R. Murali Krishna, President of the Oklahoma State Board of Health, called the 382nd special meeting of the Oklahoma State Board of Health to order on Friday, August 16th, 2013, at 7:01 p.m. The final agenda was posted at 10:57 a.m. on the OSDH website on August 15, 2013; at 10:55 a.m. on the OSDH building entrance on August 15, 2013; and at 1:00 p.m. on the Roman Nose State Park Lodge Building entrance on August 15, 2013.

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley, Janice Hiner.

Visitors in attendance: See list

Call to Order and Opening Remarks

Dr. Krishna called the meeting to order. He thanked all distinguished guests and staff for their attendance. He acknowledged special guests Senator Patrick Anderson; Senator Ron Justice; Representative Harold Wright; Tracey Strader, the Executive Director of the Tobacco Settlement Endowment Trust; and Dr. George Foster, Vice-Chair of the Tobacco Settlement Endowment Trust.

Dr. Krishna 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 2013 retreat objectives: To orient OSDH and TSET Board members to each organization, their integrated strategic priorities and programs to improve wellness; Review of Strategic Planning Framework: Mission, Vision, Values; and Develop Recommendations for Legislative Priorities.

Dr. Krishna extended a special thanks to Department staff and Dr. Cline for their continued quality improvement efforts and thanked Board members for their commitment to public health.

ADJOURNMENT

Ms. Wolfe moved to adjourn. Second Dr. Alexopulos. Motion carried.

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

The meeting adjourned at 7:29 p.m.
Saturday, August 17, 2013

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley, Janice Hiner.

Visitors in attendance: See list

Call to Order and Opening Remarks

Dr. Krishna called the meeting to order at 8:35 a.m. and welcomed those in attendance. He acknowledged special guests Gary Cox, Director 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; Pam Rask of the Tulsa Health Department; and Brent Wilborn of the Oklahoma Primary Care Association.

WELLNESS INTEGRATED STRATEGIC PLAN

Julie Cox-Kain, M.P.A., Chief Operating Officer; Tracey Strader, M.S.W., Executive Director, Tobacco Settlement Endowment Trust; Keith Reed, outgoing Director for the Center for the Advancement of Wellness.
Oklahoma Tobacco Settlement Endowment Trust

TRACY STRADER, MSW, EXECUTIVE DIRECTOR

About TSET

- Created by a constitutional amendment approved by voters 69% to 31% in 2000.
- 75% of Master Tobacco Settlement Agreement payments are invested through an endowment, and only the earnings are spent for programs to improve health.
- Governed by a seven-member, bipartisan, Board of Directors to fund and oversee programs. A separate five-member Board of Investors manages the endowment funds.

Determinants of Health and Their Contribution to Premature Death

- Social Circumstances
- Environmental Exposures
- Health Care
- Behavioral Patterns
- Genetic Predisposition

TSET - OSDH Partnership

- Shared goals in tobacco control and obesity
- Strategies defined together, playing on the strengths of each organization
- Strategies based on state plans and available evidence, and tailored to Oklahoma culture
- TSET focus on grant making: what is funded, who is funded, and how the grants are funded. Monitoring measures of progress and ensuring technical assistance, consultation, and training are available to support grantees.
- OSDH focus on providing expert resources and consultation to entire state. Specific focus on providing the technical assistance, consultation, and training for TSET-funded grants in illness.

Programs Funded - Tobacco Control

Communities of Excellence in Tobacco Control

- 34 grants, 51 counties, 1 tribal nation, 67% of state's population
OKLAHOMA STATE BOARD OF HEALTH MINUTES                              August 16-18, 2013

PROGRAMS FUNDED - TOBACCO CONTROL

Oklahoma Tobacco Helpline
- funded by TSET in partnership with Department of Health, Health Care Authority, and Employees Group Insurance Division
- served over 250,000 since 2003
- quit coaching™ significantly increases quit rates (approx. 35%)
  - patches, gum, or lozenges sent via mail order
- estimated savings of $67 million annually for direct medical cost from smokers who have quit
- ranked second in the nation in reach:
  - over 60% with incomes of $20,000 or less
  - 6,371 calls from Oklahoma Co., 1,902 calls from Cleveland Co.
  - 801 calls from Canadian Co.

PROGRAMS FUNDED - PHYSICAL ACTIVITY & NUTRITION

Physical Activity & Nutrition
- strategies similar to tobacco prevention
- create comprehensive program over time
- first initiative: community-based programs
- originally funded a three-year pilot project in Tulsa

PROGRAMS FUNDED - INCENTIVE GRANTS

Healthy Communities & Healthy Schools Incentive Grants
- communities and schools earning basic, merit, or excellence levels of certification under the Certified Healthy Communities program may be eligible for incentive grants
- wgrant funding may be used on a variety of criteria to promote health in local communities

PROGRAMS FUNDED - HEALTH SYSTEMS

Health Systems Grants
- Oklahoma Department of Mental Health and Substance Abuse Services
- Oklahoma Health Care Authority
- Oklahoma Hospital Association
  - Each organization works to support their networks in linking tobacco dependence treatment into routine care, with active linkages to the Oklahoma Tobacco Helpline. Also promotes physical activity and healthy nutrition through provider organizations and practices.
Programs Funded: Evaluation
- University of Oklahoma
  - College of Public Health - Dr. Lawrence Beebe
- Oklahoma State University
  - Department of Nutritional Sciences - Dr. Diane Hillbrand

Programs Funded: Research Centers
- Peggy and Charles Stephenson Cancer Center
- TSET Cancer Research Program
- Oklahoma Tobacco Research Center
- Oklahoma Center for Adult Stem Cell Research

Providing research and treatment in cancer and tobacco-related diseases.

Programs Funded: Unsolicited Proposals
Unsolicited Proposals
- Oklahoma After-school Network
- OSU Dining Services
- Rescue Social Change Group
- Physician Manpower Training Commission

Addressing any of TSET's Constitutional purposes.

