KING COUNTY BOARD OF HEALTH
999 Third Avenue, Suite 1200
Seattle, Washington 98104-4039

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

February 18, 2000
9:30 AM to 12:00 PM
Greater Seattle Chamber of Commerce

Roll call

- Richard Conlin
- Ava Frisinger for Dan Sherman
- Larry Gossett
- Dave Hutchinson
- Louise Miller
- David Irons
- Greg Nickels, Chair
- Margaret Pageler
- Dwight Pelz
- Joe Pizzorno
- Kent Pullen
- Alvin Thompson
- Alonzo Plough, Administrative Officer

Call to order

Chair Greg Nickels called the meeting to order at 9:36 am.

Approval of the January 21, 2000 Minutes

The minutes were unanimously approved as presented.

Announcement of Alternates

Mr. Nickels welcomed Mayor Ava Frisinger, serving as alternate for Boardmember Dan Sherman. He also welcomed a returning member of the Board, Metropolitan King County Councilmember Kent Pullen who is replacing Councilmember Jane Hague. The Board is still one member shy while we are waiting for Seattle to appoint their third member.

General Public Comments

Bruce Gryniewsky

Bruce Gryniewsky, Executive Director of the Cease Fire Foundation of Washington, a non-political research and education organization founded in 1995 that seeks to diminish gun violence through education strategies, particularly for young people.

Mr. Gryniewsky wasn't able to speak at the last meeting, but is here today to commend the Board for taking on the issue of firearm violence reduction, which clearly falls within the domain of the public health issues the Board needs to discuss. According to the American Medical Association, firearms in our society are an independent health risk. We lose 35,000 people to firearm trauma each year in the United States, far more than any other country, far more than all industrialized nations in the world combined. According to poll data Cease Fire Foundation generated in 1995, one of every two households in Washington State has a firearm in it. In King County, since 1991, firearms have killed more males than automobile accidents. There were a couple of points made at the last meeting that he wanted to address. There was criticism that the Center for Disease Control numbers used to establish firearms as a public health problem were biased. As a scientist with research published in refereed journals, Mr. Gryniewsky can tell the Board that the scientists who work for the CDC are held in the highest regard in the scientific community. Their findings are held to the utmost scrutiny of the objective standards that scientific research must pass in order to be published, including peer review. The second issue was concern that by viewing firearm reduction as a public health issue, we fail to see the role of firearms in reducing crime. The data do not support the contention that guns are used more often to prevent a crime than they are used in killing or homicides or suicides. According to a study in the New England Journal of Medicine, for every 43 suicides, criminal homicides, and unintentional shootings, there was only one example of a homicide for self-protection. So the numbers aren't there. The argument is based primarily on the work of economist John Lott whose research has not been subject to peer review. If it were, it would be roundly dismissed because there are some glaring methodological problems with his analysis. There are some great things that the Public Health Department and the Board can do to reduce this problem, particularly among young people who are really effected by it.

Richard Ludwig

Richard Ludwig is with the Small Well Owners Association. Mr. Ludwig and his wife are trying to retire. If it weren't for having their children in King County, they would sell and get out because of the over regulation, the fees and the talk of the downsizing. Since Mr. Ludwig was at the last Board meeting, he has been to 3 or 4 community meetings, in Black Diamond, Carnation, and Enumclaw. They feel that the urban areas, particularly with the Health Board and King County Council radiate on the rural areas simply because they can't radiate on the cities. They're really tired of it. Mr. Irons knows how people feel since he was at the meeting last night and that was a rather mild meeting. The Small Well Owners have been re-energized. They've contacted over 900 of the well-owners or operators now. They intend to contact all of them. The Area Council meetings, like the one in Maple Valley, is run by the council members. We, as the public, even though we live in that area, are many times not even allowed to speak. All the questions come from members of that council. They are very nice to people who come in from the Health Department or County, but just go to a meeting that's organized by the public. That's how you'll really find out what the public reaction is to the regulations, the fees and the direction the Health Board's taking in this County. Regarding the previous speaker on the gun issue, Mr. Ludwig just read an article that says that more people are killed by doctors than by guns.

Chair's Report

Natural Medicine/Public Health Integration Proposal

Dr. Pizzorno and Dr. Plough have worked up a proposal, which went out to all members of the Board via email, and is in today's materials. The Board is seeking volunteers for the ad hoc committee to flesh out that proposal for submission to the federal government in the next two months. Dr. Pizzorno, who would chair the subcommittee, asked people to imagine in the year 2010 that Seattle-King County can stand up to the rest of the country and say the incidence of cancer is decreased by 1/3 in our community, the incidence of cardiovascular disease is decreased by 50%, our children are scoring higher than they ever have before on the national exams, our behavior problems have decreased, and we're having less trouble with criminality in our community. Those sound like lofty goals, but if you look at the research literature about nutrition, environmental toxicity, etc., these are things that, if we get them under control, we can actually make these kinds of changes. There's a huge body of knowledge in thinking about health that comes from natural medicine. If we can get natural medicine together with public health and utilize some of these ways of thinking, we'll have a huge impact on health in our community. Dr. Pizzorno referred to the Board presentation he made last spring just on one nutrient, Selenium, and cancer and the huge role Selenium plays in susceptibility to cancer. That's just one of many potential nutrients. We have here in Seattle-King County, a unique opportunity. We have a Board of Health and a Public Health Department that are known nationally as being innovative. We have the leading schools of natural medicine in this area, as well as some of the leading educators and researchers of natural medicine. It's a tremendous opportunity, and Dr. Pizzorno would invite other Board members in joining him in doing something that could make a huge impact on our community. Mr. Pullen stated his agreement with everything Dr. Pizzorno said. This is a chance for King County to light the way for the rest of the country. The simple steps that Dr. Pizzorno has outlined and the work that he's done with Dr. Plough to set this up could end up saving far more lives than any of these other activities that we're involved in, just through diet and nutrition alone. He asked for details on the ad hoc committee and the volunteers being sought. Dr. Plough offered that we're looking for a core group to flesh out the draft that's been presented to the Board and really build a conceptual model of what a center like this would look like, getting a variety of perspectives, both from within the Board and within the scientific community. It needs to be relatively small, 7 to 9 people being the maximum and we could bring in other people as consultants as we need it to pull the proposal together. He's also talked with the Dean of the University of Washington School of Public Health, and they have an interest in being involved. Dr. Dick Lyons, who has been the Director for Region X Public Health for some time, has had considerable interest in this area and wants to facilitate this in any way he can.

Mr. Pelz stated that he's not very excited about this project at first blush. He's not sure at all that it's appropriate for the King County Board of Health "to create an institute to conduct research." Possibly development of innovative demonstration projects might be a function of the health board, just as the County Council developed an innovative demonstration project on natural health with the natural health clinic. He questioned whether a county health board should "Make policy recommendations regarding the advancement of prevention and population health.," "Create a research-base.," "undertake basic and applied studies." "establish " a global resource and information repository." He understands that natural medicine is insisting upon some parity with conventional medicine. But, along the lines of parity, if this was a proposal to have the Board of Health create an institute to create a research base and basic and applied studies of conventional health, Mr. Pelz doesn't think that would go very far because that's a function for the National Institutes of Health or the University of Washington or like institutions. He questions whether it's the responsibility of a county board of health to create a research institute, particularly when we just experienced a $10.8 million cut from the voters, and we still need to undertake the basic health care activities for the people of King County that we're required to do. It's fine if a subcommittee is

going to go off and create a proposal, but he's not convinced that this is an appropriate function for a county board of health.

