The final agenda was posted on the Department’s website and building entrance at 12:00 pm on January 17, 2018.

**JOINT COMMISSION APPOINTEES PRESENT:** Gary Cox, Brandie Combs, Mike Echelle, Senator A.J. Griffin, Representative Dale Derby, Ann Paul, Jenny Alexopulos, Erika Lucas, and Bruce Dart.

**JOINT COMMISSION ADVISORS PRESENT:** Tammie Kilpatrick, Scott Adkins, Myron Coleman, Buffy Heater, Tony Miller, Reggie Ivey, Hank Hartsell, Phil Maytubby, Priscilla Haynes, Patrick McGough, David Kendrick, Megan Holderness, Derek Pate, and Matt Singleton.

**GUESTS PRESENT:** See Attached List

**STAFF PRESENT:** John Gogets, Bob Jamison, Jackie Shawnee, Shannon Welch, Chris Portwood, Brendan Hope, Debbie Gallamore, Laura Holmes, and Kay Hulin

**CALL TO ORDER & WELCOME:** Gary Cox, Chair, called the meeting to order at 1:13 pm.

Gary was pleased to note there was significant progress to report today, and then provided an update on the recent Town Hall meetings and listening sessions held in several county health departments across the state. He was very interested in hearing their opinions of what was working in public health, as well as areas for improvement to get us in best position statewide to begin improving health significantly in our state. Comments heard so far were from approximately 10-15 counties total, with the following common themes:

- Current system infrastructure is an effective model (central office providing overarching administrative functions – legal, communicable disease, accounting), 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.
- Messaging around the idea that health and wellness is one of the critical supports for public health and a vibrant healthy state. The three legs of education, health and wellness, and jobs in the economy are all interdependent on one another. If one fails, it’s unlikely that we’ll have a strong, healthy, economically-vibrant state.
- The main takeaway is that staff are ready to move forward in a positive way.
INITIAL COMMENTS AND DISCUSSION FROM JOINT COMMISSION:

- Mike Echelle, Former OSDH County Administrator, St. Francis-Warren Clinic Director – Mike relayed he had been hearing the same comments from colleagues in public health as Gary. The system is not broken, we just need to tweak it. He also wanted to add in the need for accountability. We need to use this opportunity to educate the public on our programs in order to have buy-in, mainly on public health events that we must respond to, such as outbreaks, etc., and the public’s response is based on earned trust, respect, and what the county health department brings to the table. Public health and county health departments are very important to rural Oklahoma. Marketing is key and how they market is different than in the metro areas, but we need to make sure they are visible in the communities they serve.

- Brandie Combs, OSDH Regional Director – Brandie echoed Mike’s comments and noted the only thing she wanted to add was in a different direction to help push us forward. In her counties, as well as surrounding counties, it seems like the vocabulary we’re using is putting up some barriers to communication. We need to rally around common language, such as the meanings of decentralization and regionalization, which are completely different. These listening sessions are giving everyone an opportunity to become more informed and aware of what goes on in the county health departments, and that this concept of regionalization has already occurred. We don’t have fully-staffed county health departments across the state – we already share staff and services on a regional basis. It’s not a perfect system, but we need to build on what works.

- Senator A.J. Griffin – Senator Griffin echoed Brandi’s comment that some of the language we’re using as public officials, and others elected or not, needs to change so we can begin talking about the cost of healthcare being driven by poor health. We aren’t healthy as a state and we need to change that directive. The other item to remember is hopefully what we can get out of these sessions is not only a bottom-up approach towards how we structure public health, but how to structure all health care delivery. We’re at a juncture where we need to rearrange the pieces to our system, so it works based on the needs of our citizens. This is not how it’s designed currently – it’s almost as if what happens in the community is an afterthought. It’s the perfect opportunity and if we have an agency structure that needs to be changed, there’s plenty of opportunity to make the pieces fit back together differently. This is the conversation she will be having with her colleagues, and to shift the conversation from finger pointing and blame. It’s not productive, and if we need to do something this session quickly, she stands at the ready to help make it happen.