Creation of the Center for the Advancement of Wellness
- Board of Health Retreat August 2011
- Consolidate obesity programs within the agency
- Leverage knowledge and infrastructure built in tobacco to accelerate obesity efforts
- Utilize evidence-based, strategic and business planning processes to target achievements in Tobacco use and obesity prevention & reduction

Center for the Advancement of Wellness
- Purpose: Reduce/prevent tobacco use and obesity
- Distinctive Competence: Provide data, best practices, expert consultation
- Method: Impact policy, environment, social norms
- Key goals by 2017:
  - Reduce smoking prevalence from 26.1% to 23.1% of adults and from 17.9% to 15.8% of adolescents.
  - Reduce obesity prevalence from 31.1% to 29.6% of adults and from 16.7% to 15.9% of adolescents.
Oklahoma Adults – 2011 BRFSS

- 26.1% Smoke
- 31.1% Obese
- 34.4% Overweight
- 55.2% Not getting minimal Physical Activity
- 84.5% Not consuming minimum of 5 fruits and vegetables/day

ASTHO Multistate Collaborative

- ASTHO/United Health Foundation effort to improve health rankings of low ranking states
- Kansas, Georgia, Rhode Island, Arkansas, Oklahoma
- Center partnering with ODMHSAS and Tourism/Recreation on worksite wellness projects
- HealthLead assessment for baseline data to guide improvement areas
- Goal is to create scalable model for worksite wellness in state agencies to impact both employees and agency’s target population

Governor’s Get Fit Challenge

- Program for before, during or after school designed to get kids moving more and eating better
- Grades 4 through 8
- Pending IRB approval, will evaluate selected schools in the fall
- Includes DVD of warm up and core exercises plus 20 minutes of cardiovascular activity 3 days per week
- Also includes nutrition and physical activity worksheets
- Through the program, help shape healthier school environments for kids
Partnership with TSET

- One of multiple funding sources for Center
- Partners in tobacco, physical activity, and nutrition initiatives
- TSET Communities of Excellence (CX) grants in tobacco and physical activity/nutrition
- Center provides expert consultation to CX grantees, as well as schools, businesses, communities and others around the state

Strategic Priorities

Smokefree environments

- Sector-based education about voluntary smokefree/tobacco free policies
  - Entertainment industry – bars, casinos, restaurants with smoking rooms
  - Career technical centers
  - Focus on importance of clean indoor air and voluntary policies to promote health

Strategic Priorities

Registry of smokefree places

- Allows for monitoring/tracking smokefree policies around the state for goal-setting and reporting purposes
- Possible searchable public site to help connect citizens with smokefree places, including housing, bars, entertainment, etc.

Strategic Priorities

Cessation

- Cessation through systems change
  - Assess state agencies and populations served
  - Work with health care systems, insurance, county health departments, other agencies
- Cessation communications
  - Mass media campaign (with TSET)
  - Materials for providers, insurance companies, and others

Strategic Priorities

Youth engagement

- Tobacco and Physical Activity/Nutrition focus for youth advocacy
- Survey youth, look at available research
- Explore partnerships for training, support

School-based strategies

- Access to fruits and vegetables
- Wellness policies
- 24/7 tobacco free
The presentation included a media advertisement about multiunit housing units as an example of media campaigns that have resulted from the collaboration between the OSDH and TSET. See Attachments 1-3.

The presentation concluded.

**STRATEGIC PLAN REVIEW**

Terry L. Cline, Ph.D., Commissioner of Health
Oklahoma Health Improvement Plan (OHIP) Flagship Issues

- Tobacco Use Prevention
- Children’s Health Improvement
- Obesity Reduction

Core Public Health Priorities

- Children’s Health
- Infant Mortality
- Prenatal Care
- Disease & Injury Prevention
- Immunization
- Motor Vehicle Crashes
- Preventable Hospitalizations
- Imperatives
- All Hazards Preparedness
- Infectious Disease
- Mandates
- Strong & Healthy Oklahoma (Wellness)
- Cardiovascular Health
- Obesity
- Tobacco

LSTAT Strategic Planning Priority Area Lead Champions

- OHIP Flagship & Core Public Health Services
  - Strong & Healthy Oklahoma / Wellness (Trish McAuliffe)
  - Children’s Health
  - Suicide Prevention (Trish McAuliffe)
- Disease & Injury Prevention / Immunization
  - (Kathy Gross, Jackie Bradley, & Rose Harnett)
- Health Inequities
  - (Mollie Desalvo)
- Policy & Advocacy
  - (Aaron Newborn)
- Public Health Systems
  - Infrastructure, Performance Management, & Accreditation
  - Workforce
  - Disease Surveillance
  - Health Information Exchange (HIE)
  - Public/Private Partnerships
  - Resources
  - (Julie Cosgrove)

OSDH Performance Management Model: Tying It All Together

Quality improvement

Core Performance Measures Scorecard Public Health Imperatives

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual Previous Year</th>
<th>Target Current Year</th>
<th>Actual Current Year</th>
<th>5 Year Target Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interim Health Improvement</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Tobacco Use Prevention</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Injuries</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Disease</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Health</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Prevention</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Policy</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Interim Resources</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Core Performance Measures Scorecard Public Health Priority Programs

<table>
<thead>
<tr>
<th>Measure</th>
<th>Actual Previous Year</th>
<th>Target Current Year</th>
<th>Actual Current Year</th>
<th>5 Year Target Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1 - Deaths due to motor vehicle crashes</td>
<td>7.6</td>
<td>7.6</td>
<td>7.6</td>
<td>7.6</td>
</tr>
<tr>
<td>Objective 2 - % of persons living with diabetes</td>
<td>77%</td>
<td>77%</td>
<td>77%</td>
<td>77%</td>
</tr>
<tr>
<td>Objective 3 - % of adults achieving physical activity guidelines</td>
<td>25.6</td>
<td>25.6</td>
<td>25.6</td>
<td>25.6</td>
</tr>
<tr>
<td>Objective 4 - % of adults who report being in excellent or very good health</td>
<td>24.5</td>
<td>24.5</td>
<td>24.5</td>
<td>24.5</td>
</tr>
</tbody>
</table>
The presentation concluded.

