

Carolyn Edmonds, *Board of Health Chair*

**BOH Members:**

Richard Conlin  
Dow Constantine  
George W. Counts  
Jan Drago  
Carolyn Edmonds  
Ava Frisinger  
Larry Gossett  
David Hutchinson  
David Irons  
Kathy Lambert  
Frank T. Manning  
Bud Nicola  
Margaret Pageler  
Alonzo Plough

**BOH Staff:**

Maggie Moran

**KING COUNTY BOARD OF HEALTH  
MEETING PROCEEDINGS**

**April 21, 2000  
9:30 AM to 12:00 PM  
King County Council Chambers**

**Roll call**

- Larry Gossett
- David Irons
- Greg Nickels, Chair
- Dwight Pelz
- Joe Pizzorno
- Kent Pullen
- Dan Sherman
- Alvin Thompson
- Karen VanDusen
- Alonzo Plough, Administrative Officer

**Call to order**

Chair Greg Nickels called the meeting to order at 9:49 AM.

**Approval of the March 17, 2000 Minutes**

Mr. Nickels asked for any corrections or additions to the minutes to which Dr. Sherman had a comment. One of the Board members had a made some statement about certain anti-depressant medication causing increased violence in people. He did not believe that to be an accurate statement. The March 17, 2000 meeting minutes were approved as presented.

**Chair's Report**

**Public Health Month Proclamation.**

In the Board materials there is a copy of the Governor's proclamation declaring this Public Health Month in Washington State. One of recitals in that proclamation says that "individuals and communities should be empowered to take greater responsibility for their own health by minimizing known unhealthy behaviors and taking appropriate preventative measures." That states very well this Board's objective of changing unhealthy behaviors which we know are the cause of so many of the preventable diseases and disabling conditions that we face today. Mr. Nickels, who is trying to make a change, urged everyone to think about their diet and exercise, eat 5 servings of fruit and vegetables each day, take a walk and start right after this meeting.

## **Opiate Substitution Resolution.**

The Board resolution on opiate substitution treatment adopted a year ago in May included a recommendation to increase the number of methadone treatment licenses within King County. That was fulfilled when the Metropolitan King County Council voted earlier this year to raise the number of licenses available within King County from 6 to 9. That was as a direct result of this Board and its work early last year. Mr. Nickels received a letter earlier this week, a copy of which is in the Board materials. It was an unsigned letter from a bereaved family member of an individual who recently committed suicide when they were unable to obtain treatment for their addiction. It reminds us that there's a very human cost to inaction. This Board and the County Council stepped up and we're addressing the problems. Ms. Norma Jaeger, Chief of Treatment and Rehabilitation Services Section, Department of Community and Human Services will report on the other recommendations in the resolution.

Ms. Jaeger said we have made progress on a number of the 8 items that the resolution addressed and are moving in all of the areas. As Mr. Nickels mentioned, the King County Council did increase the official number of licenses available to providers in the community from 6 to 9. Her agency is working with those providers to accomplish the increase of the actual licenses. In addition, the Board resolution recommended the development of an updated needs analysis of the number of individuals suffering from opiate addiction and look at that in comparison to the availability of treatment. They do a biennial needs assessment which we will begin in October of this year. They have been in communication with the Office of National Drug Control Policy which has worked with an organization in Chicago to create a new methodology for estimating the number of individuals who are opiate dependent. So they will be looking at that estimation methodology and determining how to go about identifying the number of individuals.

One of the resolution recommendations was to develop a media and community outreach plan. Next week there will be the first meeting of a city/county heroin task force that will look broadly at the issue of heroin addiction in the community, and considering proactive efforts to reach people in need. There is certainly a need to do outreach beyond the number of individuals currently interested in treatment, although we continue to have significant waiting lists for people who want to enter treatment who are without financial ability to pay. As we talked about when discussing the recommendation to increase the number of licenses, that increase did not add additional public resources to pay for treatment for people without the means. While about half of the people currently in treatment pay for their own treatment, that leaves a group of individuals who need public support in order to participate in methadone treatment.

The resolution recommended that we continue to recognize the importance of the support services and medical care as a part of the treatment. There is certainly more to achieving effective opiate substitution treatment than simply administering the opiate substitute drug itself. All of our efforts include making sure that we have a comprehensive treatment program. We have been able to increase the availability of supported housing. We will be working with a provider to provide alcohol-and-drug-free housing for clients who are in methadone treatment and also to make detoxification for alcohol or other drugs available for individuals who are on methadone. Those are 2 major changes in the array of services that are available for people and really underscore the importance of comprehensive service.

The Board resolution recommended investigation of the incorporation of opiate substitution treatment into primary health care. Ms. Jaeger is pleased to report that 2 mobile methadone service delivery outreach sites are connected to 2 of our public health clinics and they're

looking at making that same kind of connection with a third clinic. That relationship has resulted in individuals being referred by public health services for admission into opiate substitution treatment and really spans the linkage with other kinds of health care. The Board recommended encouraging the state to facilitate implementation of physician-administered opiate substitution treatment in medical practice. Ms. Jaeger is pleased to report that the State Division of Alcohol and Substance Abuse has been very supportive of this effort. They were very helpful in obtaining approval from the Food and Drug Administration and the Drug Enforcement Agency to implement the Robert Wood Johnson-funded project at Harborview that allows for opiate substitution drugs to be provided to individuals who are coming from methadone clinics and receiving their methadone at a physician practice base. They are looking at opportunities to expand that opportunity elsewhere in the state and believe that the state is very supportive of this and is looking for opportunities to make that happen through waivers in the federal regulations.

The Board recommended encouraging other local boards of health to support the expansion of opiate substitution treatment to make more of this type of treatment available statewide. She suggests that the Board might join with the local boards of health in the other 3 counties where opiate substitution treatment is permitted to encourage additional expansion of treatment availability in those other counties where it is still not allowed as a matter of local policy. Finally, the Board recommended urging the State Division of Alcohol and Substance Abuse to increase funding to address the issue of individuals who are without financial means to pay for treatment. They are working with the Division of Alcohol and Substance Abuse to develop a funding increase request to go to the 2001 Legislature. They may come back to this Board for a letter of support or further encouragement to increase the funding that is available. As a footnote to all of this, sometimes we wonder as we take public health policy activity whether it really makes a difference. While we certainly can't make a direct attribution of cause and effect, through the efforts that were made in the past year to increase the availability of treatment, we have seen the death rate from heroin overdoses decline from 144 (the highest ever recorded in this County) to 108 in the past year. That's a significant decrease and it demonstrates that paying attention to this kind of a problem, focusing public attention and making even the scant resources that were available can make a real difference. We can continue to push that sort of progress.

#### **Board Renewal.**

The Board is approaching its third sunset date. The first was in December of 1996 after 12 months of operation, the second was in June of 1998 after 18 months and the third is June 30 after 24 months. In June of 1998, for our second sunset, we underwent a fairly significant change in reorganization and Mr. Nickels thinks that the experience has been a positive one as a result of that. The staff has been talking with Board members, getting comments and perspectives on what changes, if any, ought to be suggested to the County Council as it considers renewal of this Board of Health. Under state law, the County legislative authority establishes the Board and its composition. The Board's enabling legislation therefore is in an ordinance adopted by the Metropolitan King County Council. As happened last time, what Mr. Nickels intends to do, after we have finished the evaluation process and gotten comments, he will attempt to assemble those, put them into an ordinance and have that introduced for the Council's consideration. Everyone here will have copies of that and have the opportunity to comment on whether or not it achieves the needs they've identified. Then Mr. Nickels will ask the County Council to act expeditiously on that legislation. Mr. Nickels sense is that the Council is fairly happy and supportive of the Board's work. We've had good participation here by members from all the different jurisdictions and the health professionals and the County Council, as well. It's Mr. Nickels hope that we have a very smooth process.

He will keep the Board up-to-date as we move forward on that. The telephone survey of the members who wish to participate is complete.

