Ronald Woodson, President of the Oklahoma State Board of Health, called the 392nd special meeting of the Oklahoma State Board of Health to order on Friday, August 15th, 2014, at 7:01 p.m. The final agenda was posted at 11:00 a.m. on the OSDH website on August 14, 2013; at 10:55 a.m. on the OSDH building entrance on August 14, 2014; and at 1:00 p.m. on the National Center for Employee Development Building entrance on August 14, 2014.

ROLL CALL

Members in Attendance: Ronald Woodson, M.D., President; Martha A. Burger, M.B.A, Vice-President; Cris Hart-Wolfe, Secretary-Treasurer; Timothy E. Starkey, M.B.A.; Robert S. Stewart, M.D.


Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of General Counsel; Janice Hiner, Senior Advisor to the Commissioner; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley, Maria Souther.

Visitors in attendance: See list

Call to Order and Opening Remarks

Dr. Woodson called the meeting to order. He thanked all distinguished guests and staff for their attendance. He acknowledged special guests in attendance for the meet and greet as well as the Board meeting.

Dr. Woodson kicked off the retreat with a brief presentation. The theme for the presentation was optimism vs. pessimism. He began by highlighting the public health issues faced in the last 100 years as well as the accomplishments and advances in science and public health. Dr. Woodson described the transition from an era of infectious diseases, poor sanitation, workplace accidents, and poor food to an era of chronic diseases. Although there are still many challenges ahead, the accomplishments are encouraging. Dr. Woodson concluded with his thoughts on kicking off and ending the retreat with optimism in mind.

Dr. Woodson introduced Dr. Arnold Bacigalupo as the retreat facilitator and founder & President of Voyageur One. He briefly described the partnership between the Board and Dr. Bacigalupo explaining that Dr. Bacigalupo has been involved in the OSDH strategic planning process since 2008.

Dr. Bacigalupo thanked Dr. Krishna for the welcome. He briefly recounted the objectives of previous Board retreats since 2008 and then proceeded to discuss the 2014 retreat objectives: Discuss the current public health landscape; and Provide strategic direction to OSDH Senior Leadership.

Dr. Woodson extended a special thanks to Department staff and Dr. Cline for their continued quality
improvement efforts as illustrated through the Story Boards arranged in the conference room and thanked Board members for their commitment to public health.

ADJOURNMENT

Ms. Wolfe moved to adjourn. Second Mr. Starkey. Motion carried.

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

The meeting adjourned at 7:45 p.m.

Saturday, August 16, 2014

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of General Counsel; Janice Hiner, Senior Advisor to the Commissioner; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley, Maria Souther.

Visitors in attendance: See list

Call to Order and Opening Remarks

Dr. Woodson called the meeting to order at 8:30 a.m. and welcomed those in attendance. He acknowledged special guests Victoria Bartlett, First Lady of Tulsa; Bruce Dart, Director, Tulsa County Health Department; Bob Jamison of the Oklahoma City-County Health Department; Gary Raskob, Dean of the OU College of Public Health and member of the Oklahoma City-County Board of Health; Tracey Strader, Executive Director of the Tobacco Settlement Endowment Trust; and James Allen, Director, Partnerships for Health Improvement. Dr. Bacigalupo provided a brief overview of the retreat objectives and directed attention to Dr. Cline for the Strategic Plan Review presentation.

STRATEGIC PLAN REVIEW

Terry L. Cline, Ph.D., Commissioner of Health
WELLNESS ACHIEVEMENTS
CERTIFIED HEALTHY OKLAHOMA EVALUATION UPDATE
2014

- Perceived Ability to Impact Community Well-being & Attract New Business
- Likelihood of Using Criteria to Generate Ideas to Become a Healthier Community

Number of Community Survey Respondents = 33 (62.2%)

MOVING FORWARD

Upcoming Wellness Initiatives

GOVERNOR’S GET FIT CHALLENGE

PURPOSE:
- Provide parents with useful information on child fitness
- Assist with fitness data gap in OK
- Ages focus: Grades 3rd-8th

OVERVIEW:
- Track fitness & activity levels
- Schools get free training & software access
LAUNCH: FALL 2014
- 210+ Schools Voluntarily Participating

