

1.	JUNE 13, 2017 MEETING MINUTES
2.	STRATEGIC MAP PRESENTATION
3.	FINANCE COMMITTEE REPORT
4.	POLICY COMMITTEE RECOMMENDATIONS
5.	COMMISSIONER'S REPORT

**Agenda for the 11:00 a.m., Tuesday, July 11, 2017
Regular Meeting of the Oklahoma State Board of Health**

Posted at www.health.ok.gov

Oklahoma State Department of Health
1000 N.E. 10th Street – Room 1102
Oklahoma City, OK 73117-1299

I. CALL TO ORDER AND OPENING REMARKS

II. REVIEW OF MINUTES

a) Approval of Minutes for June 13, 2017 Regular Meeting

III. STRATEGIC MAP PRESENTATION

Julie Cox-Kain, M.P.A., Senior Deputy Commissioner and Deputy Secretary of Health and Human Services;
Adrienne Rollins, M.P.A., Interim Director, Center for Health Innovation and Effectiveness

IV. CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee – Ms. Burger, Chair

Discussion and possible action on the following:

b) Update

Finance Committee – Ms. Wolfe, Chair

Discussion and possible action on the following:

c) Update

Accountability, Ethics, & Audit Committee – Dr. Grim, Chair

Discussion and possible action on the following:

d) Update

Public Health Policy Committee – Dr. Stewart, Chair

Discussion and possible action on the following:

e) Board of Health Policies

f) Update

V. PRESIDENT'S REPORT

Related discussion and possible action on the following:

g) Update

VI. COMMISSIONER'S REPORT

Discussion and possible action

VII. NEW BUSINESS

Not reasonably anticipated 24 hours in advance of meeting

VIII. PROPOSED EXECUTIVE SESSION

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

Possible action taken as a result of Executive Session.

IX. ADJOURNMENT



Terry L Cline, PhD
*Commissioner of Health
Secretary of Health
and Human Services*

Martha A Burger, MBA
President
Jenny Alexopoulos, DO
Terry R Gerard, DO

Board of Health
Cris Hart-Wolfe
Vice President
Charles W Grim, DDS, MHSA
R Murali Krishna, MD

Robert S Stewart, MD
Secretary - Treasurer
Timothy E Starkey, MBA
Ronald Woodson, MD

1000 NE 10th Street
Oklahoma City, OK 73117-1207
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STATE BOARD OF HEALTH

Kay County Health Department
433 Fairview
Ponca City, OK 74601

June 13, 2017

CALL TO ORDER

Ms. Burger, President of the Oklahoma State Board of Health, called the 418th meeting of the Oklahoma State Board of Health to order on Tuesday, June 13, 2017, at 11:00 a.m. The final agenda was posted at 11:00 a.m. on the OSDH website on June 12, 2017; and at 11:00 a.m. on the Oklahoma State Department of Health building entrance on June 12, 2017.

ROLL CALL

Members in Attendance: Martha A. Burger, M.B.A, President; Cris Hart-Wolfe, Vice-President; Robert S. Stewart, M.D., Secretary-Treasurer; Charles W. Grim, D.D.S.; R. Murali Krishna, M.D.

Absent: Jenny Alexopulos, D.O.; Terry R. Gerard, D.O.; Timothy E. Starkey, M.B.A.

Staff present were: Terry Cline, Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Tina Johnson, Deputy Commissioner, Community & Family Health Services; Deborah Nichols, Chief Operating Officer; Brian Downs, Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director, Office of Accountability; VaLauna Grissom, Secretary to the State Board of Health.

Visitors in attendance: See list

Visitors in attendance: (see sign in sheet)

Call to Order and Opening Remarks

Ms. Burger called the meeting to order and thanked all guests in attendance.

REVIEW OF MINUTES – OSBH

Ms. Burger directed attention toward approval of the Minutes for May 9, 2017, regular meeting. **Ms. Wolfe moved Board approval of the May 9, 2017 meeting minutes as presented. Second Dr. Grim. Motion Carried.**

AYE: Burger, Grim, Krishna, Stewart, Wolfe

ABSENT: Alexopulos, Gerard, Starkey

III. COUNTY HEALTH DEPARTMENT PRESENTATION

Kelli D. Rader, MS, RN, Regional Director, Kay, Noble, Pawnee, and Payne County Health Departments
See attachment A.

CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION

Executive Committee

1 Ms. Burger reminded the Board that the retreat will be held at the OSU Stillwater Student Union / Atherton
2 Hotel, August 11-12, 2017. The planning committee has wrapped up planning and has an exciting agenda
3 planned. Many indicated interest in Public Health for future generations, so in response Dr. Rita Murray will
4 attend on Friday to talk about Generational Translation and Dean Gary Raskob on Saturday to do a deeper
5 dive into Public Health for future generations. John Auerbach from the Trust for America's Health as well as
6 Dr. Kristy Bradley have been invited to speak as well. Lastly, we will wrap up with each member thinking
7 about their next steps and action for the upcoming year. As a reminder, please let VaLauna know at your
8 earliest convenience if you are able to attend the July Board meeting.

9 10 **Finance Committee**

11 Ms. Wolfe directed attention to the Financial Brief provided to each Board member and presented the
12 following SFY 2017 Finance Report and Board Brief as of May 26, 2017:

- 13 • The agency is in "Green Light" status for the remainder of SFY-17
- 14 • The agency did experience a 2.8% reduction in SFY-17 state appropriation for SFY-18

15
16 The following are the program impacts that will result from the 2.8% budget reduction:

- 17 • Federally Qualified Health Centers (FQHC) Uncompensated Care – \$54,318
18 Reduction in payments made to qualifying FQHCs for providing uninsured primary care services.
19
- 20 • Oklahoma Child Abuse Prevention Program – \$63,797
21 Reduction in funding external contract expenditures for services provided to mothers and families to
22 establish healthy parenting habits.
23
- 24 • parentPRO Home Visitation Program – \$57,496
25 Reduction in funding to support the Parent Pro home visitation pilot offered in four counties (Bryan,
26 Creek, Jackson and Pittsburg).
27
- 28 • Colorectal Cancer Screenings - \$50,000
29 Reduction in funding to health systems providing colonoscopies to individuals without health
30 insurance.
31
- 32 • Oklahoma State Athletic Commission - \$5,042
33 Reduction in funding that supports regulatory responsibilities of the commission.
34

35 The Financial Brief focused on Trauma Funding.
36

37 **Accountability, Ethics, & Audit Committee**

38 The Accountability, Ethics, & Audit Committee met with Jay Holland. Dr. Grim indicated there were
39 no known significant audit issues to report at this time. He asked the Board to review the 2018 Audit
40 Plan for consideration and approval. Dr. Grim moved Board approval of audit plan, as presented.
41 Second Ms. Wolfe. Motion Carried.
42

43 **AYE:** Burger, Grim, Krishna, Stewart, Wolfe

44 **ABSENT:** Alexopulos, Gerard, Starkey
45
46
47

Public Health Policy Committee

The Policy committee focused on the health successes for the recent legislative session. The committee will have recommendations in July concluding its review of current policy and position statements. Those will be made available to the full board in the July packet for advance review. The report concluded.

PRESIDENT'S REPORT

Ms. Burger thanked Dr. Grim for agreeing to serve on the Executive Committee following Dr. Woodson's resignation and subsequent vacancy on the committee. This will provide some additional representation on the Executive Committee until new subcommittee assignments are made in October.

ELECTION OF OFFICERS 2017-2018

Dr. Krishna, Dr. Alexopoulos and Dr. Grim served on the Nominating Committee. The Committee recommended the 2017-2018 Officers as follows: President, Martha Burger; Vice-President, Cris Hart-Wolfe; and Secretary/Treasurer, Dr. Robert Scott Stewart. Dr. Krishna moved Board approval to approve the Committee recommendations for President, Vice President, and Secretary-Treasurer as presented. Second Dr. Grim. Motion carried.

AYE: Burger, Grim, Krishna, Stewart, Wolfe

ABSENT: Alexopoulos, Gerard, Starkey

COMMISSIONER'S REPORT

Dr. Cline thanked all the board members for their service especially those who commit to serve as officers. We are very appreciative of time away from work and families to volunteer their time to the Board. Dr. Cline introduced Mr. Gunnar McFadden as the new Deputy Commissioner for Community and Family Health Services. First, Dr. Cline highlighted the DISCUSS Group, which is an Information Technology based whose membership is made up of representatives from several large state agencies that have come together to ensure they are making the most efficient and cost effective decisions around Information Technology. That group was recognized for developing a portal identified all the services available to the aging and disabled in Oklahoma. Next, Dr. Cline highlighted the Governor's Walk for Wellness. The Governor was unable to attend due to the tornado that had impacted Elk City but the response and turnout was great. Lastly, he highlighted work in the area of Protective Health Services. He recognized Dr. Hank Hartsell as a keynote speaker around the development of a dementia toolbox, featuring Teepa Snow. This is a great example of bringing experts together to share this knowledge and serve a population in need.

NO NEW BUSINESS**NO EXECUTIVE SESSION****ADJOURNMENT**

Dr. Krishna moved board approval to adjourn. Second Ms. Burger. Motion Carried

AYE: Burger, Grim, Krishna, Stewart, Wolfe

ABSENT: Alexopoulos, Gerard, Starkey

The meeting adjourned at 12:05 p.m.

1 Approved
2
3 _____
4 Martha Burger
5 President, Oklahoma State Board of Health
6 July 11, 2017

Childhood Low Level Lead Toxicity – Risks and Realities

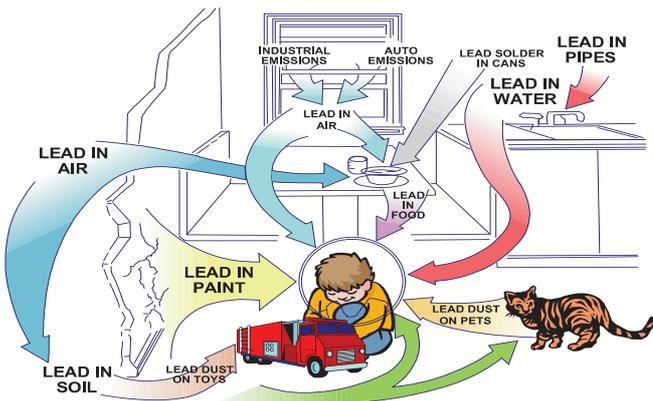
Childhood Lead Poisoning A Kay County Perspective

Oklahoma State Board of Health Meeting
Kay County Health Department
June 13, 2017

- Vast evidence* supports increased likelihood of:
 - Decrease in IQ
 - Increase in blood lead from $<1 - 10 \mu\text{g/dL} = -6.2$ IQ points
 - Increase in blood lead from $<1 - 30 \mu\text{g/dL} = -9.2$ IQ points
 - Neurobehavioral disorders such as hyperactivity and attention deficits
 - No effective treatments ameliorate the permanent developmental effects of lead toxicity

*Pediatrics. 2016; 138:1 (e20161493). Policy Statement: Childhood Lead Poisoning Prevention

What are the Lead Hazard Pathways?



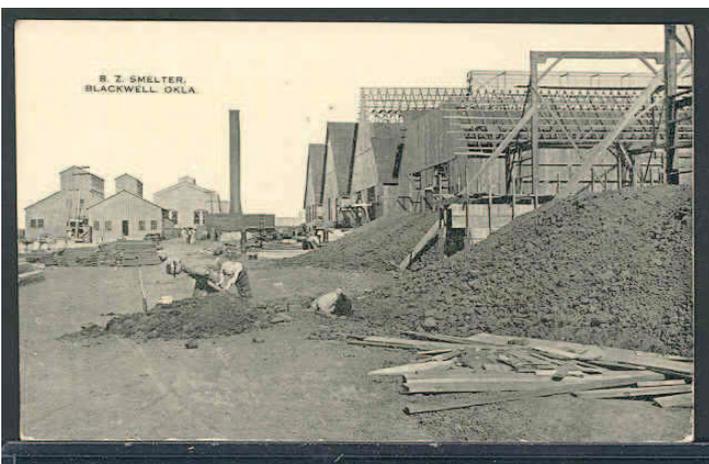
A Historical High Risk Area Blackwell, OK

- Located in Kay County
- Pop. ~6,900 in 2015
- Blackwell Zinc Company operated smelter from 1916-1974
- 42% of homes built prior to 1950*
- 88% of homes built before 1980*



*U.S Census Bureau. (2015). 2010-2014 American Community Survey 5-Year Estimates

Image Courtesy of Blackwell Uncovered



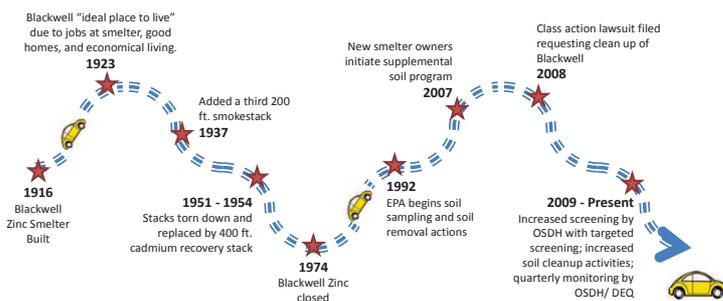
Air View of Zinc Smelter Plant, Blackwell, Oklahoma



A Historical High Risk Area Blackwell, OK

- Due to previous smelter activity, Blackwell has a history of elevated blood lead levels in children
- The Department of Environmental Quality has worked with the responsible party (now Freeport-McMoRan) and the Blackwell community to remediate soil contaminated with lead
- A study of children's blood lead levels was conducted by OSDH and KCHD in 2011
- A settlement agreement to a class action lawsuit against the responsible party was agreed upon in 2012

Blackwell, OK Timeline



2011 Blackwell Blood Lead Study

- In 2011, when the study began, the reference level for an elevated blood lead level was 10 µg/dL (micrograms per deciliter)
- 360 children participated in the study and provided blood lead samples
- The study found that 0.8% of children living in Blackwell had elevated blood lead levels

Positive Outcomes of Study

- Awareness of lead exposure increased in the community
- Additional children who had never received blood lead tests were identified and received appropriate follow-up and case management
- Partnership between OSDH, Kay County Health Department, the Department of Environmental Quality (DEQ), City of Blackwell, Freeport-McMoRan, and Environmental Protection Agency (EPA) was established

Study Limitations

- In May 2012, the Centers for Disease Control and Prevention came up with new guidance which indicated that there was no safe level of lead and that action should be taken for anyone whose blood lead level was 5 µg/dL or higher
- Change in blood the blood lead reference level when applied retrospectively showed many children in the 5-9 µg/dL range who would now be considered to have lead poisoning
- Information regarding sources of exposure in children's homes and information about soil remediation in their homes was not collected

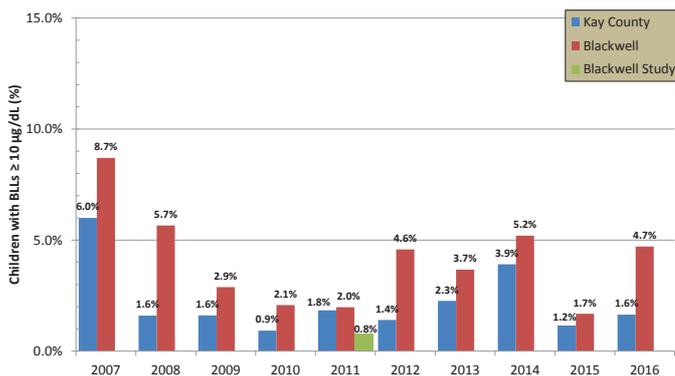
Blackwell: Contaminated Soil or Lead-Based Paint?

- The limited number of home environmental investigations performed in Blackwell have revealed the presence of lead-based paint as primary exposure source
- All environmental investigations have been in homes built prior to 1950
- Large scale soil remediation has occurred

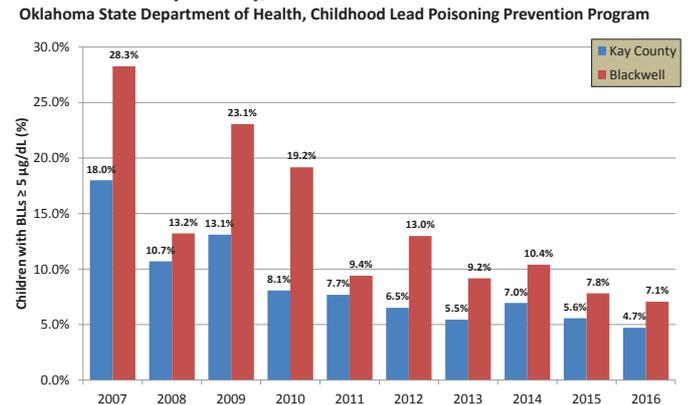
2017 Blackwell Lead Study Proposal

- Children will be randomly selected for a more representative sample of the community
- Children with a level $\geq 5 \mu\text{g/dL}$ will receive an environmental investigation to identify the sources of lead exposure
- Parents of children will complete a detailed questionnaire to aid in understanding potential lead exposure sources
- Soil remediation information will be available to correlate with elevated lead levels
- Drinking water samples will be collected at the residence of children with elevated blood lead levels

Reported Childhood Blood Lead Levels $\geq 10 \mu\text{g/dL}$
Blackwell, Kay County, and the Blackwell Study, 2007 – 2016
 Oklahoma State Department of Health, Childhood Lead Poisoning Prevention Program



Reported Childhood Blood Lead Levels $\geq 5 \mu\text{g/dL}$
Blackwell & Kay County, 2007 – 2016
 Oklahoma State Department of Health, Childhood Lead Poisoning Prevention Program



Kay County Health Department Study Role

- Multidisciplinary approach
 - Outreach, education, screening, home visitation, tracking, and coordination
- Two Certified Risk Assessors in the Blackwell area
- Will need to address multi-faceted community issues
 - Older housing
 - Soil contamination
 - Testing fatigue

Kay County Health Department Activities

- Community coalition activity
- Communication and solution building with partners
- Enhanced education
 - Parents, partners, and community
- Enhanced home visitation approach

Kay County Activities

- EPA, DEQ , and Freeport-McMoRan collaborate on remediation efforts in Blackwell
- DEQ, OSDH, and Kay County Health Department partnering to conduct 2017 Childhood Blood Lead Study
- The Kay County Health Department, City of Blackwell, City of Ponca City, tribal partners, community coalitions, and Freeport-McMoRan have engaged in community activities to increase education and decrease sources of lead exposure

Questions?