Ms. Gaylord gave an overview of what was found in the telephone survey in which 12 members and 2 alternates who participated. The questions were similar to those used in the survey 2 years ago but some questions about the planning process were added. Fourteen respondents out of 14 responded that the Board activities are consistent with the mission and goals statement. Twelve respondents agreed that the structure and composition of the Board facilitate fulfillment of the mission and goal statement. Of the 2 members who disagreed with the manner in which structure and composition are serving the mission, one pointed to the small number of medical representatives and the other believed that the Board was not representative of the County population and failed to meet the legal or constitutional standard of equal protection, 1 to 1 ratio representation. The use of alternates were supported by all but 1 respondent. Ms. Gaylord took a straw poll at the same time she conducted the evaluation to see whether there was support for changing the enabling ordinance to permit the non-voting health professional member to serve as an alternate for the voting members in their absence. There was a very favorable response to that. The special majority rule is still serving the needs of the Board according to 11 respondents. Two respondents felt that it had outgrown its role. Ms. Gaylord responded affirmatively to Mr. Nickels' question of whether the 11 members represented a special majority of the City and a special majority of the members outside the City. Satisfaction with the meetings, the way that they're structured, and the feeling that they are a worthwhile use of time was expressed. There were numerous respondents who gave a lot of credit and praise to the Chair for making that so. There was some dissatisfaction with the length of meetings, the length of briefings and a desire for more hardcore policy work at the meetings. In fact, the positive feedback about the budget workshop reinforced the message that the real work that the Board wants to get into is policy. The location of board meetings got mixed reviews with a strong preference for being downtown close to the County Council site if not in it. Staff briefings got good reviews as did the panel presentations, however, a continuing message which Ms. Gaylord will continue to take back to the Department is briefings need to be shorter and more inclusive of decision points and policy options to facilitate the Board's policymaking role. Written materials were satisfactory to all, although there were some comments on the paper pile-up. Staff will try to deal with that situation in the coming months. Board members cited a significant increase in their knowledge of public health and all of the respondents cited a high level of satisfaction with serving as a member of this Board.

There was definite agreement that there should be a planning process to set the Board's long-term policy-making agenda. There were a number of suggestions, including a planning retreat or public meetings. There was also a very clear message that there should be external input in order to avoid deciding the priority issues for the Board based on personal preference without knowing what stakeholders and the public believed to be the priorities. A list of issues were recommended by the Board that members would like to see dealt with in the next 2 years. High on the list were budget and fiscal issues, "critical public health" issues and also mental health and substance abuse issues. To sum up, the members believe that the Board is true its mission and that it is working well. There is room for improvement and we'll take back the recommendations to staff, particularly those about greater clarity in presenting and articulating issues, laying out decision options, and giving more support to the Board as a policy-making body. The planning process is desired by a majority of the respondents and we will be working to develop that in a way that is efficient and responsive to the suggestions received.

Mr. Nickels reiterated that one of the issues that came up on a number of the evaluations was attempting to have the Board think forward in involving members in planning for our

future activities and identifying emerging issues. Mr. Nickels has tried to do that as members have brought issues up and the Board has been fairly responsive to that, but it's not been done in a particularly systemic way. So Mr. Nickels is asking staff to bring back to him and the Board some options for ways they might go about that, whether it's a planning retreat or some other process the Board would go through on an ongoing basis to attempt to have a more strategic approach to these issues. A discussion will be held at a future board meeting on that. Mr. Nickels has been very proud of the work of this Board over its last 4 years, and particularly these last 2 years since we have improved the structural aspects of the Board. It has been very effective, a good forum, a good opportunity for members to learn, and through their learning process, for the public to learn about these important public health issues. Mr. Nickels thanked the members for the very hard work they have done in that regard.

#### **MVET Mitigation and Food Fees.**

Mr. Nickels explained that when the Board adopted fee increases in November as part of its review of the budget, the impact of I-695 and other factors on our ability to provide very basic core health services such as food inspection, an amendment was added particularly to the regulation raising fees for food services that the Board would reconsider the fees if the Legislature restored in part or whole the Motor Vehicle Excise Tax (MVET) that was lost by the Public Health Department. The Legislature has not yet finished its work, but the House, Senate and Governor's budgets substantially restore those funds. So the Board will, as promised, re-engage around those fees on food services. That will be an upcoming work program item. If the Legislature finishes next week, we will have that at our May meeting, at least as an introduction, and go through consideration of those fees and whether they should be reduced. Dr. Plough indicated that the situation is as Mr. Nickels outlined and that there is still a possibility that the tobacco plan control will be funded at the level that was recommended by the Tobacco Advisory Council at \$20 million a year. And, at least in the Governor's and Senate's budgets, a \$2 million public health emergency fund is there to assist jurisdictions with outbreak control. So all budgets look pretty good for local public health. Mr. Pullen stated that he would hope that we would go a lot farther that just reevaluate the question of the food fee increases. He realizes no promises were made that were legally binding, but it seems if we tell the public, vendors and others that we're going to revisit this with the strong possibility of rolling back some of those fees if the Legislature increases the funding, then we have more of an obligation to do that than to simply revisit it. That would keep faith with the public. These increases have been more of a burden than people realize.

#### **Canada Geese.**

Mr. Nickels drew members' attention to a letter regarding Canada geese from Ms. Pageler and Mr. Conlin who were unable to be present today due to the Seattle City Council's budget retreat. Staff from the City of Seattle and our Environmental Health Division are here to talk to us about a serious issue with regard to Canada geese. For years those of us in elected office have looked forward to the annual press release from the Director of Health on swimmers' itch. It must be about time for that now. But, in recent years, the population of Canada geese in particular have skyrocketed to the point that there are some serious health effects that the City of Seattle Parks Department and others are attempting to grapple with. Mr. Nickels introduced Patricia McInturff, Deputy Superintendent of Parks for the City of Seattle. She explained that last July, the Board was briefed about the growing public health problem of the increasing population of Canada geese, not only in Seattle but throughout the region. Canada geese, like lots of public health problems, don't know any boundaries. If you get rid of them in one part of the County, they simply land in another. The reason for bringing this to the Board again is: 1- the population has continued to increase despite all of the

efforts of all the Parks Directors throughout the County, and 2 - because on March 22, the US Fish and Wildlife Services issued a permit to the USDA Wildlife Services to kill up to 3500 resident Canada geese in about a 5-county area. About a month ago, the Regional Waterfowl Committee, which is made up of all Park Directors from throughout Seattle and King County, voted unanimously to try to move ahead with this strategy. These are migratory birds who actually don't migrate anymore. Because they are migratory birds they are controlled by the federal government, so that's why we have to wait to get this kind of permit from the federal government. The letter from Councilmembers Pageler and Conlin asks for a resolution in support of this at the Board's next meeting.

Ms. McInturff introduced Don Harris, an expert who has been working on this issue for many years, to give an overview of the techniques that have been used and will continue to be used on this growing problem. Mr. Harris stated that the management of waterfowl in Seattle and King County basically began in 1987 when we realized that the population was growing. They formed up the Regional Waterfowl Committee. They started initially by translocating geese to eastern Washington. That was the most effective method because they took the adult birds and transported them there. Needless to say that they recognized that we were just moving our problem there and that stopped after several years. Then the federal government issued permits. These are a regulated species even though it was the migratory pattern that was the regulated part. These have become resident geese, but they still are subject to the federal regulation, so everything we do we do through permits issued by the US Fish and Wildlife and contracting with the US Department of Agriculture Wildlife Services. Egg addling has managed to, to some extent, at least stop the birthing of a number of geese every year, but the population is continuing to grow. Wildlife Services, realizing the problem and the increasing call upon them to implement control strategies in issues of risk to the public and perhaps the threat of public health, applied to the US Fish and Wildlife for a permit to enable them to kill geese. That permit was issued. It's ironic, however, that at the same time US Fish and Wildlife on a national basis is reevaluating the whole policy they've issued. This is not a problem unique to what's referred to as the western flyway extending from Alaska to the south -- everywhere you go in this country you find problems with Canada geese. Many jurisdictions are moving to more drastic methods. In fact, we may see in the near future US Fish and Wildlife actually opening up hunting seasons and such. When we first started this, the issue was summertime problems on our swimming beaches. Now we have problems on our golf courses, children's play areas and wading pools, small craft centers and our athletic fields. One of the more graphic examples is the problem on the athletic fields, when we have parents calling and explaining that they believe that when their kids fall down on the soccer, rugby or baseball field, they are basically in a fecal stew. They haven't evaluated this from the perspective of public health, but increasing anecdotal evidence shows that there's an increase in festering cuts and such. The time has come to request the federal government to employ these more drastic means and they are looking for the Board's support.