Mr. Nickels indicated that it is intended that the ad hoc committee come back and present its recommendations so the Board will have a chance to debate and determine its policy position on it at that point. Mr. Pelz thinks there are other proposals that could challenge the Board that would be more appropriate. Mr. Pullen responded there's anything extreme about a research institute. In fact, opponents of natural medicine often say, "well that's not proven." In fact, many of the remedies used in natural medicine have been proven by double-blind placebo studies that have been well published with all the right scientific data and back up. It's just that conventional practitioners don't know about it. Conversely, many of the techniques used by conventional practitioners have never been subjected to any kind of double-blind placebo study. Bypass surgery has never been subjected to any kind of rigorous scientific study as to its efficacy. In fact, preliminary studies indicate that it's not nearly as effective as people would assume, particularly when you take into account the huge cost. So, if we had a research institute Mr. Pullen would think that would lend a lot of prestige and scientific review and analysis to answer many of these questions. That, in the long run, would help save lives and promote health, and that's what we're after. Mr. Pelz responded that the challenge is going to be in saying, for example, that we had to eliminate the adult dental program in King County or close the Eastgate Clinic because we are putting resources into a research institute to examine the efficacy of some of these principles. That's the type of question that's going to come before the Board of Health. Mr. Gossett asked Mr. Pullen about Mr. Pelz's assertion that setting up a research institute or even setting up a committee to look at whether or not to consider if there was a research institute should be primarily in the bailiwick of a University of Washington or state or national health institutions that are set up for those purposes. Mr. Pullen deferred to Drs. Plough and Pizzorno but pointed out that if creating this research institute results in saving 100,000 lives, because it's able to do the research that successfully results in putting these techniques before the University, Harborview, or the public, we're going to have a hard time arguing against putting some money into it. Right now, Mr. Pullen doesn't know what the payoffs and penalties will be. Those may come out of the ad hoc committee, the core group, or subsequent analysis. But as far as the Board of Health doing this, its leadership is renowned, it's had a lot of innovative programs, it's a regional body, with regional prestige and regional power. Because it can operate on a regional level, this institute can do things that perhaps a more narrowly-based institute cannot do.

Dr. Pizzorno acknowledged the validity of Mr. Pelz's question of what should a Board of Health be doing. That's one of the issues that will have to be handled by the committee. He commented that we have within our society made an investment in conventional medicine, in terms of how to look at how to look at and treat people and disease. Right now that investment costs us 15% of the GNP, and it continues to go up far higher than anywhere else in the world. The incidence of virtually every chronic degenerative disease has increased in every age group, every decade for the last 50 years. The projections are it will continue to get worse. Now, are we going to continue with that particular way of looking at things or are we going to say it's time to stop and reconsider what our health care system looks like. Dr. Pizzorno could say that, yes it should be done by Bastyr University or the University of Washington or someplace like that, but the reality is that conventional medicine is vested in its current system and there are not resources for natural medicine to do the research that needs to be done. We're the ones stuck paying the bill. Remember that November meeting where we were looking at the increased health care costs we're having to deal with for people who are now no longer being covered by the corporations because the corporations aren't willing to pay the health care dollar anymore. It is time for us to say something different can be done, and we're in a unique position to be able to do that. He

hopes the committee can come up with a proposal that this Board will find interesting and useful, but the reality is if we don't do it, who is going to.

Dr. Plough commented on the administrative operational side. This proposal assumes a potential funding source that Dr. Pizzorno identified in the U.S. Senate through a budget line item. From the Department perspective, consistent with the way that we deal with all applied research, and we do a lot, we don't take anything on that would provide any cost trade-off to any of the things we do. Second, it is a scientific assumption from the Department that this would have to have a formal tie-in with the National Institute of Health's Center on Alternative Medicine which is the scientific basis for where alternative medicine is reviewed in an NIH context. That would be a condition of the Department for being part of that. Third, there is precedent for this in a number of large public health departments like ours, the largest being New York City, having public health research institutes. These are all externally funded and don't put their core funding at any risk, and that is the premise of all our research funding. Mr. Hutchinson reinforced the idea that public health is prevention. It aligns itself nicely with the concept of some of the things that go on in naturopathic medicine. He doesn't know that there is another place where this relationship is being looked at. Given the entrenched powers and political situation we have, obviously there's some inertia to take a look at that. Based on major moves in public health prevention and the impact that we see through public health over the years, going back through environmental advances and so on, the idea should be explored. He thinks the idea is great because the potential is there. But unless a political group like this is willing to take a little bit of risk, not a lot, just to take a look at it, just to evaluate it, it won't happen. It's hard to visualize a political group running an institute and he doesn't know how that would work, but the idea is a really valid one and should be looked at.

Tobacco Legislation Update

The Youth Access to Tobacco amendments passed the Senate unanimously. This would restrict product displays and placement of tobacco products within retail establishments, requiring them to be behind locked counters, accessible only by the clerk. It is currently in the House Commerce and Labor Committee. This is one of the items on our tobacco agenda that we adopted in 1997, but that we are preempted by state law from acting on independently. Bills on smoking on ferries and additional bills on preemption, specifically Clean Air Act, made it through 2 committees in the Senate before they died. However, this was better progress than we had expected and probably bodes well for the next legislative session. Discussions are ongoing in Olympia regarding tobacco settlement funds - how much should be released in the next year for the public health tobacco prevention work. Apparently, the debate is somewhere in the range of $12 - 20 million for the year. The original amount being discussed was about $26 million a year. The State Department of Health is going to release whatever amount that the Legislature authorizes around September of this year.

Board of Health Enabling Ordinance Sunset

The Board of Health is a creature of the County Council, and our enabling ordinance provides for a sunset at the end of June of this year. As we did at our last sunset review, staff will be conducting an evaluation of the effectiveness of the Board. Members will be asked to participate in a 5 or 10 minute conversation with staff. Mr. Nickels asked if that was a comfortable way for members to share their thoughts on what changes or what elements of the Board structure they'd like to examine. No one objected. Mr. Nickels asked if there were any issues that members wanted to raise now for staff and the County Council to consider as they look at reauthorizing the Board. Dr. Pizzorno, recollected that the last time

the Board was reauthorized, there was provision made for alternates for the City and County Council, and it would be nice to have the same provision for the health professionals. There are two voting members and one non-voting member, and if the voting member does not show up, it seems like the non-voting member should be able to vote. Mr. Gossett would like to know how well it's worked having the alternates for Council members. That is, when people couldn't make it, are they calling their alternates and are their alternates showing up. Ms. Gaylord said that it's working fairly well with a great deal of cooperation from the members who were going to be absent and from the staffs of the two councils who often locate an alternate. Mr. Nickels added that as chair under both the 22-member and the current 13-voting member structure, this is working very well. When we had the 22 members, we had trouble getting quorums, and Mr. Nickels had to literally manage the meeting to the quorum. As soon as there was a quorum, he had to rush all the action items up because he didn't know how long he could hold that quorum. We weren't necessarily able to spend the time debating those issues, but were stuck in this kind of procedural loop. Since we've gone to the 13-member Board, we've had many meetings where we've had 100% attendance, either the member themselves or their alternate filling in. Even the meetings where we haven't had the full Board, we've been very close - within a member or 2. He doesn't believe we've lacked a quorum at any meeting. So we've been able to take action in a timely manner and the quality of debate on the issues has improved as a result. From the Chair's perspective it's been a much more effective structure.

