Executive Summary

Over the last few weeks Advisory Committees have been meeting to develop core recommendations in the following identified areas: legal/legislative, budget and programs, data and IT infrastructure. Clear themes and trends have emerged as a result of this work and should be considered central to our efforts to move forward in adopting recommendations and developing an actionable plan forward. Accountability resource allocation, and decision-making autonomy is found across all recommendations, explicitly or implicitly, illustrating a consensus among advisors. Resource allocation cannot just consider population density, however, as the needs of the rural communities are multifaceted and per capita funding allocation alone will not address the needs of those citizens residing in our rural communities. Efforts to improve health outcomes must focus on increasing efficiency, allowing local health departments to develop community specific partnerships and governance structures that best meet the needs. Examples of implementation may include shared jurisdictional arrangements enabling multi-county or regional delivery of programs and services and development of joint governance structures to allow for equal partnership between local, regional and state health departments. Another theme that emerged across all Advisory Committees is the need to update and modernize public health data and financial IT infrastructure. Real time public health data is a critical missing link for decision makers to develop programs, policies and services to meet the needs of Oklahoma communities. Transparency of public health data is not limited to the traditional health data we associate with health outcomes, but must also include the financial and operational data that drives those outcomes. Finally, each Advisory Committee recognized the evolution of public health over the last decade requires an ability to develop relationships with non-traditional partners in the community. The opioid epidemic, challenges in resource sustainability and increases in natural disaster are examples of the need for public health to move away from program-driven delivery of services, and towards population-driven strategies that reflect community identified needs and avoid duplications. Defining foundational public health services is only the starting line for these efforts, articulating the specific clinical and community strategies that will impact health outcomes for the greatest number of Oklahoma residents is a collaborative endeavor that will require multi-stakeholder engagement from our local health department experts and the communities they serve.
Advisory Committee Recommendations

**Budget/Program Assessment**

The Budget/Program Assessment Advisory Committee was tasked with developing recommendations that address transparency in budget forecasting and funding sources. In addition, this committee was tasked with developing recommendations to address governance of the overall public health system to include strategies to become more lean and efficient, effectively developing partnerships, engaging in resource-sharing and determining the applicability of defining foundational public health areas and capabilities.

- Develop a transparent budgeting and financial system that identifies all funding (federal state, and local) allocations received and disbursed through the Oklahoma State Department of Health (OSDH), in addition to the following:
  - Define how categorical funds are determined for core public health services in each county;
  - Provide monthly reports on fiscal year revenue and expenditures of all state appropriations by department or program (In alignment with the Corrective Action Report);
  - Develop a process to engage stakeholders in program funding decisions;
  - Create a format to share budget and financial data information to stakeholders (i.e. Oklahoma State Board of Health, County Administrators, Legislators and the general public).
- Identify resources to improve or replace the current billing and financial management system to improve: insurance billing, relevant and real time budget reporting, cost benefit analysis, and ROI.
- **Implement a Zero-based Budgeting** process (*In alignment with the Corrective Action Report*)
- Identify the funding streams that align with the **Foundational Public Health Services Model** and determine a formula to appropriate public health funds by region, using the foundational areas and capabilities to improve health outcomes throughout Oklahoma.
- Adopt the Foundational Public Health Services Model and ensure programming and budgets align with the foundational areas and capabilities while developing and maintaining, at a minimum, a quarterly evaluation (i.e. expenditures, revenue, etc.). Additionally, utilize accountability metrics to measure and track the progress of the Foundational Public Health Services to ensure annual ROI.
- Recommend that the Oklahoma State Department of Health work across programs/services to ensure the Foundation Public Health Services Model is aligned regionally, and consider assessing the programs/services that could be deployed from the OSDH Central Office to County Health Departments to increase or enhance the current program/services offered in counties throughout Oklahoma. Additionally, it is recommended that local public health authorities (i.e. Regional Administrative Directors, County Commissioners, and Local Boards of Health etc.) have the flexibility to determine the best method to implement the foundational capabilities/programs and to utilize Ad Valorem tax revenue to meet each county’s unique
needs. The OSDH would provide general administrative oversight, monitor grant deliverables, and ensure public health laws are applied.