Mr. Pullen asked how it is proposed to kill the geese. Mr. Harris answered that the service is carried out by Wildlife agents working for the US Department of Agriculture. They go in particularly during the molting season when the geese are not flying, round them up, take them away in trucks and subject them to carbon dioxide—they're gassed. To Mr. Pullen's question of what is done with the carcasses, Mr. Harris responded that disposal is still something that's being evaluated. What they have found throughout the country is where they have been able to disseminate the carcasses as a foodstuff to non-profit agencies trying to deal with the issue of hunger, the program has been met with more success. They did find a year ago when they started evaluating it, that there were some outlets. When briefed last July, the Board had expressed some concern about this which was somewhat mitigated by the fact that it is the USDA that is implementing this program, so they're looking

at all the human health issues. Mr. Harris can't tell the Board that they've actually worked out a relationship with the food disseminators, but it's being worked on. He asked what has changed to cause this problem to develop over the last couple of decades. Mr. Harris' understanding is that initially humans introduced more of a resident population. Also, human feeding is going on and the way we provide our park facilities in green manicured grass, we provide an ideal environment for the species and it just has stopped migrating. So in addition to introducing them initially, there is a different pattern developing. Mr. Pullen commented that in the early 1960s we still had all those wonderful green fields, lots of grass, lots of nesting areas and he remembers seeing relatively few geese. Mr. Harris responded that it was the introduction of a resident population that made the difference. Dr. Pizzorno asked how many geese are there. In response, Mr. Harris indicated that it's a difficult census that the USDA does for us, but his understanding is that in the Lake Washington basin they've had populations that range from 3,000-5,000 of the resident population. Ms. McInturff added that they have a very long life, which is the other reason why egg addling won't show much change for 20 years. Dr. Pizzorno, noting concerns about pathogens, asked if there are any particular pathogens that this resident population has. Mr. Harris indicated that he couldn't answer fully, deferring to the Health Department staff, but stated that the fecal coliform counts, which was a big problem in the closure of Juanita Beaches.

Mr. Nickels asked Larry Kirchner, Principal Environmental Health Specialist with Public Health - Seattle & King County, for the perspective of Environmental Health Services. Mr. Kirchner stated that the Department has supported the USDA proposal for what they called "alternative 4" which was the mixed bag of alternatives including killing the geese. We see a lot of public health impact. A lot of it is not easily measurable, but we do see it in beach closures, swimmers' itch problems, complaints from the public concerned with their children playing in the "fecal stew" as Mr. Harris called it. We've spent a lot of time and effort dealing with those problems and we see that other less lethal alternatives have been tried, so we have supported in writing the environmental assessment done by FDA. Mr. Nickels asked if the Fish and Wildlife Service has issued the permit. Ms. McInturff answered yes and that the next step is that the local municipalities must invite them in. Mr. Nickels asked what value there is to the King County Board of Health passing a resolution or some other statement. Ms. McInturff said that it is important because many people feel that this is just being done because it's a nuisance problem and "why don't you just vacuum up the grass and clean out the wading pools?" She wants this acknowledged that government doesn't just go out and kill animals because it's a nuisance problem, that there's a public health issue there and that's why we're addressing this problem in this very serious way. Dr. Plough indicated that he felt comfortable bringing this back as a resolution because it has been very well described and there are a number of issues here related to public health that transcend the threshold of simply being a nuisance to something really is harmful to the public's health in terms of swimmer's itch and the particular impact on youth. Mr. Pullen asked if the goal would be to have a resolution at the next meeting to be voted on. Mr. Nickels indicated that is the request of Ms. Pageler and Mr. Conlin. If that is the desire of the Board, we will bring it back for the opportunity to discuss it, debate it and potentially take action at our next meeting. Dr. Pizzorno asked about the mechanics of the law -- whether the Board of Health has to approve this in order to implement it. Ms. McInturff answered no, but that it is a very serious decision to take -- to kill animals -- and it gives it the context that it's not a nuisance issue but a public health issue. Ms. VanDusen asked, based on the question asked earlier about the food supply, that as part of the decision process next time we might have more of a briefing about the policies here in King County about what would or would not be allowed. She has gotten that question herself. This is an issue that the University of Washington is involved with and the University is a member of the Regional Waterfowl Committee. It is also an issue that the University has been struggling with for quite some time. The issue on documenting health issues, both the impact of the geese plus the potential benefit of a food

source might be appropriate to look at. It is controversial because of animal rights activists, so it has that side of it that we need to be respectful of. Mr. Nickels determined that it was the sense of the Board to bring this back at the next meeting.

#### **Tacoma-Pierce County Tobacco Regulation.**

Mr. Nickels gave a status report on the appeal to the 9th Circuit Court of Appeals on Tacoma-Pierce County's outdoor tobacco advertising regulations. The Court of Appeals decided not to re-hear Tacoma's case, so the ruling against their regulation, which is very similar to ours, stands. The outcome of that case is binding on us here in King County, according to our attorneys; therefore our regulation is no longer being enforced. Mr. Nickels asked the Board to authorize him to send a letter of appreciation to the Tacoma-Pierce County Board of Health for their leadership and willingness to follow this through in terms of the legal work that they did on the issue. If Board members desire, we can bring this back next month in Executive Session to hear from our Prosecuting Attorney on the effect and what considerations we should have with regard to the long-term outlook for our regulation. Mr. Pelz asked, when Mr. Nickels says it's no longer being enforced, do we have to rescind it. Mr. Nickels answered that that is what we would talk about next month -- whether to simply not enforce it or repeal it. Mr. Nickels clarified for Mr. Pelz that this was not something adopted by the County Council, but that it is a regulation of the Board of Health, which carries the force of law. Mr. Pelz stated that fundamentally when a decision is made not to enforce a law, that decision is really being made by another branch of government. It seems to Mr. Pelz not a very good precedent for us to be very casual about that. He would think we would want to move rapidly to formally do that, otherwise there might be an impression that that branch of government could selectively enforce rules that we adopt here.

Ms. VanDusen also requested that the Board asked for the Board to be presented a matrix similar to the one used for the opiate substitution treatment update earlier in the meeting. Mr. Nickels directed staff to bring that back to our next meeting, explaining that initially, the Board adopted a resolution that had a 5-point agenda on tobacco issues. He asked for a matrix showing what's happened with each of those and what the federal settlement does. Dr. Pizzorno stated that Mr. Pelz had a very valid concern that he supports. He would like the Board to think maybe differently. It irks him to have the tobacco lobbyists in a position where they can supercede our public health perspectives. Dr. Pizzorno, for one, is not particularly interested in taking it off the books because they went through a lengthy process and did what was right for public health. Maybe there is something we can do to make a stance. What if the legal precedent changes again and then we have to go through this long process all over again, which took 2 years? Mr. Nickels indicated that those are the kinds of discussions we can have with the Prosecutor in terms of a risk analysis. So we will come back and schedule some time for executive session with the prosecutor at our next meeting.

#### **Local Board of Health Leadership Workshop.**

The Local Board of Health Leadership Workshop is scheduled for May 4th and 5th at Seatac. There's a brochure in the board packet. There will be a lot of good presentations, an opportunity to interact with members of other local boards. The last 2 workshops have been very useful, so Mr. Nickels urged members to participate if they can.

#### **Task Force on Underage Drinking.**

The Board adopted a resolution in January of this year to support the recommendations of the ad hoc committee. One of the recommendations was the formation of a county-wide task force to pursue the activities outlined by the committee. Funding to support the work has



been settled and activities to form the task force are now underway. It will soon begin meeting on a monthly basis. Board members are to let the Chair and staff know if they are interested in participating in that.

#### **Vice Chair Positions.**

The vice chair from the City of Seattle has left the Board and so we need a replacement. King County Councilmembers have not had a vice chair appointed. That delegation ought to consider that again. The health professionals should confirm whether Dr. Thompson will continue as the vice chair for the health professionals. Staff will be doing outreach to get those names.