Violent Video Game Resolution

At the January meeting, Mr. Nickels, in his Chair's Report, talked about a resolution that he will be bringing back at the March 17th meeting on violent video games. There will be a panel presentation. He was pleased to report that within 72 hours of our meeting, the Seattle Center removed 10 of the most violent of the video games from the Fun Forest, and we've had inquiries both locally and nationally. We've raised an important issue. The perspective that the resolution will address is public recreation centers -- Seattle Center, community centers -- not having these games. The value is that it raised the issue and allows parents, community members and kids to think about the effect that these very graphic violent games have on behavior. Mr. Nickels affirmed for Mr. Gossett that someone has done studies on the impact that violent video games have on young people and that they will be on the panel.

Underage Drinking Task Force

Staff is doing the preliminary work to form the long-term task force on underage drinking that was recommended in the resolution the Board adopted in January. If any members are interested in serving please let the staff or Mr. Nickels know. Dr. Ziegler has been invited to repeat the briefing he have the Board in November at the February 22nd Seattle City Council meeting.

Local Board of Health Leadership Workshop

The workshop for local board of health members is going to be May 4th and 5th at SeaTac. Past workshops have offered excellent programs and received good feedback. It's an opportunity to learn more about public health with our colleagues from across the state.

Conference on Media and Youth

March 22nd - 24th there will be a conference on media and youth. Materials are in the Board handouts. There will be a break-out session on violent video games.

Tobacco Sales Ban at University of Washington

The University of Washington Student Union Facilities and Activities Board has voted to permanently and immediately discontinue 50 years of sales of tobacco products on campus. Mr. Conlin asked if we have tobacco sales in any of our city and county buildings. Mr. Nickels responded that we currently have tobacco sales in the County Courthouse, which is an issue being addressed within the County organization. Someone indicated that there were also tobacco sales in the Municipal Building. Mr. Conlin indicated that it may be something to look at. Dr. Pizzorno asked if there are any data supporting the idea that stopping sales at locations like that actually decreases the amount of smoking people do. Dr. Plough indicated that he would report back on that.

Director's Report

MVET Mitigation

Dr. Plough spent another day in Olympia this week, talking to about 18 legislators. It appears that mitigation for the Motor Vehicle Excise Tax share, at least for public health, is gaining a pretty good foothold in Olympia. Everyone that Dr. Plough has talked with and both the City and County lobbyists believe that a 90% mitigation of those funds is highly likely for local public health. It seems to be the only MVET mitigation issue that has that kind consensus at this time. The source for those funds is still very much up in the air. The Governor's proposal was that those would come out of the general fund, but there are alternative proposals that would have them coming out of the health services account. No one Dr. Plough has spoken with has said anything except that there will be mitigation in the 90% level. For the Board's information, given the $1.2 million cut the Department already made this year, a 90% mitigation would fill the remaining gap and allow us to go forward without any other budget cuts related to MVET. In response to Mr. Gossett, Dr. Plough explained that the health services account contains funds for a variety of governmental health functions -- Medicaid, Healthy Options, the Basic Health Plan are in there. The tobacco settlement dollars not being used for the prevention part of the tobacco settlement are not there, but are separate. All the rest of the tobacco settlement dollars which are going to be coming in -- about $1.3 billion over 20 years -- will be building up in the health services account. Because of that, the health services account has a big surplus, but that surplus is needed by public health, the Basic Health Plan, the state for continual pressures on Medicaid and where there continues to be larger amounts of people who are under- and uninsured. There is a lot of pressure on that. It's almost worthy of a special Board presentation sometime about that particular account.

Dr. Thompson, indicating that at the previous meeting he questioned a line in the minutes which did not seem to hold sacrosanct the use of those tobacco funds for anti-tobacco publicity, asked what is the mechanism for assuring that that occurs. Dr. Plough hasn't heard anyone say that they're not going to keep that $100 million for tobacco prevention intact. They have been arguing about whether to spend it out at $26 million a year for 5 years or spend it for 10 years. He has only heard about the length of time that you can spend it, and that may all the money ever designated for prevention. Dr. Thompson is disturbed about what happened in California when Governor Wilson decided to take that money used for anti-tobacco publicity and use it for children, admirable but not so much. He was also disturbed by what he read in the paper yesterday, that in Los Angeles they were going to use their share of the tobacco money to pay the liability for the actions for their police department. Dr. Plough responded that as it stands right now all of the tobacco settlement dollars are being used for health. That makes us unique, as it is not the case around the country. Although it could shift, at the moment all of the dollars are to be used for health. But

only $100 million dollars have been designated for tobacco prevention and control. By health, it means the rest of the money is in the health services account, which could go to pay for Medicaid services or Basic Health Plan or a variety of other things. There are lots of people talking about the problems with transit and ferries in the same breath that they mention the tobacco settlement dollars. Dr. Thompson stated that restriction of tobacco use is the best prevention method that's available to us in this country today, and we ought to make sure that that occurs. He could see a number of political forces that might oppose that and might be successful, but he would hope that we would remain vigilant. Mr. Nickels added that the concern Dr. Thompson raised last meeting is reflected in the minutes adopted today.

Dr. Pizzorno asked if it would be possible to put the tobacco settlement dollars into an endowment so it's perpetual and just spend the interest on these kinds of activities. Dr. Plough answered that the proposal for the $100 million is to put that into an endowment, but there has not been a proposal to put the remainder of the money into an endowment. He thinks that people have thought that that would be needed in the meantime to cover a variety of shortfalls in health. Dr. Pizzorno asked if there was any way that we could discuss and inject the suggestion that it be used in the long-term for continuous needs. Dr. Plough doesn't believe that this issue will be settled in this short legislative session, and that in the longer session next year there will be an opportunity to talk about this more. Mr. Nickels offered to schedule a discussion at one of our upcoming meetings to see if there's a desire to work toward that goal in the next session. Dr. Pizzorno said that he'd hate to see this windfall get spent. Dr. Thompson concurred. Dr. Plough offered a presentation on the tobacco settlement plan at a future board meeting so the Board could see how that statewide advisory council wanted to allocate the dollars between counter-advertising, community-based programs, school-based smoking cessation and a variety of other activities. We can have other plan members come and be on our panel to talk about how they would spend that $100 million and what was the logic behind the $26.4 million annual expenditures.

Ms. Miller stated that we initially thought that the solution for health departments was just to take the money out of the tobacco money that was coming in. She doesn't think that's going to happen. She's not even sure they're going to hang on to that $100 million for what they want to use it for. But you can be sure that the state will not give any of it to the locals unless they've decided how it's going to be spent. The second part is that we may have a permanent fix on our $10.5 million this year, but it will only be if they make it a funding action out of the general fund, and then your only concern would be, in 1 to 3 years, that they'll set it as a flat number. In other words, if you're getting $10 million now, that's what you'll get 3 years from now without taking the inflationary factor. The forecast yesterday makes it more reasonable to think that we might get the permanent fix with the draw from the general fund; that they would have that number in there and that would be a permanent number. But what happens when you feel it's eroded over a period of years and having to go back is another question. Mr. Nickels added that that is true especially with MVET. They knew MVET was a rising number and would probably handle inflation, Ms. Miller noted that we still weren't getting $10.5. We were having to have another allocation because we were the county that created the formula that allowed all 38 counties to be whole and we said that we would lobby on our own to get our incremental amount. Ms. Miller thinks that it's more possible now to maybe have a permanent fix, an allocation out of the general fund that will continue.