- Recommend that all 68 county health departments under the jurisdiction of the OSDH conduct an environmental health program/services scan to identify opportunities to reduce duplication, develop public/private partnerships, and consider co-locating programs/services to create comprehensive, holistic service in each community.
- Develop a strategic plan for those counties that consistently perform poorly on health indicators and assessments, utilizing research and evidence based practice to employ targeted interventions, technical support and resources to those counties that contribute most to Oklahoma's poor health ranking.
- Recommend that OSDH develop and establish a public health evaluation system grounded in evidence-based practice and research. Develop and maintain an annual evaluation of the Foundational Programs/Capabilities, including quarterly budget reports (i.e. expenditures, revenue, etc.) and submit the data to the OSDH Board of Health and the Joint Council. Establish a statewide health needs assessment and strategic plan with an evaluation component for each county and region.
- Develop a Health Equity office that focuses on the Social Determinants of Health and ensures the social factors that impact health outcomes are a central discussion in all public health planning while exploring how to incorporate broad services like Trauma Informed Care, which has led to health improvements in states with a similar urban/rural mix as Oklahoma.
- Create a Joint Council to review health data, plan health initiatives, prioritize services, develop private/public partnerships, evaluate outcomes, and review per capital public health spending in each county. This Council would consist of the state Commissioner of Health, Regional Administrative Directors, and the Executive Directors of the Oklahoma City-County Health Department, and Tulsa City-County Health Department.
- Ensure that Quality Improvement is used intentionally by OSDH, such as Plan-Do-Check-Act, which is focused on activities that are responsive to community needs and improving population health. It refers to a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community.
- Identify per capita funding by county from all sources. Evaluate per capita spending to ensure all counties have resources from state, federal, local and other sources to support implementation of adopted foundational services, programs, and capabilities.

**Data Assessment**

The Data Assessment Advisory Committee was tasked with developing recommendations that address the health assessment process, access to data, and effective messaging to the public. This included addressing needs to modernize IT infrastructure and enhance the ability for decision makers to utilize real time data to inform strategies.

1. **Maintain a cadence of collaboration:**

By working together across agency and public-private sector boundaries, the Data Committee was able to make progress in just a few short meetings. In order to sustain and build on this progress we request
that our meetings continue as we enter the crucial phase of planning short, medium and longer term strategy for public health information infrastructure and pursue funding to support and sustain these efforts.

2. Modernize Oklahoma’s public health data infrastructure:

Significant gaps and inefficiencies exist in Oklahoma’s public health data infrastructure, and we recommend the following improvements be made:

Implement a statewide public health electronic medical records system to provide real time data for health improvement. This data system should integrate disease surveillance, immunization registry, electronic Master Patient Index (eMPI), link all public health systems, OHCA and OSDMHSAS systems and should leverage existing resources and investments. These data systems and analysis can provide the data needed to address public health challenges, gaps in coverage, needed resources, community interventions and evaluation of effectiveness towards improving community health.

This goal includes short-, mid-, and long-term objectives identified by committee members.

Short-term:
- Complete upgrades and deployment of the public health immunization bi-directional messaging.
- Continue state agency interoperability project to link public health systems, OHCA, and ODMHSAS, and other state agencies.
- Planning for state/city-county data integration solutions with PHIDDO, PHOCIS, and OSIIS.
- Legal review of secondary use of state public health data in external systems (i.e., Health Information Exchange (HIE), Electronic Health Record (EHR), Insurance).
- Pursue available funding for implementation and long-term sustainability for HIE and public health interoperability for state match funding.
- Coordinate with existing HIEs to leverage clinical data exchange and public health messaging

Mid-term:
- Synchronize eMPI’s between state and private sector
- Synchronize provider and services directory/index
- Participate in national initiative, Digital Bridge, for electronic case reporting
- Evaluate potential implementation plans for integrated statewide public health analytics system
- Implement state/city-county data integration solutions with PHIDDO, PHOCIS, and OSIIS