#### **Meeting at Harborview.**

We will have an upcoming meeting at Harborview in the near future. We were hoping to do it in May, but that's not going to work. Perhaps June or a subsequent meeting will work so we can take a look at the Trauma Center and the role that Harborview plays in our public health and overall health system.

### **Director of Health's Report**

#### **Proposed Standards for Public Health in Washington State.**

Dr. Plough explained that the proposed standards document represents an important turning point for both public health in the State of Washington and nationally--clear and understandable standards for what the public can expect from public health departments. Developing and implementing standards has been an activity over the last 3 or 4 years initiated by the CDC, but also operating in many of the states as well. The State of Washington's framework for performance standards comes out of the CDC model standards. The state standards are in draft form and represent an adaptation to public health practice in Washington State. The standards will be the framework through which both the federal and state governments have local public health defining standards and measuring them. The proposed standards will become a part of the Public Health Improvement Plan (PHIP). PHIP, which was developed and managed by the State Department of Health, is the performance and oversight framework for all of public health in the State of Washington and will come out with its third edition in December 2000 of which the proposed standards are one part. The rest of that plan will include sections on effective public health communications; a measure of key health problems in the state and localities; the need to strengthen information and technology in local public health, particularly electronic disease surveillance systems and disease reporting systems; issues of workforce development, training, orientation and distance learning for local and state health department employees; financing recommendations -- continuing to look at and analyze recommendations for more equitable sustainable funding for local public health; and measuring gaps in critical health services and recommendations for local health departments to deliver or to make sure those services are delivered by some other entity. When the PHIP comes out in draft form later in the year we will have a presentation by the State Health Department on this.

The standards will be the template which this Department is mandated to use. The standards are in 5 areas: 1) Protecting people from disease and injury, 2) Understanding health issues, 3) Assuring a safe health environment for people, 4) Prevention is best -- promoting health living, and 5) Helping people get the services that they need. Those umbrella topics were derived from the 10 essential services put together by the CDC that we've talked about before and which are the guiding principles for our department's strategic

plan. The work done in drafting the state standards was to try to make the 10 essential services more meaningful and clear to people.

The first one is Protecting people from disease and injury. Under this umbrella are standards for communicable disease, injury and other health risks. You'll see throughout that this document is constructed in 2 parts: (1) the overall standard, which is what has to happen statewide, and (2) the roles of the local health department and the state health department in achieving that standard. Standard 1 under Protecting people from disease and injury are surveillance and reporting systems, that you have to have to monitor and track and identify emerging health threats, not only communicable disease threats, but chronic disease, injury and a variety of other disease threats. You need to be able to have the proper reporting of that. Standard 2 is a response plan delineating roles and responsibilities in the event of communicable disease outbreaks and natural disasters. We will hear Dr. Jeff Duchin's presentation later on some of our challenges in communicable disease control, which speaks to the importance of that standard. Standard 3 is that communicable disease investigation and control procedures are documented in a specific way -- that disease investigations begin within 1 working day and there are procedures for securing emergency biologics to monitor outcomes for how we do disease control. Standard 4 is that urgent public health messages are communicated quickly and clearly, and Standard 5 is that communicable disease and disaster responses are evaluated, that we are continually evaluating and have evidence that we're doing that.

The second umbrella category, Understanding health issues, is a general area of public health assessment. Standard 1 is that public health assessment skills and tools are maintained. It lays out in more detail what the local department has to do to be sure it can assess what public health problems are out there in the communities that we serve, particularly incorporating computer approaches and information systems to do that. Standard 2 is making sure there is a surveillance system to get information about health status people and environmental health threats. Standard 3 is that public health program results are evaluated, so that each of our programs have written goals and performance measures which incorporate relevant research literature, something that actually is incorporated in the current business plans for Public Health - Seattle & King County. Standard 4 is that policy decisions are guided by health assessment information so that there is an interplay between our assessment of public health issues and the policies that are developed. Finally, Standard 5 is confidentiality, that the data we keep are confidential.

The third major area is Assuring a safe healthy environment for people -- these are standards particularly for environmental health. Standard 1 is the importance of environmental health education as a component of an environmental health program. Dr. Plough believes our Department has been very good at moving beyond just the inspection to the education. Standard 2 -- environmental health services are available throughout the state and are organized for response to emergencies, written plans that delineate roles and responses of environmental health in outbreak and natural disaster responsibility. Standard 3 -- environmental health risks and illnesses are tracked and reported, so our surveillance systems need to also be monitoring diseases that are related to environmental causes. Standard 4 -- compliance with all environmental health regulations and enforcement activities, so these have to be monitored.

The fourth area is Prevention standards for prevention and community health promotion. Standard 1 -- public policies are adopted to support healthy life choices through health education information to the population. Standard 2 -- active involvement of community in developing prevention priorities. Standard 3 -- high quality prevention services are available, that these services match the complexity of disease in your county are available. Dr. Plough

indicated that these standards are intended to flex depending on the complication of the county. Where Garfield County has the same sort of umbrella standards, they will not be expected to have the same intensity of service as King County. These are not minimum standards or basic service, this is a performance measure that will have high variability between counties in terms of the services that you need to achieve this end. The surveyors that will be coming out and looking at this for the State Department of Health will absolutely expect that for us to achieve these standards, we have a far more broad array of services than the state's smallest county, Garfield. So, again, it is in no way intended to be a set of minimum or basic services, but a very flexible standard that will vary from county to county. Standard 4 -- health promotion activities are carried out at local and state levels, that there be a wide range of health promotion and educational activities that are demonstrated, targeted toward high profile public health concerns such as physical activity, tobacco use and dietary choices.

Finally, the very important area of standards for Access to critical health care services. People from this Department were involved with all of this work with the state. This particular standard was developed by the workgroup that Dr. Plough chaired, which is how we get the assurance function of public health delivered. Standard 1 -- is that each health department is going to be required to have information describing their complete health care system, not just what public health delivers, but all the resources that are critical for health protection. This is to show that you are working in partnership with those providers and that set of services is reasonable. Standard 2 -- information and monitoring on those services. Standard 3 -- that there are plans to reduce gaps in access to critical services that are implemented and addressed. Standard 4 -- that there are quality and performance outcome measures for the critical health care services that are provided, either directly by the local jurisdiction or through contracts or both, through quality assurance plans and outcome measures.

So these standards will be the guiding framework and the statutorily required framework for the Department for performance measures. They are tied into the federal government approach and become the major kind of regulatory strategy for enforcing and determining what local public health departments do in a way that we are accountable for all of our varieties of funding. Ms. VanDusen stated that, while this document doesn't say how we do this, it does say basically what we should be doing. She wondered if it would be appropriate and possible for the Department to take one of these categories or whatever seems reasonable and present to the Board of Health how we are doing or how we are addressing each of the standards within each category. By doing that the Board can have a sense of what this County is able to do currently or what it needs to be looking for and what basic public health needs to cover. This has been a fundamental question that we've all had on what is the baseline, what is fundamental. While we may have some feeling about how it needs to look in this County, at least we need to know that we are addressing it if this is the expectation for basic public health. Dr. Plough agreed that was a good idea, and said that one this summer, the state will have an independent contractor evaluate each department on where they stand in terms of their ability to meet these standards. That is information that will be brought to the Board by having the state come in and do a presentation on how we measure up with the standards. We also, in our Department's business plans for the City and County, have incorporated our lines of business from the strategic plan within these categories as well, so there will be an alignment of all the things we do as they fit into these performance measures.

### **Arsenic and Lead on Vashon Island.**

There are press releases and articles in the Board materials on this issue and the department has a lot of reports on that on our website. Our environmental health, epidemiology, planning and evaluation and public communication crew did a fabulous job on getting this draft report out to the public. The report was just the start of what will be a very long-term involvement with our agency and community partners to continue to determine what these preliminary soil samples mean for risks to the community.

### **TB Program Grant.**

The Department's TB program received a grant from the CDC to continue their partnerships with community clinics. Our TB program continues to be one of the model programs in the nation on partnerships and TB control. There are press clippings in the Board materials about the complicated work of TB outreach in the community that our Department does.