FOCUS ON CORE PRIORITIES & STRENGTHEN SYSTEMS

Henry F. Hartsel, Ph.D., Deputy Commissioner, Protective Health Services
Objectives for Inspection Frequency Mandates

Meet 100% of required time intervals and response deadlines by FY2014 for:
1. State mandated routine inspections
2. State mandated complaint inspections
3. Contract (federal) mandated routine surveys
4. Contract (federal) complaint investigations

(Fifty-two mandates were covered by the four objectives in FY2013.)

Inspection Frequency Mandates by Performance Objectives 2012 - 2013

Percentage of 32 Total Mandates Covered by the Objectives

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Inspections (14)</td>
<td>46%</td>
</tr>
<tr>
<td>State Complaints (12)</td>
<td>23%</td>
</tr>
<tr>
<td>Contract Surveys (21)</td>
<td>16%</td>
</tr>
<tr>
<td>Contract Complaints (5)</td>
<td>27%</td>
</tr>
</tbody>
</table>

Source: OKDHS State Performance Management System

Inspection Frequency Mandates by Program Areas 2012-2013

Mandates by Program Areas

- Long Term Care (34)
- Medical Facilities (15)
- Consumer Health (10)
- Health Resources (3)

Percentage of 32 Mandates Administered by Program Area

Source: OKDHS State Performance Management System

Highlights for State Fiscal Year 2013

- All long term care inspections and investigations current on 6/30/2013
- Home health agency recertification surveys current on 9/30/2012
- Food service establishment, jail, and nurse aide training inspections timely performed for second straight year
- 48 of 52 (92%) mandates brought into compliance as of 6/30/2013

Compliance with Inspection Frequency Mandates Fiscal Years 2011-2014

Bar chart showing compliance percentages for different types of inspections and surveys over the fiscal years 2011 to 2014.

Source: OKDHS State Performance Management System.
The presentation concluded.

LEVERAGE RESOURCES FOR HEALTH OUTCOMES IMPROVEMENT YEAR END REVIEW
Julie Cox-Kain, M.P.A., Chief Operating Officer

Patient Protection and Affordable Care Act

- Enacted March 23, 2010
- Establishes the Health Insurance Marketplace to help individuals and small businesses obtain health insurance coverage (including stand-alone dental)
- Provides premium tax credits and cost-sharing reductions for low and middle-income individuals who purchase health insurance through a Marketplace
- Provides a tax credit to eligible small businesses
- Originally required an expansion of Medicaid to cover additional adults and children with low incomes
- 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
- Guaranteed issue (no pre-existing condition exclusion)
- American Indian/Alaskan Native (AI/AN) special provisions
- Children’s coverage extended 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

- In June 2012, Supreme Court upheld insurance mandate requiring Americans to obtain insurance or pay a tax penalty.
- The ruling struck down the penalty requiring state Medicaid expansion, thereby allowing each state to decide.
- Oklahoma elected against Medicaid expansion and defaulted to a Federally Facilitated Marketplace (FFM).
### Types of Health Insurance Exchanges

- **State-Based Marketplace**
  - States can create and operate their own marketplaces.

- **Partnership Marketplace**
  - States and the federal government share the costs of operating a marketplace in states that do not establish their own.

### Health Insurance Exchange (Marketplace)

- **Small Business Health Options Program (SHOP)**
  - Available to all employers.
  - Open enrollment for the SHOP begins October 1, 2013.

### Individual/Family Tax Credits

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premiums as a Percent of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 150% FPL</td>
<td>3% of income</td>
</tr>
<tr>
<td>150-185% FPL</td>
<td>4% of income</td>
</tr>
<tr>
<td>185-200% FPL</td>
<td>5% of income</td>
</tr>
<tr>
<td>200-250% FPL</td>
<td>6% of income</td>
</tr>
<tr>
<td>250-300% FPL</td>
<td>7% of income</td>
</tr>
<tr>
<td>300-400% FPL</td>
<td>8% of income</td>
</tr>
<tr>
<td>Over 400% FPL</td>
<td>9% of income</td>
</tr>
</tbody>
</table>

### Individual Penalties

- **Employer Penalties** DEPRECATED

  - **Penalty calculation**
    - Employers with more than 100 full-time employees who do not offer health insurance.
    - Penalty for each employee without coverage is: 
      - 1/12 x $2,000 x the number of full-time employees

  - **Example**
    - 2014: Penalty = $2,000 x 12 employees x 1/12 = $2,000 per employee
    - 2015: Penalty = $2,000 x 12 employees x 1/12 = $2,000 per employee
Essential Benefits

- Essential health benefits (EHBs) are a set of health services categories that must be covered by every plan, starting in 2014.
- Health plans offered in the individual and small group market will be required to include all of the EHBs.
- Each plan must include those same 10 categories.