Shigellosis Outbreak

We had a shigellosis outbreak related to Senior Felix 7-layer bean dip product. Our Health Department discovered this relationship first for the state and region and got Costco to pull it

off their shelves. We informed the State Health Department and got the product pulled from the shelves throughout the northwest. There were 60 total cumulative cases in King County, about 600 or 700 cases region-wide. It's trailed off, but it's another good testament to our foodborne disease outbreak control.

Renton Public Health Center

As the Board knows, we were looking at very closely as having to close the the Renton Public Health Center and reallocate the services because of the I-695 cuts and the $1.2 million that we had to make. After some detailed analysis and given the way some of the things are moving in Olympia, we decided that that very important public health center would not be closed and to keep those services at that site, though the Board does know that we need a new site for the Renton facility. A new Renton facility is proposed in the new Health Facilities Bond because it's an important community to provide those services in, even though that building is very expensive and cumbersome to run.

Eastgate Public Health Center Air Problems

The Eastgate Public Health Center has had some air quality problems that have required it to be temporarily closed sporadically over the last week. These have happened before. We have consultants in who are trying to get to the problem of what are these air quality problems that have been causing tearing, coughing and respiratory distress amongst some of our workforce there. We are back in the building today, but still trying to get to the source of this. Dr. Oleru, our new Chief of Environmental Health who has a significant amount of experience in sick building syndrome from Boston, is applying those skills to our Eastgate site right now.

Mr. Pelz is troubled about the Renton closure. It's not a good thing to plan a closure and then pull it back. He'd like to know more about the reasons. Dr. Plough answered that in trying to make the $1.2 million administrative cuts in our budget related to MVET, we were trying to find administrative cuts that would also not be service cuts. We looked at a couple of our facilities, and the Renton facility has a long history of being expensive to run, has a bad HVAC system, is crowded and is scheduled to be replaced -- that's why we have it in the Health Facilities Bond Proposal. We were very successful in our $1.2 million administrative reduction to not have service reduction. What we were going to do was relocate the services in and around the Renton facility but close the site and have, for example, our public health nurses office out of Eastgate. They would drive but they do home visiting, so it doesn't really matter where their office is. Dental in Renton is already off-site. We were going to be working with the local community health clinics to maybe put our WIC and our Immunizations programs co-located with some of theirs. It was an attempt to co-locate some sites, but it was not ideal because the best co-location sites for our large family planning services would have been White Center, which is not obviously going to work for that population. So we looked at the social costs and access costs of relocating the services plus what it would cost us to do that. What savings we could net out of that, it didn't look like a way to get at those savings so we found them somewhere else in our budget. Mr. Pelz said that he understood Dr. Plough to mean that he made a mistake the first time around, that he didn't really crunch the numbers thoroughly, and he had a fiscal analysis that said it would be cheaper to move, therefore made an announcement, which as a public official brings an a lot of mail to Mr. Pelz and generates a lot of anxiety in the community. Then he looked at his numbers again and decided to make the cuts elsewhere. That's a management problem that visits anxiety on a community and is to be highly avoided. Dr. Plough stated that also got the letters and understands the stress caused to the community. What we announced was that we were examining the closure of the Renton facility. We never said

that the Renton Facility was going to be closed. In fairness to the staff and the community, we felt that the seriousness of this analysis was such that it should be done in the open. So, Dr. Plough met with staff and talked with community members saying that we were looking at this as a possible response to our making the $1.2 million cut, and we would keep them apprised as we did the analysis and we'd figure this out by mid-January. Mr. Pelz indicated that sometimes that distinction is lost and the effect is the same. He is also troubled by the concept that we have a capital strategy to build a Renton facility. Dr. Plough confirmed that, yes it is a capital strategy, if that bond comes out and the voters have an opportunity to vote on it, but we have no non-bond related capital that would be available to pay for that facility. This is the bond that might be put on the ballot. Mr. Pelz continued saying that the fact that there are intentions to build a building in Renton is a problem. You don't just take a building in Renton, scatter services, then build a building in Renton and send the services back. That's very disruptive to staff and the community. Dr. Plough indicated that the intention would be to build on a different piece of property a little farther east. In government, Mr. Pelz went on, when we're going to build a new facility, we build that building and then we move. The very fact that we are pursuing capital plans for a building in Renton is even a stronger indication that we should never have floated the idea that we were going to shut the building down. Mr. Pelz hopes that we don't repeat that. Mr. Pelz asked if Dr. Plough had the ability to close down a building without consulting either this Board or the County Council. Dr. Plough answered that it's an operational decision that he can make in consultation with the Executive. Mr. Pelz thinks that that may be the legal framework, but on a policy level, if we're talking about closing a site, that is a decision that he thinks should rise to at least a straw vote or something much more inclusive. As a public official representing that area, he will go to war on that. It shouldn't be considered just administrative, but something that should come back to elected officials. Dr. Plough agreed which is why we discussed with the Board as we've gone along with this. It really speaks to the seriousness of the I-695 cuts. We had to make a $1.2 million cut; we had to dig deeply and it was very painful. Mr. Pelz thinks this should be brought back. He apologized if he missed this at meetings, but closure of facilities are the kinds of things that put a lot of pressure on public officials.

Budget Policy Workshop

Mr. Nickels introduced the workshop portion of the agenda, pointing out statements of purpose of the workshop and its agenda. "Budget policy workshop" is the formal name of the presentation and discussion that will follow, but really it's a more fundamental question of how do we at the local level step up to our responsibilities for protecting the public's health. Just as the State of Washington has a paramount duty to provide for education, at the local level, we have a paramount duty to provide for the public health and safety. We will go through some historical materials, talk about trends in local funding for public health, talk about what that pays for, and try to get an understanding of the overall public health budget, because the Board will find that most of our public health budget comes from outside our local area -- federal, state and even private sources. At the end, he hopes we can have a conversation about where we are headed as a board of health and where we want to see our department of public health headed and whether we can be strong advocates for that direction.

The Department of Public Health is one we can all be very proud of. It has been a leader in many respects and this Board has taken on leadership on a number of issues as well. It has been Mr. Nickels' goal that this not be a passive board that simply receives information and then takes a vote, but that they in fact in push in those areas important for changes to occur for the advancement of public policy, and he thinks the Board has done that well. He believes that we at the local level are not fully stepping up to our responsibilities in protecting public health. For instance, if you had been in King County 5 years ago and there had been

an outbreak of meningococcal disease at your local school, we would have had the resources to go out and deal with that outbreak. He knows that because his children went to Denny Middle School and there was an outbreak and the Department of Public Health responded magnificently. Shortly thereafter there was an outbreak of tuberculosis at West Seattle High School in the neighborhood in which he lives. If that same thing happened today, it would be much more difficult for the Department of Public Health to respond adequately because as a result of the kinds of pressures that have been put on them to reduce, and become "more efficient" to respond to I-695, current expense cuts and other pressures, we do not have that reservoir of talent available. The public doesn't know that. This Board doesn't have a full understanding of that. Even some of the staff of Public Health don't know that. But it is nonetheless the case and it is important for the Board to think about that and the consequences of it. The Department of Public Health is asked each year to defend its budget and he thinks they do that very well both at the County Executive, the City Council, the Mayor and the County Council. But this Board has a role as well in advocating for the Public Health Department. So today's workshop will focus on those critical missions that we have, how we stepping up to those, and where there are gaps. He is very pleased that we have an outside resource with us today -- Dennis Braddock, Chair of the State Board of Health, CEO of the Community Health Plan of Washington, and who, as a member of the State Legislature, was a real champion for reforming our health care system. He will share his perspectives after Dr. Plough and Ms. Uhlorn provide a primer of public health funding. Finally, when you hear "budget" it really talks about trees, and he wants the Board to focus on the whole forest today. Hopefully we'll get a broad enough overview that we won't get stuck in some of the lingo and individual funding sources but will get enough of an understanding of those to be able to grasp the larger picture. Issues that are identified today can be carried over for discussion later. This is an ongoing issue as we approach our next budget processes. Mr. Nickels then turned the presentation over to Dr. Plough and Ms. Uhlorn.