### **Free Mammogram Program.**

We are having a free mammogram program in celebration of Mother's Day and the National Minority Cancer Awareness Week. The Department's Breast and Cervical Cancer Program will be arranging for free mammograms for women with limited medical resources.

### **Childhood Immunizations Booklet.**

An excellent booklet is now available from our Immunization Program, Plain Talk about Childhood Immunizations. This explains to parents the increasingly complicated world of required immunizations for children. The addition of hepatitis B and other new vaccines to the standard list has made this very complicated.

### **Heroin Task Force.**

As mentioned under the Chair's report, this group met for the first time on Monday.

## **Budget Policy Workshop Continued**

### **Public Health Nursing Presentation Summary**

Mr. Nickels asked Dr. Plough to summarize the key points from last month's public health nursing presentation, part of the Budget Policy Workshop. Dr. Plough stated that public health nursing, one of our core activities, has been maintained through a patchwork of categorical funding as local tax dollars have declined. That means that the vast majority of our public health nursing services, over 90 percent, are provided to families on Medicaid, but may not be available to other families who need them. They can be provided to families who are in Child Protective Services (CPS), but not to families who may be at risk for CPS referral. So it's good to have this categorical funding, but it very much constrains our public health mission to be able to provide the important public health nursing services beyond those populations that have a targeted funding for them. It's very Medicaid linked and categorical for their eligibility. Only 2 percent of the public health nursing budget is from local revenues, which is down from 42 percent in 1991. This decline in the local revenues which would allow us to have public health nursing be flexible enough to reach the entire population is the real point. This was brought home again to us in the response to the lead and arsenic issues on Maury and Vashon Islands. In order to get the public health nursing support that we needed to answer concerns of the residents, we had to take 2 nurses out of

our White Center Clinic. They are public health nurses who serve Vashon, but they are generally doing that for revenue-based visits. So it becomes an unfunded challenge for the Department every day that they are out there doing this important work with the community, but not being funded by the maternal and child health support services.

What can be done about that? From the Department's perspective and Kathy Carson's presentation, we need to invest to increase the efficiency of what we do. This is not just a problem of a shortage of resources, and public health nursing is working through computerization and great increases in their nursing productivity to increase their capacity in that way, but we're going to need to do more as well. The computerization is of the billing and back office activities so that you free the nurses up for the face-to-face interactions. Dr. Pizzorno asked what percentage of the day the nurses spend filling out paperwork. Ms. Gaylord recalled from Kathy Carson's presentation, 40 percent. Right now 12 nurses share 1 computer. So with the streamlining that she proposed as necessary, Ms. Carson had estimated that the time could be reduced to 25 percent. Five to 10 percent is desirable, but Ms. Carson had thought that with a 15 percent gain there would be a lot of client time added to the nurse's day. Dr. Plough said that we are working on those kinds of process efficiencies and also trying to expand our investment in child care workers and the support of public health nursing services in the child care area, supporting child care providers. We're also working to get the state to expand some of its investment in TANF (Temporary Assistance for Needy Families) savings into family support systems that can also help to support our public health nursing.

We need to allow public health nursing to be more invested in some of the upstream prevention efforts. Ms. Carson had mentioned the importance of the David Olds model, which is an early intervention program of intensive nurse home visiting for young mothers or high-risk mothers. National studies have shown that this kind of high-risk nursing involvement will reduce criminal justice involvement for the mother and the child 15 years later, compared to a sample that did not have that kind of intervention. This is a widely adopted model around the country, and it would be very good to be able to invest resources so that public health nurses could adopt this very important preventive model. Another area in which we'd like to see more resources for public health nurses is preventing our adolescents and youth from being involved with our jail system through programs like Crime Free Futures and Community Pathways. But we are not able to be involved with those programs right now because our nurses' funding is tied to the categorical maternal and child health resources. The third area, which Dr. Plough thinks is so important, is that as public health needs of the County expand far beyond just maternal and child health to adolescent health to long-term care to chronic disease (like our diabetes projects) to being able to support disease outbreak investigations, we are going to need to have funding for public health nursing so they can be involved with these broader issues. This is too important a resource just to have focus where the funding is. As important as maternal and child health nursing is, it is not at all the entirety of public health nursing that we need.

Ms. VanDusen asked how what we have in public health nursing relates to the performance standards (presented earlier) that we're expected to maintain. It would be useful to show what these activities support in terms of the standards, because what Dr. Plough summarized today all makes sense. Dr. Plough indicated that we can go into that more extensively another time, but it links in many of those standards because the public, particularly in the preventive and public education areas where we are not doing what we need to be doing around chronic disease prevention and community engagement and risk reduction, that is where we need to have those public health nursing resources, as well as in communicable disease and outbreak control. Dr. Plough continued that in fact we are not able to engage our public health nursing workforce in those standard areas because they

are so constrained in the maternal and child health public funding. Ms. VanDusen stated that that was the point she was trying to make, that if we are able to show that linkage between what we're expected to be and in effect this Board of Health is accountable to assuring it happening, it really helps to see which of these variety of activities fit with which standard. She doesn't expect that today, but futuristically we might task ourselves with always checking back to see how we're doing against the standards we have to meet. Mr. Nickels said that was an excellent point and a good request. He will ask staff to respond to that. The reason that Mr. Nickels asked staff to bring this issue to us at that last meeting in this format is because when you go in 9 years from 42 percent of the public health nurses being funded by local resources and therefore available for local priorities and local response to just 2 percent, you clearly have changed your ability to use that resource and put these nurses who are our frontline workers to move them and be flexible to address emerging public health issues. The whole point behind our conversations around the budget is to see the impact of this trend, this spiral of decreasing local support for the public health function has on our ability to address ongoing, emerging and emergency response.

#### **Communicable Disease Outbreak Control. Recognition of Dr. Jeff Duchin for preparing for WTO.**

Mr. Nickels recognized on behalf of King County the work that Dr. Duchin has done in recent months on the World Trade Organization meeting that was held here. It posed a real significant challenge for public health and our ability to prepare for what is being called bioterrorism and whether we're able to respond as public health in the event of bioterrorist activity. Dr. Duchin, head of our epidemiology and immunization section of the Communicable Disease Control Division, collaborated with folks from the CDC and the Defense Department to design and implement a population-based system that was implemented in partnership with Seattle and King County area emergency departments. The program, called the ESP system, was designed to detect clinical illnesses such as fever and rash, sudden death, things that would be signs of bioterrorism before the diagnosis was confirmed through specific testing. The result was a project that was implemented at 8 Seattle and King County hospital emergency departments during the WTO. The project received high praise from the people who participated in it. It functioned very well and established a model for ongoing collaboration. The participating hospitals have expressed a desire to enter into an ongoing relationship with public health to improve their ability to detect communicable diseases including potential bioterrorism emergency infectious diseases and pandemic influenza. Mr. Nickels thanked Dr. Duchin for the pioneering work he's done on this.

#### **Communicable Disease Outbreak Control**

Dr. Plough introduced Public Health staff Dr. Jeff Duchin, Communicable Disease Control Program Director, David Bibus, Immunization Program Manager, and Kathy Uhlorn, Chief Financial Officer, who will talk about a variety of communicable disease control issues that have been challenged due to declining local funds. Ms. Uhlorn began by reminding the Board that at the February Board of Health budget policy workshop the department presented financial information about the public health budget. Service programs were differentiated as either critical or enhanced and information was presented about the funding sources that support these programs. At subsequent meetings we've been looking at 3 critical public health programs -- last month public health nursing, and today the communicable disease program. The foundation of the communicable disease program is the immunization services. She will be presenting information today about the funding sources that support this program. She will be using the same format as she used in presenting information about the public health nurse services last month for consistency. Ms.