Premium Rate Setting Factors

- Age
- Geographic
- Smoking
- Family Size

Online Enrollment Portal

Healthcare.gov

- Open Enrollment: October 1, 2013 - March 31, 2014
- Enroll online or by phone
- Healthcare.gov 1-800-318-2395
- Expected to include links to issuer and agent websites

Centers for Medicare and Medicaid Services Timeline (CMS)

- June
- July
- August
- September
- October

Implementation Delays

- The Affordable Care Act allows for implementation delays until 2017 for many of the law’s major provisions.
- However, the law also establishes several deadlines, including
  - June 2013: Start enrollment
  - October 1, 2013: Healthcare.gov open

PPACA Medicaid Changes

- Use of the new Modified Adjusted Gross Income (MAGI) to calculate household composition and income to determine Medicaid eligibility
- Elimination of asset tests
- Implementation of waiting periods
- Automation of electronic verifications to determine Medicaid eligibility in real-time
- Simplified eligibility and connections (“hand-off”) with the Federally Facilitated Marketplace
- Former foster care children under age 26 will be eligible for Medicaid regardless of changes in circumstances; Medicaid eligibility will be extended for up to 1 year from the date of an individual’s emancipation or completion of high school
Projected Insurance Enrollment

Future Insurance Market Enrollment without Medicaid Expansion

<table>
<thead>
<tr>
<th>Market</th>
<th>2012</th>
<th>2014</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>106,877</td>
<td>209,099</td>
<td>601,812</td>
</tr>
<tr>
<td>ESI-Small Group</td>
<td>333,710</td>
<td>347,489</td>
<td>360,081</td>
</tr>
<tr>
<td>ESI-Medium Group</td>
<td>181,468</td>
<td>187,551</td>
<td>203,126</td>
</tr>
<tr>
<td>ESI-Large Group</td>
<td>265,467</td>
<td>362,769</td>
<td>376,741</td>
</tr>
<tr>
<td>ESI-GSA (Fully Insured)</td>
<td>770,768</td>
<td>776,029</td>
<td>758,026</td>
</tr>
<tr>
<td>Medicaid/CHIP</td>
<td>524,877</td>
<td>392,923</td>
<td>641,814</td>
</tr>
<tr>
<td>Uninsured</td>
<td>644,843</td>
<td>475,083</td>
<td>258,084</td>
</tr>
</tbody>
</table>

Oklahoma Enrollment by Income Level For Individual Market Under Age 65

Recommendations for Medicaid Waivers

Leavitt Partner Recommendations

- Negotiate with the Centers for Medicare and Medicaid Services (CMS) to extend Insure Oklahoma (IO) through 2014
  - An extension will provide an estimated 9,000 individuals between 0-100% FPL
  - Areas of negotiation may be limited due to state and federal rules and/or rules
  - Based on correspondence, CMS may be limited to state and federal rules and/or rules
  - Modification of caps and cost-sharing provisions may increase Oklahoma’s financial liability

Insure Oklahoma FPL Breakdown of Total Enrollment
Leavitt Partner Recommendations

- Prepare an alternative to PPACA Medicaid expansion through a demonstration waiver.
- Create a steering committee
- Leverage Insure Oklahoma (IO) as framework
- Maintain Employer Sponsored Insurance (ESI) components of IO
- Support premium assistance of private insurance coverage
- Integrate public health and rebehavior health initiatives and infrastructure
- Streamline Medicaid eligibility
- Work toward multi-payer models
- Develop a strong evaluation component
- Demonstrate cost-effectiveness
- Leverage current programs initiatives

Leavitt Partner Recommendations

- Demonstration waiver (continued)
  - Projected outcomes
    - Reduce the number of uninsured individuals in Oklahoma
    - Opportunity for innovative approaches to improve health outcomes and slow the increase in healthcare costs
    - Reduce uncompensated care costs for healthcare providers and the State of Oklahoma
  - Projected outcomes (continued)
    - Long-term opportunities
  - Costs
    - State of Oklahoma contributions to match the recommended demonstration proposal estimated at $745 - $939 million over 10 years

Leavitt Partner Recommendations

Income < 138% FPL, but don't currently qualify for Medicaid

- Commercial Insurance purchased with subsidy or APTCs
- Medicaid, Medicaid FPL, or Medicaid FPL with multiple conditions
- Healthy Bridging Assistance
- Access to EII

Income = 138% FPL

- Commercial Insurance purchased with subsidy or APTCs
- Medicaid, Medicaid FPL, or Medicaid FPL with multiple conditions
- Healthy Bridging Assistance
- Access to EII

Income > 138% FPL

- Commercial Insurance purchased with subsidy or APTCs
- Medicaid, Medicaid FPL, or Medicaid FPL with multiple conditions
- Healthy Bridging Assistance
- Access to EII

Leavitt Partner Recommendations

Costs and Savings

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Medicaid Expansion Cost Estimate (Million)</th>
<th>Medicaid Expansion Benefit Estimate (Million)</th>
<th>Total Estimated Impact (Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>$604.9 million</td>
<td>$21.1 million</td>
<td>$626.0 million</td>
</tr>
<tr>
<td>Median</td>
<td>$780.9 million</td>
<td>$21.1 million</td>
<td>$802.0 million</td>
</tr>
<tr>
<td>High</td>
<td>$277.4 million</td>
<td>$21.1 million</td>
<td>$298.5 million</td>
</tr>
</tbody>
</table>

Source: Leavitt Parners, 2013

Leavitt Partner Recommendations

Costs and Savings

- Estimates of Ten Year Net Surplus
  - Oklahoma's Total Model
  - OHCRA Program Savings
  - Other State Agency Savings
  - Total Increase in Tax Revenue
  - Net Surplus

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Total Increase (Million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>$745 - $939 million</td>
</tr>
<tr>
<td>Median</td>
<td>$211 million</td>
</tr>
<tr>
<td>High</td>
<td>$882 million</td>
</tr>
</tbody>
</table>

*Other agency savings (SMILES, CBH, and Corrections) estimated from a high-level review of cost savings and internal additional analysis*
**Leavitt Partner Recommendations**

- Develop complementary proposals to reduce uncompensated care costs for Native Americans seeking healthcare services at tribal and IHS facilities.
- Limited federal resources make it difficult for IHS, Tribal, and Urban Indian (T/I) healthcare facilities to meet demand; this burden private contract healthcare providers with uncompensated care costs.
- Uncompensated care waivers provide an opportunity for the federal government to meet their obligation to provide healthcare to Native Americans in Oklahoma.
- Allow the State of Oklahoma to mitigate costs associated with uncompensated care and improve health outcomes through greater healthcare access.
- Federal share of healthcare costs for AH/AM is 100%
- Uncompensated care waivers are not a substitute for comprehensive insurance coverage.