Dr. Plough reviewed the Department's mission and goals. These were discussed with the Board and adopted by the County Council in 1997 and are critical to the Department's Strategic Plan, which was presented to the Board last year. These frame what we do in the Health Department. The presentation will focus on the funding of critical public health services in Seattle and King County. This is a conceptual framework for trying to understand the Department budget and there will be other occasions for delving as deeply as the Board would like within particular budget items. Today's presentation will cover where the budget comes from and the major categories along which it is aligned.

There really is no "dedicated" funding for public health and that's part of the problem. The only dedicated source the Department had was MVET. All other funding sources ebb and flow and have varying sustainability. Federal funds come from the Department of Health and Human Services and a very large amount of funding from the Centers for Disease Control. These are always categorical -- we never receive any federal funding that gives us broad discretion in how to use it. State funding comes primarily from the State Department of Health, some of which are actually federal pass-through dollars. These are all categorical and we have very little discretion in how to use those. These are, e.g., communicable disease dollars, maternal and child health dollars. From Suburban Cities, MVET was our discretionary fund which allowed us to try to match local needs to those resources. Those funds, as the Board knows, have been threatened. King County funds, Current Expense (CX), is a statutory responsibility according to state law, which states that the county is to provide for critical public health services. 40% of CX going to this Department is designated. Our other local funding stream, voluntarily provided by Seattle through an interlocal agreement, is also restricted. The interlocal with Seattle specifically talks about funding of "enhancements" to improve the public health for the residents of Seattle, and we have ten

years of data that show those enhancements that made a real difference in the health status of people and has created better health indicators within Seattle than exist in the County.

Dr. Pizzorno asked the difference between categorical and designated. Dr. Plough responded that categorical is, for example, a grant from the CDC, or money under the Ryan White AIDS Care Act -- money we get from the federal government for people with AIDS and for treatment. We can't spend that money on HIV prevention. Designated is, for example, designated by King County government as an expenditure that needs to be made from the CX base. There's a designation of a large portion of the Department's CX to Medical Examiner's office, a function which connects with public health but is not in the middle of the critical public health services, but takes up a large percentage of the CX available to the Public Health Department. Mr. Nickels added that the Seattle City Council designates where its General Fund goes. Dr. Pizzorno, observing that both categorical and designated are both restricted, asked the distinction between the two. Dr. Plough responded that there's not much we can do about the categorical funds that come from the federal government. But we have members of both councils here and members of local government could decide that there are designated dollars that should be designated differently or in larger amounts, so there is some local discretion that differs from these historical categorical programs which we have limited opportunity to change.

Mr. Conlin asked about the connection between MVET and the Suburban Cities. Dr. Plough deferred to Mr. Nickels who explained that King County used to have contracts with the Suburban Cities which put money into their general funds for personal health services. The contracts generated $3-5M a year revenue and much more than that in ill will. It was a horribly divisive system. So when the State went through health care reforms, one of the changes was that the Legislature put aside some of the Motor Vehicle Excise Tax to replace the contracts that had been in place between the County and the Suburban Cities. It was discretionary what public health services could be paid out of those funds, but it did have to be public health. Mr. Conlin asked whether since that in effect took money that formerly had to be in Suburban City budgets, the State took that money away from the Suburban Cities. Mr. Nickels said no, that it in effect created a new funding source. It designated 2.9% of their local MVET taxes for public health. Ms. Pageler clarified that this was for Seattle as well as Suburban Cities. Mr. Nickels added that Seattle decided to continue making a voluntary contribution of General Fund to the Health Department because it was a higher priority issue within the City.

Dr. Plough indicated that the discussion would focus on "critical public health services." There is not a list anywhere that says, These are the public health services that every public health department is supposed to have. There are probably good reasons why that's the case. There are some things that this public health department should have related to our epidemiology and demography -- for example, water safety programs -- which would be very different from another part of the country like the Northeast, where they might have Lyme disease caused by ticks that we don't have here. A key point in this presentation is that our critical public health services have these characteristics: First, they are evidence-based practices: there is some scientific literature about the use of the service in improving individual and community health. Second, they match demonstrated need in our region. Third, they are based on epidemiological and demographic data in our region. Fourth, they aren't static -- they change over time because the underlying diseases and the demography changes over time. For example, immigration patterns will change the nature of a disease. Tuberculosis is a large problem here because immigration from countries where TB is pandemic is part of our local immigration pattern. Hepatitis C is important now; 10 years ago we didn't know there was a hepatitis C. It would be nice if it were a never-changing constellation of something that could be called "core" but there isn't. Still, the notion of critical

public health services according to these definitions are how the Department thinks about this and the way that we talk about this. We use lots of different standards and technical ways to do this: our own data, our mission statement, the Washington State Department of Health's proposed standards for public health are all things that we draw upon in defining critical public health services. The State Board of Health is also looking at ways of defining this and the US Department of Health and Human Services in its Healthy People 2010 document also provides data that structures what we mean by critical public health services.

Mr. Gossett asked Dr. Plough why he couldn't have written up the four points that he made on the practice standards because those were helpful. Dr. Plough stated that the very honest answer was that this presentation required lots of FTEs over a short period of time and we pretested it and there are still a few glitches in it. The Department has never displayed this information before and never been as precise in defining what we do as this particular session and it's been a really good catalyst to the Department from the Board to develop this framework to more clearly talk about what we do. Dr. Plough stated that he would write up that definition for the Board and Mr. Gossett said that would be helpful.

Kathy Uhlorn, Manager of Administrative Services for the Public Health Department, stated that she would provide an overview of how critical services and enhanced services intersect with the Department's 307 revenue sources. The revenues have been placed into categories. She introduced a circle diagram representing critical public health services. At the core of the circle are those services funded by local government. "Local government funding" here means King County Current Expense (CX), Seattle General Fund and MVET. For purposes of this presentation, the Department looked at MVET replacement at the recommended 2000 budget level since we are hopeful of mitigation. This is the same budget information the Board was provided in October.

Funding for critical public health services that falls outside the core local funding circle has been broken into four categories: grants, Medicaid and FQHC, HCFA (Health Care Financing Administration) match, and fees. These funding sources partner or link with local government funding to pay for critical public health services. In response to Dr. Thompson, Ms. Uhlorn explained that the HCFA match activities are those the Department performs to try to assure that there is maximum enrollment in Medicaid. This involves going out into the community to try to educate people who are eligible for Medicaid to get them into the program so that they can receive health care services. So HCFA match services include outreach and enrollment. Dr. Plough noted, for example, that 60% of children eligible for Medicaid dentistry don't ever come in and almost 40% of children eligible for Medicaid may not be coming in. Many of the HCFA match dollars go out in contracts to community-based organizations that do that kind of outreach work.