Uhlorn's first overhead illustrates the percentage of the immunization program to the overall public health fund. It's remained fairly consistent through the last decade, between 2 and 3 percent of the public health fund's budget. The next overhead depicts the level of current expense in this program. In 1991, 22 percent of the program's funding was from current expense (CX), in 1995 it was 9 percent, in 1999 it dipped to 4 percent, then in 2000 additional CX was allocated to this program to bring it back to 8 percent. The overall decline is from 22 to 8 percent currently. Another local funding support for immunizations is the general fund, 9 percent in 1991 and 9 percent in the year 2000. In 1995, we had additional federal dollars in the Seattle sites that reduced the need for general fund support in the program that year, but it has remained at about a 9 percent level the other years. In putting CX and the general fund together to look at combined local funding for this important critical service, 31 percent of the program was funding by local dollars in 1991 and it's down to 17% in the year 2000. In 1991, there were 9 funding sources. Our current number of sources is 19. In 1995 and 1996 we started seeing many additional funding sources that we were able to leverage to increase the program, but they also had the effect unfortunately of eroding some of the local funding base as that funding was moved to other critical public health services. An important other funding source for this program has been the federal immunization grant funding. That was at its peak in 1995 and 1996 and then steadily declined. Three of the conclusions that were presented at the Board of Health meeting in February are pertinent to looking at this specific program. The Department is doing a good job in getting other funding sources in grants and leveraging other dollars to support this critical public health service. The CX budget for immunization services has decreased in the last decade. The capacity to assure that immunization services are available to our public is decreasing as local control and local resources continue to shrink.

Dr. Duchin then addressed the Board. He began by providing the Board with a few introductory slides that set the stage and then gave some examples of actual disease outbreak investigations that they've done and how the changing infrastructure has impacted their ability to do the job that they should be doing. The first overhead shows, by way of background, the number of state supplied vaccine doses administered by private compared to Health Department providers. The Board has heard how critical are both the immunization nurses and the general infrastructure of the Health Department for interacting with the community on many issues. What we've done here is successfully transitioned to the private sector a large proportion, the vast majority, of immunization doses delivered through a very competent technical and logistical support system that's run by Public Health. But what you can see with the smaller bars (on the graph) is that we've maintained a stable cohort of clients who get their immunizations through Public Health despite the reduction in resources. Dr. Duchin showed 2 examples that illustrate the episodic surge in communicable diseases that occurs throughout the County. In 1999, we had about 3 times the level of pertussis cases we had during 1998. Each of these cases is associated with an investigation that involves multiple persons in the household, school and day care. An excess of cases occurred in a very compressed time frame. They didn't occur in a uniform distribution throughout the year. Dr. Duchin confirmed for Mr. Nickels that pertussis is whooping cough and that it is a vaccine preventable disease. The vaccine is designed to prevent death and severe illness in infants. The vaccine does not confer lifelong immunity, so older children and adults are again susceptible. They are the ones continually posing a risk to the young infants in the community. Mr. Nickels asked, because we had a spike in pertussis incidence in 1999, if that means people haven't been immunized. Dr. Duchin responded that these people are immunized in general. Most of the folks are immunized, but what shows is a relatively milder presentation of illness, but it's critical because, when you have a lot of adults who are coughing for several weeks, those young children less than 1 year of age who are not yet immunized are very vulnerable. The next slide illustrates chronic hepatitis C, something the Board has been hearing about and the tremendous burden on public health and clinic health

infrastructure that is going to pose for our country in coming years. Chronic hepatitis C is not a reportable condition, but you see the number of reports we have. It will be made reportable probably this summer, and we will start taking reports officially in September. Between 1998 and 1999, just based on the press and increasing public awareness which we think is wonderful, we received 1,160 reports. We currently catalog these reports, but we don't have any particular program or resources devoted to investigating or otherwise working with these patients outside of 1 program pilot -- a grant funded pilot study. One of 3 sites in the nation to do a small project, but most of these cases are just cataloged.

Dr. Duchin then addressed the immunization nurse problem. Between 1996 and 2000 we have a 28 percent reduction in the number of total of immunization nurse hours in the Department. Dr. Duchin will show how that's distributed in the coming slides, but the basic point here is we're losing nurses. The next slide illustrates the combined primary care physician and nurse practitioner hours. Dr. Duchin shares this information because these are the folks who have prescriptive authority. When we have a meningitis or whooping cough outbreak, we need frequently to write prescriptions for medication, preventive or treatment doses, and you can see that the number of clinicians with prescriptive authority has been cut in half since 1998. The vast majority of that reduction has occurred at the King County as opposed to the City of Seattle sites. That is represented on the slide which shows each of our public health clinic sites for the years from 1997 to 2000. For those sites such as Auburn, Federal Way, Northshore, Renton and White Center, capacity has completely disappeared, there are no longer primary care nurse practitioner or physician hours at those sites. You can compare the sites on the left side of the graph which represent King County sites to the City of Seattle sites on the right side and you see the discrepancy there in the infrastructure and the capacity between the City and the rest of the County.

By way of background, Dr. Duchin shared a couple of real life outbreak situations, how we responded and the implications of some of these reductions. In January, 1990, we had an immigrant child and 3 siblings who were diagnosed with rubella. These children attended 2 Federal Ways schools while they were communicable. In the course of our investigation we learned that the school-based immunization records erroneously indicated that the children had received MMR vaccine and would be immune to that disease, rubella, when they only had received measles and mumps, so they were susceptible. That instigated a massive review of immunization records and subsequently 2 schools had to close because they didn't have enough staff who were documented to be immune to rubella. In response, we very rapidly put together 4 special immunization clinics to get those susceptible students and staff immunized and protected against the disease. Three hundred and thirty-five doses of vaccine were administered to 303 students and 32 staff. Dr. Duchin showed what happened at the clinic site. The next slide illustrates changes in the Federal Way pediatrics and immunization clinic resources. The nurses, nurse practitioners and physicians in these clinics are the ones who we utilize when we have communicable disease outbreaks. In 1998, the year before the outbreak, there were 4 FTEs of pediatric immunization nurses and access to greater than 10 pool or agency nurses. There were funds to hire these nurses on a regular basis and they were employed frequently in that system. In 1999, the pediatric clinic closed and 3 of the 4 full-time RNs disappeared. This left remaining 1 half-time immunization nurse and a half-time pool or agency nurse and funds available to allow access to 3 additional pool nurses. Between 1998 and today we'll see even more dramatic changes. In 1998, we had the 1 immunization nurse in Federal Way, there were 2 public health nurses who provided logistical support and interactions with the community, parents and school system, and 1 public health nurse supervisor who also could function as a communicable disease nurse. Currently we have 1 half-time immunization nurse at this site. In 1998, we had 3 public health pool nurses on-call. Currently we have reduced access to pool nurses, and, unfortunately, those nurses that are available have diminished expertise in



communicable disease issues because they're not employed frequently enough in that domain to maintain their expertise in their current state of knowledge. There were 2 clerks and 4 interpreters available in the Federal Way Clinic in 1998, and now we have 1 half-time clerk and 1.5 interpreters. So there has been reduction across the board in capacity and infrastructure. To continue the comparison, in 1998, the Federal Way Clinic participated in 5 collaborative school-based immunization clinics with the Federal Way School District and St. Francis Hospital. It's these types of interactions with the community that we think are critical in allowing us to get in to the vulnerable, susceptible or affected populations on a very urgent basis. We have an existing relationship; we know who to call and we have communications links. This type of infrastructure is critical in any sort of emergency response capacity. That has been reduced by 40 percent. Currently, we're doing 3 school immunization clinics and, in addition to the public health resources that you've seen that were dedicated to this effort response, both St. Francis Hospital and the Federal Way School District contributed the resources shown on the slide. We don't know if they would be able to do so today. We hope that we'd be able to maintain sufficient relationships such that we would be able to leverage resources from those institutions in the community, but we just can't bank on that.