- Jenny Alexopulos, OSDH Board Member and Family Physician – Dr. Alexopulos echoed the comments of colleagues and noted with regard to our current public health infrastructure, we can all agree it’s antiquated. It has served the past but not the present. We have learned over the last ten-twelve years of the passion that comes from the county health departments and how they serve communities. She was looking forward to information from regional directors of what works and doesn’t work, and how we can put together a new infrastructure, whether centralized, regionalized or however you want to call it, in terms of how we fund those entities that will put us closer to making an impact in those communities. She’s a grassroots type of believer, and we need to really glean on the successes and weaknesses that some of these programs have had at the local level that will help us further strengthen our infrastructure.

- Erika Lucas, OCCHD Board Member and CEO of StitchCrew – Erika recognized that there’s many people looking hard to find efficiencies and improvements and it requires much effort. We really need to pay close attention to those recommendations and not let this be another report on the shelf.
These recommendations need to be taken in a serious manner and she noted it does create a lot of frustration when people see initiatives whose work is to reform processes. She had also been speaking to other colleagues on the importance of investing in our own communities. One example was the new proposed Amazon headquarters, with Oklahoma City not even making it on the list for consideration. She longs to see the day when we start investing in resources in our community so we can begin shifting that focus. We can’t have a healthy economy unless we have a healthy community. This is the message we need to get out.

- Ann Paul, Tulsa Health Department Board Member and Chief Strategy Officer at St. John’s Health System – Ann voiced her agreement on the comments made so far. She asked in reference to the town hall listening sessions, approximately how many people attended in total and were any stakeholders represented? Gary responded that it was various county health department staff, including administrators, and he didn’t keep an exact count, but estimated it was several hundred. He noted we encouraged the dialogue and staff didn’t hold back.

- Bruce Dart, Director, Tulsa Health Department – Bruce noted in the past week we’ve started to see that people are beginning to come together collectively and focus on where we want to end up. For the first time in a long time, we’re starting to see movement. Positive movement starts with people being dissatisfied and this was the common ground in which we could begin focusing on how we create a system that serves all Oklahomans fair and equitably. In a crisis situation, fear is completely understandable. We certainly have a deep empathy to how people feel and what they’ve gone through both professionally and personally. He personally appreciated how people are now engaged and showing a vested interest.

- Representative Dale Derby – Rep. Derby commented that he was a firm believer in the way our forefathers set up our country and government for individual states and those states would come up with the good ideas, and the central government would be a place to keep order, but the real innovation would happen in states. He had no doubt that our health departments, at the county level where services take place, will see great innovations that carry out into other areas. We already have several organizations in the state that are very innovative in what they’re doing, so we need to look at those ideas and incorporate them. We don’t have to recreate the wheel, we just need innovation at the local level, not big central government. We need to get out where the people are and deliver our services.

**UPDATES FROM ADVISORY COMMITTEE CHAIRS:**

Data Advisors Committee - David Kendrick, Chair, started his report by thanking and introducing his fellow committee members, Becki Moore - OMES, Derek Pate - OSDH, Matt Singleton - OMES, Kelly VanBuskirk – THD, and Megan Holderness - OCCHD.

They held an initial meeting two weeks ago and decided to meet in the off weeks of the large joint meeting to make sure their report is ready for the commission. Work began by first doing an asset analysis, considering what assets we had at the federal level, state assets, county and private sector, including tribal assets as well. He felt their charge was to understand how to get data where we need it to most benefit the population we’re tasked with serving. It’s as simple as that. In medicine, there’s a saying, “You can’t fix something that you can’t measure.” And you can’t measure something without data. It’s their belief that making information available, not just centrally, but to where it’s needed to make decisions, as well as to bring information in so policy and decisions can be based on evidence. Their approach was to first build an
Joint Commission on Public Health
Special Meeting Minutes
January 19, 2018 – 1:00 pm Auditorium
NE Regional Health & Wellness Campus
2600 NE 63rd Street
Oklahoma City, OK 73111

asset list of large & small projects, and to then connect them. Next was gaps in our infrastructure – surveillance, bioterrorism, monitoring for disease outbreaks, etc. Oklahoma and Tulsa counties have their own internal structure for disease monitoring and surveillance, but the rest of the counties don’t have such a service. This is a critical need that must be addressed early on and will be included in their recommendation list.