Ms. Uhlorn explained a concentric circle around the circle representing critical public health services. This new circle represents enhancements which are services or activities that may not be critical to public health but link very closely and are often services that are done by public health and large agencies. Enhancements have special, designated funding sources, and doing them does not trade off on performing the critical public health services. There might be one exception that will be talked about later, which is the CX enhancement. Dr. Plough added that enhancements are very important but they are things that you will only find public health departments doing when there's special designated funding that does not come into any conflict or into any zero sum relationship with the critical services that are in the middle. These are good things to do, and large urban public health departments like ours do things like this, e.g., run their EMS systems. There's a logical linkage between pre-hospital risk and the kinds of things we do, but in a public health practice sense, running an emergency medical service system is a real enhancement over your assurance function. It's

not the sort of standard thing that you would expect to have unless there was some kind of voter-designated levy to do that. The same is true for the Department of Adult Detention. A large portion of the population we look at as central is being served in the jail. But we would only be doing jail health if there was a special funding relationship for it. So the enhancements link to our critical public health mission but it is only because they have special funding that we are able to do them. And one of the criteria for being able to do an enhancement is that it has no funding trade off with things that are critical -- the services shown in the middle part of the circle.

Ms. Uhlorn explained that "CX enhancements" refers to CX designated in our budget which is not in a critical public health function and which provides for important services of health care. Examples are: health care for the homeless, which does allow us to bring in Federally Qualified Health Center (FQHC) patient revenues, a significant revenue source for the Department; the Board of Health; dental sealants for children in the County; and the community health clinics which are a very important aspect of our total public health system but not critical public health services. The "regulatory CX" refers to CX relating to a specific statute, e.g, the Medical Examiner and the money we set aside for costs of local government.

Ms. Pageler clarified that the Families and Education Levy is just in Seattle. Dr. Plough responded that this was a special, voter-approved enhancement. The network of school-based clinics is really important; but these are the kinds of things you would do because you had special funding, not the kinds of things you would do out of funding sources that form the critical core.

Dr. Pizzorno asked Dr. Plough to further differentiate between critical public health functions and enhancements. Dr. Plough responded that critical refers to those most important things and set of services that match the epidemiologic and demographic needs of the County around public health and meet them at the most basic level. The enhancements are things that are really good to do and tie to the critical public health services but in order to do them, you're going to have to have special funding sources. E.g., we do some things for adolescent health in our critical public health funding. These include prevention programs, for instance, smoking cessation. We are able to do even more through the enhancement that we get for Seattle adolescents for school-based clinics in the middle and high schools. That's a very important enhancement, but we must invest our critical public health service dollars in the more population-based, critical services because the cost of having a network of school-based clinics is so high it would require a designated funding source. It's an important enhancement, but not something you see unless there's been a designation of special funding for something like that. So an enhancement links to the critical public health service, expands what you can do in a very important way, but usually will require at a local level, a special commitment to funding something through a voter-authorized levy or an act of local government to designate parts of their general fund or current expense to providing that particular service.

Ms. Pageler noted that 5-6 years ago the EMS levy that came back to Seattle did not begin to fund EMS services in the City. So there were $10-12M a year that Seattle's general fund was paying to supplement the EMS levy. She asked what that dollar amount is now. Dr. Plough stated that he will get for her the amount of Seattle general fund supplementing the Medic One in Seattle. On the County side, there is about $350,000 to 375,000 current expenses subsidizing the regional EMS role that the Department plays.

Ms. Uhlorn then summarized that 42% of the total public health budget of $199M is in enhancements, leaving 58% in the critical public health services. Dr. Plough pointed out that often people will say, With a $199M budget, why can't you find the wherewithal to do some things within those inner circles. It's because those funds in the outer circles are completely designated for those special enhancements. We cannot take EMS levy dollars and solve a communicable disease outbreak problem them. You can't take the Medical Examiner's money and provide more public health nursing for high risk maternal and child health. So that's a real critical point to remember, as it's perhaps one of the most confusing things about the Department's budget.

Ms. Uhlorn reviewed charts showing that 19% of the funding for critical public health services comes from that central core of local government funding; and the remaining 81% of critical public health services revenues comes from non-local government funding. Within the non-local government funding grouping, there are 4 categories: grants, Medicaid and FQHC, HCFA Match and fees. Grants represent 34% of critical public health services revenues, totalling $39M. The State consolidated contract is the largest grant at about $20M. It is important to note that these grants are categorical in nature -- they pay for critical health services, but being categorical, they can't pay for anything else.

Ryan White funding usable for AIDS treatment but not AIDS prevention is a classic example.

Note: At this point, tape recording of the meeting ceased due to an equipment malfunction. The remaining minutes have been reconstructed from notes, handouts and the speakers? recollections.

[Ms. Uhlorn continued] Medicaid and Federally Qualified Health Care Center (FQHC) reimbursements make up 20% of critical public health services revenues ($22.6M). FQHC provides an enhanced Medicaid rate for qualifying health centers serving a high percentage of low-income persons. The FQHC rate does not fully pay the cost but it is above the fee-for-service Medicaid reimbursement rate.

HCFA match, which was discussed earlier in the meeting, provides 9% of critical public health services revenues ($10.5M). Examples of services for which HCFA match can be claimed are outreach and medical interpreter services for non-English-speaking clients. Dr. Plough mentioned that an excellent example of this outreach is Kids Health 2001 -- a program that generates HCFA match to do outreach to the 30% of Medicaid-eligible children who aren't covered. This is an example of public health's assurance role.

Environmental and personal health fees account for 18% of critical public health services revenues ($20.5M).

Dr. Pizzorno asked Dr. Plough what are the 3 to 4 critical public health purposes. Dr. Plough responded: prevention programs addressing infectious and chronic diseases in the whole population; providing or assuring essential health services to improve both individual and population-wide health in underserved and high risk groups; promoting a healthy environment; and responding to emergency conditions that threaten health such as outbreaks, epidemics, and disasters. Dr. Plough is on a task force of the State Board of Health that is developing a listing of essential public health services to guide local health boards.

Referencing the slide showing the revenues from fees, Mr. Pullen offered his observations on environmental health services. It is very important to have public acceptance of the regulatory scheme. He has constituents who want to put in onsite sewage systems and have

been complaining about the length of time it takes and the difficulties it poses. It used to be that you would just run a perc test. Now environmental health staff look at things subjectively. We need some objective criteria for viewing applications. Dr. Plough responded, noting that all the good ground is gone and the soils are now tougher. Ms. Miller stated that she would have responded similarly. Mr. Irons requested a briefing on fee increases adopted by the Board last fall.

Ms. Uhlorn moved to a set of slides showing the local government funding core of critical public health service funding. The three types of local government funding are King County Current Expense (7.7% of critical public health services revenues; $8.9M), Seattle General Fund (2.6% of critical public health services revenues; $2.9M) and MVET (9% of critical public health services revenues; 10.5M). There is a great deal of similarity among the programs supported by these funding sources. Ms. Uhlorn pointed out that local government funding is an important source of matching funds, allowing the Department to maximize external funding such as Medicaid and HCFA match. Another example of local fund leveraging is the Health Care for the Homeless Program that qualifies the Department for the FQHC reimbursement enhancement; local CX goes into the funding for that program.