Strategic Map Update

OKLAHOMA STATE DEPARTMENT OF HEALTH



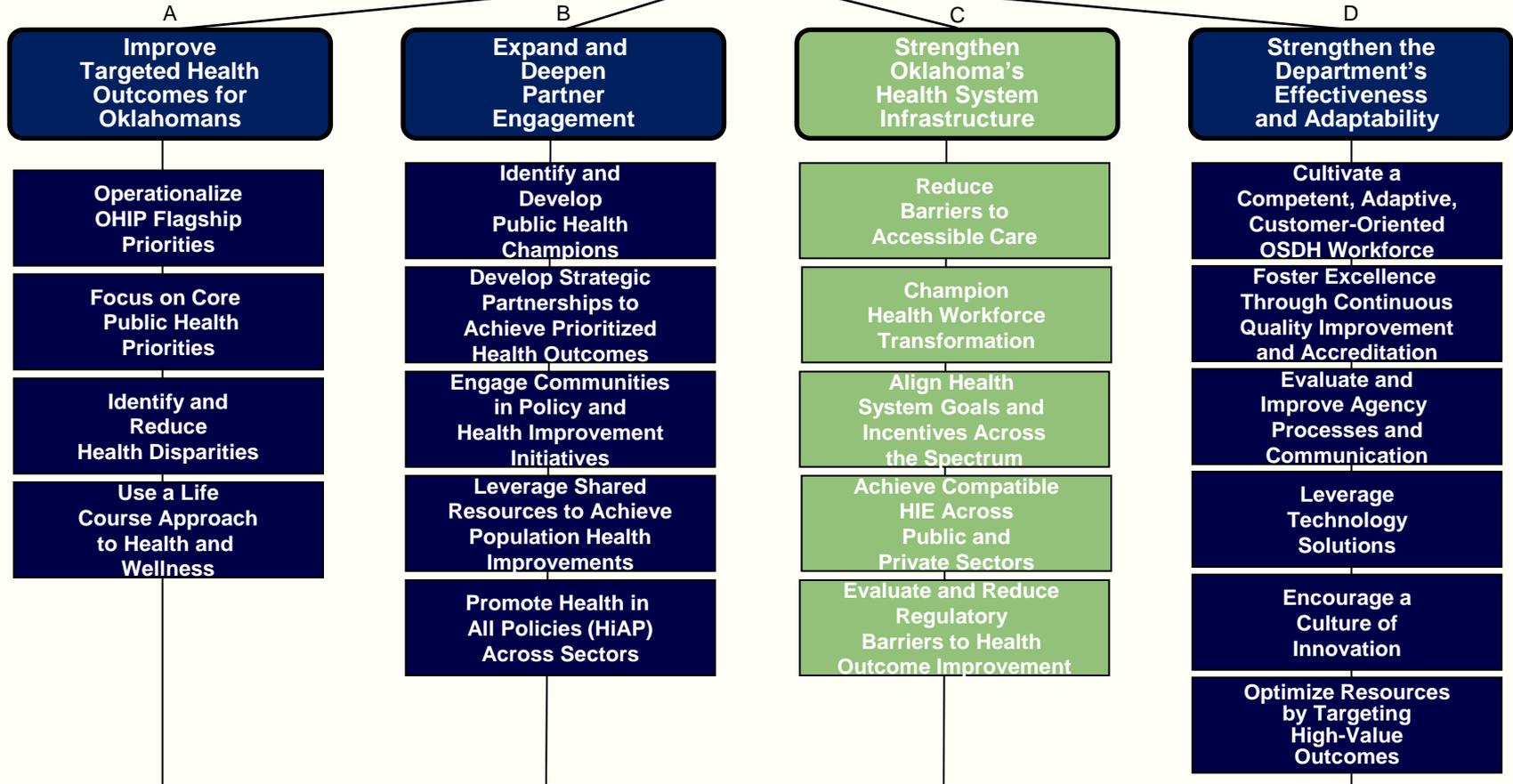
Julie Cox-Kain, M.P.A.

Deputy Secretary of Health and Human Services

Senior Deputy Commissioner

July 11, 2017

Improve Population Health



Address the Social Determinants of Health and Improve Health Equity

Promote Health Improvement Through Policy, Education and Healthy Behavior

Foster Data-Driven Decision Making and Evidence-Based Practices

Reduce Barriers to Accessible Care

Opportunities

- Data Sharing & Integration w/Licensure Boards
- FQHC Uniform Data Set
- Expand National Health Service Corps and FQHC sites
- Expand use of J-1 Visa Waivers
- Safety Net Directory

Barriers

- Data Standardization
- Data Quality
- Data Visualization Tools
- Data Needs – Telehealth & Local Economic Information

Measures of Success

- Improve Data for Detailed Analysis
- Increase Safety Net Sites & Workforce
- Increase Public Information

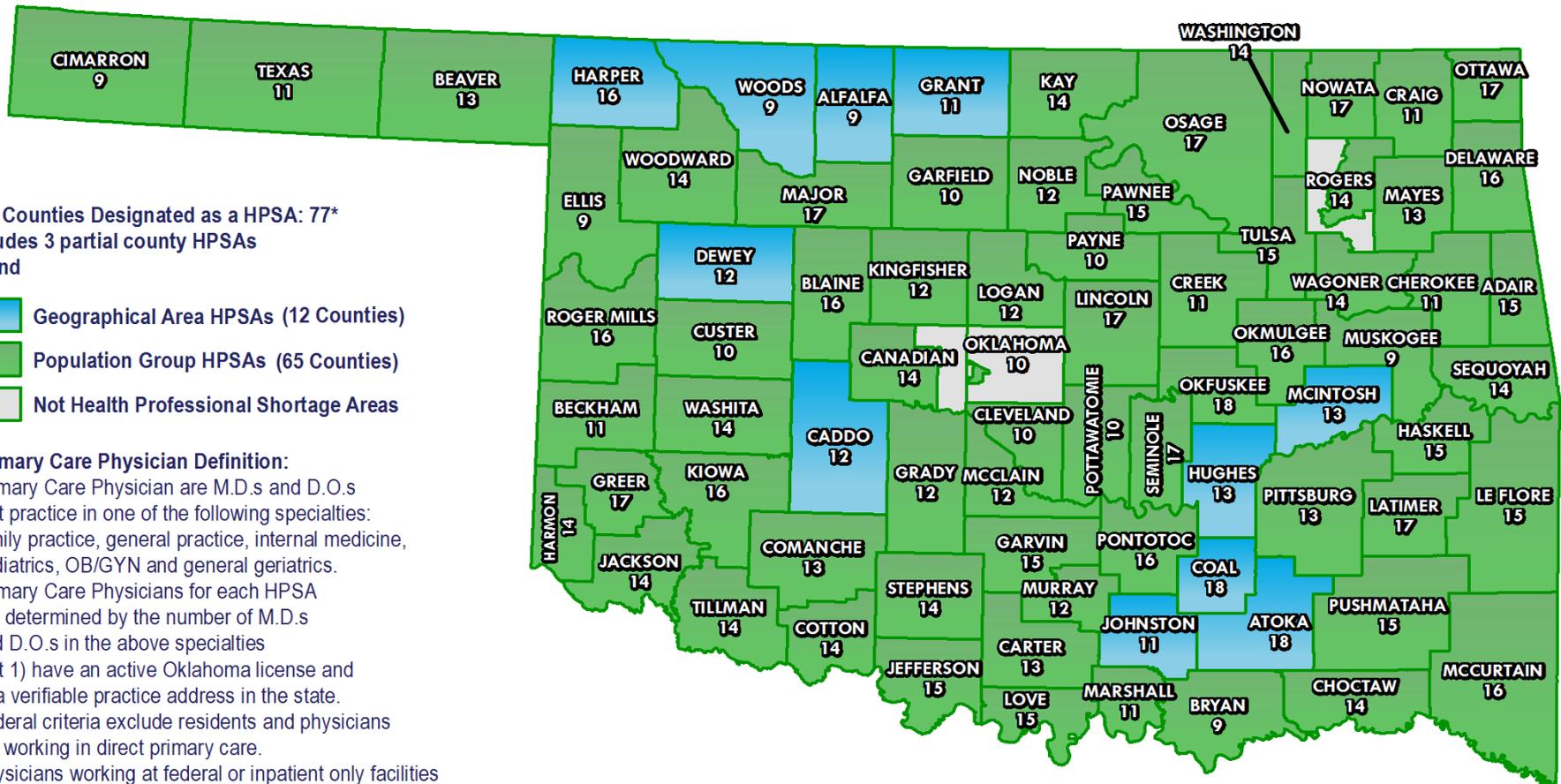


Accomplishments

- New Access Point Sites Identified
- More NHSC Awards than Any State in Region
- 13 High Priority Critical Access Hospitals Identified for NHSC
- J-1 Foreign Physician Waivers Increased by 47%
- Safety Net Directory Outreach



Primary Care Health Professional Shortage Areas (HPSAs)



Total Counties Designated as a HPSA: 77*

*Includes 3 partial county HPSAs

Legend

- Geographical Area HPSAs (12 Counties)
- Population Group HPSAs (65 Counties)
- Not Health Professional Shortage Areas

Primary Care Physician Definition:

Primary Care Physicians are M.D.s and D.O.s that practice in one of the following specialties: family practice, general practice, internal medicine, pediatrics, OB/GYN and general geriatrics.

Primary Care Physicians for each HPSA are determined by the number of M.D.s and D.O.s in the above specialties that 1) have an active Oklahoma license and 2) a verifiable practice address in the state.

Federal criteria exclude residents and physicians not working in direct primary care.

Physicians working at federal or inpatient only facilities are also excluded from HPSA calculations.

Notes on Health Professional Shortage Areas:

HPSAs demonstrate a critical shortage of primary care physicians, in accordance with the federal Health Resources & Services Administration (HRSA) Shortage Designation Branch guidelines. Each type of HPSA is further classified into one of the following categories: geographic, population group, facility, or automatic. Each HPSA is given a score by the Shortage Designation Branch based on certain specific criteria for each type of HPSA. This score indicates the degree of shortage. HPSA designations are updated every 3-4 years.*

Data Source: HRSA Datawarehouse, SDMS, Office of Primary Care & Rural Health Development

Projection/Coordinate System: USGS Albers Equal Area Conic

Created: 5.5.2017

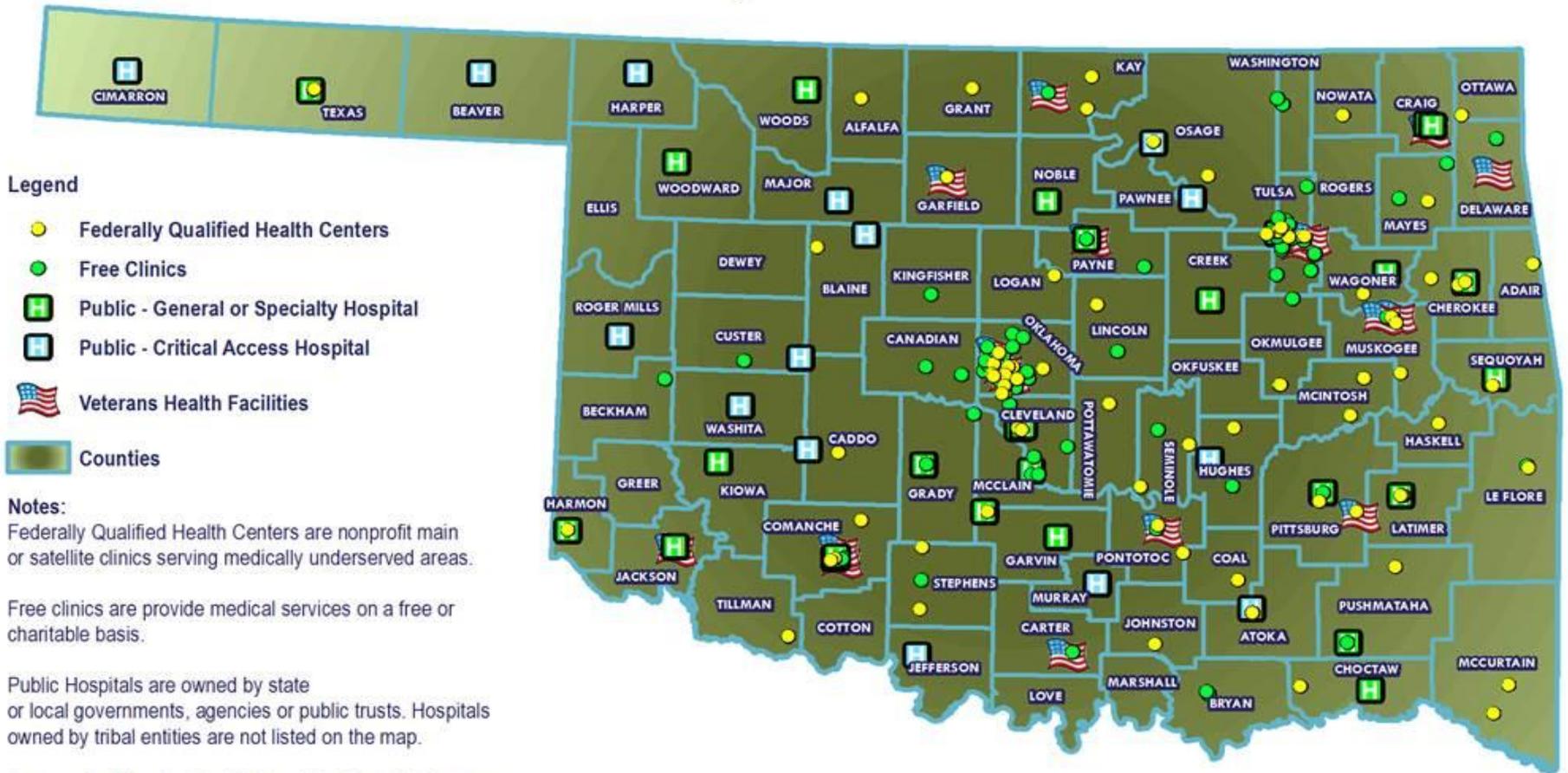


Office of Primary Care & Rural Health Development
Center for Health Innovation & Effectiveness
Oklahoma State Department of Health



Disclaimer: This map is a compilation of records, information and data from various city, county and state offices and other sources, affecting the area shown, and is the best representation of the data available at the time. The map and data are to be used for reference purposes only. The user acknowledges and accepts all inherent limitations of the map, including the fact that the data are dynamic and in a constant state of maintenance.

Safety Net Facilities



Legend

- Federally Qualified Health Centers
- Free Clinics
- H Public - General or Specialty Hospital
- H Public - Critical Access Hospital
- Veterans Health Facilities
- Counties

Notes:

Federally Qualified Health Centers are nonprofit main or satellite clinics serving medically underserved areas.

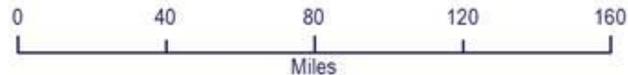
Free clinics provide medical services on a free or charitable basis.

Public Hospitals are owned by state or local governments, agencies or public trusts. Hospitals owned by tribal entities are not listed on the map.

Veterans facilities include VA Hospitals, State Vet Centers and Community Based Outpatient Centers.

Data Source: Safety Net Provider Directory

Projection/Coordinate System: USGS Albers Equal Area Conic



Disclaimer: This map is a compilation of records, information and data from various city, county and state offices and other sources, affecting the area shown, and is the best representation of the data available at the time. The map and data are to be used for reference purposes only. The user acknowledges and accepts all inherent limitations of the map, including the fact that the data are dynamic and in a constant state of maintenance.

Created: 06.26.2017



Office of Primary Care & Rural Health Development
Center for Health Innovation and Effectiveness
Oklahoma State Department of Health

Champion Health Workforce Transformation

Opportunities

- Health Workforce Subcommittee
- MACRA/MIPS/H2O Technical Assistance Assets
- HHS Cabinet Governance
- Medicaid Waiver for Transformation (DSRIP)
- Health-e Oklahoma

Barriers

- Funding
- Emerging Profession Infrastructure

Measures of Success

- Health Workforce Development & Distribution
- TA & Training for Transformation



Accomplishments

- NGA TA Grant Improved Medicaid 1115 Waiver for Supplemental Payment to Support Recruitment and Retention
- White Papers: Community Health Worker & Community Paramedic



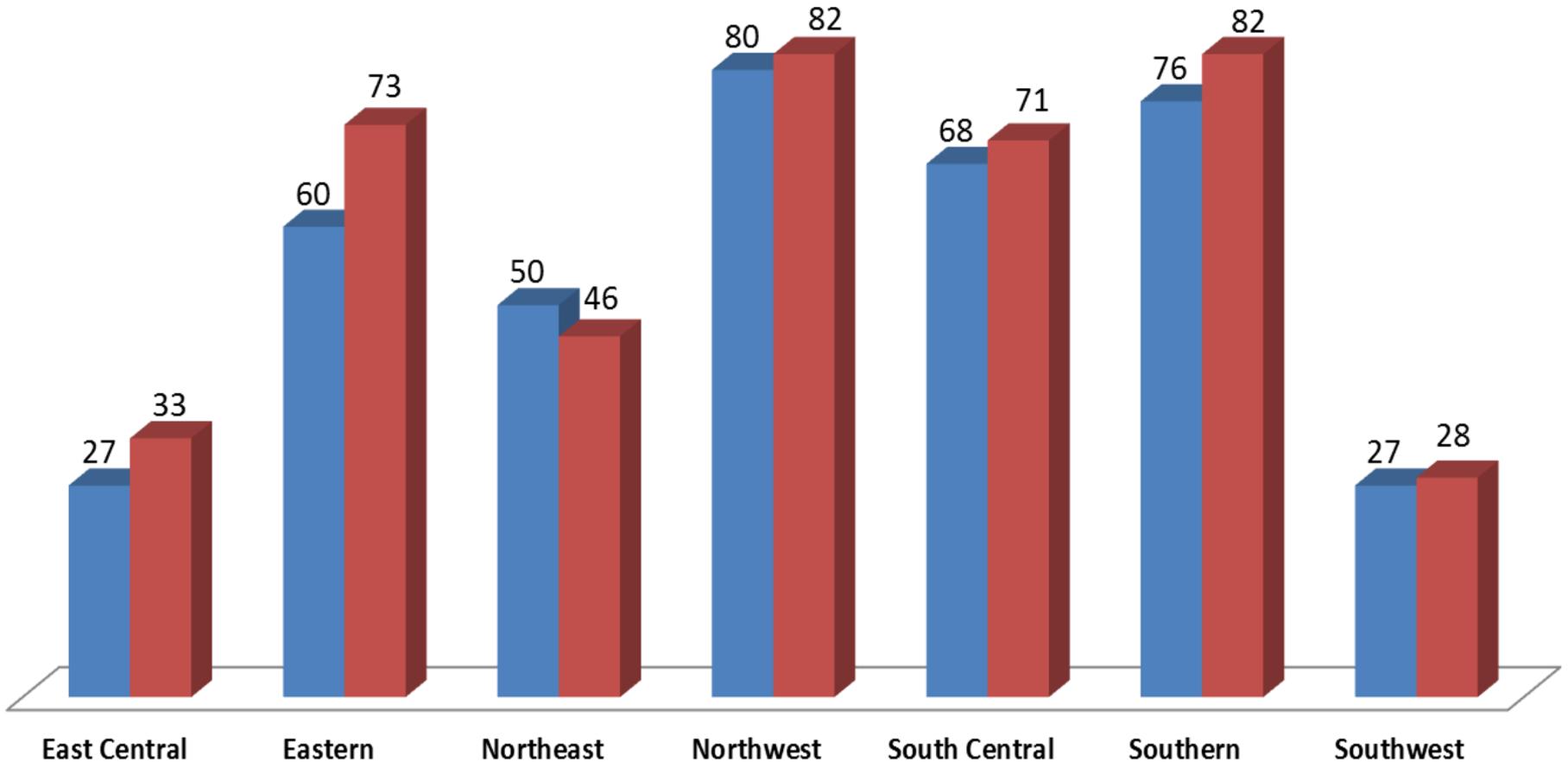
Ranking: 2016-2026 Openings

SOC	Description	Ranked by Total 2016-2026 Openings
29-1141	Registered Nurses	1
29-2061	Licensed Practical and Licensed Vocational Nurses	2
11-9111	Medical and Health Services Managers	3
29-2041	Emergency Medical Technicians and Paramedics	4
29-1089	Physicians and Surgeons, All Other	5
29-2071	Medical Records and Health Information Technicians	6
29-1062	Family and General Practitioners	7
29-1123	Physical Therapists	8
29-1051	Pharmacists	9
29-2012	Medical and Clinical Laboratory Technicians	10
21-1014	Mental Health Counselors	11
29-2011	Medical and Clinical Laboratory Technologists	12
31-9097	Phlebotomists	13
29-1171	Nurse Practitioners	14
29-1071	Physician Assistants	15
29-2034	Radiologic Technologists	16
29-1041	Optometrists	17
29-1021	Dentists, General	18
21-1094	Community Health Workers	19
29-1126	Respiratory Therapists	20
29-2032	Diagnostic Medical Sonographers	21
29-1087	Surgeons	22
29-1063	Internists, General	23
29-1151	Nurse Anesthetists	24
29-1066	Psychiatrists	25
29-1061	Anesthesiologists	26
29-2035	Magnetic Resonance Imaging Technologists	27
29-1065	Pediatricians, General	28