Another gap item has been our state immunization registry. This registry touches everyone who was born here and/or who receives a vaccine as well as those who provide them. In 2009, as a result of legislation, there were some components put into place to create efficiencies. Up to that point, when a child was seen in a clinic, it would be entered into the electronic health system as well as a second system, OSIIS (Oklahoma State Immunization Information System), which was a redundant effort as well as expensive to have that kind of data entry. The Health Department has been working for quite some time towards a modernization of that infrastructure, but because it’s a requirement for providers to have access, it becomes a real gap in the ability of providers to stay certified. So, its not just for reasons of health, but also a function of the healthcare delivery system.

Other items that were identified as gaps were some of the state health registries needed to be made available in electronic form that could be fed automatically, eliminating the duplication of data entry, which would help build a very efficient command control center for public health in our state so we know where to deploy resources, not on an annual basis, but rather a day-to-day basis.

His committee also discussed how they would make these a priority, so they did a cost analysis to determine the return on investment. From OSIIS, they obtained the total number of immunizations submitted manually, and it was on the order of millions of data entry points. Therefore, assuming three minutes per vaccine of manual entry into the electronic health record system, the cost comes to $2 million in duplicative effort, just for vaccines. So, in just that one item there’s a return on investment for every health care provider in the state, every pharmacy who orders vaccines, and everyone else involved in those processes who will benefit.

The next area for discussion was tangible actions – there were three initial urgent items. The first was to establish regular meetings between OSDH staff and county health department staff, to make sure we have a working group to tackle these efforts together and develop a culture of collaboration. It’s this culture that will sustain this work beyond the initial crisis.

Secondly, work on data requests coming from Tulsa & Oklahoma counties, in particular those dealing with early childhood programs. There are some short-term opportunities to capitalize on funding… not state tax funding, but philanthropic dollars that might be available to build infrastructure in the county health departments to assist in delivering and documenting their services, without double entry. The goal would be to get the various data entry programs tuned up and made available to county health departments so they can begin to access the data.

Thirdly, longer-term items include establishing some core guiding principles, sustainability models, policy and privacy security that is not just a state policy but includes and discusses with the private sector to develop healthcare policy that goes across state and private sectors. This would include transparency and principles of efficiency – finding and eliminating waste. The end result would be putting into place a
statewide public health electronic records system and not one that each county has to purchase and sustain on their own. Also, we need to look at providing analytics capability statewide.

Finally, one item that should be done quickly is funding around these efforts. Everything that he had talked about costs money, and as everyone is aware, there currently is a lack of money, but there’s some definite opportunities around data. This funding has been on the table for some time but will expire in 2021. The High-Tech Act of 2009 created a 90/10 match from federal level to fund infrastructure, specifically for a public health information exchange. Funds are still available and he keeps getting asked, where’s the proposal for Oklahoma? We now at least have the opportunity to say between our first and second meeting, significant action has already been taken to identify and begin contracting with a subcontractor who has much experience in putting these kinds of proposals together. Hopefully, we can move very quickly. This model as designed does not require state tax dollars, instead it uses philanthropic dollars from the community to bring funds to the table.

Legislative/Legal Advisors Committee – Tammie Kilpatrick, Chair, started by relaying she too had a wonderful group to work with that possessed great legal and legislative expertise, and introduced her fellow committee members: Dr. Raskob - OUCOPH, Myron Coleman - OCCHD, Julie Ezell – OSDH, Buffy Heater – OSDH, Scott Adkins – Scott Adkins Consulting, and Chanteau Orr, THD.

Their first meeting was organizational, with time spent figuring out their role as legal and legislative advisors. The group consensus was their primary goal is to support and help the committee’s recommendations come to fruition and implement plans the overall Joint Commission deemed important that might require legislative and/or regulatory action.

Secondly, their focus is on the importance of communication given the misunderstandings and misperceptions surrounding public health, why is it important and how it impacts everyone. They will start focusing intently on this area today. Their plan is to come up with the “elevator speech” or standard way of describing public health and its impact so our messaging can become consistent. This would not be honing in on specific issues or changes the Commission may come forward with, but rather laying the foundation to help make these things easier to talk about when we do come to the specifics. Her committee hoped to come up with a plan that would include grass roots messaging to support the work of the Joint Commission.