Ms. Uhlorn then displayed bar graphs contrasting the percentage of critical public health service revenues each of the funding categories represented in 1991 and nine years later in 2000. Medicaid and FQHC reimbursements went up from 7% to 20% of the total critical public health services revenues in 2000. HCFA match was a significant new revenue source that was not available in 1991 which makes up 9% of the total in 2000. Fees declined from 20% to 18% and grants increased from 31% to 34%. MVET increased from 8% in 1991 to 9% in 2000. General fund went from 10% to 2.6%, although Ms. Uhlorn noted that it is voluntary and most of the general fund is in enhancements. Current expense as a share of critical public health services revenues declined from 24% in 1991 to 7.7% in 2000. It was pointed out that a secondary effect of the CX decline results from the fact that certain CX-funded services, such as the Medical Examiner and community health centers, are held harmless -- maintaining their funding levels while other programs are reduced by greater degrees than the level of CX funding decline would suggest.

Dr. Pizzorno said that he was getting the impression that while we have a perspective on where the priorities are, it seems like the priorites are set by where the dollars are. Dr. Plough concurred in this observation, noting that the Department is constantly destabilized by this factor. Fortunately, we are able to meet a number of our priorities because they are other people's priorities, e.g., diabetes, breast and cervical cancer. So it's a mix of our priorities and then what we can get funding for. The Department does not go after grants that are not within the areas that represent our priorities, but sometimes we are not able to refine the money to our actual priorities because the money just isn't there for that.

Ms. Pageler requested an accounting of Seattle's contributions to the Department -- where has General Fund been placed in the Department historically?

Dr. Plough spoke about Public Health's response to the decline in CX. The Department made a number of adjustments over the last 4 to 5 years. One was essentially to move all of the CX out of primary clinical care. There had been about $1.5M County funds in Department clinical services that are now down to about $150,000, so one of the major things the Department did was make that kind of reduction by replacing revenue where we do those services. We've been maximizing on FQHC revenues, and on all sorts of revenue sources, although "maxing" out on that kind of revenues has its own kinds of problems. Other responses were to cut South County clinical services, using CX to leverage other funding sources, and doing some administrative streamlining within the Department.

Examples of adverse program impacts of CX decline are communicable disease control (e.g., the pertussis outbreak and Public Health's inability to have clinical supports in the field to handle it); public health nursing (90% dependent on Medicaid); and cuts in STD. When so much of services tied up in revenue, it is difficult to keep pursuing the mission-driven services for unentitled populations, i.e., persons lacking in health care coverage.

Regarding the slide showing the significant decline in the percentage of CX in critical public health service revenues, Mr. Pelz asked the historical reason for this decline. Mr. Nickels observed that like other local governments, King County has been facing a tougher CX budget situation each year. Also, because the Health Department budget is so complex, it can be hard to generate a lot of support for it because it's so hard to tell what you're cutting or supplementing. You see percentage cuts across the board instead of programmatic cuts. Also, there may be increase in other areas, e.g., grants, that would reduce the percentage of CX. For example, 15 years ago, AIDS was getting no revenue. Now it gets a lot of funding, so the % of CX would be going down even if the dollars weren't.

Mr. Pelz asked the constant dollar difference between 2000 and 1991. Ms. Uhlorn responded that the department was working with the budget office on that and would get back to him.

Dr. Plough stated that independent of that shrinking CX pool, he has seen five consecutive years of annual CX cuts since he came to the Department. Also, independent of the sales tax base diminishing, the public health responsibility of the County remains constant and the problems keep going. With some of the CX earmarked for programs like the Medical Examiner, the impact of the CX reductions on the programs that are not earmarked is multiplied. So we need to look at whether the right amount of CX is in public health.

There was discussion of how the sales tax base in King County was destroyed. Many people have moved from the County into cities. Mr. Pelz noted that the responsibility was shifted from the cities to MVET. What had been a city responsibility to pay for these things was just moved over to MVET, so MVET was not some sort of new funding but rather a new home for old funding. Part of the reason there was less CX was because of annexations and incorporations. It was noted that there is next to no commercial base left in unincorporated King County.

Mr. Pelz stated that there are some specifics that make the graphic showing the decline in CX less dramatic than it appears on first glance. Mr. Pelz stated that the causes for the decline should be identified and analyzed to determine whether it is all due to a "cheapskate" Council or some other causes are responsible.

Dr. Plough turned to a series of slides showing Public Health's role in the provision of critical public health services. In response to the slide stating that Public Health "can't and shouldn't do it all," Mr. Pelz urged removing the phrase "and shouldn't." Dr. Plough concurred, but suggested that sometimes Public Health shouldn't do certain things when we're in a partnership with someone who does those things better.

Dr. Plough explained the Department's "assurance role" -- assuring that critical public health services are available in the community, either because Public Health provides them directly or because Public Health assures that someone else does. There are certain services Public Health can do quite well, e.g., family planning and public health nursing, high risk clinical services to non-English-speaking populations. We do these better than most and are able to provide a higher level of uncompensated care than anyone else in the County: no one else slides to zero.

Dr. Plough then gave examples of the Department's statewide and regional roles. These include CHILD Profile immunization tracking program (a local program being implemented statewide); the Vista program for collection and analysis of community health data (a King County program being picked up by public health throughout state); Breast and Cervical Health Program (King County runs the program in five other counties); and tobacco compliance checks (King County is under contract to perform compliance checks in many counties throughout the state).

Dr. Plough then described the Department's role as a community partner in the provision of critical public health services, pointing out that 30 to 35% of all the Department's funding is in contractual relationships with partners. Some grants like the Ryan White monies for AIDS treatment are virtually all contracted out to partners. Public Health makes it possible for many of its community contractors to claim HCFA matching funds. The Department uses its grant-writing capacity to create coalitions such as that formed to obtain the diabetes REACH grant. He offered to return to the Board to talk in more detail about our community-based public health initiative to extend the kind of partnering work that we do, particularly in high-risk, low-income communities. Ms. Pageler noted that with respect to environmental health services, Public Health is backed up by public utilities.

Dr. Plough stated in conclusion that the Department has had increasing problems in the decline in CX. The Department's core mission is at risk when so many of our services are tied to funding sources and our inability to provide services to people who don't have a funding source increases, which is not the point of public health. So not having that buffer of local funding to provide for uncompensated people in need of a variety of our services has a negative impact on us. We are doing a good job. We have been and will continue to be aggressive with the grants, but that's not a substitute for the local government funding core because grants come with strings and categories.

Mr. Nickels introduced **Dennis Braddock, CEO of the Community Health Plan of Washington**, Chair of the State Board of Health, and a member of the Steering Committee for the King County Health Action Plan, and asked for his observations on the roles and responsibilities of Public Health - Seattle & King County. Mr. Braddock indicated that he would speak from the perspective of the each of the several positions noted above by Mr. Nickels and also as a member of a number of national boards looking at the issue of access to health care. Concern over this issue is not unique to King County, and it is getting more attention than ever. He hopes this means that money could be coming our way to address access. The reason that the issue of access resonates more with the public health community is that the absence of insurance can be a health risk factor.