Supply and Demand: Regional Example

Respiratory Therapist SOC 29-1126

■ 2016 Jobs ■ 2026 Jobs



Align Health System Goals & Incentives

Opportunities

- Alignment of State Agency Goals
- DSRIP Waiver
- Alignment of Innovation Programs
- Improved Outcomes & Ease Regulatory Burden

Barriers

- Provider & Agency Capacity
- Funding
- Interoperability
- Transparency on Cost of Care
- Healthcare Policy Uncertainty

Measures of Success

- Agency Quality Measure Alignment
- Triple AIM



Accomplishments

- Draft Agency Quality Measure Set
- 1332 Waiver Authorization/Market Stabilization
- DSRIP Waiver Authority



HHS Quality Measures



- NQF 0018 - Controlling High Blood Pressure
- NQF 0024 - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
- NQF 0028 - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- NQF 0032 – Cervical Cancer Screening
- NQF 0034 - Colorectal Cancer Screening
- NQF 0041 - Influenza Immunization
- NQF 0057 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- NQF 0059 - Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- NQF 0418 - Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
- NQF 0421 - Preventive Care and Screening: BMI Screening and Follow-Up
- NQF 1959 - HPV for Adolescents
- NQF 2372 - Breast Cancer Screening
- SBIRT – like Screening for Substance Abuse

Created by YuguDesign from Noun Project



Achieve Compatible HIE Across Public & Private Sectors

Opportunities

- Improved Healthcare Information
- Lower Costs
- Improved Outcomes
- Improved Patient and Caregiver Engagement

Barriers

- Governance
- Funding
- Resources

Measures of Success

- Established Governance Board
- Strategic Roadmap
- Federal Funding
- Increased Health Information Technology Usage



Accomplishments

- Federal 90/10 funding awarded for technical assistance to develop HIE plan/waiver
- Request For Proposal developed and under review
- Begin with 'Use Case' developed for Admission, Discharge, Transfer (ADT) Notifications
- Draft Governance Legislation under review



Reduce Regulatory Barriers

Opportunities

- Ease Regulatory Burden on Healthcare
- Assess Health Impacts of Regulation
- Administrative Efficiency
- Engagement

Barriers

- Agency Capacity

Measures of Success

- Analysis of State to Federal Regulations
- Analysis State Regulation to Best Practice
- Analysis of Internal OSDH Administrative Breakdowns



Accomplishments

- Request For Proposal Development for External Contractor (Objective 1 & 2)
- Prioritized Objective 3
- Engaged Hospital Advisory Council



QUESTIONS



**OKLAHOMA STATE DEPARTMENT OF HEALTH
BOARD OF HEALTH FINANCE COMMITTEE BRIEF
July 2017**

SFY 2017 BUDGET AND EXPENDITURE FORECAST: AS OF 06/22/2017

<u>Division</u>	<u>Current Budget</u>	<u>Expenditures</u>	<u>Obligations</u>	<u>Forecasted</u>	<u>Not Obligated or</u>	<u>Performance</u>
				<u>Expenditures</u>	<u>Forecasted</u>	<u>Rate</u>
Public Health Infrastructure	\$ 21,664,900	\$ 15,122,432	\$ 4,880,329	\$ 1,395,796	\$ 266,343	98.77%
Protective Health Services	\$ 60,230,724	\$ 49,265,273	\$ 3,981,457	\$ 6,794,533	\$ 189,461	99.69%
Office of State Epidemiologist	\$ 54,209,340	\$ 40,865,721	\$ 8,144,697	\$ 5,071,317	\$ 127,605	99.76%
Health Improvement Services	\$ 31,629,048	\$ 20,339,705	\$ 4,704,011	\$ 6,161,692	\$ 54,318	99.83%
Community & Family Health Services	\$ 223,370,395	\$ 180,034,696	\$ 11,166,831	\$ 32,164,959	\$ 3,909	100.00%
Totals:	\$ 391,104,407	\$ 305,627,827	\$ 32,877,325	\$ 51,588,297	\$ 641,636	99.84%
< 90%	90% - 95%	95% - 102.5%	102.5% - 105%	>105%		

Expenditure Forecast Assumptions

- Payroll forecasted through June 30, 2017
- Forecasted expenditures includes the unencumbered amounts budgeted for:
 - Travel reimbursements
 - WIC food instrument payments
 - Trauma fund distributions
 - Amounts budgeted for county millage
 - Amount budgeted to support rural EMS agencies
 - Budget amounts for fiscal periods other than state fiscal year not yet active

Budget and Expenditure Explanation

- The amounts reported as 'Not Obligated or Forecasted' are not an estimate of lapsing funds. This represents planned expenditures that OSDH is currently taking action to execute.
- Overall budget was reduced to known revenue levels.
- OSDH will request carryover funds of \$54,318 for uncompensated care.
- The agency has a current overall performance rating of 99.84%, a net change of .14% from June's report.

Oklahoma State Department of Health

Board of Health – Finance Brief

JULY 11, 2017

Focus: Women Infant Children (WIC) Service

The OSDH WIC Program is under the direction of the Deputy Commissioner of Community & Family Health Service

Program History and Benefits:

- Created in 1972; by the end of 1974, WIC was operating in 45 states including Oklahoma;
- Federally funded providing food, nutrition education, and access to health services for:
 - Low-income pregnant women;
 - Women who have recently given birth;
 - Infants and children up to age 5;
- Average participation in Oklahoma per month is 80,647 (Women 19,582, Infants 20,763 and Children 40,302)
- Longer, safer pregnancies;
- Fewer premature births and infant deaths;
- Improved dietary outcomes for infants and children and Improved maternal health;
- Significant savings in healthcare costs when compared to non-participants at the same income level—*For every dollar spent on pregnant women on WIC, up to \$4.21 is saved in Medicaid (Nat'l WIC Ass. June 2015)*

e-WIC Overview:

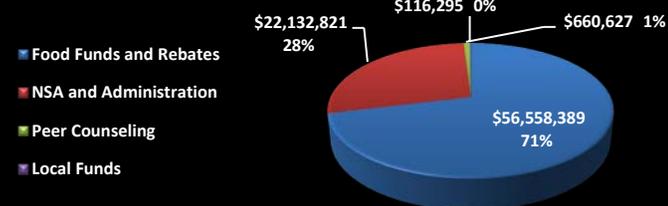
- eWIC is an initiative to transition from paper food instruments to electronic cards;
- Federal Mandate to implement by October 1, 2020;
- WIC Service has coordinated with WIC approved grocers statewide to provide card reading equipment/software;
- Xerox servers track client benefits/account balance;
- After transaction remaining client balance will be printed on cash register receipt;
- eWIC cards will require PIN number for all transactions;
- OSDH client staff add benefits to client accounts;
- OSDH Staff provide helpdesk lines for clients when there are transactional issues, vendor help lines for issues with eWIC transactions, specific vendor staff for training to new vendors and vendor visits for monitoring the program.

e-WIC Benefits:

Eliminate staff time and effort and supply costs associated with printing paper food instruments;

- Eliminate vendor contract costs associated with processing food instruments;
- Easier and more efficient as in most cases not necessary to separate WIC from regular food purchases at checkout;
- eWIC cards will provide greater flexibility with purchases; items may be purchased 1 at a time;
- Eliminates stigma of shopping with paper food instruments;
- eWIC along with online nutrition education will help create healthier choices and improved health outcomes;
- Safeguard feature – Client benefits are not stored on the card so lost cards can be easily replaced.

Current WIC Program Funding



DATE: June 27, 2017

TO: Members, State Board of Health

FROM: Public Health Policy Committee, State Board of Health

Please review the attached policy and position statements. The current set of policy and position statements can be summarized as directives to the Department of Health from the Board. Many directives have been carried out as internal policies or organizational changes within the Department. Some directives represent the policy, budget, or program priorities of the Board at the time of adoption. And finally some attempted to bridge a gap in communication at the time of adoption.

Following the May action combining Board Policy CP 54 (Office of Accountability) with the Department Policy on the Office Accountability, the Policy Committee has reviewed current policy and position statements and will make the following recommendations:

- Elimination of duplicative or non-operational policy and position statements.
- Title 63 O.S., Section 1-103-104 & Administrative Rule OAC 310:1-1-4 are the Board's governing documents and should continue to serve as governing framework for operations of the State Board of Health.

The index of policy and position statements includes a quick reference sentence briefly identifying the content just below each heading. Please send any comments or questions to Brian Downs at BrianD@health.ok.gov or VaLauna Grissom at VaLaunag@health.ok.gov in advance of the policy committee meeting on July 11, 2017.

Attachments

- Statutory Authority for the creation, description, & duties of the Oklahoma State Board of Health
- Oklahoma Administrative Code, Title 310, Chapter 1, Rule 1-4 (known as OAC 310:1-1-4)
- Current policies and position statements

CURRENT POLICIES

- P•1 Health Care Reform • March 18, 1993**
Board support for health care reform.
- P•2 Tobacco Use Prevention • March 24, 1994**
Tobacco problem statement/prevalence data then BOH directs Department to focus on 8 policy directives
- P•5 PLUTO • April 28, 1994**
Directive from BOH to focus resources on 5 programs in rank order when resources are limited.
- P•7 Communicable Disease Control • March 16, 1995**
Directs OSDH to maintain resources to carry out its mission and mandates related to detection and surveillance of disease.
- P•8 Rule Making • April 26, 1995**
Directs the OSDH on the general rulemaking process and consistent with the Admin Proc. Act.
- P•10 Public Health Laboratory • February 8, 1996**
Directs the OSDH on the roles and responsibilities of the Public Health Lab
- P•12 Chronic Disease • June 20, 1996**
Directs OSDH to provide leadership around Chronic Disease programs
- P•13 Continuum of Care and Assisted Living Policy Paper • September 18, 1997**
Directs OSDH regarding nursing and continuum of care facilities, some reference to mandates required in HB1540.
- P•16 Community-Based Family Resource and Support Programs • November 20, 1997**
Evaluation efforts for community based family resource and support programs.
- P•22 Injury Prevention • June 18, 1998**
Responsibilities of the Injury Prevention Service.
- P•24 Trauma Systems • June 18, 1998**
Directs OSDH to plan, develop and implement a coordinated system of care.
- P•26 School Health • June 18, 1998**
Responsibilities of School Health programs, directs OSDH to collaborate with Dep. Of Ed.
- P•28 Breastfeeding • November 18, 1999**
Promotion of breastfeeding; integration into spectrum of care.
- P•32 Newborn Metabolic Disorder Screening Program • March 16, 2000**
Elevates and separates this program from the Pub Health Lab.

- P•35 Principles of Organization for the Department of Health • March 16, 2000**
Discuss services statutorily mandated to be provided to every person in state by pub health.
- P•36 HIV/AIDS • March 16, 2000**
Responsibilities of the OSDH in addressing HIV.
- P•37 Teen Pregnancy • March 16, 2000**
Supports expansion of program, urges OSDH, Dept. of ed, and Legislature to take certain actions.
- P•39 Unintended Pregnancy • March 16, 2000**
Urges the state to adopt new social norm that all pregnancies should be intended; issues challenges to multi-sectors.
- P•41 Board Operations • July 6, 2000 • Amended September 13, 2007 • Amended September 10, 2009 • Amended August 18, 2013**
Framework for operations of BOH & committees and governance; establishes a Board work calendar and contents
- P•44 Adult Immunizations • March 15, 2001**
Strategies to promote adult vaccination.
- P•47 Health Information Security Policy • September 27, 2001**
Directive regarding protection of confidential health data; concern over misuse; urges legislative remedies to restrict market use of PHI.
- P•49 Obesity • September 27, 2001**
Directs OSDH to become lead agency in promoting/implementing worksite wellness; general promotion and action to address obesity.
- P•51 Affiliation Agreement-University of Oklahoma and Department of Health • Nov. 4, 2004**
Charges OSDH with pursuing Formal affiliation agreement between OUHSC and OSDH.
- P•52 Collaboration Agreement: State Board of Health, Oklahoma City-County Board of Health and Tulsa City-County Board of Health • September 15, 2005**
Directs at least 1 joint meeting annually; seeks collaboration between departments, board members and agreement in policy/resolution.
- P•53 State of the State's Health Report • March 13, 2008**
Directs SSHR report to be published by both OSDH and BOH (policy committee); focus on health priorities of BOH and OSDH.
- P•54 Office of Accountability Systems • August 18, 2013 • Eliminated May 9, 2017**
Established duties of the OAS; framework for interactions between OAS, OSDH, BOH; procedures for handling of complaints or other inquiries.

Health Care Reform

Historically, the role of public health has been distinct from private medical care in the sense that only those problems of disease that required a coordinated public effort to solve were the distinct purview of governmental health programs. Where control of a disease, crossed the lines of clinical treatment to include water supplies, quality, or methods of conveyance or propagation that could not be met even by the concerted effort of the private health care system, public health stepped in to coordinate immunization, sewage treatment, and reduction of environmental toxins.

During the last decade, the cost of health care for all Americans has grown steadily at twice the rate of inflation. Almost twenty percent of all Oklahomans have no traditional health insurance and probably could not afford it if it were offered. In a sense, the cost of health care has become as dire as an epidemic. The fact that millions of Americans rely too often on an emergency room rather than a family physician, too often on acute care rather than prevention, all too frequently at public expense has served to blur the lines between public health and private medical care.

Today Oklahoma State Department of Health delivers basic health care services throughout the state for pregnant mothers and small children who otherwise could not afford nor have access to such care. This assistance is delivered in collaboration with private medical care in a cooperative relationship of concern for the importance of prenatal care and the extraordinary future benefits of tending to the wellness of small children.

Clearly a new partnership should be forged between all health care providers, both public and private, if we are to uphold the ethical considerations of our profession and make certain that no Oklahoman forgoes needed health care because they cannot afford it or because it is not reasonably available to them. We must protect all Oklahomans, urban and

rural alike, from preventable health problems and injury whether it arises from the transmission of a disease or lack of access to good primary care. It is no longer reasonable to maintain a bureaucratic distinction between prevention and primary medicine. The best form of prevention is health education and affordable access to skilled care providers who utilize both medicine and counseling as part of the everyday tools of their practice.

Therefore, the Oklahoma State Board of Health both commends and encourages current efforts by the governor and the legislature to reform health care. While many important details remain to be decided, and, in that regard, there may be honest disagreement, the Board of Health, as a matter of policy, is seriously committed to assisting in every way possible the development of a new public-private collaboration that will integrate the delivery of health care in a way that will best insure the well-being of the citizens of this state.

The Board of Health stands ready to lend its resources and experience in whatever way may be feasible to provide governance and support to this effort. It offers the important elements of a statewide network of dedicated professionals, reservoirs of statistical information regarding health care providers and disease so critical to reform, and, most importantly, its demonstrated commitment through the actions already in place throughout the state to not only prevent illness and trauma, but to provide, in collaboration with private physicians, much needed care for all Oklahomans.

Tobacco Use Prevention

Problem Statement

The number one preventable cause of death in Oklahoma is smoking. According to *Highlights of State Tobacco and Health Data* (Office of Smoking and Health, March 1990), Oklahoma was ranked among the top 15 states for its smoking-attributable mortality rate. The lung cancer mortality rate alone was 58.9 deaths per 100,000 persons compared to the national average of 52.1 deaths per 100,000, ranking Oklahoma as 10th highest for lung cancer deaths. Additionally, Oklahoma was ranked 10th for stroke mortality, 18th for coronary heart disease mortality, and 30th for chronic obstructive pulmonary disease mortality.

The 1988 Behavioral Risk Factor Surveillance System data (Oklahoma State Department of Health) showed that 24.2% of those who completed the survey smoked cigarettes. In 1989, this percentage increased to 26.7%. The 1989 data also showed, as in 1988, that a higher percentage of women ages 18-24 smoked (21.8%) compared to the same age group for men (16.6%). Overall, Oklahoma had the 8th highest smoking rate out of 40 states participating in the 1989 Behavioral Risk Factor Surveillance System. The bottom line is that Oklahomans simply smoke at an alarmingly higher rate than much of the nation, resulting in excessive smoking attributable deaths.

These data are confirmed by the latest national 1989 Current Population Survey (CPS) results conducted by the U.S. Bureau of the Census for the National Heart, Lung and Blood Institute. In fact, the CPS data even paint a grimmer picture for smoking among women in Oklahoma. For women ages 35-64, Oklahoma ranked first among 50 states and the District of Columbia for smoking prevalence (35.4%). Just as disturbing, Oklahoma women of childbearing age, 18-44, ranked 6th for smoking prevalence (31.5%) putting them at higher risk for miscarriages, low

birth weights, and premature births. Finally, according to the 1989 CPS data, Oklahoma was one of only two states reporting a higher percentage of women smokers than men smokers (35.4% for women compared to 31.8% for men).

Oklahoma's continued high prevalence of cigarette smoking is due in part to a poor quit ratio as compared to other states. (Quit ratio is the percentage of persons who have ever smoked who were former smokers when interviewed.) In 1989, when Oklahoma's Behavioral Risk Factor Surveillance System (BRFSS) data were standardized for population characteristics, Oklahoma ranked 40th out of 40 BRFSS states for the cigarette smoking quit ratio. Likewise the U.S. Census Bureau's 1989 Current Population Survey (CPS) results show Oklahoma ranked as 45th out of 50 states and the District of Columbia. Particularly disturbing is the especially low quit ratio among Oklahoma's female population and the low quit ratio for both males and females in the 20-44 age group. This deadly combination of high smoking prevalence and low quit ratios puts Oklahoma near the very top of the list for smoking-attributable diseases.

In addition to a severe problem with smoking attributable deaths resulting from a high rate of cigarette use, Oklahoma has one of the highest rates of smokeless tobacco use in the country. Chewing or dipping smokeless tobacco poses health risks similar to cigarette smoking. The carcinogens found in cigarette smoke are also found in tobacco juice. The 1990 *Highlights of State Tobacco and Health Data* shows Oklahoma's smokeless tobacco use prevalence rate at 11.0% for males aged 16 and over compared to a U.S. rate of 5.5%. This rate ranked Oklahoma 8th highest nationally for smokeless tobacco use. The 1992 Behavioral Risk Factor Surveillance System data

(Oklahoma State Department of Health) confirmed the 1990 *Highlights of State Tobacco and Health Data* results for smokeless tobacco use and revealed a trend that may be a cause for concern. For men, smokeless tobacco use ranged from 6.1% to 12.6% among 25 to 65+ year olds. However, 24.8% of the young men in the 18-24 year old age group reported using smokeless tobacco. Continued use of smokeless tobacco among the individuals in this younger age group will put them at much greater risk for oral cancer as well as dental complications.

Current Programs

In September 1993, the Health Education and Information Service of the Oklahoma State Department of Health was awarded a five-year CDC cooperative agreement for tobacco use prevention and control. The purpose of the cooperative agreement is to build the Oklahoma State Department of Health's capacity for tobacco use prevention and reduce the state's overall tobacco use rates. Specific activities related to the grant include, advocacy, policy development, data collection and analysis, coordination of local tobacco prevention efforts, regional conferences, and education.

A highly successful smoking cessation effort already accomplished by the Oklahoma State Department of Health was the nicotine patch give-away program. Sponsored by Lederle Pharmaceutical Company and the Association of State and Territorial Health Officials, the program enrolled 866 clients through 20 county health departments. From this group, 543 completed the 6-week therapy and 431 reported they had stopped smoking at the end of the therapy.

Other grassroots tobacco prevention and cessation efforts at the community level will continue. In particular, an effective community organization model, Planned Approach to Community Health (PATCH), will be employed to prevent tobacco use among youth and help adults quit.