The next example is the Denny Way Middle School outbreak which illustrates so many important things about the way we need to respond to crises. In 1995, there was an outbreak of meningococcal meningitis, a potentially deadly disease, in the Denny Way Middle School. Dr. Duchin compared the resources we had to respond to that type of situation in 1995 in the City of Seattle and the resources we currently have in King County if a similar situation should occur. In 1995, in the City of Seattle, we had 4 pharmacists, 1 who was dedicated to this outbreak response full-time for 7 days and oversaw the assembly of over 1,000 prescriptions for preventive antibiotic therapy. This was provided to students and staff. Currently we have no pharmacist available at King County sites. In the City of Seattle, during the outbreak, we had 2 immunization nurses available for outbreak response and 2 physicians available. Currently, we have no reserve in nursing capacity that could be dedicated to an outbreak response and we have limited or no capacity in our physician complement for outbreak response. In the City of Seattle in 1995 and currently we have 3 primary care centers with pharmacies. Columbia Health Center was dedicated as the clinical site for the outbreak where students, staff or community members could receive care. Currently, we have 1 primary care center in King County, there are no pharmacy services and there are reduced hours at all our King County immunization clinics. Finally, during the Denny Middle School meningitis outbreak, the Epidemiology Section of the Health Department contributed 2 immunization nurses, 3 administrative assistants and 2 physicians from our epidemiology staff. We will do that whenever we can, but again, we can't predict whether those staff might be otherwise occupied with another communicable disease problem. So the availability of the staff in the Epidemiology department isn't really an ideal resource to depend on for responding to communicable disease outbreaks in the community. We never know how many of our public health nurses that are usually doing surveillance activities are going to be able to leave their desks, stop taking calls about acute hepatitis and answering public inquiries and go out in the field. For other resources, we had a volunteer physician who donated his/her time during that outbreak and multiple Seattle School District staff, and we assume we'd be able to muster that type of community input again today.

Dr. Duchin then gave more details about the change in the immunization clinic hours between 1997 and 2000. The City of Seattle is represented on the left of the chart. Between 1997 and 2000, there were 3 sites that have been stable and the changes in immunization clinic hours has been a modest 1.5 percent, virtually no change. In King County in 1997 we had 11 sites; we currently have 10. The number of immunization clinic hours available to the public has dropped from 293 to 192.5, a one-third reduction. That means that immunization clinics are closed on certain days of the week and their hours are restricted, there's no staff

there and nobody there to see patients, take tests, take diagnostic samples, do cultures, prescribe or triage.

The final example is related to pertussis. Dr. Duchin wanted to share with the Board how this actually works in real time with one of the pertussis outbreaks where you can see the number of cases and investigations by week. We usually investigate between 5 and 10 cases a week. At week 5 we started peaking such that by week 11, in the middle of March, we were seeing 40, 50, 60, 70 cases a week. This is a tremendous increase in the number of investigations. We've talked previously about the stress that this placed on all levels of the system. In response to that outbreak that was happening on the Eastside, we put together all available resources in 1999. Dr. Duchin gave a comparison between what we had then and what we have now, just 1 year later. In 1999, there was very little reserve in nursing capacity for outbreak response without adversely impacting or stopping routine services, and that is indeed what happened. Other patients who were coming in for other reasons besides pertussis could not get care. Currently, as Dr. Duchin has shown, we have even less reserve in our nursing capacity available for outbreak response without totally closing down the clinics to other needs. For the pertussis outbreak, both the Northshore and Eastgate Clinics provided 1 nurse FTE for 4 weeks. Currently, we only have 1 communicable disease trained nurse available at Northshore, and there are no previously trained staff in communicable diseases available at the Eastgate Clinic. For the pertussis outbreak in 1999, Eastgate had 2 consulting nurses on staff. Currently, those positions have been cut in half and 1 is remaining. But even with the staff that was there in 1999, as Dr. Duchin showed, they couldn't respond adequately with respect to human infrastructure and needed to hire agency nurses to assist in answering community inquiries, providing testing services, evaluating and referring patients and facilitating patient appointments at whatever primary care clinics were available. Currently, there are no resources for hiring such back-up, safety net pool nurses. Additionally, expertise in that pool has diminished with decreasing utilization. It's only high utilization that keeps their expertise up to current standards.

The last slide depicts the remainder of the resources that have changed between 1999 and today on the Eastside. In 1999, for the pertussis outbreak we redirected physician activities to help prescribe and evaluate persons with pertussis. The Eastgate staff with diagnostic and prescriptive capacity currently has been cut and they have no flexibility to redirect that staff and Dr. Duchin will show why. In 1999, there were 1.5 physicians and 1.75 FTEs of nurse practitioner time. Even with that complement, which is fairly skimpy, there was a serious impact on routine services and patients coming in for other reasons couldn't get service. Currently, there's only 1 nurse practitioner, a 43% reduction, and, although there are still 1.5 M.D.s budgeted, this is not a full-time Health Department employee, but a contract person who's not available for extra hours, unusual assignments or anything outside of what's specified in the contract. In addition, both of the positions are under-filled and not even meeting the 1.5 FTEs that are available on paper because of fiscal constraints, so they're not really there in reality. Back in 1999, immunizations were available daily at both Northshore and Eastgate to contacts of pertussis cases and there were 27.5 hours per week of immunization clinic time. Currently, the immunization clinic days have been reduced by 50 percent, the clinic's only open 2.5 days a week and it's open 19.5 hours a week, a 30 percent reduction in the time during which these services can be accessed and during which we can access these services for outbreak control. Finally, Eastgate, during the 1999 pertussis outbreak, held some primary care clinic appointment times to accommodate the community because the private sector was completely overwhelmed by the number of patients that were coming in and were just referring them directly to the Health Department for care. Currently, Eastgate doesn't have enough appointment time for their existing patients, so the idea of holding spots open doesn't make sense. You can see that the human infrastructure, the resources and the immunization and primary care nurses that are no

longer available to us for immunizations and primary care are also sorely missed in the area of communicable disease outbreak and control activities. Mr. Nickels asked what risk that establishes, what happens then if we have an outbreak like the meningococcal outbreak or something else that we haven't thought of. Dr. Duchin responded that, in general, the ability to reduce the impact of the communicable disease outbreak, no matter what the disease, to reduce the morbidity and mortality, to reduce the number of persons infected and the subsequent economic, social and personal cost depends on how rapidly the problem can be identified and how rapidly transmission of the agent can be interrupted. When, for instance, someone calls the Eastgate Clinic and says that they have a child who has yellow eyes and would like to come in, and the clinic is closed or says can you call back tomorrow when we have a staff member on hand who's got the expertise to handle that, when there is no resources in the community to help us find the affected individuals and to get them the treatment that can interrupt transmission, what we will see is a delay in identifying and stopping the disease from propagating and we'll see more cases. We may see more advanced cases or cases in more vulnerable populations. Things happen slowly, they'll still happen and we'll still get the job done, but the number of persons who will be adversely affected will be greater.

Dr. Duchin introduced David Bibus, the Program Administrator, who will present a model we're proposing to enhance our ability to do communicable disease control and outbreak response capacity that we think will give us improved flexibility and make the most of the limited resources. Mr. Bibus stated that they have been developing this the last few months, and knew that they couldn't go backwards in terms of reestablishing services that were there before, but considered how they could take advantage of what we do have within the Department as well as in the community. Referring to the first slide that Dr. Duchin had shown about vaccines, Mr. Bibus commented that we have very good relationships in the private sector and stated that we want to beef up infrastructure within our immunization clinics and within the Department and then do more with the private sector. The first of 4 main objectives in the proposed model is to assure trained staff within our public health sites, including working with other programs such as family planning where we could train some folks to be prepared and to have the flexibility to be able to help us with outbreak response. Mr. Nickels asked what it would take to train someone, if it was like continuing medical education. Mr. Bibus responded that there are certain procedures that happen within an outbreak and so some of it is procedural, but some it is how to handle the epidemiology of tracing contacts and what kinds of questions to ask. We have certain protocols we like people to follow. Mr. Bibus confirmed for Mr. Nickels that it would require an increase in the training budget to be able to do that. The second objective is to assure a minimum level of RN staff at immunization clinic hours among all of our sites. We want to go back to having full-time clinics even though they might be minimally staffed. We want to make sure that there's coverage in each area. We think we're a little below that right now, so we want to have some increase in RN staff just for immunization clinics. Third is to establish some Department policies and procedures for public health emergency response and disease control. This would establish those procedures for working internally with other programs and within our clinics and how to best respond when the bell has rung for an outbreak response. Fourth is to facilitate agreements with health care agencies outside of public health. This is a basic model that we're proposing. The RN staff, again, is for the immunization clinics. The public health nurses are more adept at education and training, so they would be more in charge of the training aspect internally with other providers and other programs and externally with health care providers in the community and also establishing those relationships with the community and those procedures that we could follow. Dr. Duchin interjected that these folks would be able to be mobilized rapidly and move from 1 site to the next. They wouldn't be tied to a specific site. These public health and registered nurses could be directed where a problem was for a short time and then come back to their

regular duties. Finally is just having the capacity with the interpreters and clerks and then that pool of temporary nurses having some training with those folks as well. We could possibly contract with them to be available in the event of an outbreak and have that flexible schedule. There's an approximate cost there of \$390,000.

