BUDGET / PROGRAM ADVISORS PRESENT: Patrick McGough, Co-Chair, Reggie Ivey, Co-Chair, Michael Romero, Tony Miller, Tina Johnson, Kristy Bradley, Hank Hartsell, Phil Maytubby, and Priscilla Haynes

WELCOME AND INTRODUCTIONS: Reggie Ivey, Co-Chair, called the Meeting to order at 1:56 pm and welcomed those in attendance.

A round of introductions followed - representing Tulsa Health Department: Reggie Ivey and Priscilla Haynes; Oklahoma City-County Health Department: Patrick McGough, Tony Miller, and Phil Maytubby; and Oklahoma State Department of Health: Michael Romero, Tina Johnson, Kristy Bradley, and Hank Hartsell.

Reggie noted that his and Patrick’s role was to guide the process through to a consensus, and even though there may not be agreement in every area, there may well be some instances where we might need to agree to disagree in order to move forward.

In addition, prior to this meeting they had asked Michael Romero to give a presentation at the next meeting in reference to internal financial and budget controls that had been put into place at OSDH. There was some good information contained within the recent Corrective Action Report, and as Interim Commission Doerflinger referenced earlier, we want to link that Report to efforts of the Joint Commission.

ROLE OF THE BUDGET AND PROGRAM COMMITTEE: Patrick and Reggie delivered a PowerPoint Presentation, with the role of the committee (as adopted from the role of the Commission) outlined as follows:

- To support the Governor’s charge to develop a plan of excellence for Public Health in Oklahoma.
- To provide guidance to the proposed FY 2019 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.

PUBLIC HEALTH FOUNDATIONAL CAPABILITIES: Reggie referenced this earlier slide in Gary Cox’s presentation, showing the foundational capabilities and the fundamental programs (Communicable Disease Control, Environmental Public Health, Prevention and Health Promotion, and Access to Clinical Preventative Services). He noted the need for additional information from the State Health Department to determine how we’re doing in these areas. Specifically, how does the funding align with the fundamental programs? When we look across the country and focus on public health, many agencies and states are considering the foundational capabilities and fundamental programs, because these are the areas that supports public health activities and improvements in health. Given the fundamental programs, it’s important for us to understand how the state and federal funds align with public health spending. The additional programs listed on the slide represent ancillary programs, but are typically not funded at maximum capacity.

In addition, Reggie and Patrick had been reviewing other states that have better health outcomes than Oklahoma. We are currently ranked 43rd, and have been in the 40’s ranking over the last ten years. How do we do better? Similar states, such as Oregon, have a similar population to Oklahoma, and they are ranked 20th. Their per capita spending is less than ours, the revenue stream is similar, and they have fewer county health departments. How are
they doing it differently? Another state is Nebraska, and even though they have half our population, their ranking is 13th. Oregon and Oklahoma have a similar rural/urban mix. Both are also decentralized.

**OKLAHOMA PUBLIC HEALTH SYSTEM STRUCTURE AND DEMOGRAPHIC INFORMATION:**

Patrick noted that some of the following slides may be outdated, and asked Tina Johnson for her assistance in supplying updated information to the committee as needed. In addition, he requested that as members had thoughts, concerns, or ideas to send to him or Reggie, to also please copy the rest of the committee so that the thought process could be kept moving forward in between meetings.

- National, State and Zip Code Level Rankings;
- Oklahoma: County Health Department Regional Directors (as of 2016, need updated map);
- Oklahoma: DIS Coordinators;
- Oklahoma: WIC Program Consultants;
- Lead Nurse and NHV’s;
- OSDH Family Planning Model – APRN Hub and Strike Team Locations;
- Regional Medical Planning Groups (RMPG).

Phil Maytubby noted on the last map, RMPG, each of these areas have developed capabilities and resources that vary for each region. It has been put together in a response mechanism that works really well for the whole region. CDC took note of this at a rural health meeting and thought it was a good model for just about any activity. He noted that we did not develop this solely, but in conjunction with the Department of Homeland Security.

Kristy Bradley noted this model, through administration with a cooperative agreement from CDC, had been used in public health preparedness for quite some time now. Keep in mind, regional models are necessary for certain public health responses, but not all responses. The reason you need to go to a regional structure for preparedness, for example, is you need to coordinate transportation of care if you have a mass morbidity or mortality event. You have physical assets such as trailers and medication that need to be distributed in a short period of time, so logistically that lends itself to a regional model. There are times in certain public health applications that regional models are advantageous and other times when a centralized approach provides more efficiencies and better utilization of resources. Therefore, she thought this was an important aspect of the discussion.