Policy Statement

Tobacco use can no longer be viewed as just a social issue or a matter of personal choice. In fact, it is a public health issue of enormous consequences. Just as the Oklahoma State Department of Health is obligated to protect the health of Oklahomans by providing immunizations and AIDS prevention education, so must we be obligated to protect citizens from Oklahoma's number one leading cause of death, tobacco use. In particular, strong and immediate steps must be taken to prevent tobacco use among our youth. Oklahoma's high smoking rates among adults are the result of easy access to tobacco for minors. As stated in the 1994 Surgeon General's report, most of today's adult smokers are addicted to nicotine because of tobacco use that began in early adolescence, typically by age 16.

Economically, we cannot afford to ignore tobacco use as a public health issue, especially during this era of health care reform. The effects of tobacco use directly and indirectly cost Oklahoma over \$1 billion annually. We see these costs as medical expenses for treating tobacco-related disease and lost productivity and income due to tobacco-related illness and death (Smoking Attributable Mortality, Morbidity, and Economic Costs Data, 1990, Oklahoma State Department of Health).

Although there has been some success in preventing tobacco use among youth, helping adults quit tobacco, and limiting exposure to second-hand smoke, there is much work yet to be accomplished. Specifically, there should be a focal point within the health department to address the following directives from the Oklahoma State Board of Health:

1. *Ban Vending Machine Sales* — Ban the sale of tobacco products in vending machines to help limit the access of tobacco to minors.

2. *Prohibit Free Samples* — Prohibit the distribution of free tobacco products to help limit the access of tobacco to minors.

3. *Schools* — Prohibit tobacco use in child care centers, and within and on the grounds of all elementary, middle and secondary schools.

4. *School Health Education* — Establish, in cooperation with the Oklahoma State Department of Education, tobacco use prevention curricula as part of the Health/ Safety and Physical Education requirements of House Bill 1017 in all elementary, middle and secondary schools.

5. *Youth* — Provide legislation that would revoke licenses of tobacco sales for vendors who sell tobacco products to minors.

6. *Advertising* — Eliminate or severely restrict all forms of tobacco product advertising and promotion.

7. *Remove Pre-emption* — Strongly recommend amending or rewriting the Oklahoma Smoking in Public Places Act to remove the preemption clause which prohibits cities and towns from enacting smoking control laws more stringent than current state law.

8. *Smoking in Public Places* — Prohibit smoking in public places and reduce exposure to second-hand smoke which has been designated as a Class A carcinogen by the Environmental Protection Agency.

In addition to the above directives, the Oklahoma State Board of Health supports the efforts of organizations such as the Tobacco-Free Oklahoma Coalition and locally based tobacco control initiatives. Assistance will be provided in the form of data collection and dissemination, support for community-based tobacco use prevention planning, regional education conferences, and tobacco use prevention education and information materials.

PLUTO

In order to guide discussion with county health departments regarding existing flexibility in resource allocation and to provide a basis for inserting a sense of the Board's direction in the application for those federal funds that presently permit state flexibility, the following general policy guidelines are hereby adopted (the general categories are listed in order as ranked by the Board):

Communicable Disease

Population-based interventions such as immunization, outbreak epidemiology and HIV education and surveillance are seen as critical core functions of Public Health. Board policy and resource commitments currently reflect this concern and should be maintained or enhanced. Attention must be given to aggressive surveillance to detect changes in disease transmittal rates, with particular concern for newly resistant bacterial and changing viral strains, which raise the threat of presently controlled or minimized diseases causing wider harm to the public.

Reproductive Health

In the present and prior to the full implementation of universal coverage, the Board recognizes that low numbers of primary care providers in rural areas combined with significant levels of economic distress *require* that the Department of Health maintain the levels of limited primary care now provided to mothers and children. Additional family planning emphasis to prevent unintended pregnancies, especially among teenagers, must be achieved as the most cost effective way to effect the well-being of families and the health of children. Births resulting from unintended pregnancies give rise to a host of other societal costs ranging from clinic care, to nutrition and possible spousal violence and child abuse.

Consumer Protection

The widespread incidence of food borne illness continues to be a problem that engages the public and requires the unique prevention skills of department personnel. Protecting the quality of food and its preparation, including attention to restaurant inspections and food safety, remains an important concern of the Board. The milk program, licensing of hotels and motels, and inspection of swimming pools are other important activities recognized in the PLUTO process.

Child Health

The WIC program should receive close attention with an increased effort to improve participation in the program in underserved urban areas. WIC provides a unique opportunity for integrating services provided to pregnant mothers and babies, with the clear understanding that the benefits of nutritional supplements are only one aspect of achieving good health outcomes for our children in an integrated system of preventive services.

Other areas of child health require careful examination, such as better coordination between the OSDH and community mental health clinics. Psychology, child development, speech and language services, and other interventions with or on behalf of children should consider educational and treatment modalities with a tighter focus on specific problems. Understandable and demonstrated outcomes in the lives of children plagued by violence, family dissolution and poverty would bring greater support from the public for such programs.

Pediatric care, like areas of reproductive health, must be maintained until full-scale health care reform takes place. Traditional child health delivery should examine opportunities in the school setting as a place to integrate health,

mental health and social services for the child and family. Dental health education and dental care are effective preventive programs. More emphasis on fluoridation of community water supplies should be encouraged in collaboration with the Department of Environmental Quality.

Chronic Disease

Chronic diseases are major causes of mortality and morbidity in Oklahoma. Current efforts in cancer and heart disease prevention must continue. The prevention of diabetes, which serves as an underlying factor in many chronic diseases, needs more emphasis. Behavior and lifestyle factors contribute to the third actual cause of death in Oklahoma and the U.S. The behavioral change interventions typical of this are cost effective, as the Board has already indicated in a separate policy statement on tobacco usage. Eldercare must be reviewed separately in the context of changes in the Department of Human Services regulations for Medicaid reimbursement under a newly granted Home and Community Based Service waiver.

Summary

It is the position of the Oklahoma State Board of Health that fewer programs done well are vastly preferred to the gradual diminishment of quality in all areas that will be experienced *if* resources continue to decline. The preceding information forms a factual basis for programmatic reduction or enhancement. The Board recognizes the growing need for collaboration with other health care providers and encourages local health departments to work with hospitals, physicians and other local entities through contracts or other acceptable arrangements to improve the level of services provided. It is the Board's intention to regularly update this information and base its consideration of future policy statements on information understood through this process.

Note: Reactions to this policy statement are welcome and should be provided to the Policy Sub-Committee Chairman Dr. Gordon Deckert. To allay any misinterpretation, however, this

statement does not recommend the elimination or downgrading of any program. Language amendatory to the policy will be considered on a continuing basis. Additionally, this policy did not attempt to address regulatory issues or programs not delivered by local health services. Finally, the Board's perspective is the State of Oklahoma; conditions and perspectives within a given county may differ.

Communicable Disease Control

Background

Infectious diseases have plagued humans since the dawn of civilization. Despite scientific advances over the past 200 years, certain diseases show a propensity to persist and reemerge, e.g. tuberculosis, or a new expression of disease appears, e.g. necrotizing fasciitis caused by Group A streptococcus or Hantavirus infection in the desert Southwest.

The Institute of Medicine in its publication, "The Future of Public Health," described the mission of public health as "fulfilling societies interest in assuring conditions in which people can be healthy." A core public health function toward that end is to regularly and systematically collect, assemble, analyze and disseminate information on the health of the community. Without such assessment and communication, the reemergence of a disease can go relatively unnoticed.

As an example, tuberculosis control is complex. It's mode of transmission places everyone in the community at some degree of risk. Evaluation of suspected cases and contacts who have had direct exposure is often difficult. Societal problems such as homelessness and substance abuse make successful treatment difficult thus giving rise to increased transmission and the potential for the development of drug-resistant organisms. Treatment of active cases often requires directly observed therapy for those at risk for not completing treatment, and even in some cases, confinement.

The Oklahoma Public Health Code addresses disease prevention and control specifically. It is the Board of Health's authority to "adopt rules and regulations... it deems necessary to aid in the prevention and control of communicable diseases" and to establish "a system of reporting of cases of diseases diagnosed or detected by practicing physicians and/or clinical laboratories."

Policy Statement

1. The Department of Health must maintain the resources necessary to carry out its mission and mandate to detect the occurrence of disease.
2. A well trained staff of epidemiologists, nurses, appropriate statistical and computer support is necessary to carry out this mission.
3. It is this agency's particular responsibility to coordinate disease surveillance efforts involving both public and private health care providers.
4. Detection of disease must be accompanied by rapid response to control its occurrence. This includes analysis of data, implementation of prevention and control strategies and evaluation and dissemination of information.
5. Clinical laboratories are an important component of a sensitive surveillance system. State of the art laboratory methods to identify infectious agents and monitor drug resistance patterns must be encouraged. Information must be forwarded to the OSDH rapidly and completely.
6. It is primarily the responsibility of the private sector to identify individual cases or provide treatment. However, with certain diseases or in particular communities or in particular instances of outbreak of communicable disease, health departments must be prepared to step in to contain and control further spread. Again coordination and cooperation with the private sector is encouraged.

Rule Making

Introduction

Anyone familiar with the activities of the State Board of Health knows that much of its time is spent hearing presentations and discussing matters related to a major responsibility: Rulemaking. In some instances, these are massive compendiums seemingly covering every detail of an institution's existence — from its architecture to the quality of its procedures practiced within.

Rulemaking may be the outcome of citizens seeking greater protection, industries seeking reasonability in the face of changing technologies and increasing costs, or legislatures facing demands from all sides writing statutes which cannot and often should not have the detail that would make rulemaking unnecessary. Inevitably, Boards are faced with the constant responsibility to consider and pass judgement on a growing complexity of rules. For this Board of Health, these rules at their core, are intended to protect and promote the health of our fellow Oklahomans.

Unquestionably, the public health regulations have had an extraordinary effect on the health and life span of all of our citizens. Required immunization against communicable deadly disease; standards for insuring the quality of air and water, mandated procedures dealing with sexually transmitted disease; and standards for industries as diverse as restaurants and hospitals; all are principle factors in increasing life expectancy and our capacity to enjoy the years that we live without disability. As an example, procedures to handle tuberculosis virtually eliminated this killer during this century, but with its resurgence we are reminded of the importance of unrelenting enforcement of rules that make it possible to contain this disease.

Since the first State Board of Public Health was created in Massachusetts in 1869, there has been a constant struggle between rulemaking in the

public interest and rulemaking that may intrude upon individual liberty. This tension will always exist. We must find an appropriate balance. Even those most dedicated to regulatory frameworks should stand back occasionally and acknowledge that over-regulation can occur. Over the last twenty years, and with increasing emphasis, deregulation has shown that it can be a valuable tool in decreasing cost and improving the climate for initiative and flexibility, particularly, in the private sector. We must ask, with the people we serve, certain fundamental questions. Will this rule, in fact, have an impact on the health outcomes with which the Board is concerned? Can this rule be written that it can be easily understood? Will this rule simply increase the likelihood of litigation? Will the cost for enforcing this rule be commensurate with the value of the outcome? Does this rule provide sufficient flexibility to permit minimum standards to be exceeded without penalties to the parties involved? Does this rule simply benefit a particular special interest group or does it benefit the public at large?

Sensitive to these concerns, the Board requests through this resolution that the Commissioner establish additional procedures for the preparation and presentation of rules consistent with the Administrative Procedures Act utilizing the criteria listed below. Further, the Board by adoption of these policies commits itself to a process consistent with those criteria that lead to more efficient rulemaking, that focus on the purpose of the Board's authority, the improved health of Oklahomans, but without unduly interfering with the flexibility of commerce or the concept of individual choice so important to our cultural tradition.

Policy Statement

1. Rulemaking shall be presented to the Board from a calendar providing as much advance notice as possible of the likelihood of rule

consideration of a particular type during the year. This calendar shall be presented as information to the Board when the President of the Board considers setting the annual schedule of Board meetings. The calendar should be revised on a regular basis to reflect changes in statute, federal rules, or individual requests that might stimulate additional rule consideration.

2. Presentations shall be scheduled regularly to review the effectiveness and efficiency of existing rules to determine whether the Board, on its own initiative, would wish to modify, suspend, or eliminate unnecessary or ineffective regulations.

3. Members shall be provided with copies of legislation, or some notification of legislative proposals, which could require additional rulemaking in order to permit individual Board members the opportunity for comment and in order for the Board, on its own motion, the opportunity to issue collaborative statements regarding the desirability of additional legal requirements.

4. Each rule presentation shall be introduced by a concise, plain language statement of the circumstances which require the rule, and the manner in which the rule would change those circumstances. If the rule being presented is voluminous, then this statement should be a summary of the most important changes and their collective effect. Of equal importance in this plain language statement is a description of the benefit, and value of that benefit in terms of health outcomes of the proposed rule, and the cost of implementation, if any, both in terms of enforcement and industry compliance. (In some instances, the Board recognizes that these may be very rough estimates that hopefully will be improved as the Department gains experience with the rule.) Most importantly, this summary must state in direct terms how the Department intends to verify the effect of the rule through performance or outcome measures. (A rule with no or little desired result simply contributes to inefficiency and leads to a general disrespect for the rulemaking process itself.)

Public Health Laboratory

Background

The state and territorial Public Health Laboratories collectively constitute an essential component of the national public health infrastructure. Public health programs depend on high quality data which are generated by public health laboratories. State public health laboratories clearly operate with a different mission and purpose than do clinical laboratories. The need for an effective national public health laboratory network is as great or greater today than ever before.

Public health laboratories generate information which is critical for public health activities. The nation's state and territorial public health laboratories play a vital role in disease prevention and represent a first line of defense in the rapid recognition of the spread of communicable diseases. Although the role and responsibilities of public health laboratories may vary by state there are certain core functions, responsibilities and characteristics which are common to all public health laboratories.

The Oklahoma State Board of Health believes that the Public Health Laboratory is an essential service because of characteristics specific to the Public Health Laboratory.

Policy Statement

1. The Public Health Laboratory must provide support for disease control and prevention programs, maternal and child health programs, and epidemiological programs. The Public Health Laboratory must support surveillance activities, outbreak investigation efforts, and helps monitor the emergence of new infectious agents as well as the reemergence of infectious agents of public health importance.
2. The Public Health Laboratory must oversee laboratory quality assurance for County Health Department laboratory operations.

3. The Public Health Laboratory should provide training of laboratory personnel in the private and public sector. All state public health laboratories, in cooperation with the National Laboratory Training Network, are responsible for assessing laboratory training needs and developing training opportunities for the laboratory community.

4. The Public Health Laboratory must keep in step with state of the art technology. The Public Health Laboratory has the responsibility for developing and improving upon methods for testing when those methods are not readily available. The Public Health Laboratory may be called upon to develop practical applications of research methods for routine use in public health monitoring activities.

5. The Public Health Laboratory should provide diagnostic product evaluation for new testing products entering the market place. This comparison data can be used by other government or private laboratories to assist them in selecting the correct test for their specific use. The large volume of specimens tested and the expertise within the laboratory, places the Public Health Laboratory in an excellent position to perform comprehensive laboratory diagnostic product evaluations.

6. The information generated by the public health laboratory is essential for public health analysis and assessment and provides the foundation on which policy decisions are made. Ready access to high quality data for public health purposes represents one of the strongest justifications for the state public health laboratories.

7. The Public Health Laboratory provides unique testing that is necessary to the Public Health Laboratory mission.

Examples:

- low volume
- expensive
- risky from liability standpoint
- controversial
- related to enforcement activities
- supportive of epidemiological studies
- confirmation that is not readily available in the private sector

8. It is essential that the Public Health Laboratory maintain flexibility in responding to changing public health priorities including response to public health emergencies.

9. With the diminished role of federal reference laboratories, it is imperative that state public health laboratory retain its expertise in reference services for the laboratory diagnosis of diseases of public health significance.

10. The Public Health Laboratory plays a pivotal role as a national surveillance link. Through programs like the Public Health Laboratory Information Service (PHLIS), the state Public Health Laboratory serves as a major data link with the Centers for Disease Control and Prevention. Other linkages exist with the Food and Drug Administration.

11. The Public Health Laboratory must provide statewide newborn genetic screening. The surveillance of Oklahoma's large population base allows abnormal results to be identified specific to our population and its definition of normal values.

Chronic Disease

Background

Cardiovascular disease, cancer and diabetes, account for 70% of the mortality, morbidity and disability for Oklahomans. Additional statistics reflect on lost opportunities for sustaining quality of life or lead to sentinel events:

- 25% of women > 50 years have not had a Pap smear within the desired screening frequency and are the most vulnerable group for death and disease
- 73.1% of women > 65 have not had a mammogram and clinical breast exam within the last 2 years, the group with the highest risk for breast cancer
- 36% of Oklahoma women are diagnosed of breast cancer in the earliest stage, whereas nationally some 55% of women are diagnosed in the earliest stage.
- Oklahoma ranks 11th in the nation for cardiovascular disease mortality and loses 770.9 years of productive life annually.
- Stroke mortality reduced 35% in the 70s and 80s, but the decline in public awareness on high blood pressure control has mortality increasing 10% in 1990.
- Oklahoma nationally ranks 10th for lung cancer and 15th for cervical cancer deaths
- Diabetes prevalence is 10% within the state, and of this group, only 50% are aware they have the disease.
- Diabetes health care costs 1.2 billion dollars both directly and indirectly for Oklahoma.

Policy Statement

The Oklahoma Board of Health seeks to reduce the burden of chronic diseases and disabling conditions for Oklahomans. Toward, this end,

the Oklahoma State Department of Health should provide the leadership for policy development, assessment, surveillance and evaluation, quality assurance, and the development of innovative intervention programs.

1. Investigate the problems of chronic disease mortality, incidence and prevalence morbidity, complications, and disability through assessment and surveillance activities, such as the Oklahoma Central Cancer Registry.
2. Mobilize statewide community partnerships which address the burden of the major chronic diseases, identify and solve problems, address care standards in a reformed health care system, and develop policy recommendations.
3. Assure capacity and competence of chronic disease public health professionals.
4. Empower, educate and inform Oklahomans through State-Based Plans for action to Reduce the Burden of Chronic Diseases and which promote positive health beliefs and behaviors.
5. Research and develop innovative solutions, program interventions and/or approaches for chronic disease prevention.
6. Evaluate the effectiveness of solutions, approaches and/or programs developed to address reducing the burden.

Continuum of Care and Assisted Living Policy Paper

Background

Nearly 30,000 people, or almost 1% of the state's total population, live in nursing facilities and residential care homes in Oklahoma. Data from the first half of 1997 show an estimated 26,100 living in nursing facilities and 3,600 in residential care homes. But apart from simple counts of residents,¹ little is known about this segment of Oklahoma's population. Reliable information on the health and disability status of these residents is not yet available, although initial steps have been taken to establish a health assessment system.

On a monthly basis, all nursing facilities report occupancy data to the Oklahoma State Department of Health and the Oklahoma Health Care Authority.² The reports are compiled and published by the Department, and the data can be used to show trends in facility use. For example, Figure 1 illustrates that occupancy in Oklahoma nursing facilities during the five most recent state fiscal years declined by about 2,000 residents, or 8%. The monthly occupancy exceeded 28,000 residents from July 1992 through January 1993. The average number of nursing facility residents dropped below 27,000 in February 1996 and below 26,000 in March 1997. From January 1997 through June 1997, Oklahoma had an average of 26,100 nursing facility residents.³

The occupancy data were originally implemented simply to measure institutional capacity. Given the public health community's interest in reducing morbidity,^{4,5,6} one might be tempted to propose that a shrinking resident census in the context of an expanding elderly population⁷ reflects reduced disability and improved health for Oklahomans. However, the institutional bias of the nursing facility data does not support such a proposition. Other institutional data suggest that the change in resident numbers may be correlated with increases in the availability of alternative care providers. For example, the Department has seen

a 275% increase in Medicare-certified home health agencies since 1992.⁸ During the same time, the average daily census in Medicare-certified hospital-based skilled nursing units increased from 170 patients to 600 patients.⁹ Twenty new hospice providers have been licensed in the last year, bringing the total to more than 70 licensed hospices.¹⁰ Other service coordinators and providers contributing to a decline in nursing facility census might include Eldercare, home-and-community-based programs, and assisted living centers.