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**The Uninsured and Uncompensated Care in Oklahoma**

- 644,843 or 17% of Oklahoma's population is uninsured.

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**Oklahoma Population Under Age 65 by Type of Insurance in Thousands**

- Medicaid / CHIP: 525
- Other Government Programs: 212
- Uninsured: 615
- Individual Worker: 109
- ESI - Small Group: 254
- ESI - Large Group: 865


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**Uninsured by Income Level, 2011**

- Percentage of Total Uninsured:
  - Less than 100%: 32%
  - 100-138%: 12%
  - 139-200%: 12%
  - 201-399%: 15%
  - 400% or more: 14%

Source: U.S. Census Bureau, Small Area Health Insurance Estimates (SAHIE) Program.
Percentage of County Hospital Net Revenues Represented by Medicare Fee for Service Payments

This measure provides an indication of the risk that hospitals are subject to as Medicare fees are reduced. 
Source: "Oklahoma Uninsured Care Analysis" Table 4-29

Oklahoma Medicaid DSH Allocation vs. Expenditure in Millions

- Federal Allocation for Oklahoma
- Projected Federal Share of Total State Expenditures

Challenges for Public Health
- Integration of public health and healthcare
- Maintenance and advancement of community level health protection & primary prevention
- Reallocation of federal funds from public health to PPACA implementation
- Diversification of revenue
- Other barriers to access to care

Determinants of Health and Their Contribution to Premature Death

Access to Care Framework

Modified from Institute of Medicine (IOM), Access to Health Care in America
Dr. Cline and the Board acknowledged Chris Bruehl, Director of Appointments for Governor Mary Fallin, for taking time from his schedule to thank the Board of Health for their efforts as he passed through the retreat facility.

Dr. Cline and the Board thanked Representative Jeff Hickman for the time he spent addressing the Board as well as advocacy efforts in public health. Representative Hickman thanked the Board for using their expertise in healthcare to improve public health and encouraged members to contact their local legislators and advocate for public health policy that will make a difference.

The presentation concluded.

**MISSION, VISION, VALUES**
Arnold Baciagalupo, Ph.D.

Dr. Baciagalupo briefly described the importance of an organization’s Mission, Vision, and Values statements. He emphasized that intermittent review of these statements is critical to the continued alignment of an organization. He drew Board attention to the handout in the packet which outlined the process used by the Department for the review of the current Mission, Vision, and Values statements.
The recommended Mission Statement is as follows: *To protect and promote health, to prevent disease and injury, and to cultivate conditions by which Oklahomans can be healthy.*

Ms. Wolfe moved Board approval to adopt the Mission Statement as presented. Second Dr. Alexopulos. Motion carried.

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

There were no modifications to the current Vision Statement.

Mr. Starkey moved Board approval to table action on the values statements until August 18, 2013. Mr. Starkey moved Board approval to appoint an Ad Hoc Committee consisting of Ms. Burger, Dr. Stewart, and Dr. Alexopulos for the purpose of modifying the proposed values Statements, based on Board comments, and presenting recommendations back to the Board on August 18, 2013. Second Ms. Wolfe. Motion carried.

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

The presentation concluded.
2013 LEGISLATIVE AGENDA BREAKOUT
Mark Newman, Ph.D., Director, Office of State and Federal Policy

The Board discussed potential policy and legislative issues they would like to support during the upcoming legislative session.

Ms. Wolfe moved Board approval to explore and develop language to transfer hearing aid dealers and fitters to the Board of Examiners of Speech Language Pathologists and Audiologists; Workplace Drug and Alcohol Testing Program to the Department of Labor; and Certified Workplans and HMO’s to the State Department of Insurance. Second Ms. Burger. Motion carried.

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

Ms. Burger moved Board approval to explore and develop language prohibit the sale of ecigarettes to minors. Second Dr. Alexopulos. Motion carried.

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

Dr. Gerard moved Board approval to explore and develop language to propose a tax credit for the construction of tornado shelters or sales tax-free materials when constructing a tornado shelter. Second Ms. Wolfe. Motion carried.

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

Dr. Grim moved Board approval to explore and develop language to support smoking policy disclosure of multiunit housing. Second Dr. Stewart. Motion carried.

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

ADJOURNMENT
Dr. Krishna advised the Board and Department staff that the proposed Executive Session on August 18, 2013 would need to be moved to the first item on the agenda in order to allow Dr. Alexopulos to attend. A motion would be made the morning of August 18, 2013.

Ms. Wolfe moved to adjourn. Second Dr. Stewart. Motion carried.

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

The meeting adjourned at 4:37 p.m.

Sunday, August 18, 2013

ROLL CALL

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

Staff present were: Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; 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; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office: Diane Hanley, Janice Hiner.
Visitors in attendance: See list

Call to Order and Opening Remarks
Dr. Krishna called the meeting to order at 8:30 a.m.

Ms. Burger moved Board approval to move the Proposed Executive Session to the first item on the agenda. Second Ms. Wolfe. Motion carried.

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

PROPOSED EXECUTIVE SESSION
Dr. Grim moved Board approval to move into Executive Session at 8:32 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.

- Conflict of Interest discussion

Second Alexopulos. Motion carried.

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

Dr. Alexopulos moved Board approval to come out of Executive Session at 9:19 a.m. and open regular meeting. Second Dr. Gerard. Motion carried.

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

No action taken as a result of Executive Session

Dr. Baciagalupo thanked the Board and Department staff for their commitment and participation throughout the meeting. He asked the Board if their expectations of him were met. 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.