Patrick noted we were trying to find out where can we share resources and staff economically and when is it a good application. All good points. Kristy agreed and said there were some challenges in getting contractors for our regional medical response system in some of the less populated areas. Currently, our Emergency Preparedness and Response System is having to cover several regions because it’s challenging to find groups in these less populated areas to take on those contractual responsibilities. Patrick noted his agreement to the comments, and it’s exactly what the committee wants to look at – resources and how we find and share them. In looking at the map, he was seeing many similarities in regionalization across the board.

**Handouts:**
- Oklahoma Counties/Population
- County Health Departments / Employees

**Needed Information:**
- County Health Departments / Services (Tina)
- OSDH Revenue Streams / Allocations (Michael)
Reggie asked Michael if he would be able to gather information on the revenue streams that come into the state so the committee can see how funds are disbursed into each of the counties. Michael responded yes, but the challenge would be the timeframe because their system is a legacy mainframe, which means it has to be processed into something readable and meaningful, but he would get some examples to view.

Patrick then directed attention to the remainder of the maps in the presentation:
- Total Population Map
- Female Population Over 18 Years of Age Map
- Population Under 5 Years of Age Map
- Population with High School Diploma / Equivalent
- Median Household Income Map
- Primary Care Provider Rate Map
- Uninsured Residents (percent of population) Map

Priscilla Haynes asked Michael when he pulls information for the state budget, will the committee also be able to see if there is a certain formula that is used to see how the money is distributed to the county health departments? What is it based on, services, population, etc. Mike responded that he could include whatever the drivers of those dollars were, and would certainly be cooperative in the information produced. Patrick asked her if she was wanting to know if it was pass through information from a grant, federal money, etc. Priscilla responded affirmatively and Michael said that would be identified in the report.

Kristy noted that she did not know what level of granularity they can get to on their federal grants – it has to be realistic because most of the grants that come through her area such as preparedness, yes, that would more readily available. But keep in mind there’s many centralized services that are inherent in all of our public health foundational programs. For example, PH laboratory is a very core piece of emergency preparedness and response, and would not be cost efficient to try and build a PH laboratory in four quadrants of the state, so there’s going to be a fairly significant proportion of the preparedness grant that goes to support our public health laboratory services so we have the capabilities to respond to emerging infectious disease outbreak, bioterrorism, etc. This is a shared investment by all the residents of Oklahoma, even though the asset is centralized. Patrick acknowledged that obtaining some information may be complicated. Kristy noted she was just trying to figure out what type of services and level of information because this may be a hard task for Michael to accomplish in a meaningful way. Patrick said he thought maybe the group needed to identify the priorities and others voiced their agreement.

Erika Lucas asked if there was a way to evaluate how monies are spent on a per capita basis? Michael responded this went back to the comment Kristy just made. We’re getting into the realm of some very granular analysis when we’re talking about a corrective action report that’s listing developing internal controls. We don’t want to compare apples to oranges, but what he did suggest was, with the guidance of these very knowledgeable public health professionals he worked with, he could begin to bring some things together that can then be utilized for discussion to develop the focus. But at this juncture, it is definitely a difficult task. Patrick noted that part of Mike’s presentation at the next meeting would include controls that have been put into place and Mike responded affirmatively, but wanted to qualify that all of this information was not readily available at the click of a button at this juncture.

Kristy asked if it would be more helpful to look at it from a different angle in terms of which public health programs and services are currently centralized. There may be some advantages to distribution of regionalization versus those
centralized for fiscal efficiency and where there might be some areas of enhancing trickle-down distribution. Patrick stated the committee was depending on everyone’s expertise in this regard. Reggie provided an example of screening clients at THD and the time-lapse of receiving results, and whether it would be more useful to contract with a local lab instead, and a brief discussion followed on centralization vs. decentralization of services.

**ENGAGEMENT EXERCISE:** Reggie started the exercise by asking for recommendations from committee members that would improve programming and budgeting within the State Health Department. The list of questions included:

1. 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?
2. What internal controls and reporting structure should be implemented?
3. What potential changes could be made to the current County Health Department system structure to better serve Oklahomans?
4. Should this committee recommend per capita spending in the counties, with a weighted formula for rural/smaller counties with limited resources?
5. Is the public health system in Oklahoma targeting, to the fullest extent, specific measures that impact our national health ranking i.e. chronic disease reduction, uninsured reduction, increased immunization rates?
6. How do we increase efficiencies and avoid duplication of services and staff among counties (including metro areas) and Central Office?
7. Would increased autonomy and independence in budgeting and program efforts at a County Health Department level prove beneficial? If so, how/why?
8. Would county private public partnerships with hospitals, insurance, clinics, education, mental health and others prove beneficial?
9. Could co-located partners with public health (mental health, primary care, & other community resources) act as a driver for comprehensive/holistic services and additional resources needed to address upstream causes of poor health?

In reference to Question 7, Reggie relayed in recent discussions with various county personnel, some of them had reported they did not know their budgets for their counties. Another area was how are the ad valorem taxes in those counties utilized, and how much revenue does that bring into the State Health Department.

