departments when children with elevated levels are identified
- ❖ Ottawa County and Blackwell (Kay County)
- ❖ Budget request for \$260,150



10

## Childhood Lead Program continued

- ❖ Supplemental grant funding received
  - Focus on adults with elevated blood lead levels
    - Adult blood lead results that we currently have into our HLPPPS system
    - Cross check addresses for adults with elevated blood lead levels to addresses of children with elevated blood lead levels
    - Provide education to adults with elevated leaves & recommend for any children in the home be tested
  - Coordinate with HUD to ensure children with elevated blood lead levels are not living in government housing
  - Investigate possible reimbursement for environmental investigations



11

## Oklahoma Childhood Lead Poisoning Blood Lead Surveillance Data for CY 2017 as of 12/17/2018:

- Received 57,678 lead test results on 52,204 Oklahoma children age 6 – 72 months
  - ~27.2% of 12 and 24 month old children received their mandatory blood lead test, an increase from 23.5% in 2016.
- 1,608 children received case management services
- 978 (1.9%) of children had an elevated blood lead level (EBLL)  $\geq 5 \mu\text{g/dL}$
- 20 children received an environmental investigation (1 EBLL  $\geq 20 \mu\text{g/dL}$  or 2 EBLL 15 – 19  $\mu\text{g/dL}$ )



12

## Staffing update:

- Newborn Screening—One FTE RN
- Newborn Hearing Screening—Two FTEs
- Childhood Lead Poisoning and Prevention— One FTE (two- 0.5 FTEs)
- Interviewing for AA position
  
- Request for 2020
  - One FTE (NBS AA) due to expanding our NBS testing panel.
  - One genetic counselor FTE
    - Serve multiple departments with OSDH: NBS, Hearing, Birth Defects, SoonerStart, C1, Cancer Registry



13



This picture shows what makes all of this happen! A small but mighty group that has passion for the mission of Screening & Special Services: To provide statewide surveillance, screening and specialized programs to protect the health of Oklahoma children and their families.



14

**Elevating Care in Nursing Homes**  
through the Reinvestment of  
Civil Monetary Penalties in  
Oklahoma

Presented to the Oklahoma State Board of Health  
by Protective Health Services  
Deputy Commissioner Rocky McElvany  
and Julie Myers, DrPH, CPHQ

**Civil Monetary  
Penalty Fund**

OKLAHOMA STATE DEPARTMENT OF HEALTH



Protecting Residents. Empowering Staff.

**Objectives**

- Describe the history and purpose of the Civil Money Penalty (CMP) Fund Program
- Detail funds available
- Share examples of current projects
- Review the fund application and award process



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## Vision

Elevate the quality of care  
in nursing homes  
by funding effective projects  
based on the needs of  
Oklahoma

# Elevate Care

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## CMP Fund Program

- Created by the Social Security Act of 1987
- Patient Protection and Affordable Care Act of 2010 updated these provisions
- May fund only those projects designed to benefit residents in Medicare or Medicaid certified nursing facilities.
- The Centers for Medicare and Medicaid Services (CMS) must approve all projects.
- Revolving fund established per Oklahoma Statute at Title 63, Section 1-107.4

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## Revolving Fund

- October 2018 Balance: \$7,186,609.16
- \$2.4 million awarded SFY2019
- \$4.5 million allocated for new and continuing projects in SFY2020
- Estimate \$1.2m per year available thereafter



## Application and Selection

- <https://CMP.health.ok.gov>
- Interagency contracts
- State Solicitation process
- Proposal review and selection
  - State role
  - CMS role



## CMP Fund Program Goals

- Help Oklahoma become the leader of nursing home quality in our region
- Stretching toward the goal of a 6.0 or better composite score
  - Improved our State Score 20% since December 2014



## Commonalities in Facilities with Composite Scores >

13.03:

- Falls with Major Injury
- Excessive Weight Loss
- Antipsychotic Medication
- Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine
- Percent of Residents Assessed and Appropriately Given the Pneumococcal Vaccine



## Funding Focus Areas

- Antipsychotic Use
- Dementia Care
- Catheter Use
- Depression
- Falls/Mobility
- Vaccines
- Medications
- Pain
- Pressure Ulcers
- UTIs
- Underweight
- Consistent Assignment
- Hospitalizations
- Person-Centered Care
- Staff Stability



## CMP Fund Partnerships

- OUHSC Colleges
  - Nursing,
  - Public Health, and
  - Pharmacy
- LeadingAge Oklahoma
- DISCUSS
- State Ombudsman
- Oklahoma Foundation for Medical Quality
- TMF Health Quality Institute
- Apiari
- Eden Alternative
- Geriatric Collaborative Care Nursing Services
- DHS Aging
- OSDH Program Areas



## Current CMP Fund Projects

- Quality Assurance and Performance Improvement Support
- Medication Optimization
- Oral Care
- Immunizations
- Dementia Care
- Fall Prevention
- Medication Optimization
- Long Term Care Leadership Academy

SFY20 Request for Proposals coming spring 2019



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## Questions?