Whether Oklahoma citizens moving through these various facilities and services experience a continuum of care is unknown.

Alternative providers alone would not appear to account for all the variation in resident numbers over the last five years. The general decline in occupancy has included a wave-like pattern, with annual troughs centered around June each year, and peaks around October each year. These cycles might correspond to health-related factors, such as outbreaks of influenza or pneumonia; that is, as morbidity increases, nursing facility occupancy increases. Or, the cycles might reflect an inverse relationship; as mortality increases, nursing facility occupancy decreases. Unfortunately, the lack of data about the health of residents precludes the establishment of convincing claims about relationships between changes in the population's health and changes in numbers of residents.

Oklahoma is not alone in having inadequate health data.¹¹ A national effort to address the problem was initiated by Congress for services delivered by Medicare and Medicaid providers.¹²

Medicaid- and Medicare-certified nursing facilities and skilled nursing units in Oklahoma already collect the information for the MDS 2.0, but the collection is not automated so the results cannot be generalized to Oklahoma's population. A pilot test of a computerized

reporting system begins in November 1997, and formal implementation for these facilities may follow as early as March 1998.¹³

Problem Statement

The Continuum of Care and Assisted Living Act became law in Oklahoma on July 1, 1997. It authorizes two new facility types that will expand the scope of care and services currently available for Oklahoma citizens. The first, *assisted living centers*, will serve those who need assistance with personal care and/or who need nursing supervision or intermittent nursing care.¹⁴ The second type, *continuum of care facilities*, will offer nursing facility services and at least one lower level of service: assisted living or adult day care. The intent is to increase a provider's capability to offer a range of services, thereby reducing the need to transfer residents when needs change, but at the same time allow residents to live as autonomously and independently as possible.

A key to ensuring that residents are properly placed in this range of services is the "comprehensive resident screening assessment to measure the needs of and capabilities of residents in all settings."¹⁵ This requires that the Board of Health adopt rules relating to the screening instrument with advice from the Standards Council. The following problems are evident.

- 1 Oklahoma has no baseline data on the health and disability status of residents in nursing facilities and residential care homes.
- 2 The MDS 2.0, a comprehensive assessment instrument, is required only of Medicaid and Medicare-certified nursing providers and is not computerized on a statewide basis at this time.

Board Policy

- 1 Collection of occupancy data for nursing facilities should continue on a monthly basis, and should be extended to continuum of care facilities and assisted living centers

after those providers are licensed in 1998. Such collections also should be extended to residential care homes.

- 2 The resident screening instrument being developed under HB1540 should:
 - 2.1 gather information adequate to assess the level of disability in each resident;
 - 2.2 be administered to determine the resident's level of disability prior to admission and periodically thereafter; and
 - 2.3 be adequate to permit aggregation of data for the purposes of assessing and analyzing levels of disability across all residents in all settings.
- 3 Periodically, the Department should collate, analyze and distribute data collected from the screening instrument. For purposes of planning and assessment, analysis should provide pertinent information toward answering such questions as:
 - 3.1 Are residents appropriately placed or located?
 - 3.2 Do families and/or residents participate in such decisions?
 - 3.3 What array of facilities and services minimize morbidity and mortality and enhance resident satisfaction?
 - 3.4 What continuum of facilities and services is cost effective?

References

- ¹ Resident is used here to mean a person living in a residential care home (Residential Care Act, Title 63 O.S. Supp. 1996 Section 1-820.18) or a person living in a nursing facility (Nursing Home Care Act, Title 63 O.S. Supp. 1996 Section 1- 1902.18).
- 2 The statutory authority for collection of occupancy data is found in 63 O.S. Supp. 1996 Sections 1-851.2.C and 1- 857.4, but it applies only to nursing facilities, skilled nursing units, and specialized nursing facilities

for mentally retarded persons. Residential care homes are not required to file monthly occupancy reports with the Department. However, Department surveyors do count residents each time they visit a residential care home. Survey notations made during the first half of 1997 suggest a 64% occupancy rate in 5,663 licensed residential care beds, yielding an estimate of 3,627 residents.

³ Oklahoma in 1995 had 34,500 nursing facility beds, or 78 beds per 1000 population age 65 and over. The national figure for 1995 was 53:1000. See Strahan, G.W. 1997. "An overview of nursing homes and their current residents: Data from the 1995 national nursing home survey." *Advance data from vital and health statistics*, No. 280. Hyattsville, MD: National Center for Health Statistics.

⁴ See for example Fries, J.F. 1996. "Physical activity, the compression of morbidity, and the health of the elderly." *Journal of the Royal Society of Medicine*, Vol. 89, February 1996, 64- 68; and, Guralnik, J.M. and Schneider, E.L. 1990. "The compression of morbidity: A dream which may come true, someday!" in Lee, P. R. and Estes, C.L., eds. *The nation's health*. Boston: Jones and Bartlett Publishers. Pp. 42-53.

⁵ Reduced health care costs would be one benefit of the compression of morbidity. Annual costs for residential home and nursing facility care in state fiscal year 1998 may exceed \$640 million, based on a daily cost of \$61.05 per day for each of 26,100 nursing facility residents, and \$1000 per month for each of 3,600 residential care home residents.

⁶ A 1964 history of the first 75 years of public health in Oklahoma optimistically projected: "There have been many changes in the disease picture in these 75 years. The most prevalent diseases mentioned in the reports from 1890 to 1930 are malaria, typhoid fever, smallpox, and dysentery of infants. . . .These diseases have been replaced by the so-called chronic diseases: cancer, diabetes, heart diseases. These too, shall be controlled no doubt in the next 75 years." See Darcey, H.J. and Fullerton, E.E. 1964. "Seventy-five years of public health in Oklahoma." Unpublished manuscript. pp. 48-49.

⁷ Oklahoma's population is also older than the nation's. See Oklahoma State Board of Health. January 1997. *The State of the State's Health*. Oklahoma City: Oklahoma State Department of Health. p. 2.

⁸ The Department's Medical Facilities Service reports 384 Medicare-certified home health agencies in July 1997, compared to 102 certified agencies in 1992. An additional 137 agencies are licensed but not certified.

⁹ Health Resources Development Service, Special Health Services, Oklahoma State Department of Health.

¹⁰ Medical Facilities Service, Special Health Services, Oklahoma State Department of Health.

¹¹ See Strahan, G.W. 1997. Interestingly, this report of a national survey of nursing home residents provides no health information: residents are described based on age, gender and race.

¹² See the Social Security Act, Section 1819(f)(6)(A-B) for Medicare and Section 1919(f)(6)(A-B) for Medicaid, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). As a result, the Health Care Financing Administration has released the Minimum Data Set Version 2.0 (MDS 2.0). See Appendix A for the instrument.

¹³ OSDH staff estimates the costs to each facility to be \$3,000 for computer equipment, \$200 for training, plus the cost of employee time.

¹⁴ Existing residential care homes generally are limited to ambulatory residents who do not require skilled nursing care. This is not meant to suggest that staff in residential care homes are unskilled. Skilled nursing care is used here in the sense defined in the Nursing Home Care Act at 63 O.S. Supp. 1996 Section 1-1902.10 to refer to medical or nursing care. Assisted living centers will have more capability than residential care homes to serve residents with limited needs for skilled nursing care.

¹⁵ House Bill 1540, Section 3.A.1.

Community-Based Family Resource & Support Programs

Background

Community-based family resource and support programs are intended to enhance the family's ability to care for itself and produce healthy members. Such programs promote parental competencies and behaviors by expanding a family's capacity to be effective and nurturing. By learning to access a variety of community resources, families utilize their existing skills and acquire new skills. While services are offered to all families, families accept services only on a voluntary basis.

These programs also assist communities to create and/or expand support resources for expectant families and families with children, thereby enhancing their child rearing capabilities and reducing social isolation.

Unintended Pregnancies

- 31% of American women giving births between 1990 and 1995 had an unintended pregnancy (22% mistimed and 9% unwanted). (National Survey of Family Growth, 1995).
- In Oklahoma, 46% of all births and 70% of births to teens within a given year are unintended pregnancies, identified as mistimed and/or unwanted. (Oklahoma PRAMS, 1988-1995)
- 13% of all Oklahoma mothers and 20% living below the Federal Poverty Level and delivering a live birth stated that their pregnancy was unwanted. (Oklahoma PRAMS, 1988-1995)
- The risks of child abuse and neglect, low birth weight, and infant mortality are greater for unplanned children than for those actively planned and welcomed. (Carnegie Task Force, 1994)

Prenatal Care, Pregnancy and Delivery

- Close to one-in-five Oklahoma women (19.3%) gain less than the recommended amount of weight during pregnancy. (Oklahoma PRAMS-Gram, 1996)

- Oklahoma women who gain less than the recommended amount of weight during pregnancy are at greater risk of low birth weight (Oklahoma PRAMS-Gram, 1996)
- For every instance of low-birth weight averted by earlier and more frequent prenatal care, the U.S. health care system saves between \$30,000 and \$143,000 in newborn hospitalization in the first year and in long-term health care. (Carnegie Task Force, 1994)

Infant Mortality

- Oklahoma's Infant Mortality Rate has been worse than the United States' Infant Mortality Rate since 1990. (Oklahoma Vital Records 1996)
- Oklahoma ranked 36th, 14 states and the District of Columbia were worse, in Infant Mortality in 1995 (Oklahoma Vital Records 1996, National Center for Health Statistics 1997).
- Oklahoma had the highest white Infant Mortality Rate in the United States in 1994 and 1995 and Oklahoma's African American Infant Mortality Rate is twice as high as the white Infant Mortality Rate. (Oklahoma Vital Records 1996)
- Infants whose mothers did not receive prenatal care were 3.8 times more likely to die in the first year than infants whose mothers received first trimester prenatal care. (Oklahoma Vital Records 1996)

Maternal Depression

- In Oklahoma 2 out of 3 (67%) of all mothers and 74% of mothers living below the Federal Poverty Level report some level of depression months after their recent delivery. (Oklahoma PRAMS, 1988-1995)
- In Oklahoma, 4% of all recent mothers and 6% of those living below the Federal Poverty Level report the time of their recent pregnancy as the

“worst time in their lives.” (Oklahoma PRAMS, 1988-1995)

- 29% of Oklahoma women delivering a live birth report during their pregnancy was “a moderately difficult time,” a “very difficult time” or the “worst time in their lives.” (Oklahoma PRAMS, 1988-1995)

Teen Mothers

- Two-thirds of Oklahoma women who had their first birth before age 20, live in poverty. (Oklahoma PRAMS, 1988-1995)
- 20% of teen births in Oklahoma in 1996 were teens who have had at least one previous birth and repeat teen mothers are more likely than adults to have low birth weight or short gestational age babies. (Oklahoma Vital Records and Oklahoma PRAMS, 1988-1995)
- Women who first give birth before age 18 and have a subsequent birth are 10 times more likely to NOT complete high school at a later date than first time mothers age 20 or older. (Oklahoma PRAMS, 1988-1995)
- Of teens who give birth, 45% will go on welfare within four years; of unmarried teens who give birth, 73% will be on welfare within four years. (Carnegie Task Force, 1994) Families in Poverty
- Across all ethnic groups and family structures, more children under three live in poverty than do older children, adults or the elderly. (Carnegie Task Force, 1994)
- 60% of all Oklahoma women (77% of African-American women and 79% of Native American women) delivering a live birth between April of 1988-March of 1995 lived below 185% of the Federal Poverty Level. (Oklahoma PRAMS, 1988-1995)
- 44% of Oklahoma women delivering a recent live birth and living below the Federal Poverty Level had an income from a job or business. (Oklahoma PRAMS, 1988-1995)

- 58.6% of Oklahoma two year olds live below the Federal Poverty Level. (Oklahoma TOTS 1995-1996)

Stresses

- Almost 6% of Oklahoma women who live below the Federal Poverty Level were homeless at some time in the year before delivery. (Oklahoma PRAMS, 1988-1995)
- 11% of Oklahoma women who lived below the Federal Poverty Level were physically hurt by their husband or partner in the year before delivery. (Oklahoma PRAMS, 1988-1995)
- 33% of Oklahoma women living below the Federal Poverty Level with a recent birth were divorced or separated from their husband or partner in the 12 months before delivery. (Oklahoma PRAMS, 1988-1995)
- 29% of Oklahoma women living below the Federal Poverty Level with a recent birth had someone very close to them with a drug or alcohol problem in the 12 months before delivery. (Oklahoma PRAMS, 1988-1995)
- 1 in 8 Oklahoma 2 year olds live in a home where their mother was divorced or separated in the last year. (Oklahoma TOTS, 1995-1996)

Child Health

- In Oklahoma, 26% of 2 year old children are not adequately immunized. (Oklahoma State Department of Health)
- 1 in 6 Oklahoma 2 year olds have been diagnosed by their health care provider as being delayed in at least one developmental area. (Oklahoma TOTS 1995-1996)
- 1 in 4 Oklahoma 2 year olds do not always ride in a car/safety seat. (Oklahoma TOTS 1995-1996)
- 18% of Oklahoma 2 year olds live in a home where both parents smoke. (Oklahoma TOTS 1995-1996)

Child Abuse and Neglect

- In Oklahoma, 29 children died as a result of child abuse and neglect in state fiscal year 1996. (Oklahoma Department of Human Services, 1997)
- There were 11,646 confirmed cases of child abuse and neglect in state fiscal year 1996. (Oklahoma Department of Human Services, 1997)
- Of perpetrators in confirmed cases of child abuse and neglect, 47% were biological mothers; 21% were biological fathers; and 6% were step parents; which is a total of 74% of all confirmed cases. (Oklahoma Department of Human Services, 1997)
- Child maltreatment most often happens in a child's own family. (Oklahoma State Department of Health, 1996)
- 48% of mothers of abused children were abused themselves and 74% percent of batterers (domestic violence) were abused as children. (Douglas, et al, 1994)
- Among American women whose first sexual intercourse was before the age of 15, 16% was involuntary and 20% of all American women had at least one experience with involuntary sexual intercourse. (National Survey of Family Growth, 1995)
- Childhood maltreatment increases the risk for arrest for violent crimes in adulthood (Douglas, et al, 1994)
- Witnessing violence in childhood increases the risk of adulthood violence. (Douglas, et al, 1994)
- The future lost productivity of severely abused children is \$658 million to \$1.3 billion, if their impairments limit their potential earnings by only five to ten percent. (U.S. Advisory Board on Child Abuse and Neglect, 1995)
- Children raised in abusive and neglectful homes are high risk for developmental delays, school-related problems, and physical and emotional problems throughout their lives. (Carnegie Task Force, 1994)

- When considering the combined factors of child deaths, child abuse and neglect, teen suicide, females and males incarcerated per capita, children in poverty and divorces—Oklahoma ranks in the top ten of the 50 states. (Douglas, et al, 1994)

Expected Outcomes With Intervention

Based on the research findings of Dr. David Olds from the Prenatal and Early Childhood Nurse Home Visitation Program implemented in Elmira, New York, Memphis, Tennessee, and Denver, Colorado; Dr. Deborah Daro's research findings from the Hawaii Healthy Start Program and Healthy Families America sites in Indiana, Arizona and Virginia; and, the Family Resource Coalition Best Practices Research, as well as other researchers, the expected outcomes of community-based family resource and support programs are as follows:

Short-Term Outcomes

- pregnant women are more likely to maintain regular prenatal health care visits
- pregnant women will be more likely to know the effects of smoking on the fetus and reduce smoking behaviors
- pregnant women will have improved diets during pregnancy
- pregnant women will have fewer kidney infections during pregnancy
- pregnant women will have fewer hypertensive disorders
- women will deliver fewer pre-term babies
- women will deliver fewer low birth-weight babies
- mothers will be more likely to breast feed their infants
- mothers are more likely to have a greater sense of control in their lives

- parents are more likely to have appropriate parent-child interaction
- parents will be more likely to have greater knowledge of appropriate parenting practices and attitudes such as empathy, parenting roles differing from child roles, and child development
- parents will use appropriate methods of child guidance and discipline
- parents will be more likely to provide an appropriate home environment for their children
- parents will provide a home environment with fewer health and safety hazards
- parents will be more likely to utilize community resources
- mothers will be less likely to have further unintended pregnancies
- children will be less likely to receive unintended/intended injuries
- children will have fewer emergency hospital visits
- children will have fewer hospitalizations for injuries and ingestions
- children will be more likely to receive immunizations
- children needing developmental intervention will be more likely to be identified earlier

Long-term Outcomes

- parents will have higher employment rates
- parents will have increased use of formal and informal social support systems
- there will be a reduction in the use of public welfare programs by parents
- parents will be less likely to be involved in criminal behavior over time

- children will be less likely to be involved in delinquent behavior over time
- healthier children over time
- children entering school better prepared

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Policy Statement

The Oklahoma State Board of Health concludes that community-based, family resource and support programs must be enhanced in Oklahoma. The evidence is overwhelming and appropriate interventions have demonstrated positive outcomes.

The Oklahoma State Board of Health asserts that community-based, family resource and support programs should be based on the following assumptions:

1. Families are our primary social unit. They offer the best source for health, growth and development for family members.
2. Families should be capable of assuming responsibility for their own healthy functioning.
3. Families are the building blocks of the larger community in which they live. Families are strengthened by interacting with their community. The community, in turn, is strengthened by such interaction.

The Oklahoma State Board of Health supports the following quality assurance standards for community-based family resource and support programs:

1. Services are offered to and accepted by families on a voluntary basis.
2. Services are prevention-oriented, child-centered, family-focused and community-based.
3. Services are offered at the earliest possible point, namely, when the family is formed.
4. Since resources in a community are limited, priority should be given to providing services to first-time parents and parents of newborns identified as having present such risk factors as poverty, limited social support, limited health

care, a special needs child, a history of family violence, a history of substance abuse, or a history of mental illness.

5. Programs should promote the availability of community-based family resource and support services and ensure that all family members are aware of how they may participate in such services.
6. Programs provide a comprehensive array of services utilizing qualified staff to address the needs of children and families throughout the stages of the family life cycle including home-based, agency-based and community-based parent education and support services.
7. Provision of services must be based on a standard of nondiscrimination, recognizing and respecting the ethnic, cultural and linguistic diversity of families.
8. Planning, implementation and evaluation of program services are in partnership with families.
9. Programs should emphasize effective interagency cooperation and public/private collaborations within communities.

The Oklahoma State Board of Health requires that evaluation of the effectiveness of community-based family resource and support programs be conducted by the Oklahoma State Department of Health. The Oklahoma State Department of Health will take responsibility for identifying model programs for this purpose. Evaluation data will be appropriately analyzed and disseminated. Further, lessons learned from evaluation efforts will be used to identify areas of strength on which to continue to build, targeted areas for improvement and areas to be discontinued.

Evaluation of model programs will include the following:

1. Assessment of the operation and activities of family support services;
2. Utilization of a systematic method of reporting program outputs including the reporting of client demographics, staffing patterns, number of

services provided, number of families served and number of children served;

3. Utilization of a systematic method of assessing the family's satisfaction with services;
4. Identification of program impacts relative to outcomes;
5. Examination of associated dollar costs, particularly in relation to outputs (cost-efficiency) and impact (cost-effectiveness).