Budget/Program Advisors Committee – Patrick McGough and Reggie Ivey, Co-Chairs
Patrick began by expressing his appreciation to everyone involved and noted he appreciated the opportunity and challenge, and their committee was look forwarding to presenting some great recommendations. He wanted to outline the committee’s process and how they were arriving at recommendations, and because budget and programs encompass so many pieces, it can get easy to get lost in the details. Their first item of business was to adopt the same charge the Joint Commission had been given as their own. This is of significant gravity because we’re discussing what is going to improve health, not just for one particular metro or county health department, but for all health departments and citizens in the state, and what will improve public health in general.

Role of the Budget & Programs Advisory Committee:
- To support the Governor’s charge to develop a plan of excellence for Public Health in Oklahoma.
- To provide guidance to the proposed FY2019 budget for the OSDH.
- To look at current public health infrastructure in Oklahoma and identify strengths and weaknesses.
To look at the use of all resources available for public health and whether or not they efficiently support programs and services across the state.

Lastly, to make recommendations that improve health outcomes, protect citizens and deliver important services to the residents of Oklahoma.

Foundational Public Health Services:

Other Services Particular To A Community

Programs/Activities Specific to an HD and/or Community Needs
Most of an HD’s Work is “Above the Line”

Foundational Areas

Communicable Disease Control
Chronic Disease & Injury Prevention
Environmental Public Health
Maternal, Child, & Family Health
Access to and Linkage w/Clinical Care

Foundational Public Health Services

• Assessment (Surveillance, Epidemiology, and Laboratory Capacity)
• All Hazards Preparedness/Response
• Policy Development/Support
• Communications
• Community Partnership Development
• Organizational Competencies (Leadership/Governance; Health Equity, Accountability/Performance Management; QA; IT; HR; Financial Management; Legal)

Patrick noted that Chairman Cox had presented this Foundational Public Health Services at the first meeting, and he also felt the need to center around models, research and data that’s leading the nation, with this particular model put forward through the Institutes of Medicine, RWJ, NACCHO, CDC, etc. It’s still in developmental phase, but everyone involved in public health is putting this model forward. It’s widely agreed that if you don’t have the foundational public health services and capabilities listed, then you’re not meeting what is considered to be the minimum expectation for public health. Therefore, the committee is keeping this model in the forefront of their minds when moving forward. The original model encompassed four areas, but at the recommendation of Jan Fox, they adopted this model with five foundational areas.
National, State and Zip Code Level Rankings:

Reggie directed attention to the National, State and Zip Code Level Rankings, and noted Oklahoma is 43rd. When we look at the past ten years, we have hovered in the 40’s, so we’re not improving the way we should. This gives us the perfect opportunity to look at our public health system and ask what should we be doing better to improve our overall state ranking. Of the 77 counties, the darkest shade of green represents the 19 counties ranked poorest in our state. Our discussion has been should we conduct community health needs assessment and community health improvement plans in each of those counties. The committee heard this morning that this is likely happening, or they’re connected to a regional community needs assessment or community health improvement plan. That’s great, but unfortunately if you overlay for a number of years this particular slide over past slides, those same counties are doing the poorest. We have to look at how we can strategically do better and incorporate public health best practices to improve those poorest counties, therefore potentially improving our entire state.

We recognized that the committee did not have all the data it needed to make decisions. These questions are a subset of a longer list of questions for information that the committee desperately needs:

• What are the OSDH funding streams and how is the funding allocated to the counties? What is the current public health per capita spending in each county?
• How is ad valorem in the counties used to support OSDH?
• How many employees work in each county health department? What do they do? What programs and services do the county health departments offer? How will the pending layoffs impact programs and services?
• Where are the FQHC’s located in Oklahoma? Are there FQHC’s located in the same counties as health departments? Are there opportunities to partner?
He relayed that OSDH staff had been presenting to the committee and were forthright in providing information. Mike Romero, CFO, had presented earlier but he noted that some of the information the committee was asking for related to funding was difficult to pull under the current antiquated system. There is a need for a new accounting system which will be very expensive, but on the other hand, how can we get information that is needed to guide our work.

This week marks the 50th anniversary of the death of Dr. Martin Luther King. Reggie then provided a quote by him: “The time is always right to do the right thing.” This is the time to improve our health ranking. People in our state will live longer and with a sense of health and well-being. That’s why this work is so important.