To be realistic, we thought that we should also have an emergency outbreak response and training fund. In the first year this would be more expensive, but in subsequent years it would not be as much. This would include some of the training and backfill of staff for when they are being trained. And, in the event of an outbreak, if you, for instance, took staff from family planning, their patient revenue is going to go down or they're going to need to backfill staff at those clinics that are already established. So in order to pull key staff members, one has to make arrangements to have that backfilled. Those are the kinds of expenses that happen both with training and in the event of an outbreak. So we thought the first year we could do some of that training capacity building, both internally and in the private sector, and in subsequent years have that fund if and when we need it. Mr. Nickels then asked if he understood correctly that if a staff person who may be on a specific project, funding out of a specific program (federal/state) could be pulled off and we'd have a fund then to reimburse that or back-fill for that function that would normally be billed for that person's time. Mr. Bibus confirmed this.

Mr. Nickels, referencing the last bullet on the slide which says "facilitate agreements with health care agencies outside of public health to enhance the capacity", seems to him to have exciting potential. He asked how realistic is that given that other agencies, by and large, are on a fee-for-service basis to the extent that if they respond to an emergency, they're going to be losing that revenue. Is there an ethic that they would volunteer that time as a community service and community response or is there an expectation that we would need to reimbursement for that lost revenue. Mr. Bibus answered that it's a little of both. A good example is with Community Health Centers. We might in certain areas need to draw on Community Health Centers to do blood draws. In order to do that they need to have some sort of reimbursement, so that's where the emergency fund would come in as well. On the other hand, if it's a very large outbreak, all providers out there in the private sector are willing to pitch in, and we saw that with the pertussis outbreak, that to a certain extent they are willing to do what they can do. Mr. Nickels added that they move their patients to us to respond, so in return we would provide them with training and ask them to join with us in that response. Dr. Duchin added that this is very critical issue, and there are multiple levels involved here. There's the level of providing training to the community to allow them to feel more comfortable with some of these diseases which they don't feel comfortable with now. For instance, we've had cases where persons with a rash illness (measles or rubella like illness) have called in and been told we don't have an appointment available for you, and measles is an emergency type of situation. So just getting that training out would be one thing and then having these public health nurses who can liaison with the community and just bring them up to speed on how to handle some of these cases will allow us to better manage. There's also the issue of the covered lives, that the health insurance providers and the managed care patients who are sent to Public Health to get services which we think could be provided potentially by their regular health care providers. This is an area that needs to be addressed at an executive level. It's something we've been thinking and talking about and something we may bring to the King County Health Action Plan. Dr. Plough commented from the Action Plan perspective that this is getting more difficult, particularly in the kind of partnerships that Dr. Duchin needs. These physician practices that contract with plans are almost all are what are called risk contracts. They get a capitated amount and those particular providers, those physicians and nurses, are at risk to manage to that budget. They have no resources at that level to chip in to an emerging situation and they staff and hold the capacity just up to manage under those resources. If they overexpend, those

physicians will lose money and that is the basis through which all the plans are now contracting with the large physician groups who would be the logical people that we would partner with. From the larger perspective, it is increasingly difficult to get them to do things they're not funded to do, and something a little difficult to get them to cover their covered lives in an emerging situation when it outstrips staffing for the day. We've talked to the King County Health Action Plan about this, and this is just one of those unpleasant realities about the nature of the managed care system now. Whereas Dr. Plough thinks that we can develop partnerships, he doesn't want to leave the impression that that will be without having to make a dollar investment. We will pay for that training and that capacity.

Dr. Duchin offered another example that is relevant. We've had meningitis cases in which we need to give treatment immediately to close contacts of the cases to prevent the disease from occurring. And at night, when we don't have clinic time, we'll sometimes ask patients to go to their nearest emergency department. Emergency departments will charge these patients several hundred dollars to be seen to get 1 tablet of antibiotic for this purpose. These are the types of things we need to address with the community. Ms. VanDusen, saying that Dr. Duchin has given the Board several good examples of outbreaks, asked isn't it true that while these outbreaks that have been presented are dramatic, while these may be going on there are other outbreaks going on as well. So the picture that Dr. Duchin has painted is really not as bad as it really probably is. Dr. Duchin agreed saying that we've been lucky. Ms. VanDusen stated that there can be multiple outbreaks likely to happen at once, some not causing as many victims, but the capacity issue is really critical and she doesn't think that we can necessarily depend on the private sector unless they choose to volunteer a lot of activity and time. She doesn't know that that's a good way to operate something so essential. Next to environmental health, which she will always be a proponent of, this is the most critical public health issue we've got before us. There is nothing more important for us to be doing in Ms. VanDusen's opinion. Dr. Duchin indicated that Ms. VanDusen's comments are very perceptive, and when you think about influenza for instance, during a routine influenza season our hospitals are at capacity, we read in the newspapers ICU beds are filled and patients are in the hallways. We've been lucky because if we had a bad influenza year like we're going to have, Dr. Duchin asked where are those patients going to go. They're going to overflow into the public health sector. If we had West Nile Virus like what happened on the East coast last year, a new disease just appeared overwhelming the clinical capacity of the private sector, where are these patients going to go. They turn to the Health Department. Ms. VanDusen stated that another element here that makes it potentially worse is that there is an increasing gap between the numbers of people who should be vaccinated and the numbers who are, so that we have a larger pool of susceptible people out there. She asked if it's also possible that as our population in King County continues to grow and we have a potential larger pool of susceptibles, we have more people in general and diminished resources. Dr. Duchin agreed that the population growth and density are very important factors in the transmission of infectious diseases in general.

Dr. Duchin thinks we've been very fortunate here in our Department to have an immunization program that's kept our childhood immunization levels up extremely high, among the highest in the nation. However, our adult immunization levels are abysmal nationwide. We're no worse off here than we are nationally. But what if we had, for instance, a bad influenza outbreak. Our influenza vaccine coverage rates of the institutionalized nursing home patients is very good, but in other adult persons who have indications for vaccine it's very poor. The same is true of our pneumococcal vaccine. If we had a bad influenza outbreak like a pandemic or something close to that, most people are dying from pneumonia, a secondary complication, which is theoretically preventable if we had good vaccine coverage. So we can definitely do things to minimize the impact of one of these catastrophes on our community, but we need to have the infrastructure in place to do that.

Mr. Nickels wrapped up the budget workshop continuation saying that next month we'll take a look at what is happening with chronic diseases such as diabetes and asthma and our ability to do preventive work.

### **Election of the Chair**

This is scheduled for next month. Nominations should be given to staff by May 11th and the meeting will be May 19th.

### **Committee on Integration of Natural Medicine into Public Health - Status Report**

Dr. Pizzorno, chair of the Board's Ad Hoc Committee on Integration of Natural Medicine into Public Health, stated that the committee has met several times and is making good progress. Mr. Pullen is also a member of the committee. The goal is to have a recommendation prepared for the Board of Health by the May meeting. Unfortunately, Dr. Pizzorno has to attend a conference at the same time in Tucson, Arizona so will be testing the communications capability of our meeting facility to see how that works. The focus of the proposal is primarily on research and the intent is to do demonstration projects and research to look at how various natural medicine concepts can be brought into public health practices to the betterment of all. Dr. Pizzorno has been delighted by the quality of thought brought to the process by the members and the staff of Public Health -- Seattle & King County.

### **King County Council Committee to Meet at Bastyr University**

Mr. Nickels was asked by Mr. Pullen to announce that the King County Council's Committee of the Whole meeting on May 15th is going to be held at Bastyr University. Mr. Nickels doesn't have the agenda, but he assumes that it will include some of the issues that the King County Council and this Board of Health have worked on in collaboration with Bastyr. Members would be welcome if they wish to attend that.

The meeting was adjourned at 11:55 AM.

KING COUNTY BOARD OF HEALTH

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s/Greg Nickels/s