Injury Prevention

The State Board of Health's policy for addressing injury prevention in Oklahoma shall be:

- The Injury Prevention Service will monitor and report the incidence of hospitalized and fatal traumatic brain injuries, traumatic spinal cord injuries, burns, and submersions in the state, as well as monitor and address emerging injury issues and potential threats to the public's safety. The Commissioner of Health will mandate hospitalized and fatal suicide attempts as reportable for special study during 1999-2001. The Injury Prevention Service will continue to maintain and make available county-specific injury morbidity and mortality data.
- The Injury Prevention Service will also be responsible for developing, implementing, and evaluating appropriate community-based injury prevention programs based on surveillance data which will be utilized to determine priorities for injury prevention programs in Oklahoma. These programs may include smoke detector, bicycle helmet, and car seat programs as well as programs designed to prevent submersions, falls, and suicides.
- The Injury Prevention Service in collaboration with the Maternal and Child Health Service will develop and implement a statewide educational campaign to:
 1. educate parents of the risks associated with having firearms accessible in the home; and
 2. emphasize to physicians and other health providers the importance of screening families with children regarding access to firearms, drugs, or other lethal methods.
- In collaboration with the Oklahoma Department of Mental Health and Substance

Abuse Services, the Oklahoma State Department of Health will:

1. establish an Ad Hoc Committee charged with creating recommendations and guidelines for developing community suicide prevention plans; and
 2. develop and implement a suicide prevention/ intervention/postvention train-the-trainer program, especially targeting adolescents.
- The Oklahoma Legislature will be asked to make funding available to provide education and injury prevention products (car seats, bicycle helmets, smoke alarms) to high-risk families (i.e., county health department clients).
 - In conjunction with the Oklahoma Department of Education, elementary schools throughout the states will be encouraged to implement the Oklahoma Elementary School Injury Prevention Education: The Subject-Integrated Safety Curriculum for Teachers. The Injury Prevention Service will maintain an up-to-date library of national and state injury prevention educational and research materials. Age-appropriate injury prevention counseling will be provided through county health departments, especially in existing clinics and programs.
 - In collaboration with other public and private agencies, the adoption and enforcement of injury prevention laws should be encouraged. Potential laws include:
 1. graduated licensure of motor vehicle drivers to allow more on-the-road practice for beginning drivers;
 2. enacting a bicycle helmet law requiring riders less than 16 years of age to wear helmets;

3. lowering the blood alcohol concentration that can be admitted as prima facie evidence that a driver is under the influence of alcohol from 0.10% to 0.08% and increasing fines and penalties for violations of alcohol laws;
 4. enacting legislation requiring four-sided fencing around public and private swimming pools; and
 5. revising the current motorcycle legislation to require all motorcyclists to wear helmets.
- Injury prevention activities, to date, have been funded by federal grants. In order to carry out this policy, core funding for surveillance, interventions, and prevention education must be obtained from more reliable non-federal sources.

Trauma Systems

The State Board of Health's policy for developing trauma systems in Oklahoma shall be:

- The OSDH will seek funds to train all Emergency Medical Service providers statewide regarding standardized triage and transport guidelines.
- The OSDH will assist in developing a State Trauma Care System Plan which outlines the goals and implementation of a formal trauma system.
- The OSDH will support the statewide implementation of enhanced 9-1-1 emergency services.
- The OSDH will support phasing in mandatory reporting to a statewide trauma registry and will train hospital personnel on collecting data. The trauma registry will allow for linking traffic data, criminal justice data, and mortality data.
- Obtain state funding for the ongoing administration of statewide trauma systems development in Oklahoma.

Background for Injury Control and Trauma Systems

Injuries are the leading killer of Oklahoma's children from 1 year of age through the teen years. From 1990-1994, injuries accounted for 56 percent of all deaths to children 1-14 years of age, and 84 percent of all deaths among adolescents 15-19 years of age. After the first year of life, more children die from injuries than all other causes of death combined.

Overall, injuries are the third leading cause of death in Oklahoma, following heart disease and cancer, accounting for more than 2,000 deaths each year. Among teens, the leading causes of all deaths are traffic crashes (45%), suicide (14%), homicide (13%), and drownings (3%).

The leading causes of injury death are traffic crashes, suicides, homicides, falls, and fire/burns and the costs of hospitalization, lost work and productivity, lives lost, and disabilities due to injuries, total \$1.5 billion annually in Oklahoma. From 1990-1995, Oklahoma's death rates due to traffic injuries, drownings, falls, fire/burns, and suicide were higher than national rates.

More than 3,200 persons in Oklahoma are either hospitalized or die each year as a result of a traumatic brain injury (TBI). Approximately 1,000 of these injuries occur among children. Nonfatal injuries and their associated disabilities and long-term costs among this population are substantial, as many children require lifelong care and medical attention. Young survivors of severe TBI may live 40-50 years, and the lifetime costs associated with the most severe injuries may exceed \$4 million per patient. In Oklahoma, a substantial portion of medical costs associated with head injuries are paid by public tax dollars.

Many people think injuries are unavoidable chance happenings. In reality, injuries, like disease, occur in highly predictable patterns. While the circumstances leading to an injury, such as a motor vehicle crash, may not be avoidable, the injuries sustained in that crash can often be prevented or lessened by wearing seat belts or having airbags in the vehicle. Wearing bicycle and motorcycle helmets, installing smoke alarms in residences, and constructing four-sided fences around swimming pools are examples of other proven effective injury prevention strategies.

Preventing injury requires a combination of strategies including education and behavior change, legislation and enforcement, and engineering and technology. Although there are effective methods to prevent injuries, Oklahomans don't always use them. Less than 40% of motor vehicle occupants in Oklahoma wear seat belts. Approximately 45% of children less than 6 years of age are properly restrained in

a car seat, including only 51% of infants. Driving while drinking continues to be a contributing factor to motor vehicle crashes. Forty-two percent of persons 14 years of age and older who died in motor vehicle crashes tested positive for blood alcohol. Only 32% of the persons involved in motorcycle crashes wear helmets. This less-than-popular use of helmets is costly. In 1994, acute hospitalization charges for motorcycle crash injuries were more than \$4.5 million.

Oklahoma has made progress in increasing safety behavior through public education campaigns. Reported bicycle helmet use among children is now 25%. Helmet use in 1992 was only 6% prior to widespread implementation of bicycle helmet programs developed by the Injury Prevention Service. Studies show, however, that legislation, combined with public education and enforcement, is the most effective means to increase safety behavior. Some citizens oppose legislation that mandates safety behavior. They question where the public harm is if a citizen's behavior affects only him- or herself. One answer to this question has come from the states' highest courts who have said the cost of injuries is borne by the entire society, not just individuals and their families.

Another primary reason for Oklahoma's unusually high injury death rate is the lack of a comprehensive, statewide trauma care system. In Oklahoma, 350-400 persons die annually from a preventable death partly due to delays of four or more hours in receiving appropriate treatment. These are persons who suffer from major trauma from motor vehicle crashes, gunshot wounds, stabbings, etc. For patients whose injuries are "time sensitive," meaning they must receive definitive care as rapidly as possible, any delay increases the probability of death or permanent disability. Based on models from other states, Oklahoma could significantly reduce the number of preventable trauma fatalities and lifelong disabilities with a properly planned and coordinated trauma care system. Subsequently, the overall costs to society will decrease as fewer persons are injured and many of those injured and their families no longer must seek

public assistance due to continuous institutional care or permanent disability.

A trauma care system improves the chances of patient survivability and subsequent functional independence by optimizing the management of the injury patient throughout the continuum of care; system components include injury prevention, system access (9-1-1), pre-hospital care, acute emergency and surgical care, and rehabilitation.

The mission of the Oklahoma State Department of Health is to reduce both human suffering and economic loss to society resulting from premature death and disability due to injury in the State of Oklahoma. The OSDH intends to plan, develop, and implement a comprehensive, coordinated system of care that includes prevention, pre-hospital, acute and rehabilitative care, and community re-entry, thereby enabling injured persons to achieve their maximum level of productivity.

School Health

Background

Oklahoma ranks above the national average in serious health risk indicators for children and adolescents in the following areas: injuries, tobacco usage, alcohol abuse, substance abuse, teen pregnancy, child death, and violent deaths to teens. Additional areas of concern are poverty rate 21.7% (1:4 children in poverty), increased low birthweight (prematurity affects growth and maturity for school), increase in abuse and neglect, increase in juvenile arrest, poor nutrition habits, inadequate diets and lack of physical activity.

Over 23 percent of the children and adolescents (18 and younger) are uninsured. Thus, almost one out of every 4 young people have very limited access to health care. Increasing numbers of students come to school each day with a variety of physical, emotional and social health problems that impede their capacity to learn. At the same time, the number of school health providers has declined as a result of local school district budget cuts.

Few, if any, school districts have a sequential health education program for grades K-12, far below the 75 percent goal of Healthy Oklahomans 2000. Health services that are either school-linked or school-based are infrequent in our state. The health of those learning and working at school is vital to the educational process. Students and teachers that do not feel safe because of a violent atmosphere cannot conduct the business of education. The health of students, and the adults they become, is critically linked to the health-related behaviors they choose to adopt.

Policy Statement

- School health services, health education, and healthy school environments, which are based on local planning and community delivery, will be promoted, developed, and evaluated.
- The Oklahoma State Department of Health will collaborate with the Department of Education and local school districts. OSDH will work in

partnership with schools and community organizations to identify the needs of the school-age population, provide health education and health promotion programs (K-12), facilitate school-linked health services, maintain healthy school environments, and develop integrated service systems that are community-based and school-linked by utilization of a multidisciplinary health education team approach.

- The Oklahoma State Department of Health will work in collaboration with local school districts to collect timely, accurate health data for the school-age population in Oklahoma. Baseline data will be provided to monitor the health status, the health risk behaviors, and the effectiveness of health services for children and adolescents. Local surveys, such as the Youth Risk Behavior Survey (YRBS) and other age appropriate surveys will be administered to students to collect this data. Linkages with community resources for program development and implementation will be made available.
- The Oklahoma State Department of Health will provide leadership and technical assistance in implementing a statewide plan of improving the health and educational outcomes of our children/students.

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School Health Update

In 1996, the 1st Grade Survey was implemented. In February 1997, an initial draft of a school health manual and plan was completed and a multidisciplinary school health committee was formed. In June 1997, Judy Igoe, Office of School Health, University of Colorado, provided technical assistance to Oklahoma State Department of Health, School Health Committee. In July of 1997, two MCH Pediatric staff attended a Leadership Training in School Health conducted by the University of Colorado. In August of 1997, the Office of School Health was established within the OSDH.

Two school-based health centers have been developed in the Oklahoma City School District. These are primary and preventive care clinics. Because of their successfulness, other community groups assumed the responsibility for these clinics in January 1998.

The Oklahoma County Medical Society, Oklahoma City Public School District, Oklahoma City-County Health Department and the Oklahoma State Department of Health have initiated a comprehensive school health program in 8 elementary schools for the 1997-98 school year. The Schools for Healthy Lifestyles program is modeled after the Louisville, KY Health Promotion Schools of Excellence program. Future plans call for possible replication of the model in other urban school districts.

Breastfeeding

Background

Breastfeeding is unequalled as a way of providing food for the health, growth, and development of infants. Human milk is uniquely superior for infant feeding and is species specific. Breastfeeding and the use of human milk for infant feeding offers distinct advantages to infants, mothers, families and society. The nutritional and immunologic components of human milk and the physiological, psychosocial, hygienic and economic benefits of breastfeeding make it the optimal way to nurture infants.^{1,2}

Human milk contains the ideal balance and form of nutrients for infants, and breastfeeding affords a unique occasion for mother-infant interaction and bonding.³

Human milk feeding decreases the incidence and/or severity of diarrhea,⁴⁻⁸ lower respiratory infections,⁹⁻¹² otitis media,^{6, 13-17} urinary tract infection¹⁸ and necrotizing enterocolitis.¹⁹⁻²⁰ Positive protective effects of human milk feeding have been demonstrated in relation to sudden infant death syndrome,²¹⁻²² insulin-dependent diabetes mellitus,²³⁻²⁵ Crohn's disease,²⁶⁻²⁷ ulcerative colitis,²⁷ lymphoma,²⁸⁻²⁹ allergic diseases,³⁰⁻³² and other chronic digestive disorders. Breastfeeding has also been related to possible enhancement of cognitive development.³³⁻³⁴

Breastfeeding can enhance a mother's self-esteem³⁵ and facilitate her physiologic return to the pre-pregnant state by increasing levels of oxytocin, resulting in less post-partum bleeding and more rapid uterine involution.³⁶ Recent research demonstrates that lactating women have an earlier return to pre-pregnant weight,³⁷ improved post-partum bone remineralization³⁸ with reduction in hip fractures in the post-menopausal period,³⁹ reduced risk of ovarian cancer⁴⁰ and pre-menopausal breast cancer.⁴¹ Although not considered a form of birth control, exclusive breastfeeding results in delayed resumption of ovulation with increased child spacing.⁴²⁻⁴⁴

Beyond these positive health benefits, breastfeeding offers social and economic benefits to families, society and the nation. Use of human milk decreases infant formula expenditures, minimizes health care costs by improving health and decreasing morbidity in the pediatric population, and reduces employee absenteeism for care attributable to child illness.⁴⁵⁻⁴⁷

Problem

Numerous barriers to breastfeeding have been identified.⁴⁸⁻⁵⁷

- Lack of awareness and acceptance of the benefits of breastfeeding among health care professionals and the population in general.
- Lack of consistent and accurate information about breastfeeding.
- Hospital practices which are oriented toward bottle feeding.
- Lack of a support network during the critical postpartum period.
- Psychosocial barriers including misconceptions, negative attitudes, low self-esteem, and lack of flexibility in the work place.
- Cultural barriers including sexual connotations associated with the breast and/or lack of role models or family support.
- Formula advertising and the display and distribution of infant formula by health professionals and in hospitals and public health programs.

Despite these and other barriers to breastfeeding, the incidence and duration of breastfeeding can be increased by enhancing factors that encourage breastfeeding.

Many major professional organizations including the American Academy of Pediatrics, the American

Dietetic Association, the American College of Obstetrics and Gynecology, and the National Association of Pediatric Nurse Associates and Practitioners etc.,^{48, 58-62} acknowledge breastfeeding as the preferred method of infant feeding. The United States Department of Health and Human Services has identified breastfeeding as one of the goals of Healthy People 2000. The target is to increase to at least 75% the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50% the proportion who continue breastfeeding until their babies are 5 to 6 months old.⁶³ To work toward these goals, it is recommended that the Oklahoma State Board of Health serve as an advocate for breastfeeding. The State Board of Health's support will help ensure that women have the ability to make informed decisions about infant feeding.

Policy Statement

The Oklahoma State Board of Health identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as fundamental in achieving optimal infant and child health, growth, and development. Therefore, the Oklahoma State Board of Health encourages activities that promote, protect and support breastfeeding and the health of all Oklahoma children.

It is the policy of the Oklahoma State Board of Health that:

- Breastfeeding be integrated into the spectrum of health care.
- Parents be provided complete current information on the benefits of breastfeeding which allows them to make an informed choice regarding a method of infant feeding.
- All pregnant women be encouraged to breastfeed unless contraindicated for medical reasons.
- Breastfeeding be recommended for at least 12 months and thereafter for as long as desired.
- Exclusive breastfeeding be encouraged for approximately the first 6 months after birth and

iron enriched solid foods complement breast milk during the second half of the first year.

- Health care professionals receive adequate basic and continuing theoretical and practical training in breastfeeding.
- Public health professionals identify and reduce barriers to breastfeeding that may exist within communities.
- Health care settings and public health clinics strive to create a positive, supportive environment to encourage breastfeeding as the preferred method of infant feeding.

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Newborn Metabolic Disorder Screening Program

Oklahoma's comprehensive Newborn Metabolic Disorder Screening Program (NMDSP) is an essential public health program that provides universal screening to assure all newborns are appropriately screened and receive treatment for preventable causes of mental retardation and disability (universal defined as all infants are screened regardless of ability to pay).

This highly effective preventive health program currently screens for phenylketonuria (PKU), congenital hypothyroidism, galactosemia, and sickle cell disease. To ensure the integrity of this program, the Board of Health presents this policy statement as an expansion of the Public Health Laboratory Policy Statement issued on February 8, 1996. To ensure Oklahoma maintains an adaptable preventive health program, this statement provides guidance to address advances in genetic technology that promise to provide challenging new opportunities for public health newborn screening programs. The policy statement precedes detailed background information that provides an overview of comprehensive services.

Policy Statement

- The NMDSP will assure that no child is denied testing because of inability to pay.
- The NMDSP will collaborate to assure that affected infants have access to specialized clinical services and required treatment.
- The NMDSP shall implement the State Board of Health (SBH) Rules and Regulations to monitor and provide quality assurance parameters that delineate the responsibility of the health care providers, parents, hospitals, laboratories, state screening program, medical, and community support services to ensure accurate, timely screening and treatment, with referral and follow-up of affected newborns.

- The NMDSP should systematically evaluate new technology to determine if mass screening is suitable, and if such screening provides treatment opportunities that might not be available without screening, and that such treatment will prevent mental retardation, and/or reduce infant morbidity and mortality.
- Newborn screening for additional disorders must be integrated into the existing NMDSP. A pilot program for development and evaluation will be performed prior to formal implementation, and education will be provided for parents and health care providers.

Background

The Newborn Metabolic Disorder Screening Rules and Regulations (revised 1998) are established under Public Health Code 63 O.S., 1981, Sections 1-533 and 1-534. The codes authorize the State Board of Health to set up laboratory facilities and educate providers regarding "Phenylketonuria and related inborn errors of metabolic disorders." The SBH shall mandate testing "if sufficient evidence exists that the public has been negligent in accepting such practice and if the Board considers it in the public interest to do so." It also states that "no child shall be denied such laboratory work or tests because of inability to pay." The SBH currently requires screening for phenylketonuria (PKU), congenital hypothyroidism, galactosemia, and sickle cell disease.

The NMDSP is a collaborative program between the Maternal and Child Health Service and the Public Health Laboratory Service. Its mission is to prevent developmental disability by providing a mechanism for the early detection and treatment of affected infants with congenital hypothyroidism, galactosemia, phenylketonuria (PKU) and sickle cell disease.

To ensure all affected newborns receive effective treatment, the Newborn Metabolic Disorder Screening Rules and Regulations, revised 1998, state “for appropriate comprehensive medical care, all confirmed cases of congenital hypothyroidism, galactosemia, phenylketonuria, and sickle cell disease should have a consult or referral to a pediatric sub-specialist.” The rules define pediatric sub-specialist as “a physician licensed in Oklahoma, board certified in pediatrics and board certified in a pediatric sub-specialty of pediatric endocrinology or pediatric hematology; or a physician licensed in Oklahoma, board certified in pediatrics whose primary area of practice is pediatric endocrinology, pediatric hematology or metabolic specialist.” The NMDSP collaborates with specialists, primary care providers and Children with Special Health Care Needs (CSHCN), part of the Title V MCH Block Grant, to ensure optimal comprehensive services are available to all affected infants (regardless of ability to pay/insurance status).

In 1989, a newborn screened by another state without comprehensive follow-up services was identified with an abnormal screen for PKU. The child was not diagnosed with PKU until six years of age, and unfortunately suffered irreversible mental retardation. Without the NMDSP comprehensive follow-up services an Oklahoma infant could be missed. In Oklahoma, abnormal results are followed aggressively in a collaborative effort between the provider, parent, and NMDSP until a normal repeat is received or diagnosis with treatment date. In 1996, all infants with abnormal screen results were followed up except 2% that were lost to follow-up.