COMMUNITY RELATIONS/INVOLVEMENT
Arnold Baciagalupo, Ph.D.

Dr. Baciagalupo asked Board member to briefly provide an overview of local health issues from their respective communities. Each Board member discussed outreach opportunities as a result of the previous year President’s Challenge in which Dr. Krishna challenged each Board member to develop an individual Board member action plan. Board members also highlighted opportunities for collaboration and partnerships within their communities as well as the barriers faced by some communities such as access to care, impacts of natural disasters, poverty, and increases in domestic violence.

2014 BUDGET / BUSINESS PLAN
Julie Cox-Kain, M.P.A., Chief Operating Officer
The presentation concluded.

OFFICE OF ACCOUNTABILITY SYSTEMS POLICIES AND PROCEDURES
Terry L. Cline, Ph.D., Commissioner of Health

Dr. Cline presented the Office of Accountability Systems Policy with highlighted additions for approval to the Board of Health. He briefly discussed the controls built into the policy to ensure consistent and fair review and the creation of the Coordinating Complaint Council, which will serve to maximize the resources of the Board and Department and eliminate the duplication of investigations.

Office of Accountability Systems

Background

The Office of Accountability Systems (OAS) was created pursuant to Title 63 of the Oklahoma Statutes, Section 1-105f (63 O.S. § 105f) by the Oklahoma Legislature in 2006. Pursuant to statute, there is a Director for OAS who reports directly to and under the direct supervision of the Board of Health, but is also under the general supervision of the Commissioner of Health, 63 O.S. § 105f (B)(2). The duties of the OAS are established at 63 O.S. § 105f (A) & (B) as:

1. Coordinate audits and investigations and make reports to the State Board of Health and State Commissioner of Health within the State Department of Health and State Health Officer relating to the administration of programs and operations of the State Department of Health, see, 63 O.S. § 105f (A) (1);

2. Except as otherwise prohibited by current law, access all records, reports, audits, reviews, documents, papers, recommendations, or other material which relate to programs and operations with respect to which the Director of the Office of Accountability Systems has responsibilities, see, 63 O.S. § 105f (A) (2);

3. Request assistance from other state, federal and local government agencies, see, 63 O.S. § 105f (A) (3);

4. Issue administrative subpoenas for the production of all information, documents, reports, answers, records, accounts, papers, and other data and documentary evidence, see, 63 O.S. § 105f (A) (4);
5. Administer to or take from any current or former employee of the State Department of Health an oath, affirmation, or affidavit, see, 63 O.S. § 105f (A) (5);

6. Receive and investigate complaints or information from an employee of the Department, service recipient or member of the public concerning the possible existence of an activity within the State Department of Health constituting a violation of law, rules or regulations, mismanagement, gross waste of funds, abuse of authority or a substantial and specific danger to the public health and safety, see, 63 O.S. § 105f (A) (6);

7. Cause to be issued on behalf of OAS credentials, including an identification card with the State Seal, see, 63 O.S. § 105f (A) (7);

8. Keep confidential all actions and records relating to OAS complaints, see, 63 O.S. § 105f (A) (8);

9. Keep the State Board of Health and the State Commissioner of Health fully informed of matters relating to fraud, abuses, deficiencies and other serious problems of which the Director is aware relating to the administration of programs and operations within the State Department of Health. Further, the Director shall recommend corrective action concerning such matters and report to the State Board of Health and the State Commissioner of Health on the progress of the corrective matters, see, 63 O.S. § 105f (B) (1); and

10. Report expeditiously to the appropriate law enforcement entity whenever the Director has reasonable grounds to believe that there has been a felonious violation of state or federal criminal law, see, 63 O.S. § 105f (B) (3).

Policy Statement

In adopting this Policy Statement, the Board of Health has reviewed and takes into account certain programs and policies of the OSDH, including the OSDH Personnel Advisory Committee, the Civil Rights Administrator for the OSDH, the Internal Audit Unit of the OSDH and OSDH Administrative Procedure 1-30a. OSDH Administrative Procedure 1-30a establishes a process for the handling and referral of complaints and other inquiries received by OAS, which includes when OAS receives a complaint or inquiry concerning the President of the Board of Health, any current member of the Board of Health, the Commissioner of Health, a member of Senior Leadership of the OSDH, (for the purposes of this policy “Senior Leadership of the OSDH” is defined as a Deputy Commissioner for the OSDH, the Chief Operating Officer for the OSDH, the Director of State and Federal Policy for the OSDH, and the Executive Assistant/Senior Advisor for the Commissioner of Health) any individual who directly reports to the Board of Health, (including the Director of OAS, the Secretary of the Board of Health and the Director of Internal Audit) and any other complaint or inquiry received by OAS, as follows:

A. If the complaint involves the President of the Board of Health, the OAS Director will inform the Commissioner of Health and the Chair of the Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and nature of the complaint and after consultation with the Commissioner and Committee Chair, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

B. If the complaint involves a current member of the Board of Health, who is not the President, the OAS Director will inform the Commissioner of Health, the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee concerning the receipt and nature of the complaint and after consultation with the Commissioner and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;
C. If the complaint involves the Board of Health in total, the OAS Director will inform the Commissioner of Health concerning the receipt and nature of the complaint. After consultation with the Commissioner of Health, if an investigation is required, the Director of OAS will follow the procedures set forth in OSHD Administrative Procedure 1-30a;

D. If the complaint involves the Commissioner of Health, the OAS Director will inform the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and nature of the complaint and after consultation with the Committee Chair and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

E. If the complaint involves a current member of Senior Leadership of the OSDH, the OAS Director will inform the Commissioner of Health, the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee for the Board of Health concerning the receipt and nature of the complaint and after consultation with the Committee Chair, Commissioner of Health and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a;

F. If the complaint involves a person in a position that directly reports to the Board of Health, the OAS Director will inform the Commissioner of Health, the President of the Board of Health and the Chair of the Accountability, Ethics and Audit Committee concerning the receipt and nature of the complaint and after consultation with the Commissioner of Health and Board President, follow the procedures set forth in OSDH Administrative Procedure 1-30a; and

G. If the complaint does not fall within any of the categories listed above, The OAS Director will convene a meeting of the OSDH Coordinating Complaint Council and after consultation with the Council follow the procedures set forth in OSDH Administrative Procedure 1-30a.