PARKS PASSPORT

PURPOSE:
- Promote Outdoor Physical Activity
- Ages focus: 4th Grade
OVERVIEW:
- Participate in physical activity in state parks
- Earn rewards
LAUNCH: FALL 2014

GET FIT VIDEO AND CURRICULUM

PURPOSE:
- Promote physical activity
- Grades: 3rd-5th
OVERVIEW:
- 6-week Fitness Challenge
- Partnering schools get:
  - DVD promoting physical activity
  - Take-Home worksheets for students
LAUNCH: FALL 2015
Dr. Stewart and Tim Starkey briefly discuss vaccine shortage in recent years for privately insured patients. Dr. Stewart inquired as to whether or not physicians may use Vaccines For Providers (VFC) stock and replace it or pay for it. Toni Frioux responded that unfortunately, the federal guidelines for VFC vaccines use are very strict and does not make allowances for this. Dr. Cline invited members of the Board to attend the Governor’s Get Fit Launch on September 26th at the Capitol. Kevin Durant will join Governor Fallin to launch a series of challenges to Oklahoma students around physical health and fitness.

The presentation concluded.

OKLAHOMA HEALTH IMPROVEMENT PLAN
Terry L. Cline, Ph.D., Commissioner of Health; James Allen, M.P.H., Director, Partnerships for Health Improvement
STATE BOARD OF HEALTH
ANNUAL RETREAT
OKLAHOMA HEALTH IMPROVEMENT PLAN
PARTNERING FOR HEALTH IMPROVEMENT

James Allen, MPH
Director
Partnerships for Health Improvement

OKLAHOMA HEALTH IMPROVEMENT PLAN
- Commissioned by the Oklahoma Legislature in 2008 by Senate Joint Resolution 41
- Collaborative effort to improve and sustain the physical, social and mental well being of all Oklahomans
- Current plan focuses on three flagship issues (Tobacco, Obesity and Child Health) along with public health infrastructure
- Prerequisite for Public Health Accreditation

OKLAHOMA HEALTH IMPROVEMENT PLAN
GOVERNANCE
- OHIP Executive Team
- OHIP Full Team
- OHIP Workgroup Team Leads

Flagship Infrastructure
- Tobacco - Health Workforce
- Obesity - Access to Care
- Child Health - Public/Pvt. Partnerships

OHIP RE-WRITE PROCESS
- Quantitative Data + Qualitative Data + Evidence Based Practice = OHIP
- State of the State’s Health + Community Chats + Workgroups of Content Experts

OHIP RE-WRITE PROCESS
- Compile health outcomes data for Oklahoma (completed via the State of the State’s Health Report)
- Obtain community and population input via community chats, listening sessions and surveys
- Identify/Confirm flagship health issues and the systems infrastructure areas with OHIP Leadership/Governance
- Develop, with guidance from content experts, goals and objectives based on science and evidence of effectiveness

OHIP RE-WRITE PROCESS
- Compile Quantitative + Qualitative + Subject Matter Expertise into a single, comprehensive OHIP
- Obtain public feedback on this OHIP with attention to the communities and populations involved in the Community Chat process
- New OHIP and realigned workgroups begin implementation of action plans in January of 2015
- Process will begin again in five years for 2020
OKLAHOMA STATE BOARD OF HEALTH MINUTES  
August 15-17, 2014

OHIP RE-WRITE TIMELINE

A CLOSER LOOK AT THE COMMUNITY CHAT PROCESS AND OUTCOME

COMMUNITY CHATS

- General Community Chats
  - Tulsa: April 18 (36 attendees)
  - Enid: April 17 (27 attendees)
  - OKC: May 14 (30 attendees)
  - Muskogee: June 5 (38 attendees)
  - Lowell: June 9 (45 attendees)

- African American Community Chats
  - Tulsa: April 14 (28 attendees)
  - OKC: May 6 (37 attendees)

- Hispanic Community Chats
  - OKC: May 5 (33 attendees)
  - Guymon: June 19 (49 attendees)

Tribal Consultations
- Tulsa: April 7 (36 attendees)
- Little Axe: June 14 (47 attendees)

Total Attendance (484):
- Caucasian: 176
- African American: 65
- Hispanic: 82
- Tribal: 83

Online Surveys
- English: 108
- Spanish: 23

WHAT WE’VE HEARD

- Health Access
  - Health Care (Medicaid expansion cited)
  - Preventive Services
  - Healthy Foods
  - Outlets for Physical Activity
  - Health Services/Health Education