In 1998, the NMDS section of the Public Health Laboratory Service performed 53,177 screens for Oklahoma’s 49,354 newborns. Immediate follow-up of 2,660 abnormal screening results assured prompt diagnosis and treatment for 45 affected infants. The fee charged for the blood collection kit partially supports the activities of the NMDS section of the state laboratory. The

cost per kit is \$10.50. The cost of our collaborative program of laboratory testing, follow-up services, and subsidy for comprehensive clinic programs is \$1,191,904 per year. The following provides an overview of program services for affected newborns:

Overview of Program Services

Using PKU as an example, the benefits of newborn metabolic disease screening by the Public Health Laboratory Service and comprehensive follow-up services by Maternal and Child Health Service, the Oklahoma State Department of Health Newborn Metabolic Disorder Screening Program (NMDSP) has been screening for PKU since 1963 and has prevented mental retardation through early detection and treatment for 56 known affected Oklahoma infants. Prior to 1963, newborns were not screened for PKU. Untreated PKU results in profound mental retardation. Today the cost to institutionalize one affected untreated child for 10 years is a staggering \$1,129,750.

Metabolic Services for Phenylketonuria (PKU) and Galactosemia: CSHCN subsidizes two regional clinics. The State Metabolic Coordinator and a metabolic specialist staff the clinics. The State Metabolic Coordinator monitors and tracks all referred infants and identified clients with PKU to ensure access to comprehensive medical care is maintained. Assistance with treatment is provided through CSHCN and Title V. The medical food to treat PKU is expensive and is not covered by most insurance plans. Low-phenylalanine formula and amino acid bars are provided to all affected children until 21 years of age. Low-phenylalanine formula is provided for affected women who desire to become pregnant. The state coordinator and NMDSP participate in the PKU Parent Support Group and PKU Task Force. The PKU Task Force was established in 1997 to advocate for the specialized needs of affected families.

Congenital Hypothyroidism: Parents and providers are notified of a medical specialist in their area. NMDSP collaborates with endocrinologist and providers to ensure appropriate referral and treatment are received.

Sickle Cell Disease: CSHCN subsidizes two regional clinics. Each clinic provides a team approach to maximize services. Staff includes the State Sickle Cell Nurse Coordinator, social worker, and pediatric hematologist. Monitoring and tracking services are provided to ensure that access to comprehensive medical care is maintained for each referred infant. The program has been beneficial in providing medical care and educational resources for the primary care provider and ensuring that affected newborns and their families receive coordinated primary and specialty care necessary for health promotion and prevention of secondary disabilities. Additional support and community services are offered in collaboration with the Sickle Cell Disease Association of America, Oklahoma Chapter.

Oklahoma Genetics Advisory Council (OGAC): The OGAC was established to advise the Commissioner of Health. OGAC is a diverse council that provides a forum to address the complex issues of genetics. To address newborn screening issues and to ensure Oklahoma maintains a program of excellence, OGAC has established the Newborn Screening Programs and Pediatrics Committee.

Community and Support Group Activities: affected families receive information regarding specialist in their area, and local and national parent support group activities.

In summary, newborn metabolic disorder screening is more than just a Public Health Laboratory Service activity; it is a highly effective, comprehensive preventive public health program, that includes universal screening, evaluation, education, follow-up, quality assurance, tracking of abnormal screens and affected infants, and oversight components.

The NMDSP communicates with parents, health care providers, birth hospitals, and treatment specialists to ensure all infants are adequately screened and affected infants identified, placed on treatment, and referred for comprehensive services in a timely manner. Families are notified of the national support group. The NMDSP interventions to ensure repeat testing are obtained is in addition to the responsibility of the health care provider, and does not relinquish the health care provider from their responsibility in follow-up. To ensure optimal comprehensive medical services are available for affected newborns regardless of insurance status or ability to pay, the NMDSP collaborates with health care providers, specialists, and parents. NMDSP quality assurance measures include educational programs, provider reporting and referral requirements, and annual reporting by established clinics on referred infants' health status.

Principles of Organization for the Department of Health

The Department of Health is responsible for an array of services aimed to prevent disease and injury, promote health and assure conditions by which people can be healthy. Some services are statutorily mandated to be available to every person in the State.

1. Central and Local organizational structure within OSDH should be such that it enhances programs that are implemented at the Local Level.
2. Local Health Departments should be organized to facilitate integration and delivery of preventive health services. Organizational structure should enhance the delivery of quality services delivered in the most effective and cost conserving manner. Since Local Health resources and priorities can vary from county to county, structures may differ somewhat. Local Health Departments are encouraged to implement a system of total quality management involving all levels of local staff in understanding and utilizing programmatic guidelines for the purpose of improving the delivery of services.
3. There are public health priorities that transcend local delivery units. Central Office organization must take these programs into consideration so that equity and quality are consistent across the state. Therefore, ordinarily, Local Health Services within the Agency should not have such programmatic responsibility, but other services within the Agency who do have such programmatic responsibilities should not have direct lines of authority to the Local Health Departments. Therefore, it is imperative that Local Health Services and the programmatic areas develop partnerships which allow them to share responsibility for the management of programs in the Local Health Departments.
4. Regulatory Programs that assure services by which people can be healthy must necessarily be centralized to have uniform training, guidelines and inspection procedures.
5. Some programs require centralization to maintain a master data file, such as vital records.
6. Highly technical services, such as the Public Health Laboratory and data management are best concentrated at the central site to facilitate quality control and efficiency.
7. A central intake and accounting system is best suited for tracking and maintaining complete financial, purchasing and grants management.

HIV/AIDS

Background

Title 63 section 534.1 of the Oklahoma Statutes states that “the Oklahoma State Department of Health shall be the lead agency for the coordination of programs and services related to the Human Immunodeficiency Virus (HIV).” The State Board of Health recognizes the responsibility of the Oklahoma State Department of Health to provide primary leadership to effectively intervene in the course of the HIV epidemic. The Board of Health is first and foremost an advocate for the public’s health. Current epidemiologic data indicates that the elements of a potentially expanding epidemic are present in this state. Therefore, all involved agencies of government and private organizations must work together to mobilize an effective response to this urgent public health concern.

Policy Statement

The State Board of Health’s policy for addressing the HIV/AIDS epidemic is that the Department will:

1. Monitor and report the progression of HIV infection and AIDS.
2. Create and continually update an inventory of available resources from comprehensive assessments of need.
3. Develop, modify, and continue to support programs to educate the public in general.
4. Act jointly with the Department of Education to establish a consistent, age appropriate HIV/STD prevention component within a comprehensive school health program in all Oklahoma school districts. Until a vaccine or cure can be developed, education and prevention is the only hope for altering the course of this epidemic.
5. Develop, modify, and continue to support culturally specific programs for populations engaging in risk behaviors.
6. Develop, expand, and continue to support the availability of Partner Counseling, Testing, and Referral (PCRS) and Health, Education and Risk Reduction (HERR) services statewide at selected confidential/anonymous community-based organizations.
7. Act jointly with the Department of Human Services, Department of Corrections, Department of Mental Health and Substance Abuse Services, and other appropriate governmental and non-governmental agencies to improve and expand prevention programs, treatment options and services to ensure that appropriate care is available statewide.
8. Develop and modify appropriate guidelines for health care workers and assist in their education.
9. Work with other agencies, health care institutions, community leaders, and consumers in planning and developing treatment and support services for low-income persons with HIV infection.
10. Provide leadership and direction to public agencies, health professionals, community-based organizations and concerned citizens to encourage and ensure effective programs to combat HIV/STDs.

Teen Pregnancy

Background

In Oklahoma 57 of our 77 counties have a teen birthrate higher than the national average; two-thirds of these pregnancies are unintended. The economic impact of teen pregnancies is a source of growing public alarm. Oklahoma mothers with recent births who had their first child at 17 or younger are at least ten times more at risk for not finishing high school by age 18 compared to women who have their first child after age 19. Teen mothers earn about half the lifetime income of women who first gave birth in their 20's or later. For every tax dollar spent on families begun by teenagers, Oklahoma presently spends only one cent on primary prevention of teen pregnancy.

The Oklahoma State Department of Health, in an effort to reduce teen pregnancy, provides prevention education training, youth development programs, and technical assistance to communities across the state. Currently there are fourteen (14) community-based programs, funded through OSDH, that implement strategies that have been shown to be scientifically proven to be effective in reducing teen pregnancy. These projects provide: programs for youth that seek to change the knowledge, skills, attitudes and behavioral intentions related to teen pregnancy prevention; community education for adults and/or parents of adolescents advocacy for community efforts; and are being evaluated for their effectiveness. They reach young people, both males and females, with information that has proven useful in providing positive incentives to avoid adolescent sexual activity. Additionally, there are six (6) Abstinence Only Education projects, which provide primarily school-based abstinence only education programs to adolescents.

Historically, the Department of Health has emphasized abstinence as the most effective method of preventing teen pregnancy and

sexually transmitted diseases. The present facts are clear that many teenagers are sexually active and are at risk. For those teens, public health must provide readily accessible family planning services, which include education, counseling and contraceptives.

In addition to emphasizing abstinence as the most effective method of preventing teen pregnancy, the Oklahoma State Department of Health believes that parents should be the primary sexuality educators of their children. Partnering with faith communities and other groups has been successful in increasing the education skills of parents.

Adolescent sexual behavior and teen pregnancy is a complex issue with no "magic bullets." Many strategies are necessary to reach the diverse needs of the adolescents of Oklahoma.

Policy Statement

As a matter of general policy, the Oklahoma State Board of Health supports the expansion of its current community-based teen pregnancy prevention projects statewide into all 77 counties.

The Board urges that the following specific actions be taken by the legislature, the State Department of Education, and the Oklahoma State Department of Health:

1. An additional \$1.5 million in funding should be provided to expand current community-based teen pregnancy prevention projects for those communities that have a rising teen birth rate.
2. The Oklahoma State Department of Health should complete at the earliest possible date participation in the national Youth Risk Behavior Survey in order to provide more specific information regarding sexually active teenagers who are presently at risk of

pregnancy and sexually transmitted diseases. Such data are critical in order to get services and evaluate effectiveness of programs.

3. The Oklahoma State Department of Health should endeavor to expand community awareness of the consequences of teen pregnancy in order to achieve a more rational and agreeable public climate in which to deal honestly with the problem of teenage sexuality.
4. The goal of greater community involvement in devising and carrying multiple solutions to the risks of early sexual involvement and unprotected sexual behaviors should be maintained. OSDH partnership with local communities is key to achieving success.

Unintended Pregnancy

Background

Bearing children and forming families can be the most meaningful and satisfying aspects of adult life, particularly when families are healthy and prepared. It is within the context of encouraging intended pregnancy that the Oklahoma State Board of Health supports that Oklahoma families be strengthened by supportive services that decrease the percent of pregnancies that are unwanted.

- Fifty percent of all live births in Oklahoma are the result of pregnancies that are unintended.
- Approximately 10.9 % of all births in Oklahoma are the result of pregnancies that are unwanted.
- In FY'98 the infant mortality rate in Oklahoma was 8.1 per 1,000 live births.
- In FY'98 the current percentage of low birth weight infants was 7.2%, and has not changed in many years.
- Unwanted births in Oklahoma cost State Medicaid \$22 million each year in prenatal, newborn and intensive care costs.
- Current family planning services are able to serve on 36% of the estimated women considered to be at or below the federal poverty level and who need family planning services.
- New Medicaid and social welfare program changes will further limit family planning services to Medicaid clients thereby causing more of them to seek services as uninsured clients through the public health clinic system.
- Child abuse and neglect reports steadily increase each year with 34 children dying in FY'95. During the same year, of the 39,831 cases of child abuse and neglect that were

reported and investigated, 11,700 were confirmed.

Policy Statement

The Oklahoma State Board of Health urges that the state adopt a new social norm that all pregnancies should be intended; that is, they should be consciously desired at the time of conception. Further, this new norm would substantially reduce unintended and unwanted pregnancies by promoting accessible, affordable and comprehensive family planning services, enhancing the quality of life for all individuals and families in Oklahoma by:

- reducing infant mortality,
- reducing low birth weight babies and birth complications,
- reducing birth defects,
- reducing the number of abortions,
- reducing dependency on public assistance and welfare,
- reducing child abuse and neglect,
- reducing public health costs.

For every \$1.00 spent on contraceptive services, the state saves up to \$6.20 which would otherwise be spent on birth related costs, Medicaid, TANF, food stamps and WIC. Reducing unwanted pregnancies saves public expenditures:

- by providing cost efficient, high quality, comprehensive family planning services, at an annual cost of less than \$250 per client,
- by reducing neonatal intensive care Medicaid costs for unwanted pregnancies, at a savings of approximately \$7 million per year in Oklahoma,

- by reducing pregnancy related Medicaid costs for unwanted pregnancies including prenatal care, delivery and newborn care costs, at a savings of approximately \$15 million per year in Oklahoma.

The total estimated savings in Medicaid costs for both pregnancy related and neonatal intensive care is \$22 million per year for unwanted pregnancies alone.

Further, the Oklahoma State Board of Health, in its desire and efforts to improve the social, economic and personal quality of life for all Oklahomans, issues the following challenges to:

The State of Oklahoma

- provide accessible services to reduce unintended pregnancies from approximately 22,000 per year to an annual number of 14,000 by the year 2004,
- provide accessible services to reduce unwanted pregnancies from over 6,000 per year to 4,200 per year by the year 2004,
- improve knowledge of all Oklahomans about contraception and reproductive health.

The Oklahoma State Legislature:

- provide \$4.5 million in new and ongoing state funding in FY'01 for approximately 16,000 new clients to access services,
- designate state funding for family planning services as a budget line item.

Local Communities

- coordinate the efforts of various community resources, including schools, churches, social and health services, families, businesses, hospitals and private and public clinics to support family planning health services and the reduction of unintended and unwanted pregnancies,

- develop local task forces and identify plans in local areas to address the issues of unintended and unwanted pregnancies,
- conduct community fund raising events to support the cost of providing services in those communities,
- develop and support local media events, which promote reproductive health and family planning education,
- promote and address organizational issues, which may impede local residents' access to local services.

The Media

- develop ownership and leadership in the concept of family planning as prevention as it relates to other social and health issues,
- promote the concept of planning pregnancies and promote family planning services throughout the State of Oklahoma,
- promote reproductive health education throughout the State of Oklahoma.

Board Operations

1. No items in this policy regarding Board operations shall be at variance with applicable law, particularly pertinent items that are quoted below.

1.1 "... (the) Board... shall elect... (a) President, Vice President and Secretary" (§ 1-104)

1.2 "The Board shall adopt rules for its governance." (§ 1-104)

1.3 "... any newly appointed member (shall be briefed) within 2 weeks (of appointment)." Furthermore, the member should be provided with "...a copy of the last twelve monthly operating budgets..." (§ 3101)

2. No item within this policy regarding Board operations shall be at variance with Title 310, Chapter 1, Procedures of the State Board of Health. Item of particular relevance is quoted below.

2.1 "... (the) Board shall accept... appropriations... made or offered to it or the State Department of Health".

3. Officers

3.1 **President:** Seen as Chief Executive Officer of the Board, sets the agenda of Board meetings, presides over **Executive Committee**, ordinarily officially communicates *new* policies, procedures, rules or actions of the Board to the Commissioner, other Boards or Agencies of the State, the Legislature, the Governor's Office and the media. The President may designate another member of the Board to act in this capacity on specific occasions.

3.2 **Vice-President:** Ordinarily is seen as President-elect. Acts in the absence of the

President and chairs the **Finance Committee**.

3.3 **Secretary:** Receives, reviews and edits the first draft of Board minutes, and receives and distributes written communications to the Board or to Board members to all Board members. The Secretary summarizes such communications to the Executive Committee and to the Board at Board meetings as may be appropriate.

4. Standing Committees

Standing Committees are appointed by the President after appropriate consultation with Board members.

4.1 **Executive Committee:** Meets regularly with Commissioner. Reviews communications to the Board. Gives follow-up reports on actions taken by the Board as appropriate. In this regard the Executive Committee has a responsibility for seeing that actions taken by the Board are implemented. The Executive Committee may also bring items for discussion and possible action to Board meetings proper. To the extent authorized by law, the Executive Committee acts on behalf of the Board between meetings carefully following existing Board policy and after consultation with other members as required.

Meets with appropriate members of the Department before a draft of new rules is prepared. Reviews draft when developed and is prepared to recommend adoption to the Board with modifications, if indicated or, if indicated, tabling action to a later meeting. A similar process is to be followed with major changes to an old rule, that decision to be made jointly by the committee and appropriate members of the Department. If changes are minor, a review

can be made at a committee meeting prior to the Board meeting.

Develops, publishes and implements a periodic evaluation of the Department and the Commissioner and ensures that there is a process for evaluation of the Deputies and other members of the Executive Group, and of the Board itself. Follows the time table in the Boards Work Calendar as requested by the Board, its President or the Commissioner, deliberates and makes recommendations regarding personnel matters.

4.2 **Finance Committee:** Reviews monthly Department finance reports. Participates in the budget process taking into account Board and Department priorities. Testifies in this regard with legislative committees and makes reports to the Board.

4.3 **Accountability, Ethics, and Audit Committee:** Meets regularly with appropriate departmental staff. Represents the Board in meeting its obligation of oversight, and provides the Board with information for these types of activities.

The committee will also receive internal and external audit reports, making recommendations to the Executive Committee and the Board thereto.

4.4 **Public Health Policy Committee:** Receives policy and resolution recommendations, initiates policies and resolutions for review and action by the Board. Works with appropriate departmental staff to develop the annual State of the State's Health Report. Follows the timetable in the Board's Work Calendar.

5. The President may appoint Ad Hoc Committees to perform a specific task over a specific time limited period. When the final report is received by the Board, the Ad Hoc Committee stands down.

6. Members

6.1 Board members are ultimately responsible to the public. At times this may heighten tension between the Board and entities or organizations that serve the public or individuals, or entities or organizations that represent a given constituency.

6.2 Board members are expected to declare a conflict of interest whether real or when likely to be perceived as such by the public, and are expected to abstain when votes are taken on such matters.

6.3 Discussions during the Executive Sessions of the Board are to remain confidential, both source and content, except as agreed to by the board or as acted on during open session.

6.4 When communicating to members of the Department, the Legislature, the Governor's Office, entities or organizations within the public, to the public directly or through the media, Board members are expected to make clear the distinction of when they are speaking for the Board, speaking as a member of a Subcommittee, speaking as a member of the Board or speaking as an individual.

6.5 Written communications to the Board or to members of the Board regarding Board activities are to be copied and distributed to all Board members. This activity is to be coordinated with the secretary as outlined above. Also, communications regarding Departmental activities are to be copied and distributed in a similar manner to all Board members and to the Commissioner unless confidentiality as to source has been requested and granted.

6.6 Working documents developed by individual Board members are not to be distributed until such time as they are

utilized in the context of an announced agenda of the Board or one of its subcommittees. Such documents are to be labeled as not representing an official position or action of the Board proper.

7. Board Work Calendar

A Board Work Calendar will be developed on a regular basis by the Executive Committee and approved by the Board. The content should include the following.

7.1 Regular Board meetings.

7.2 Summer working retreat.

7.3 A timetable regarding:

7.3.1 Finance reports due to the Committee and its report due to the Board.

7.3.2 Audit reports due to the Committee and its report due to the Board.

7.3.3 The content outline of the year's State of the State's Health Report due to the Board, the target date for when the draft of report is to be presented to Board and the target dates for approval, publication, release and distribution.

8. As a general principle, the Board and its members will strive **not** to delegate its guardianship role to the Commissioner either through action or inaction. At the same time, the Board is not an investigating body per se. Nor, on the other hand, is the Board responsible for administering the Department. That responsibility and authority resides within the organization and particularly within the executive leadership. Board members will strive **not** to intrude into that domain.

9. The Board and the Department share in common the following vision, mission and principles of operation:

Vision

Creating a State of Health

Mission

To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy.