OSDH Administrative Procedure 1-30a establishes the Coordinating Complaint Council, the Council members and the Council duties. It is the intent of the Board of Health that all OAS staff comply with the requirements of OSDH Administrative Procedure 1-30a. This Board of Health Policy Statement is written to provide a framework for the interaction between the OAS and the OSDH, and to maximize the limited resources of the Board of Health and the OSDH.

H. Effective this date, the Director of OAS may exercise the duties listed in paragraphs (3), (4) and (10), above with the written approval of the President of the Board of Health and/or the Commissioner of Health.

I. Effective this date, the Identification Cards issued by the OSDH meet the requirements of paragraph (7) above.

J. Effective this date, the Director of OAS may exercise the duties listed in paragraphs (1), (2), (5), (6), (8) and (9), above, when a complaint is received by OAS concerning any member of the Board of Health, the Commissioner of Health, a member of Senior Leadership of the OSDH or a complaint alleging that an employee of the OSDH has committed a fraud or has abused his/her authority to the community regulated by the OSDH or to the general public who is not an employee of the OSDH, in the performance of his/her job duties.

The presentation concluded.

Ms. Wolfe moved Board approval to approve the Office of Accountability Systems Policies and Procedures as presented. Second Dr. Woodson. Motion carried.

AYE: Alexopulos, Burger, Gerard, Grim, Krishna, Starkey, Stewart, Wolfe, Woodson
AD HOC COMMITTEE REPORT FOR PROPOSED VALUES STATEMENTS

Robert S. Stewart, M.D.; Martha A. Burger, M.B.A.; Jenny Alexopulos, D.O.

Dr Stewart presented five (5) Values Statements proposed by the Ad Hoc committee. The committee felt these statements were representative of the feedback provided by the Board, Department employees, and Public Health Partners. The Board discussed possible modifications as well as the ordering of the Values Statements. The Board agreed that Leadership should lead the statements but did not have a preference for the ordering of the remaining statements.

1. **Leadership** - To provide vision and purpose in public health through knowledge, inspiration and dedication. To be identified as the leading authority on prevention, preparedness and health policy.

2. **Integrity** - To steadfastly fulfill our obligations, maintain public trust, and exemplify excellence and ethical conduct in our work, services, processes, and operations.

3. **Community** - To respect the importance, diversity, and contribution of individuals and community partners.

4. **Service** - To demonstrate a commitment to public health through compassionate actions and stewardship of time, resources, and talents.

5. **Accountability** – To competently improve the public’s health on the basis of sound scientific evidence and responsible research.

Ms. Burger moved Board approval to approve the values statements as presented giving the Department Senior Leadership the flexibility to wordsmith. Second Dr. Stewart. Motion carried.

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

ABSENT: Alexopulos

ADJOURNMENT

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

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

ABSENT: Alexopulos

The meeting adjourned at 11:17 a.m.

Approved

R. Murali Krishna, M.D.
President, Oklahoma State Board of Health

October 9, 2013
Little cigars are almost identical to cigarettes in shape and size. They generally have filters like cigarettes, but are wrapped with either a tobacco leaf or a substance containing tobacco, and not solely paper, as is the case with cigarettes. Little cigars are often sold individually.

Health Harms
- Regular cigar smoking causes cancer, heart disease, and chronic obstructive pulmonary disease (COPD).¹
- Cigar smoke contains the same toxins as cigarette smoke. Any difference in risks between cigars and cigarettes is likely attributable to differences in frequency of use and the fact that not all cigar smokers inhale.
- Little cigars and cigarillos are more like cigarettes and therefore are more easily smoked and inhaled like cigarettes.
- Another use of cigars, known as "blunting," involves a cigar that is hollowed out and filled with marijuana.²

Youth Access
- Between 2001 and 2008, the sale of cigars increased by 87%. Little cigars contributed to that growth at a rate of 158%.³
- Nationally, high school students are about twice as likely as adults (13.1 percent vs. 6.6 percent) to report smoking a cigar in the past month.⁴ Nationally, high school students are about twice as likely as adults (13.1 percent vs. 6.6 percent) to report smoking a cigar in the past month.⁵
- In Oklahoma, 13% of high school students reported current use of cigars (10.6% of females and 15.9% of females).⁶ Almost two-thirds (63.5%) of high schools students who smoke cigars usually or always smoke flavored cigars (females: 58.4%, males: 67.3%).⁷
- Tax increases have not affected all tobacco products equally. Although cigarettes and little cigars are similar products, little cigars can be purchased for substantially less than cigarettes, making them more attractive to price-sensitive populations.⁸
- The state excise tax on little cigars is 3.6 cents each. A pack of 5 little cigars would result in 18 cents state excise tax and 25 cents federal (43 cents total).⁹
- Cheap, sweet cigars can serve as an entry product for kids to a lifetime of smoking.¹⁰
- Minimum pack size requirements would make the products less accessible by youth, since the prices would be higher.
- Most cigars are sold in convenience stores rather than in cigar shops.¹¹

⁷ Youth Tobacco Survey 2011
⁸ Tobacco Control Legal Consortium. Regulatory Options for Little Cigars
⁹ Oklahoma Tax Commission: Oklahoma tax rates
¹⁰ Campaign for Tobacco Free Kids. Not your Grandfathers Cigar. March 2013
Multiunit Housing Smoking Policy Disclosure