The following is a list of questions being used by the committee to generate dialogue:

- In an effort to be transparent, should the Oklahoma State Department of Health have a financial and budgeting system that provides revenue and expenditure data that is real time, clear and reflects federal and state allocations?
- What internal controls and reporting structure should be implemented?
- Should this committee recommend per capita spending in the counties, with a weighted formula for rural/smaller counties with limited resources?
- How do we increase efficiencies and avoid duplication of services and staff among counties (including metro areas) and Central Office?
- Would increased autonomy and independence in budgeting and program efforts at a County Health Department level prove beneficial? If so, how/why?

Other State Public Health Systems:

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Draft Recommendations:

Patrick noted that everything the committee had been working on was ever-changing. A couple of weeks ago, the following grid was developed from recommendations and suggestions, and it’s becoming quite extensive at this point but following is a small sample. This past week an individual assignment was given for members to come back with some personal recommendations after they had time to consider what was discussed at the first two meetings; what should they be looking for, what questions should they be asking, what data, etc. A fifth foundational column will also be added. This is a living document so that every recommendation that comes forward from the group will be included.
<table>
<thead>
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<th>Recommendations</th>
<th>Notes</th>
<th>Statutory Change</th>
<th>Policy or Procedure Change</th>
<th>PHFP Communicable Disease Control</th>
<th>PHFP Environmental Public Health</th>
<th>PHFP Prevention and Health Promotion</th>
<th>PHFP Access to Clinical Preventive Services</th>
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<td>Identity all public health funding for each county</td>
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<td>Per capita funding for all County Health Departments, with a weighted formula for rural counties</td>
<td>Comment: No to per capita – this would be detrimental to rural counties/communities</td>
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<td>Regional Administrators have the authority to utilize ad valorem dollars as needed to address public health needs without oversite from OSDH</td>
<td>Increase local control More input from counties in relation to funding opportunities (more autonomy/flexibility) Concern regarding loss of millage</td>
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<td>Transparency of funding by county (Federal, State and local, Private, etc.)</td>
<td>Assess how OSDH funds are distributed throughout the state based on population and county needs/resources</td>
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<td>Provide a review and reporting of spending by core public health</td>
<td>Need a better business plan</td>
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**Process Recap** - Patrick outlined the committee’s processes:
- Understand Roles/Responsibilities
- Identify Budget/Program Models & Research
- Q/A - What Do We Need To Know
- Q/A – Group Exercise – “Top of Mind” Ideas
- Established Committee Meeting Schedule
- Independent Exercise - Personal Recommendations
- Fact Finding
- Draft Grid of Recommendations
- Align Similar Ideas & Identify Themes
- Finalize Recommendations
- Make Recommendations to the JCPH
Gary relayed his thanks to committee chairs and members for their heavy lifting and very thoughtful reports.

It struck him, in talking about the Foundation of Public Health Services, and leading that into comments we’ve heard around the state from county health department staff, particularly in the rural areas. There are simply not enough resources to provide the foundational health services. We’ve got to find a way to push resources in those directions, because the basic premise is every person in Oklahoma should be entitled to the basic set of services to protect and improve their health. Therefore, it’s imperative we find a solution.

**DISCUSSION OF PRELIMINARY RECOMMENDATIONS TO LEGISLATURE AT FEBRUARY 2ND MEETING:** Gary Cox noted at the upcoming Feb 2nd meeting was only two weeks away, and asked Senator Griffin and Representative Derby for their thoughts in meeting the deadline for preliminary recommendations.

Senator Griffin stated that we have time, so keep moving forward and we’ll find a way. It might require some creativity but we’re up to it. Representative Derby responded affirmatively as well.

**FUTURE MEETINGS**
Friday, February 2, 2018 @ 1:00 pm

Gary relayed to members to get in contact with Kay to make any suggested changes to the January 5th minutes.

Meeting was adjourned at 2:11 pm. Following adjournment, there was a breakout into the Joint Council Advisors Group meetings.

**Joint Council Advisors Group Meetings:**
- Legislative / Legal Advisors—Meeting Today After Adjournment of Joint Commission (Board Room, OCCHD)
- Budget / Program Advisors – Meeting at 10:00 am Today (Board Room, OCCHD)
- Data Advisors – Meeting on Fridays at 1:00 pm when the Joint Commission is **Not** Meeting (via Conference Call and at OCCHD)

Respectfully submitted:

[Signature]
Gary Cox, JD, Chairman

[Signature]
Kay Hulin, Recording Secretary