Long-term:
- Deploy statewide Public Health EHR
- Evaluate potential implementation strategies for statewide syndromic surveillance monitoring

Legislative/Legal
The Legislative/Legal Advisory Committee was tasked with developing recommendations that address opportunities to proactively work with locally elected officials to improve transparency in public health through budgeting, accountability and modernized legislation.
• Develop a statewide coalition of stakeholders who will provide input to the Joint Commission and help to education around public health generally and the Joint Commission’s recommendations.
• Develop a cohesive and unified message for communication around both public health and the recommendations of the Joint Commission.
• Work with the Governor and Legislature to develop strategy for implementation of the Joint Commission Policy recommendations.
• Continue the Joint Commission through implementation of policy reforms and facilitate additional opportunities for healthcare, education and business community stakeholders to participate in the process.

Summary

We are appreciative of the good work that has been undertaken and accomplished by the Advisory Committees. Addressing the core, thematic areas including autonomous decision-making, shared jurisdictional arrangements, enhancing Data and IT infrastructure, defining foundational public health services, and developing a joint council to address health outcomes and disparities, is a first step in restoring the credibility of our state’s public health system to the communities we serve, and putting Oklahoma on a path to health improvement. We cannot afford to ignore the evolution of public health, and the explicit need to modernize our systems for resource allocation, data and IT infrastructure. While much work has been put into the development of these recommendations, it is now time to create actionable plans to operationalize and implement. Continuing to engage public health leaders, locally elected officials, and other diverse stakeholders already participating as members of the Joint Commission will be critical to this next step in modernizing the Oklahoma Public Health System.
Suggestions Received from publichealthcommission@gmail.com

The counties most in need of services are poorer rural counties with low populations and no local assistance. If money is only distributed by population, the metro regions will be the only regions funded enough to provide needed services. Transportation is an issue for poorer counties. For all Oklahomans to receive equal medical care, the distribution of money can’t be only where large populations reside and where alternative care is accessible. For equitable care, health workers are needed in all four corners of the state.

Reform is needed and a 12 story building in OKC full of administration staff is not needed. Our system works, it’s just administration heavy. I advocate for local health departments to have more control and transparency; however, I feel we will be creating disparities and inequities if services are not readily accessible in poorer rural counties. Good work is accomplished at the central office, they just have too many programs and workers who are not providing the core 10 essential services of public health (see below). All counties have been asked to do more with less and some without any staff after March 1st. I believe services should come before administration. If we continue to the path of decentralization, all of Oklahoma will suffer. We will pay for increased teen pregnancy, std’s, infant mortality, etc. The question we should be asking ourselves is how do we want to pay? We can choose to be proactive by providing services to all Oklahomans or reactive once the damage is done. Reactive carries a much higher price tag.

My suggestion is to require posting of the results of a health inspection prominently on the front entrance of all restaurants with a requirement that it remain there until the next inspection. I have noticed this practice in restaurants in a number of states.

It provides transparency of the work of the health department and also needed information regarding the restaurant.

There are too many counties in Oklahoma where restaurant inspection is not taken seriously if its done at all. Not too many years ago in Tulsa one would periodically read a report that a restaurant had been closed. However, this no longer seems to be a practice.

Possibly, with some time and effort a citizen may be able to view the health inspections online, but the number of diners who do this must be quite small. If one is visiting from out of town are they really expected to do a search of a local health department for restaurant inspections.

I believe publicly posting health inspections is long overdue in Oklahoma.

In Public health the food stamp program could benefit from making some significant improvements and guidelines. It would be neat to see the wellness programs from the state health departments make a partnership with the Department of Human Services (DHS) to modify the food stamp program and
provide the families with education on nutrition and cooking. Our tax dollars for food stamps should have restrictions to only buying foods that have nutritional value, especially if our tax dollars are paying for it. The Federal program Women Infant Children (WIC) program is sufficient at this, why is the food stamp program providing similar guidelines?