CMP Fund Program

405-271-6576

CMP@health.ok.gov

<http://CMP.Health.ok.gov>

Julie Myers, DrPH, CPHQ



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## CHIEF MEDICAL OFFICER UPDATE

February 12, 2019

Edd D. Rhoades, M.D., M.P.H



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### Background:

#### Oklahoma State Department of Health

#### Corrective Action Report - January 1, 2018

- Chief Medical Officer (CMO) position proposed as part of the agency senior leadership team
- Recommended responsibilities of the CMO included:
  - ❖ Work with partner agencies and health professionals in advocating for public health initiatives
  - ❖ Provide consultation and assistance to programs across the agency on public health topics and medical needs.
  - ❖ Focus on the public health functions of the agency
  - ❖ Provide subject matter support to the Commissioner's public health responsibilities.



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### **Current Responsibilities: Health Policy and Planning**

- Researches, prepares or reviews health policy
- Advises agency leadership on public health and medical issues
- Participates on the Oklahoma Health Improvement Team (OHIP)
- Participates on the Core Accreditation Team (PHAB)
- Facilitates the Infant and Children's Health Advisory Council
- Facilitates The Children's Health Group (OHIP)
- Participates on the Oklahoma Perinatal Quality Improvement Collaborative



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### **Current Responsibilities: Partnership Engagement**

- Medical Advisory Committee, OHCA, designee
- Oklahoma Partnership for School Readiness, designee
- Child Death Review Board, OCCY, designee
- SoonerStart Early Childhood Intervention Coordinating Council, designee
- Child Abuse Examiners Board, OCCY, alternate designee
- Oklahoma State Medical Association, member
- Oklahoma County Medical Society, member
- Oklahoma Chapter, American Academy of Pediatrics, member
- Identifies presenters for monthly training meetings of the Oklahoma Head Start Health Managers with the Region VI Health Specialist, Office of Head Start



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## Current Responsibilities:

### Medical Oversight and Consultation

- Annually reviews and approves the Public Health Nurse Protocols used in county health departments
- Approves Public Health Nurse Protocols for public health nurses in the central office
- Serves as Interim Medical Director for county health departments when vacancies occur
- Approves the Infection Prevention and Control Manual, Family Planning Manual, and Maternity Program Manual
- Serves as medical director for agency contract with the OHCA and commercial health plans
- Maintains credentialing with OHCA, BCBS, CC



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### Medical Oversight and Consultation (cont.)

- Serves as medical consultant to the Public Health Laboratory for College of American Pathologists accreditation
- Serves as medical consultant for purchase of select pharmaceuticals used in Maternal and Child Health
- Family Health Service:
  - ❖ Serves as medical consultant to Family Health Service programs
  - ❖ Medical Director, Child and Adolescent Health Division, Maternal and Child Health Service
  - ❖ Medical consultant to the Childhood Lead Poisoning Prevention Program, Screening and Special Services



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### Medical Oversight and Consultation (cont.)

- Emergency Medical Services (EMS) Division, Protective Health Services:
  - ❖ Provides consultation, as needed, on local EMS agency protocol modifications
  - ❖ Serves as Medical Director for licensure renewal of EMS staff
- Emergency Preparedness and Response Service, Prevention and Preparedness Service:
  - ❖ Serves as Medical Director for the Oklahoma Medical Reserve Corp
  - ❖ Assists with emergency shelter responses when needed



### Current Responsibilities:

#### Other OSDH activities:

- Institutional Review Board, member
- Standards Review Committee, reviewer
- Medical Marijuana Food Safety Board, member
- Occupational Health and Risk Management Committee
- Association of State and Territorial Health Officials (ASTHO)
  - ❖ Environmental Health Policy Committee, member



## Role Development (in progress) - Next Steps

- Consult with Chief Medical Officers in other similarly organized state public health agencies to further inform the development of the role of the CMO (currently underway)
- Meet with Deputy Commissioners and other agency leaders to further identify needs and develop the role of the CMO (currently underway)



## Questions?

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