- Social Determinants
  - Transportation
  - Economic Development/Funding
  - Education
  - Behavioral Health

POPULATION-SPECIFIC FEEDBACK

- African American Community:
  - Strong community focus
  - Safety
  - Loss of inner city sports leagues and other outlets for physical activity in safe places
  - Economic development
  - Educational attainment
  - Increase focus on primary prevention

- Hispanic Community
  - Adolescent pregnancy
  - School health/health education
  - Youth are sometimes the only English speaking members of the family, which can place a burden upon them
  - Economic development
  - Family focus/involve families

Oklahoma State Department of Health
The presentation concluded.

Dr. Bacigalupo asked the groups to consider the following questions and report out. Below are the common themes for each group.

**Vision of Healthy State**

Vision for a healthy state included: improvements to the built environment to include bike trails, pedestrian walkways, safe parks, green space; community gardens, farmers markets, and healthy corner stores; tobacco and/or smoke free indoor and outdoor public spaces; access to care; 100% of citizens covered by insurance; low crime, good transportation; and high performing schools.

**Barriers**

Culture; politics, lack of education; inadequate information systems; lack of knowledge regarding health and healthcare and difference between the two; balancing individual rights versus public good; lack of funding, resources and infrastructure; insurance providers are unwilling to provide rebates or incentives on improved health outcomes; lack of community champions; poverty; and complacency.

**Recommended Strategies**

Policy; population outreach using diverse media formats; engage communities of faith; engage education systems to begin health education earlier; support policies that support the healthy choice as the first choice; modify healthcare system to increase focus on prevention; rebates and economic incentives for healthy habits and improved health outcomes; conditions on the use of food stamps; targeted 10-20 minute community presentations by the Board members; robust and highly interactive health risk assessment for individuals using cell phone technology; establish healthy living pact.

**OHIP ACCESS TO CARE**

Julie Cox-Kain, M.P.A., Senior Deputy Commissioner
LEVERAGE RESOURCES FOR HEALTH OUTCOME IMPROVEMENT YEAR END REVIEW

August 2014

Overview of the ACA

Patient Protection and Affordable Care Act

- Simplifies the eligibility rules for Medicaid and the Children’s Health Insurance Program (CHIP)
- Requires most individuals to purchase health insurance or pay a tax penalty
- Required large businesses to provide health insurance to employees or pay a tax penalty
- Guaranteed issue (no pre-existing condition exclusion)
- American Indian/Alaskan Native (AI/AN) special provisions
- Extended children’s coverage on parent’s health plan to age 26
- No co-pay for A & B rated clinical preventive services
- Medical Loss Ratio limitations – caps on administrative and overhead costs of insurance companies (80% - 85% must be spent on healthcare)
- Created the Prevention and Public Health Fund

Patient Protection and Affordable Care Act

ACA Delays and Changes for Individuals

- More than 40 significant changes have been made to the ACA:
  - 16 passed by Congress, 2 by the Supreme Court, and 24 made by the Administration
  - Individual Mandates
  - Employer Coverage Levels/Penalties
  - Requirements for Qualified Health Plans
  - Concessions for hardship waivers, individual mandates and qualified health plan if plan cancelled
  - SHOP Delay
  - SHOP Employer choice
  - Basic Health Plan
  - Deductibles
  - Cost Sharing
  - Risk Corridor Program

Strategic Map: FY 2011-2015
Central Challenge

Actions Targeted Improvements in the Health Status of Oklahoma

- Insure Targeted Health Institutions
- Local Public Health Agencies/Programs
- State Public Health
- State Health Insurance
- State Health Plan
- State Health Data
- State Health Information
- State Health Planning
- State Health Research
- State Health Training

- Target Community
- Targeted Programs
- Targeted Services
- Targeted Education
- Targeted Policy

- Employers
- Consumers
- Providers
- Government Agencies
- Community Organizations

- Identify:
  - Drivers
  - Barriers
  - Opportunities

- Target:
  - Outcomes
  - Indicators
  - Targets

- Monitor/Measure:
  - Outcomes
  - Indicators
  - Targets

- Achieve:
  - Outcomes
  - Indicators
  - Targets
In April the nation’s largest health insurers were surveyed and reported that 15-20% of their new customers had not yet paid their first premium—which meant they were not yet covered.