From the perspective of the State Board of Health, Mr. Braddock stated that because of its size, Public Health - Seattle & King County (PHSKC) has a major role and influence on development of State Board policies. Recent examples are HIV reporting and protection of the public from food borne illnesses resulting from juice and juice products. Mr. Braddock pointed out the State Board's priority issues for next two years, noting that all of these relate to issues that King County faces: children's health; health disparities among various populations; public health systems improvement; environmental justice; and communicable disease control. One of the difficulties public health has is that its returns are not very rapid. Making the investment in public health is often put at a lower level of priority, but then when you have an outbreak, you miss the infrastructure to deal with it. The people facing immediate needs don't want the infrastructure for protecting their community reduced.

Mr. Braddock stated that there is not really an answer to the question, What are critical public health services, although the State Board of Health will be working on that question, since it is their responsibility to be sure that the critical public health issues are met. The definition will vary from community to community. The State Board will also assist in setting standard requirements for local public health departments.

Mr. Braddock then switched to the perspective of CEO of the Community Health Plan of Washington which specializes in serving low-income and diverse populations. The Community Health Plan contracts with PHSKC for primary care services under the Medicaid program and Basic Health Plan. The Community Health Plan also partners with PHSKC on a number of health improvement projects including STDs, asthma, diabetes, smoking cessation and the Well Being project. PHSKC is making a very active attempt to bring insurers into the system. This is extremely difficult to do; in fact no one has done it yet in the United States.

He's got a business that has a vested interest in the health of the low-income and under-served population -- if they stay healthy, the plan saves money. But no health plan is doing an adequate job in meeting prevention measures, although this is an area of great potential. Approximately $150M in health care premiums come into King County managed care plans for lives covered under the Medicaid program and the Basic Health Plan. That's a lot of money. But we need to ask, if one could convince health plans that if there were a public health improvement initiative that could save them a percentage of medical expenses, why couldn't they be convinced to give up some of those premiums? Yet it is unlikely that managed care plans will take the initiative on population-based health improvement. Managed health care has factors mitigating against doing that. One is that there is so much turnover in the Medicaid population, which almost turns over every year. Basic Health Plan enrollees turn over completely every two years. So if a plan works to make everybody healthier, then their enrollees will be moving over to another plan, so why do it? Asked to describe some activities that health plans could do to reduce health costs, Mr. Braddock responded that they could stop acting like independent entities.

Mr. Braddock explained that the King County health infrastructure is losing money on every Medicaid recipient who is not enrolled in the Medicaid managed care through either a community health center or a public health department clinic. The reason is that community health centers and health department clinics are Federally Qualified Health Centers which are entitled to an enhanced Medicaid reimbursement rate for which other health plans participating in Medicaid do not qualify. The amount being lost is approximately $25 per member per month. If all of the 88,000 Medicaid-covered lives in King County could be seen by Federally Qualified Health Centers, an additional $20M plus would be available for health care for low-income people. In response to a question from Dr. Pizzorno, Mr. Braddock explained that if an individual enrolled in Medicaid and went to, for example, Group Health or Aetna for care, those plans are not eligible to get the $25 FQHC enhancement. But the Health Department clinics and community health centers are eligible for the additional money. Group Health, Aetna, or whoever will see the person, but the additional money will be lost to the system. This additional money could pay for interpretation services and other services that safety-net providers offer their clients beyond strictly medical services. The money could allow us to expand services to uninsured people.

The King County Health Action Plan is looking for ways to make "the business case" for plans to keep Medicaid and Basic Health Plan enrollees healthy, since currently no case can be made. Mr. Braddock believes that Public Health could have a partnership role with the plans to respond to this issue.

Mr. Braddock concluded by pointing out that there are multiple national initiatives being funded to address the issue of the uninsured. Communities that can create cooperative alliances among health insurers, hospitals and clinicians to serve under-served and uninsured populations will receive funds. Dr. Pizzorno asked whether King County had the kinds of coalitions and partnerships that could take advantage of these funds. The answer is yes because the Health Department and community health clinics are in their own plan and have demonstrated their effectiveness in serving the Medicaid population and are the benchmark plan in terms of cost-effectiveness, are all FQHC, have good relationships with the federal funding source, the Health Resources Services Administration (HRSA) and if this is now emerging as the preferred model of care for Medicaid populations, we're it in this area. Multnomah has the same kind of partnerships in the Portland area; large urban counties have generally have these kind of arrangements. The millions of dollars coming from HRSA are to create these care networks focused on the poor and the $25M grant that we're applying for will be to strengthen and extend the kinds of networks the Health Department and the community health centers have in order to provide really good community-based managed care for the Medicaid population with the recognition that those kinds of partnerships seem to be doing a better job for Medicaid patients than the managed Medicaid contracts with the private sector.

Mr. Conlin summarized what we need to do next in order to answer the question, How much should we be spending on public health? He observed that the size of the public health budget doubled between 1991 and 2000. He recognized that there has been a decline in CX. He suggested a number of things we need to look at next: What is the constant dollar level? What is the impact of annexation and county growth? What new services have been added during this nine-year time period? Are there things we may be doing now that others were doing before, i.e., has Public Health picked up the burden for things it didn't carry in the past? Which services have gaps? Which services have had growth, e.g., EMS grew a lot during this period; did it really help in these other areas? What impacts are our programs making? You need to understand where the financing gaps are so you can pinpoint where the problem is. To analyze what the problem is, you need to know where the shortfalls are -- the places where growth has not kept up because it was not commensurate with demand or growth in one area is masking decline in another.

Conclusion

Mr. Nickels concluded the discussion by presenting three budget policy issues Public Health and the Board now face. The first is inadequate capacity to respond to communicable disease outbreaks due to lack of reserves of nurses or clinical locations to provide outbreak control services such as immunizations. Communicable disease control staff are already functioning at capacity under normal circumstances, and when there is an outbreak, there is no reservoir of resources to turn to. During the recent hepatitis A outbreak at a Mercer Island childcare facility, Public Health had too few nurses to handle the demand for immunizations. Nurses had to be pulled from billable activities to work on outbreak control, for which there was no reimbursement. Last fall's pertussis outbreak on the Eastside overwhelmed the medical private sector, which directed their patients to public health clinics. Managed care plans do not pay Public Health for outbreak services it provides to their enrollees. Possible responses to this issue, in addition to increasing local funding for public health nurses, include training staffs of community health centers to respond to communicable disease emergencies and asking the medical community, insurers and large health care institutions to assume more of the staffing and financial responsibility during outbreaks.

Public health nurses promote healthy development and support family functioning -- an important service for the prevention of child abuse. However, due to lack of flexible funding

from local government, public health nursing services are restricted to those families who have Medicaid coverage to the exclusion of unsponsored families and are subject to Medicaid benefit limitations. Chronic disease prevention and healthy aging services have no sustainable funding base. Yet, Public Health needs to have the ability to respond to chronic disease prevention needs, especially in view of pronounced disparities in disease occurrences among people of color -- diseases like asthma, heart disease, diabetes. Local demographics compel our attention to the health promotion and prevention needs of a growing aging population.

Mr. Nickels indicated that in the next few months, the Board will come back to these individual issues and how we will respond to that paramount duty to meet the public health needs of our citizens.

The meeting was adjourned at 12:19 PM.

KING COUNTY BOARD OF HEALTH

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s/Greg Nickels/s, Adopted March 17, 2000