Guiding Principles

We strive to be recognized as a great agency, a leader in public health. Our Agency is committed to treating our customers and each other as we would like to be treated: with trust, dignity, fairness, and respect; with professionalism and impartiality. We will pursue excellence through quality customer service, teamwork, leadership, open communication, and continuous improvement.

Adult Immunizations

Background

Vaccines are among the greatest achievements of biomedical science and public health. Diseases that once caused significant morbidity in Americans — particularly children — have been virtually eliminated from the population through effective immunization programs. However, in contrast to the successes in the prevention of childhood infectious diseases, progress in adolescent and adult immunizations lags significantly behind.

Despite the availability of safe and effective vaccines, each year at least 50,000-70,000 adults die from complications due to infections with *Streptococcus pneumoniae* (pneumococcus), influenza and hepatitis B, the primary vaccine-preventable diseases affecting adults.⁽¹⁾ In addition to excessive mortality, these diseases result in significant morbidity and increased health-care costs. Pneumococcal disease is one of the leading causes of pneumonia and the most common cause of nursing home-acquired pneumonia.⁽²⁾ In Oklahoma in 1998, pneumonia was the leading reason for all hospitalizations (excluding childbirth) and the leading cause of in-hospital death.⁽³⁾

Other vaccine-preventable diseases that may affect adults include tetanus, diphtheria, hepatitis A and rubella.

The utilization of vaccines in adults is significantly less than in children. In contrast to immunization rates approximating 90% for most childhood preventable diseases, data from the 1997 Behavioral Risk Factor Surveillance System indicate that for adults aged > 65 years, only 66% had received influenza vaccine in the previous year and only 45% had ever received the pneumococcal vaccine; the coverage rates are even lower for minority populations.⁽⁴⁾ This underutilization reflects a lack of emphasis on vaccines for adults in comparison to children.

The adult immunization goals of “Healthy People 2000: National Health Promotion and

Disease Prevention Objectives” are as follows: (a) adults aged > 65 years for pneumococcal and influenza vaccines (60% for noninstitutionalized and 80% for institutionalized); (b) immunization of high-risk populations under 65 with pneumococcal and influenza vaccines (coverage goals vary from 60-90% depending on high risk group); (c) and hepatitis B coverage for occupationally exposed workers (90%) and other high-risk individuals (50%).⁽⁵⁾

The “Adult Immunization Action Plan” of the Department of Health and Human Services Workgroup on Adult Immunizations describes five major goals for adult immunization in the U.S.⁽⁶⁾ These are:

1. Increase the demand for adult immunization by improving provider and public awareness.
2. Increase the capacity of the health care delivery system to effectively deliver vaccines to adults.
3. Expand financing mechanisms to support the increased delivery of vaccines to adults.
4. Monitor and improve the performance of the nation’s immunization program.
5. Enhance the capability and capacity to conduct research on adult immunization issues.

The United States Task Force on Community Preventive Services has conducted systematic reviews of interventions designed to raise vaccination coverage levels in children, adolescents and adults.⁽⁷⁾ The following interventions have been determined to be effective in increasing adult immunization rates and are recommended by the Task Force:

1. Increasing community demand for vaccinations through education (this is most

effective when combined with other interventions, as described below).

2. Client reminder/recall systems.
3. Reducing out-of-pocket costs
4. Expanding access in medical or public health clinical settings (e.g., reducing distance to vaccine settings, convenient hours, reducing administrative barriers, and providing vaccines in nontraditional settings).
5. Home visits
6. Provider reminder / recall
7. Assessment and feedback for vaccination providers
8. Standing orders

A recent CDC report has specifically addressed the issue of providing adults vaccines in nontraditional settings and the use of standing orders as potentially effective means of increasing adult immunization coverage.⁽⁸⁾

Policy Statement

The Oklahoma State Board of Health recognizes that adults experience elevated levels of morbidity and mortality from several diseases that could be prevented by the use of safe, effective and readily available vaccines. The Board of Health also recognizes that these vaccines are underutilized and that additional emphasis must be given to adult immunization. Also, recent research has identified interventions that are effective at increasing adult vaccine coverage rates. Therefore, the Board of Health supports and encourages implementation of the following strategies to increase the use of adult vaccines.

- Promote adult vaccination through yearly educational efforts by state and local health departments (employing media campaigns and local initiatives) to inform the public and

health-care providers about the severity of influenza and pneumococcal disease and the effectiveness of vaccination in preventing these diseases.

- Increase adult vaccination in clinical settings by encouraging clinicians to screen all adult patients in office and hospital for pneumococcal and influenza vaccine status and vaccinate if indicated.
- Screen all county health department clients for pneumococcal and influenza vaccine status and either provide vaccine if available or recommend client receive vaccine through other provider.
- Increase outreach efforts by county health departments and Eldercare staff to disseminate information regarding pneumococcal and influenza vaccines among senior citizens.
- Implement Board of Health rules requiring nursing homes to administer pneumococcal and influenza vaccines to all residents for whom the vaccines are indicated, unless specifically declined or contraindicated.
- Encourage hospitals and physicians to explore initiatives to increase pneumococcal and influenza vaccination of hospitalized patients, including the use of standing orders.
- Explore opportunities to deliver adult vaccines in nontraditional settings, such as pharmacies, churches, and senior citizen centers.

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Health Information Security Policy

Background

The Board acknowledges that use of personal health information carries with it a solemn obligation and duty to protect the privacy of the individual. The guardianship of such sensitive and personal data is directly linked to the need to accurately measure and evaluate public health conditions and set effective policies, which improve those conditions. Additionally the Board recognizes that inappropriate use or release of private health information would only serve to deplete public trust of public health and likewise impede the ability to improve the health status of Oklahomans.

Federal and State laws clearly allow for access to health information sources for public health purposes. 1996 HIPAA regulations were designed to improve security surrounding patient identifiers. HIPAA seeks to clarify confidentiality requirements and clearly states,

“nothing in this rule shall be construed to invalidate or limit the authority, power or procedures established under any law providing for the reporting of disease or injury, child abuse, birth or death, public health surveillance or public health investigation or intervention.”

The Oklahoma Health Information Act specifies general categories of information and providers from whom information is be collected. However the statute assigns development of specific variables and procedures to the State Board of Health.

“The State Board of Health shall adopt rules governing the acquisition, compilation and dissemination of all data collected pursuant to the Oklahoma Health Care Information Act.”

The collection and encryption of personal identifiers are included in the intent of the act. References to identifiers and application of all federal and state laws protecting confidentiality

appear in several places. The State Statute directs the Health Care Information Division to “implement mechanisms that encrypt all personal identifiers.” Encryption is in place.

The Health Care Information unit is contained in a lock down facility with 24-hour camera and software surveillance. Multiple firewalls restrict access both externally from the Internet and internally from the department system. Access to the encrypted data is limited to seven authorized staff. In addition to login procedure requiring two passwords the user is screened using electronic fingerprint technology. As data is entered into the system, all personal identifiers are replaced with a unique identifying number. Once entered into the system, the original personal identifiers are no longer a part of the patient record. This security meets and exceeds that of the HIV system, which is nationally regarded for its security.

Professional ethics and legal safeguards for confidential data have controlled the use of health information by the public health community. Unfortunately the historic vigilance and track record of public health is often confused with the relative ease at which certain private health and insurance sector concerns market and sell personal health information.

The Board and the OSDH have been and continue to be concerned with the misuse of individual health information. All reports that are provided by the OSDH have had all personal identifiers removed. Many insurance companies, pharmaceutical manufacturers and health providers do not afford citizens the same level of protection. While some types of companies have a greater commitment to individual privacy, others sell individual data and identifiable information to a variety of purchasers.

The Board recognizes the need to build public trust in the capability of the OSDH to protect personal health information. For that reason the

OSDH and the Board have invited our partners to both tour the operation and review security measures currently in place.

The Legislature and the Oklahoma Hospital Association have been invited to employ consultants to challenge the security of our systems. The Board restates this offer.

Policy Statements

The Oklahoma State Board of Health recognizes the Legislative mandate for and the essential nature of health data collection and its analysis. The Board is strongly committed to the preservation of confidential individual health information. The public relies on the public health system to interpret data for multiple important applications including the following:

- tracking infectious disease trends and outbreaks
- law enforcement and public safety concerns during disasters
- disease and cancer registries that collect data
- trauma registries to identify and contribute to the reduction of injuries
- data analysis to guide formulation of legislative and other public policies
- data analysis to guide optimal utilization of limited health care funding and resources

In view of Oklahoma's low health indicators as compared nationally, the importance of collection and analysis of Oklahoma data is evident.

Therefore the Oklahoma State Board of Health shall require preservation of individual confidentiality while meeting the public need. To this end the following policies are hereby enacted:

1. The Board supports a "no tolerance" policy in any event that may compromise the

security of individual health information on the part of OSDH staff. The Commissioner is directed to make investigation and prosecution of those cases the utmost priority should it occur.

2. The Board and the OSDH shall continue to adopt policies and procedures, which vigorously address emerging methods for further enhancing the protection of individual information.
3. It is the Board's intent that staff continually investigate and implement the least invasive measures be utilized to collect health data such as limiting use of the social security number to only the last four digits, and any new technologies for improving the encryption of personal identifiers.
4. The Board is adamantly opposed to the sale or distribution of personal health information or related lists for marketing or any other purpose. The Board encourages the Governor, Legislature and congressional delegation to refine and adopt legal remedies, which further restrict the market use of personal health information.
5. The Board is also concerned with the potential misuse of health information, especially in the rapidly evolving area of genetics. The potential uses of genetic information to determine adverse risk for insurance coverage or employment eligibility are becoming a reality. Vigilant regulatory protections against inappropriate uses of genetic information should be enacted.
6. The Board recognizes the key role that the Health Information Advisory Board plays in identifying and communicating concerns and standards to the OSDH and the Board. The Advisory Board represents a broad cross-section of public and private health providers and is encouraged to provide recommendations that further assure the integrity and protection of health information.

Obesity

Background

Obesity (calorie addiction) is a devastating form of malnutrition. It is directly linked to 5 of the 10 leading causes of death and disability. It accounts for health costs of approximately \$100 billion a year or 8% of the national health care budget. There is a growing list of obesity related disorders that are exacerbated by the lack of physical activity and poor nutrition (diabetes, heart disease, stroke, cancers, arthritis, gallbladder disease). National experts have labeled this the Sedentary Death Syndrome (SeDS) for which 60% of Americans are currently at risk. SeDS is expected to add as much as \$3 trillion to health care costs over the next ten years. Furthermore, national and Oklahoma data indicate that the prevalence of obesity is increasing at an alarming rate! Data from the Behavioral Risk Factor Surveillance Survey (BRFSS) indicates that 47 of the 50 states show significant increases in obese populations in the past ten years. Today, almost two thirds of Americans are either overweight or obese, i.e. having a Body Mass Index (BMI) ≥ 25 .

Statistics for young people are even more alarming! The National Health and Nutrition Examination Survey III (NHANES III) reveals that 1 out of every 5 children aged 7 to 19 years are overweight. There has been a 30% increase in obesity prevalence in this age group since the late 1970s. Of this group, 25% have one risk factor for chronic disease and another 10% have two risk factors.

Oklahoma mirrors this picture of the growing epidemic of obesity. According to the *State of the State's Health 2001 Report*, 21.1% of all Oklahomans 18 years of age and older were considered morbidly obese compared to the 1998 national percentage of 18.3. BRFSS data of 1999 indicates that an additional 34% of Oklahomans 18 years of age and older are overweight (having a BMI of ≥ 25 to ≤ 30).

Findings from 1st and 5th grade surveys of Oklahoma children indicate that 50% of these children lead sedentary lives, get less than one hour of physical activity per day, and spend two or more hours watching television, playing video games or computer games (Maternal and Child Health survey, 1998). The 1999-2000 YRBS results showed that 33% of Oklahoma teens are overweight and that 40% are attempting to lose weight (9-12 high school grades). Only 25% eat five or more fruits and vegetables a day, and less than 40% engage in physical activity. Adults 18 years of age and older in Oklahoma are the 3rd most sedentary population in the U.S. with 47% of Oklahomans getting no leisure time physical activity. If one combines the co-morbid conditions of sedentary lifestyle with being overweight or obese, 85% of Oklahomans are at risk for developing chronic diseases.

The goals of obesity intervention must be two-fold. The first is to prevent obesity in the non-obese. The second is to prevent further weight gain and encourage weight loss in individuals already overweight or obese. Even modest weight losses are clearly associated with health benefits, e.g. improvement in blood pressure and lipid profiles, and enhanced glucose tolerance. Reversing the obesity epidemic requires not only changes in individual behavior, but also the elimination of societal barriers to healthy lifestyle choices. Promoting physical activity and healthy eating prevents obesity.

Policy Statement

The Board of Health recognizes obesity as a major public health problem in Oklahoma. Therefore,

- I. We must mobilize Oklahoma's public health officials, physicians and other health care workers to combat obesity;
- II. We must generate public support for increased funding of school and

community-based physical-activity/fitness and nutrition programs;

- III. We must create new economic and workplace incentives for weight-reduction efforts.

Towards these ends, the Department of Health should:

1. Determine the status of health among its employees by conducting the BRFSS, Thus establishing a baseline against which program evaluation can measure progress.
2. Take the lead as the agency that addresses obesity among its employees, and the clients they serve, and thereby, serve as a model for the state as a whole.
3. Offer incentives to state employees to participate in effective wellness and weight management programs.
4. Develop incentives to promote healthy lifestyles in the private sector as well.
5. Promote collaborative planning among school personnel, students, families, community agencies, and businesses to develop, implement, and evaluate nutrition and physical activity programs for youths and adults.
6. Promote strategies to change daily food consumption to include more fruits and vegetables, reduce dependence on high calorie fast foods and substitute water for soft drinks.
7. Partner with health insurance companies to educate members on obesity and document cost savings through obesity treatment programs.
8. Work toward adequate reimbursement to health care providers offering appropriate and effective prevention programs.

9. Promote environmental changes by developing a comprehensive program to increase physical activity including physical activity in schools, alternatives to car use, community facilities, and work-based physical activity programs.

10. Generate public support to fund a statewide Obesity Task Force.

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Affiliation Agreement - University of Oklahoma and Department of Health

Background:

A formal affiliation agreement can become a win-win-win situation for Oklahoma, for the University, and for the Health Department.

The Department of Health is primarily a public health service organization. The University, especially the Colleges of Public Health and Medicine, is primarily an education and a research organization.

The Department must focus on programs that are effective in terms of outcome and cost effective in terms of use of resources. This speaks to research. Furthermore, the Department must increasingly focus on employees that are trained in public health - in the context of a shortage of such personnel. This speaks to education.

The University needs sites in which its students can learn, and public health services and programs amenable to evaluation and research, and pilot projects flowing from research. This speaks to public health service structures.

Both organizations need increased efficiency of operation and the potential for additional sources of revenue. (e.g., joint appointments, endowed positions, jointly solicited grants, etc...).

In summary, each is a potential resource for the other and in the process of collaboration Oklahoma can benefit.

Policy Statement:

The Board of Health seeks a formal Affiliation Agreement between the

University of Oklahoma and the Department of Health.

- I. Our intent is that the Agreement will be developed primarily by the executives of both organizations and then submitted for approval by their respective governing bodies.
- II. Our goal is formal approval of the Agreement by the Board of Regents and the Board of Health.
- III. We recommend that the Agreement clearly recognizes the primary responsibilities of both parties, flows from the development of a set of principles, and creates an overarching structure through which both parties function.
- IV. We further recommend that the implementing details of specific collaborations be developed through appropriate Memorandums of Agreement consistent with the overarching principles and structures of the Affiliation Agreement.

**COLLABORATION AGREEMENT: STATE BOARD OF HEALTH,
OKLAHOMA CITY-COUNTY BOARD OF HEALTH AND
TULSA CITY-COUNTY BOARD OF HEALTH**

Background

By statute, the State Board of Health is the governing body of the State Department of Health, which in turn has jurisdiction over all county health departments except those of Oklahoma and Tulsa counties. These are autonomous and are governed by independent Boards.

However, given the fact that circa 45% of Oklahoma's population resides in these two counties, and given that Oklahoma has experienced a downward health trend since 1990, Oklahoma can clearly benefit from an improved process of collaboration between these three Boards and these three Departments.

Therefore, the following Policy Statement serves as an agreement between these three Boards.

Policy Statement:

- I. Each Board will notify the other Boards of the time and place of their meetings and include their proposed agenda.
- II. Depending on the agenda, the State Board members who represent Oklahoma County or Tulsa County will attend the appropriate county

meetings. Similarly, members from each county will attend State Board meetings, again depending on the agenda. Each Board can request an item for the agenda of another Board.

- III. In particular, proposed policies and/or resolutions developed by the Policy Committee of the State Board will be sent to the Oklahoma and Tulsa County Boards for possible input and/or possible action. By this means we intend to speak with one voice on issues we share in common.
- IV. In return, the County Boards may choose to send potential policy statements and/or resolutions to the State Board for possible action.
- V. Our intent is that the three Boards will have at least one conjoint meeting annually. Presidents will determine the time, place and agendas and will rotate in presiding at these meetings. These meetings must meet the requirements of the State's Open Meeting Act.
- VI. Finally, we collectively expect our respective Chief Executive Officers and their staffs to work collaboratively when appropriate.

State of the State's Health Report

Background

The SSHR was created in 1996 by the Board of Health with the first issue published for 1997. No such report existed within the Department of Health at that time and the Center for Health Statistics did not exist. The initial goal was to inform the public of Oklahoma's health status. Over the years broad recommendations were added. There is now considerable evidence that we have an informed public. Some of the recommendations have been implemented. We have a Center for Health Statistics, and a more effectively integrated Health Department. The Turning Point organization mobilizes local communities and a variety of statewide entities are responding with programs to hopefully improve our health status.

Therefore, the Board of Health responds with the following policy statement regarding the SSHR.

Policy Statement

1. Effective this date, the SSHR will be published by both the Board and the Department of Health.
2. An introduction to each report will be developed and signed by the Commissioner of the Department and the President of the Board.
3. A draft of the report will be developed collaboratively by appropriate Departmental staff and members of the Board's Policy Committee.
4. The report will focus to a greater extent on the top health priorities of the Board and the Department. There also will be greater emphasis on providing pertinent data by county. Programs and/or interventions shown to have positive outcomes will be summarized.
5. Finally, specific policies and/or recommendations will receive greater emphasis.

OKLAHOMA STATE BOARD OF HEALTH
COMMISSIONER'S REPORT
Terry Cline, Ph.D., Commissioner
July 11, 2017

PUBLIC RELATIONS/COMMUNICATIONS

OETA, Steve Bennett – Interview

STATE/FEDERAL AGENCIES/OFFICIAL

Health & Human Services Cabinet Meeting
Senator Anastasia Pittman, Pastor DeWayne Case, Allen Starks – Men's Health
Representative Leslie Osborn
Becky Pasternik-Ikard, CEO, Oklahoma Health Care Authority

SITE VISITS

Kay County Health Department, Blackwell
Lincoln County Health Department
Logan County Health Department
Noble County Health Department
Payne County Health Department

OTHERS:

Tribal Public Health Advisory Board Meeting
Oklahoma Health Improvement Plan Full Team Meeting
Tulsa C-1 Parents Day Graduation Event
Kate Neary, CEO and Ty Kaszabowski, Board President, Tulsa Cares
Michelle Briggs, President/CEO, Avedis Foundation and the following site visits in Shawnee:
 St. Anthony's Shawnee Hospital
 Expo Center
 Community Renewal of Pottawatomie County - Brandon Dyer, Executive Director
 Shawnee Splash - Justin Erickson, City Manager
 Blue Zones – Health Initiative
 Community Garden and Market (Regional Food Bank)
 1500 E. Independence Property (New Avedis building site)
 Shawnee Middle School – Avedis Park
Page Woodson School Renovation Tour
Oklahoma Commission on Children and Youth
PHAB Board Meeting