Because more than 3 million people signed up for coverage that didn’t begin until May 1 or later, their premiums weren’t due until at least April 30.

Final numbers regarding payment of initial premiums have not yet been reported.
Oklahoma HB 3286

- Oklahoma state Navigator law provides:
  - Navigators must complete a background check and pay an annual licensing fee (up to $50).
  - Requires Navigators to "record the names and contact information for each individual or group whom the navigator assists in enrolling in the exchange and the data of contact, to provide such information to the navigator entity immediately and to retain that information for up to three years."
  - May contradict federal rules that Navigators must retain personally-identifying information — including names and contact information — after their session with the enrollee has ended, in order to protect enrollee privacy.
  - Navigators cannot provide recommendations about particular health plans or benefits or solicit anyone known to be currently insured.

Insurance Market Migration

- The size of the Oklahoma insurance market is expanded by 2.5% between 2013 and 2017 (140,000).
- The size of the individual market is expanded by 1.6% (20,000).

- The numbers are driven by projected enrollment in individual health insurance marketplace (FMM).

Oklahoma Insurance Market Enrollments

- Population Under Age 65:
  - Figure 3: Oklahoma Loss by State of Coverage - Changes from 2013 to 2014.

Enrollment and Change in Medicaid/CHIP Among Non-Expansion States During FMM Open Enrollment Period

- States that Declined Medicaid Expansion vs. US
  - Pre-ACA: 2014 vs. 2013
  - Rate of change in Medicaid enrollment between 2013 and 2014.
  - Rate of change in Medicaid/CHIP enrollment.
  - Rate of change in Medicaid/CHIP enrollment.

Non-QHP Enrollment

- Estimated Oklahoma Population with non-QHP in the Individual Market (FMM):
  - Estimated Oklahoma Population with non-QHP in the Individual Market (FMM):
  - Estimated Oklahoma Population with non-QHP in the Individual Market (FMM):

All age brackets saw substantial decreases in enrollment, with the most significant decrease in the 19-24 group. The majority of the 25-34 age bracket saw increases in ACA compliant plans, with the exception of the 35-49 age group, which saw decreases in ACA compliant plans.
Figure 3. A comparison of changes in deaths prevented and costs associated with expanding health coverage, improving care, and investing in community primary prevention.

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Oklahoma Health Improvement Plan Framework

Recent Activities in Oklahoma’s Healthcare and Public Health landscape

Healthcare Innovation & Redesign
Pay for Success
Value-Based Insurance Design
Multi-Payer Initiatives
Integration of PH and Health Care
Health Access Networks
Prioritization of Outcomes
Chair: Julie Can-Marin, MD

Purpose of SIM Grants

- SIM is a public and private sector collaboration to transform the state’s delivery system, it is NOT Medicaid expansion nor Medicaid managed care
- SIM is not designed to reduce the number of uninsured or creates programs directed at the uninsured
- SIM is based on the premise that state innovation with broad stakeholder input and engagement, including multi-payer models, will accelerate delivery system transformation to provide better care at lower costs
- CAMI will provide up to $3 million per state (one-year project period) for up to 15 Model Design cooperative agreements to design new State Health System Innovation Plans
- SIM should facilitate the design, implementation, and evaluation of community-centered health systems that can deliver significantly improved cost, quality, and population health performance results for all state residents
The presentation concluded.
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Mark Newman, Ph.D., Director, Office of State and Federal Policy; Toni D. Frioux, MS, APRN-CNP, Deputy Commissioner for Prevention and Preparedness Services

Medical Marijuana

- According to NCSL, 23 states and the District of Columbia have medical marijuana access, 2 of those states allow recreational use.
- In addition, 10 states, including Mississippi and Utah, have passed some form of legislation allowing the use of low tetrahydrocannabinol (THC - the psychoactive factor in marijuana) and high cannabidiol (CBD - a non-psychoactive component). The medicine derived from CBD marijuana is reportedly being used to help children with intractable epilepsies.