Kristy stated she thought it might be helpful to talk about the three primary parts of their budget, because the majority of her programs were funded through federal grants, and those can be very prescriptive in terms of performance measures and objectives, and what eligible costs they are able to pay. They then take what’s made available to them and apply it in the best manner possible with our public health infrastructure. So, there are constraints on federal funding streams and that’s a huge portion of their budget. In addition, there are revolving funds, for example, some of the laboratory tests such as newborn screening, that they charge for and receive reimbursement. Lastly, there’s the portion of state funds that are more discretionary.

Before the listing of recommendations, there was a discussion of county resources regarding Reggie’s earlier comment on the county budgeting process. Brandie Combs provided clarification that regional directors do know their local budgets; they reconcile to the penny every single month with their local dollars. There’s many funding streams that lend to the complexity, with other resources and monies coming in that help pay for salaries, and that fluctuates month to month. One area would be Family Planning, because there’s many things included like
personnel, supplies, etc., and they don’t have an exact dollar amount because of the complexity of trying to dissect that grant.

Reggie stated he wanted to make his previous comment clear, the question was asked, of the federal, state and local dollars coming into your county, do you have a budget that reflects all of those dollars, and the answer was no. Brandie noted that comment was correct. Mike Echelle also provided clarification regarding county dollars and budgets, and discussion followed regarding the committee’s mandate to recommend the best method of resource utilization within the counties.

Phil Maytubby:
- It would be good to know what the levels of funding are (total) for grant, revolving and apportionment, and the process for equitable distribution.
- Also, the role that county ad valorem dollars play in the budget as far as utilization.
- Counties should have a say in their own budgets and expenditures.

It was noted that all ad valorem dollars stay within that particular county. Reggie asked if the committee could find out which counties actually receive ad valorem dollars and the amount? Tina replied that all 68 counties that have health departments have ad valorem dollars. There are two that receive funding from sales tax, and one receives both ad valorem and sales tax. In Oklahoma, to have a county health department, it has to be voted by the people and that ad valorem tax can only be used for that county. Mike noted the variance in rates, with the maximum millage amount being 2.5, which was established back in the 1960’s. Comments followed regarding the budgeting process between counties and OSDH.

Kristy Bradley:
- Avoid mission creep!
- Provide review and reporting of spending by core public health pillars and assess whether current budget allocations align with core public health priorities. Need better business planning.
- In reference to Question 4: Develop a formula to quantify the fiscal resources and technical assistance CCHDs and CHD are receiving from centralized OSDH services and centralized information system management.
- Are the CCHDs defining this as “in kind” funding support that OSDH is providing?
- Engage each CCHD and Regional CHD Director to identify potential public-private partners and then what resources would be needed to establish those.

Jackie Fortier, public radio reporter, noted that in the discussion of the core function of OSDH, who actually makes that determination? Kristy responded some were determined by law, so our first and foremost aspect would be the statutory requirement of protecting the public health of Oklahomans. Next, by other public health partners and groups, for example, the Oklahoma Health Improvement Plan, as well as at the national level which are driven by federal agencies such as CDC and others, in an effort to push public health agenda programs. Ms. Fortier asked Kristy if she knew what their core function was currently and she responded she did, but others probably had areas of conflicting opinion. It would be good to step back and have a discussion regarding consensus on core public health functions and priorities.
Hank Hartsell:
- Response to Question 1: Yes, with the caveat that “real-time” may mean monthly, quarterly, or some other period for reconciliation.
- Response to Question 4: In addition to per capita, explore using cost benefit, cost effectiveness, return on investment, or other appropriate gauges of financial performance, when financial management system can facilitate such measures.
- Response to Question 5: Refine our shared understanding of “public health system.” Some of the services OSDH is required to provide (e.g. by state law mandate) are generally not considered “true” public health. An example would be former programs such as licensing locksmiths, and people who fill fire extinguishers.
- Response to Questions 8-9: Yes, and include higher education as well.

A discussion followed regarding “real-time” reporting, with Gary Cox outlining the method OCCHD uses which provides immediate, detailed real-time reporting in all areas of finance, and is available to all employees and the Board. Mike informed members that the system OSDH uses is a mainframe system from the late 1970’s to early 1980’s, so when comments are made in reference to “real-time”, one of the challenges is that he has had to construct a work-around for large amounts of data and transactional activity until they have the ability to switch to a completely integrated system. He believed the steps they were currently undertaking would allow the Department to transition smoothly when a changeover does occur.