- About 10% of Oklahoma’s housing units are in multiunit housing (5 units or more).
- 80% of Oklahoma apartment residents live in buildings that have no policy on smoking.*
- State smoking laws protect hallways, offices and other areas that are indoor workplaces. Private residential areas are not protected by these laws.
- When smoking is allowed in one area, smoke can and will spread to other areas within the building.
- A majority of Oklahoma nonsmoking apartment residents report they have experienced smoke infiltration into their apartments.*
- 60% of Oklahoma apartment residents would prefer to be in an entirely nonsmoking building.*
- Secondhand tobacco smoke causes disease and premature death in nonsmokers. There is no safe level of exposure.**
- OSDH and the OHIP recommend smokefree homes, including multiunit housing.
- Consideration should be given to nonsmoking zones outside of entrances, open windows and patio doorways, especially in multiunit housing, to prevent smoke entering homes.
- Oklahoma’s Commissioner of Health has issued a public health warning advising persons with heart disease or at elevated risk for heart disease not to enter places where smoking is allowed.***

Footnotes from front (sources)

* 2011 survey of Oklahoma multiunit housing residents by Spears School of Business, A Oklahoma State University
E-Cigarettes

What is an e-cigarette?

- A battery-powered device that heats a liquid solution to produce a vapor for inhalation.
- Some look similar to cigarettes and even have a tip that lights up when the user inhales. Other vapor products look less like cigarettes but serve the same purpose. Some are refillable and rechargeable, while others are disposable.
- The liquid solution comes in various flavors and nicotine levels, including a 0% nicotine option.
- Use of an e-cigarette is often referred to as “vaping” rather than “smoking.”

Are they safe? Are they regulated?

- As e-cigarettes are a relatively new product, there is limited research about them.
- E-cigarettes don’t contain traditional tobacco, but they do contain nicotine, which is a tobacco-derived product. As a result, a federal court has determined they can be regulated as a tobacco product, and the FDA has announced its intent to regulate e-cigarettes.
- Because the products are not currently regulated and many are produced outside the United States, there is no oversight of manufacturer’s claims or independent reseller’s claims regarding ingredients, nicotine content, safety, or possible use as a cessation aid.
- The liquid nicotine solution can be dangerous to children or pets if ingested.
- Even with limited research, there is reason to believe that these products can cause harm. Certain metals have been found to be present in e-cigarettes which could be harmful if inhaled. Additionally, there have been incidents of the battery exploding or causing fire.
- Research on the health effects of secondhand vapor is limited. At one time in history, smoking in buildings and vehicles was considered a safe practice, but years of research have proved otherwise. Research on e-cigarettes is new and evolving, and it may be some time before we know the total health effects of these products to users and those exposed to secondhand vapor.

Where can e-cigarettes legally be used? Who can buy them?

- Because state clean indoor air laws were written before e-cigarettes, the law is silent on their indoor use. Organizations may pass voluntary policies that prohibit indoor use of e-cigarettes.
- The law does not prohibit the sale of e-cigarettes to minors, however, most stores have voluntary policies requiring a customer be 18 to purchase an e-cigarette product.

What other concerns exist about e-cigarettes?

- Kid-friendly flavors such as cherry and chocolate are banned by the FDA for cigarettes because of their potential to appeal to children; that is not the case with e-cigarettes. E-cigarettes come in many flavors, which may increase the appeal for youth.
- Because many e-cigarettes look like traditional cigarettes and emit a vapor that looks like traditional cigarette smoke, e-cigarettes also have the potential to impact social norms and public perception of smoking prevalence that the tobacco control community has worked so hard to change.
• Laws that restrict cigarette advertising do not include e-cigarettes, so ads are appearing in magazines, on television, and in other public places, which also impacts the social norm regarding these products and potentially social norms about smoking overall.

• Even if future research finds that harm to the individual could be reduced, there could be increased harm to the public if 1) people who would have otherwise quit tobacco use e-cigarettes instead, and 2) people who would have otherwise not used a tobacco product take up e-cigarettes or other tobacco products.

Are e-cigarettes a proven cessation aide?

• There is limited research on the effectiveness of e-cigarettes as a cessation aide and their long-term safety is unstudied. However, there are multiple FDA-approved nicotine replacement therapy products available for individuals who wish to quit. These approved products, which have been studied for effectiveness and side effects, are available for free by calling 1-800-QUIT-NOW.

• Some people who have no intention of quitting traditional tobacco products may use e-cigarettes to get nicotine throughout the day and still comply with bans on traditional cigarette smoking in public. This is a form of “dual use” and has the potential to increase overall tobacco use, though more research is needed on this topic.

• Many people have shared anecdotal stories about switching from cigarettes to e-cigarettes; however, it is not clear in most cases if those individuals have quit using cigarettes but continue to use e-cigarettes, or if they have quit nicotine use entirely.

What action should we take related to e-cigarettes?

Note: These are possible actions if e-cigarettes are an area of focus relevant to your community and your organization’s work at this time. It is not required that you take any action.

• To protect other customers and employees who choose not to be exposed to chemicals, businesses should adopt policies that prohibit the use of e-cigarettes on their property as part of a comprehensive tobacco-free policy.
  o If local organizations have voluntary tobacco-free policies, revise those policies to include e-cigarettes.
  o If no voluntary policy exists, work toward passing a comprehensive tobacco-free policy that includes e-cigarettes.

• Although e-cigarettes are a popular topic right now because of their novelty, it’s important to continue working on evidence-based best practices for overall reduction in tobacco use. While it is important for us to address this new concern in tobacco control, we cannot lose sight of the still large problem of tobacco use, which kills about 6,200 people per year in Oklahoma. We have the 4th highest smoking rate in the country. Sales of e-cigarettes in the U.S. last year reached $500 million, but e-cigarettes are still a small fraction (0.5%) of the total tobacco market in the U.S. (Source: New York Times)