Possible Medical Uses of CBD

- Non-psychotropics
- Spasms associated with multiple sclerosis
- Animal studies show reduction in certain tumors
- Anti-seizure/anticonvulsant
- Appetite
- Anti-inflammatory
- "Home grown" cancer gene in marijuana
- Ameliorates binge alcohol-induced neurodegeneration

Adverse Health Effects of Marijuana

- Unsafe driving
- Impairment of judgment, motor coordination, and maze reaction time
- Chronic bronchitis
- Lower educational and career attainment
- Significant decline in intelligence test (from prolonged use starting in adolescence)
- Addiction
- Up to 50% of daily smokers

Possible associations

- Reproductive health
- (THC) unique risks for male fertility problems
- May lead to increased risk of ovarian cancer among females
- May increase risk of initiation or use of tobacco products
- Appears to increase risk of abuse of other drugs
- May increase risk or severity of mental illness, particularly in people with a predisposition
- May impair cognitive ability, especially with chronic use
- Unknown if increases cancer risk
- Unknown if increases risk of employment
- Unknown risk from second-hand smoke exposure (respiratory, other)

Colorado and New Jersey
Different Approaches

Colorado
- Remediation as well as medical
- The information below is specific to medical marijuana, not recreational.
- Testing requirements for potency done by independent, state-certified laboratories.
- As of April 2014, 1,678,800 in possession of medical marijuana ID cards.
- As of December 31, 2013, the annual fee for ID card was $15.
- In the first and second quarters of the fiscal year, Colorado medical marijuana dispensaries (MMOs) generated $316 million in revenue and over $6 million in state tax revenue.

New Jersey
- Medicated only
- Registered and background-checked Alternative Treatment Centers (ATC) as distributors, operate as not-for-profit or for-profit organizations.
- As of today, only three ATC are operating, the most recent being November 2013.
- Testing for potency, mold and pesticides done at the Public Health and Environmental Laboratory.
- December 2013 - 1,677 qualifying applicants issued ID cards.
- Two-year limit for patients - $200. Reduced fee for those receiving SSD or SSI benefits - $25.

Combustibles - Smoking

Governor Fallin’s initiative petition
Surgeon General’s latest report
Other anti-smoking efforts
**Governor Fallin’s Smoke-free Indoors Initiative Petition**

- Employees of the Department who support the petition may, during nonworking hours:
  - Sign the petition
  - Promote the petition
  - Other activities in support of the petition

At all times, employees are allowed to educate the interested public about the dangers of secondhand smoke and the facts about the petition.

**Surgeon General’s report on the Health Consequences of Smoking – 50 years**

- Estimated 20 million deaths caused by smoking or related illnesses since 1965
- Smoking among adults in the US has gone from 42% of the population in 1965 to 18% in 2012 (23.3% in OK)
- The vast majority of smokers begin by age 26 (98%)
- Patterns of use are changing – intermittent use of combustibles and an increase in the use of other nicotine delivery methods

**Surgeon General’s report – Increasing revenue collection and minimize tax avoidance**

- The Surgeon General’s report indicates that implementing a high-tech cigarette tax stamp, improving tobacco licensure management and making stamps harder to counterfeit are possible methods of increasing revenue and holding tobacco product producers accountable.
- This could be done through a track-and-trace system, similar to the MITS (Marijuana Inventory Tracking Solution) system for marijuana instituted by Colorado. This is an RFID (Radio Frequency Identification) system to allow for tracking goods all along a supply chain, ensuring taxes are paid at every required stop along the way.

**Surgeon General’s report – Current and End-game Strategies**

**Current**
- Increase the price point (including establishing minimum packaging in order to raise retail price*)
- Smokefree indoor policies
- Media campaigns
- Full access to cessation programs
- Funding of statewide tobacco control programs

**End Game**
- Reduce the amount of nicotine in tobacco products
- Greater restrictions on sales, up to and including bans on entire product categories

* Increased quantity means an increased price, reducing attractiveness and availability to minors and younger smokers

**Non combustibles – E-cigarettes**

Liquid nicotine – unregulated

Spike in calls to Poison Control Centers

**Number of calls to poison centers for cigarette and e-cigarette exposures in the United States, by month, September 2010–February 2014**
Liquid Nicotine Poisoning

- American Association of Poison Control Centers issued a warning to parents about the use of e-cigarettes and liquid nicotine around children, especially as the potential poison can be brightly colored or highly flavored, and there is no regulation concerning what ingredients are utilized in the mixture.
- In 2013, the AAPCC reported 1,471 exposures to e-cigarettes or liquid nicotine with slightly more than half of those exposed being children under six. So far in 2014, the AAPCC reports 1,932 such calls.
- No deaths, but nausea and vomiting reported, in some cases severe enough to warrant emergency room visits.
- FDA is currently considering rules requiring warning labels, as well as e-cigarette companies having to register with FDA and disclose their liquid nicotine ingredients.