Dr. Alexopoulos stated in terms of the federally mandated grants and revolving funded programs, does each county have an assessment of the skilled workforce that is required to undertake those programs? Are there any shortfalls in meeting those benchmarks by program because of a lack of trained workforce? One example being restaurant inspectors - what is the mandate, and do we have enough human capital resources engaged in that program to actually execute and deliver on the expectation? Hank responded there does need to be some consideration of the funds that are being invested in a county through programs with the county health departments that are not really involved with, such as nursing home or hospital inspections. In answer to her question, he thought the answer was no. A few brief comments were made regarding the lack of a skilled workforce in rural areas.

Priscilla Haynes:
- Assess how the state funds are distributed throughout the state based on population and county needs/resources. Process for distribution.
- Statewide strategic plan and implementation.
- Review and update legislative mandates for the states. (i.e. statewide immunization registry; structured sex education in public education)
- Updated electronic health systems – need integrated system.
- Maximum reimbursement of services for sustainability.
- Advance HIE
- ROI benefit

Patrick encouraged members to make recommendations, and even if they didn’t fall under the purview of this committee, the recommendations would be referred to the appropriate committee for further consideration.

Priscilla closed her portion by noting in Tulsa, as far as supplies that are used from the state, she did not have the dollar amount associated with those. For example, medications for TB, STD testing, etc. – she does not have this information and thought it would be most helpful to have on a frequent basis.
Tina Johnson:
- More input from counties in relation to funding opportunities (more autonomy/flexibility).
- Researching public partnerships with hospitals, insurance, etc. — providing guidance in relationship to developing these partners.
- Looking at options of providing services that may be more efficient.
- No per capita — this would be detrimental to rural Oklahoma.
- Not recommend Regional County Health Departments — our citizens struggle with transportation now — this would be another roadblock for them to have improved health.
- Concerns of a loss of millage.

Tina also discussed the requirement of providing mandated services in unorganized counties (those without a county health department), i.e. restaurant inspections, acute disease follow-up, TB, etc. so we do have to remember that piece in this whole process.

Reggie relayed that next Wednesday, January 10th, from 10:00 am to noon, THD had a person coming in who had helped Nebraska restructure their public health system, and he wanted to extend an invitation for anyone interested in attending.

Phil Maytubby asked if OSDH utilized telehealth. Tina Johnson responded that they are piloting telehealth in some programs such as WIC nutrition education and one county was utilizing telehealth through the 1422 grant with the College of Pharmacy in Weatherford. We would like to continue to look at other options for telehealth.

Phil asked Tina if the state used any mobile services for those counties where there was no office, that provided services at a specific location, perhaps one day of the week? Tina responded they did not have a mobile service as such, but Brandy did have a relationship in Comanche county with a (inaudible) caravan that provides some immunization services. She thought this was indeed an option that needed to be explored.

Tony Miller:
- In response to Question 1: Yes, an accounting system should be put in place that provides detailed revenue and expenditures. Ideally, this information should be broken down by revenue source (federal, state, county, and fees) as well as program and counties (real-time).
- In response to Question 3: Programs (get a list of what is currently centralized) be evaluated to determine which programs could be decentralized. If a program must be centralized, a clear explanation should be provided.
- In response to Question 6: Shared resources where possible between counties; is it possible to combine county health departments where feasible.

**AUDIENCE INPUT:** Reggie noted that all in attendance had heard ideas from committee members, and provided an opportunity for input from the audience. Following is an abbreviated list of suggestions.

Mike Echelle:
- Public/private partnerships are doable.
- Tribal member partnerships are vital, especially in rural areas.
- Access and availability of care is critical.
Brandi Combs:
  • Levels of resources must be available for preparedness efforts. (current reductions affecting efforts)

LaWanna Halstead, representing the Oklahoma Hospital Association:
  • Partnerships are decreasing infant mortality rate.
  • There is a need to be able to make agile decisions.
  • Newborn screenings – transit times have been decreased through partnerships.
  • Rural hospitals are struggling – need to work together to process access in rural areas.

Representative from Oklahoma Primary Care Association:
  • Partnerships still untapped – plenty of room for improvement.

Senator A.J. Griffin:
  • Current Statutes are a trainwreck – cumbersome and obsolete. Need overhaul.
  • Mission creep is very evident.

Patrick noted the next steps would include reviewing these recommendations for further discussion and consideration. In order to meet the March deadline, we must stick with the overarching priorities and get those stated and then later, as the work of the committee continues, we will look at some additional areas.

Bruce Dart:
  • Provided encouragement - there’s nothing we can’t accomplish. Set our goals high and strive to be innovative.

**ESTABLISH COMMITTEE MEETING SCHEDULE:** Patrick and Reggie stated they would like the committee to meet weekly at 10:00 am every Friday from now until the end of February, and asked Kay Hulin to send out a calendar invitation to all committee members.

Meeting was adjourned at 3:50 pm.

Respectfully submitted:

[Signatures]

Reggie Ivey, Co-Chair  Patrick McGough, Co-Chair

Kay Hulin, Recording Secretary