Furthermore there should be some partnership with the SoonerCare insurance program and family planning. In order to qualify for SoonerCare, education should be provided on how to prevent unwanted pregnancies and parenting. This would prevent families from having multiple children on SoonerCare without getting some type of required education on ways to maximizes the benefits that they are seeking from public assistance.

Provide the public with health education in return for the services and benefits they want to receive. A partnership in State and Federal tax dollars.

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Dear Commission,

Thank you for the hard but necessary work you are doing. I have been a local health dept employee for almost 13 years and I still believe in the work we do! It is important, life-changing and is imperative that we get it right.

I just wanted to share some feedback and suggestions:

1) To retain top talent throughout the state, allow employees to apply for and fill “state-level” jobs without requiring their workstation to be at the OSDH Central Office. It seems that if one wants to advance in their career at OSDH, many of those jobs/opportunities are located at the OSDH Central Office. I believe many talented people throughout Oklahoma do not want to move to OKC or commute to OKC for this and we are missing out on great people in these positions. I believe many of these positions could be located throughout the state in county offices or at least in “Regional Hubs” which would allow a true regional/ rural perspective in these positions/ programs. It would also free up office space at OSDH, and fill some of the space that is free in county health dept offices.

2) Please invite talented, qualified local health department employees to be a part of the commission and subcommittees. Results may be very different if it is a leadership-only commission.

3) At the local level, we absolutely need data to drive decision making. We are frustrated here feeling like we are responding to public health 5 years later (or longer) because the data we use is sometimes old and irrelevant. We need real-time data to make change and to be able to target effective interventions.
There are some activities at OSDH that add no value, do nothing to improve health outcomes, and are costly in staff and to businesses. Top of my list is the outdated Certificate of Need process for long term care and mental health facilities. It will take legislative action to terminate the CON process. It discourages new business and protects old monopolies. Other areas of health care got rid of CON years ago. It’s time to get rid of this last vestige of the past that is costly and helps no one.

Good Morning,

As a former administrator, I applaud each and every employee for staying with OSDH for their own specific reasons in the midst of uncertainty, financial issues, and unfavorable media coverage. I’ve CC’d all my co-workers because I believe “transparency” is of the utmost importance and the ONLY avenue to build trust, rapport, and a team.

After yesterday’s videoconference, I felt compelled to list my top 3 areas of improvement:

1) A more user-friendly version to capture ALL health education efforts & data. It’s about relationships, partnerships, and going through all the steps to necessary to complete a successful health education event.

2) Local money should stay local and local people solve local needs, not other places. If county health departments’ pay into systems/departments at the state level, those county health departments should be seen as a customers and should be an advocate for those departments at the county level. As a result, payment of systems/departments should equate to field representation among the county health departments. To further illustrate this point, I called OMES and he mentioned, “we get to work from home”, not the ideal as when computer problems inhibit work.

3) More credence must be given to ACE’s study and score for Oklahoma children. Several years ago, the state of Oregon mandated the ACE for every child. Let’s look at positively functioning health departments and take a lesson. As a yesterday, it sounds like we don’t need to go very far. Let’s look at Oklahoma City and/or Tulsa for starters.

There are no easy solutions to this complicated challenge, but active listening to employees is a start.

Good afternoon!

First thank you for all you are doing to assist our agency. We greatly appreciate also listening to us and valuing our input.

Would it not be more productive to go to regional health departments. Utilize the larger counties and the staff from the smaller counties to have a better coverage of staff than what having to do now. We are traveling to other counties to cover those small and larger counties with nursing and clerical staff.
This does not provide continuity of care when you borrow from one county to cover than it limits services in the county you borrowed from. Counterproductive and the clients are uncertain of when can come for services even with a schedule. I think this must be discussed at many different level including legislature to get this to happen. I know that when we close Henryretta and Beggs that the clients had no difficulty with coming to Okmulgee. We find that individuals including ourselves when we need to get somewhere we make arrangements in some way. We do provide information on transits etc. to assist clients.