Prescription Monitoring Program

- How it can Work
- Long Term Goals

PMP - Successes

- According to the CDC, Oklahoma has one of the highest rates in the nation of painkiller prescriptions per 100 people, at 128.
- New York implemented a PMP in 2012, and in one year saw a 75% drop in patients using multiple prescribers to receive the same drug.
- Tennessee, which had a prescription rate of 143 per 100, has seen a 36% drop in patients attempting to use multiple prescribers to receive the same drug.
- Both New York’s and Tennessee’s PMP require patient look up before the patient can receive prescription.

PMP – Long-term goals

- Interoperability – easing the ability for physicians to utilize the PMP by allowing exchange of data and use of data analytics.
- Marked reduction in prescription painkiller abuse and deaths.
- Reduction in the number of patients able to acquire multiple doses of the same narcotic drug from more than one source.
- Increase in quality of care received.
Dr. Newman asked for discussion or recommended policy initiatives. Members of the Board discussed pre-emption as a possibility but felt it may be a distraction should the Governor choose to move forward with an Initiative Petition. Members of the Board agreed the Department should be prepared to take a stance on the use of medical Marijuana should legislation be introduced in the upcoming legislative session. Board
members also supported possible comprehensive safety packaging legislation in response to the lack of regulations in the vaping industry. All members of the Board supported a new Public Health Laboratory. Members supported charging the Long Term Care Advisory Committee with making policy recommendations regarding Long Term Care improvements. Board members were supportive of prescription monitoring program (PMP) legislation.

The presentation concluded.

The meeting adjourned at 3:59 p.m.

Sunday, August 17, 2014

ROLL CALL

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

Members Absent: Jenny Alexopulos, D.O.; R. Murali Krishna, M.D.

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Senior Deputy Commissioner; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Office of State and Federal Policy; Don Maisch, Office of General Counsel; Janice Hiner, Senior Advisor to the Commissioner; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley, Maria Souther.

Visitors in attendance: See list

Call to Order and Opening Remarks

Dr. Woodson called the meeting to order at 8:30 a.m.

COMMUNITY RELATIONS/INVOLVEMENT

Martha Burger, Vice-President, Oklahoma State Board of Health

Martha Burger provided a brief sampling of opportunities for community collaboration and partnership provided by Board members.
Each member briefly discussed successes and barriers faced in their respective communities. Board members asked for the Department to develop the following: canned 20 minute presentations and talking points around current public health policy issues; speaker’s bureau; State of the State’s Health and Oklahoma Health Improvement Plan presentations; opportunities to push public health issues through social media; and a site to host the materials. Board members are also interested in another tour of the Public Health Laboratory.

The presentation concluded.

2014 BUDGET / BUSINESS PLAN

Julie Cox-Kain, M.P.A., Senior Deputy Commissioner; Debbie Boyer, Director, Human Resources

Julie Cox-Kain presented a year end update on the 2015 Budget and Business Plan. Debbie Boyer presented an update on employee engagement and workforce initiatives.
SFY 2014 ACCOMPLISHMENTS

- Completed network transition/upgrade
- Completed classification/compensation process
- Career progression reauthorized
- Awarded and implementing LMAS
- Negotiated enterprise service bus (with eMPI) as a statewide contract to enable shared service
- Signed contracts with private insurers and established private billing contract (BC/BS & Community Care)
- Finalized Repair and Renewal plans for majority of central office in August 2014

SFY 2015 BUSINESS PLAN PRIORITIES

- Complete mechanical backbone upgrade
- New Public Health Laboratory
- Implement ESB/eMPI in OSDH and as an HHS shared service
- Finalize OSIS and Electronic Billing Projects
- Requirements for PH EHR (possible shared services)
- Integrate OMES DRP to OSDH COOP
- Fully optimize network and plan to connect to state fiber
- Develop and implement strategies to address recruitment, retention, workforce development, and employee wellness with an emphasis on data collection and analyses, customer satisfaction, and enhanced communication

EMPLOYEE ENGAGEMENT SURVEY

- Survey conducted by Durand Crosby, COO of ODMHSAS as part of a research project for dissertation
- Compared OSDH with other state agencies and a non-profit organization
- Survey measured employee engagement and related variables including the following:
  - Public service motivation
  - Perceived organizational image
  - Organizational commitment
  - Organization identification
  - Meaningfulness of work
  - Job satisfaction

RESEARCH MODEL

[Diagram showing engagement as a "state" with related variables and factors]
RESULTS - ENGAGEMENT

Employee engagement is described as the degree to which an individual is attentive and absorbed in the performance of his or her job (Saks, 2006).

RESULTS - JOB SATISFACTION

Job satisfaction is defined as the extent to which a person's hope, desires, and expectations about the employment he/she is engaged in are fulfilled.

RESULTS - ORGANIZATIONAL IDENTIFICATION

Organizational identification is the extent to which a person identifies themselves with the organization; a possessing or sharing of organizational values.

RESULTS - ORGANIZATIONAL COMMITMENT

Organizational commitment is a person's psychological attachment to the organization.

RESULTS - OVERVIEW

- OSDH scores for several important variables (e.g., engagement, public service motivation (PSM), and job satisfaction) are above normed averages.
- All tested variables (PSM, image, and meaningfulness) predicted engagement.
- Engagement predicted commitment, identification, and job satisfaction.
- OSDH scored high for job satisfaction.
- OSDH scored highest on perceived reputation among state agencies tested.
- OSDH scored highest (tied) for PSM among entities tested.
- OSDH scored well-above norm for engagement (second highest).
- OSDH scored surprising low for commitment (36%).

WORKFORCE DEVELOPMENT AND SUPPORT

- Oklahoma State Department of Health
RECRUITMENT
- Recruitment materials and health display
- Quarterly advertisements in the Oklahoma News
- Visual imaging contrast
- Alerts when job openings are posted
- Job postings on agency approved social media outlets

Path Forward . . .
- Online Recruiter “Talent Toolkit”
- Online Applicant Resource Center
- Online Application
- Applicant Tracking and Demographics
- Career Maps

Oklahoma State Department of Health

RETENTION

Averages Response Rate of 30.1% Exit Survey interviews (FY 2012, 2013, and 2014)

Top Reasons for Leaving
- Retirement (FY 2012, 2014)
- Promotional Opportunities (FY 2012, 2013, 2014)
- Wages (FY 2012, 2013)
- Work Environment (FY 2014)
- Family (FY 2015)

2012 Climate Survey Area of Focus
Focus Areas: Negative responses by > 33% or positive responses by < 33% of respondents (top 3 or 5 areas of focus)

Some good opportunities need to improve. A few areas are very good.

Pay rate for your job has been properly set.
Pay increases are administered fairly and consistently.

The survey was distributed to 2,487 employees
A total of 1,494 employees completed the survey with a 60% response rate
A total of 1,740 employees completed the survey in 2012 with a response rate of 73%

View of Job: Job Advancement

2012
- 7.5% increase in positive responses
- 7.4% decrease in negative responses

2014
- No change in neutral responses

View of Job: Pay Rate Properly Set

2012
- 1.5% increase in positive responses
- 19.1% decrease in negative responses

2014
- 6.1% increase in neutral responses
The presentation concluded.

Dr. Bacigalupo thanked the Board and Department staff for their commitment and participation throughout the meeting. He also encouraged them to provide feedback as to his performance after they have had an opportunity to reflect on the outcomes of the retreat.

PROPOSED EXECUTIVE SESSION
Mrs. Burger moved Board approval to move into Executive Session at 10:39 a.m. pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

- Presentation concerning possible litigation regarding last legislative session.

Second Ms. Hart-Wolfe. Motion carried.

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

Dr. Grim moved Board approval to come out of Executive Session at 11:40 a.m. and open regular meeting. Second Mr. Starkey. Motion carried.

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

No action taken as a result of Executive Session

ADJOURNMENT

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

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

The meeting adjourned at 11:41 a.m.

Approved

Ronald Woodson, M.D.
President, Oklahoma State Board of Health
October 7, 2014