Concerns: Limited staff-expectations to continue coverage in all county health departments even if it means having to have staff (nurses and clerical) travel to those sites to cover from a distant cavity. I feel it is counterproductive especially with the number of clients actually seeing.

I mentioned in the meeting that I see the county like a foundation of a home that we are trying to restore or flip.

You must first have a strong foundation. I see the counties and the community and the citizens of Oklahoma needs and delivery of those core services is priority. Then you build upon that foundation with the program areas that will support those core programs (internal and external). This builds the framework that is supported upon the foundation.

The roof is the State office and its leadership and financial pieces along with the monitoring and auditing and also the grant writing etc. as the Board and Leadership is developing presently.

Our goal is to improve health outcomes; protect our citizens and deliver those important services. I believe in the one stop shopping and referral internal and external. Knowing our resources within our community. Partnership and education early is the key to prevention.

We must also stream line and be effective with what we have by regionalization of Health departments and utilizing staff we have to effectively work to get the outcomes desired. Not because within that legislature domain they promise to keep the health department that may see only 5 people a day and being paid the same those staff that multiple more clients. Those times should be over.

I believe every health dept. should look the same with the core services/directives delivery of care. Then the needs be determined by as mentioned community assessment to determine the what partnerships and additional help needed to write grants obtain help from the state level and add in those services within our local health department.

Thank you!
Here’s a copy of the comments I made at today’s meeting with Dr. Cox.

Given Oklahoma’s poor ranking in health outcomes such as heart disease, hypertension and diabetes - due to the high number of our friends, neighbors and family members affected by these and other chronic conditions, it seems like we should focus as much attention as possible on prevention.

We know there are many factors contributing to high rates of these preventable illnesses, and that a few key behaviors – diet, physical activity, tobacco and drug use are associated with most of our leading causes of premature death.

We know that many unhealthy behaviors result from adverse social and living conditions in which people find themselves, resulting in wide health disparities.

We also know that efforts to change individual behaviors are extremely challenging in the absence of places and social norms that support healthier choices and make it easier to be well.

Improving the environments where people spend the most time - such as worksites, schools, child care facilities, churches, neighborhoods and homes requires significant effort and collaboration with many organizations and community partners.

In lots of Oklahoma counties, the health department is one of the few or only entities able to work with these stakeholders in a comprehensive and ongoing way. Without a public health presence at the table, we miss numerous opportunities for creating healthier communities and better health outcomes in our state.

I didn’t have a chance to sit through the meeting, but I, like everyone else, is very concerned about the direction our health department clinics are being sent. I too believe that a big solution is to cut the fat at the top and allow services to continue unchecked at the county level.

I have been hearing rumors that certain programs are being cut and would hope that this can be prevented.

On that note, in the future, I would like to see the addition of a clinic—namely, a men’s clinic. It is easy to overlook the needs of men in our society for we forget that men can face the same economic struggles as women and children and often don’t have as easy access to certain types of insurance such as Medicaid, as women and children.

I would also suggest that the paperwork be trimmed. The information on many of our forms are already duplicated on other forms. Plus, check in time is slowed down even more. It is not unusual for a client to take 15 minutes or more filling out paperwork. This is especially a problem when an appointment is scheduled from check in time to finishing with a clinician for 30 minutes.

The clinic where I work is small and will be even smaller come March, meaning fewer people to see our clients, meaning even less appointments to be offered.

I am truly in hopes that somehow, this can be averted.
Current system infrastructure is an effective model (central office providing overarching administrative functions – legal, communicable disease, accounting, etc), but there is a need for local control so counties can make decisions based on community needs.
  - Trend over the years has been a system focused more on the central office rather than individual county needs.
  - The system has worked in the past – counties worked together and state shifted resources as needs arose.
  - Don’t look at a system solution to a leadership issue – look at improving the efficiencies and processes of our current system.

State plan needs to be developed from ground up and allow for flexibility of delivery based on local needs.

Many counties desire to integrate/co-locate with other service providers; there are vast differences in culture and need from county to county.

Strong desire for improvement in IT infrastructure, data and social media presence.

Desire local input to be sought and implemented for problems.