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

Carolyn Edmonds, *Board of Health Chair*

KING COUNTY BOARD OF HEALTH
MEETING PROCEEDINGS

June 16, 2000
9:30 AM to 1:00 PM
King County Council Chambers

Roll call

- Richard Conlin
- Larry Gossett
- David Hutchinson
- David Irons
- Louise Miller
- Greg Nickels, Chair
- Margaret Pageler
- Dwight Pelz
- Joseph Pizzorno
- Kent Pullen
- Dan Sherman
- Alvin Thompson
- Karen VanDusen
- Anita Geving, Administrative Officer

Call to order

Chair Greg Nickels called the meeting to order at 9:43 AM.

Approval of May 19, 2000 Minutes

A motion was made and seconded for approval of the May 19, 2000 minutes. Dr. Thompson asked for a correction to page 16, 13th paragraph, 2nd sentence. It currently ends with "blindness is for diabetes induce glaucoma." Instead, it should read "...blindness due to diabetes and glaucoma." Dr. Thompson explained that there is no such thing as diabetes induced glaucoma and that glaucoma is an exceedingly frequent problem. It is, in fact, more remediable as a cause of blindness than is diabetes. That was one of the reasons he wanted to note the change. The minutes, as corrected, were approved unanimously.

General Public Comments

Richard Lee stated that the cameraman from the cable channel for the County wasn't present. It's tricky getting these tapes from the County. They're a bit evasive about providing a good copy to work with. Mr. Nickels indicated that this is not being videotaped by the

County and confirmed for Mr. Lee that not all public meetings are broadcast. Mr. Lee said that is it good he brought his own taping equipment so the viewers of his program on Channel 29 will have the opportunity to see that you were willing to respond this morning to my concerns about Dr. Plough and his supposed review of the issues that I brought up at the last Board of Health meeting concerning the appointment of Dr. Harruff as King County Medical Examiner. You did say that I could expect a response in writing to the materials that I directed to you, Mr. Nickels. However, I should let you know that there is a letter dated June 2nd that I have here from Dr. Plough, the Director of the Board of Health. This letter, which was not mailed until ten days later for whatever reason, purports that "I have reviewed your correspondence, the attachments and your claims of misconduct by personnel at the Medical Examiners Office and their handling of the investigation. After a thorough review of the case and the King County Medical Examiner's Office, it's my position that a complete and accurate death investigation was conducted. No indication exists that misconduct by personnel of the Medical Examiner's Office has occurred." This two paragraphs are cursory, at best. His "thorough" examination of the handling of the Cobain case and the publication related to that and in the Journal of Forensic Sciences is completely undescribed. In other words, Dr. Plough has given white paper which consists of about 150 words here that purports to clear Harruff of any suspicion of misconduct in this case. That just doesn't add up to anything. All it adds up to is that Plough made the appointment of Dr. Harruff without consulting anyone on the Health Board, without consulting the King County Executive, as far as I have been able to determine, without any public hearings whatsoever. Now King County Executive Ron Sims is indicating that it's okay for Dr. Plough to engage in this review of his judgment, or lack thereof, in appointing Dr. Harruff as the Medical Examiner.

Mr. Lee read from the section from the Journal of Forensic Sciences on conflicts of interest. "A conflict of interest for a given manuscript exists when a participant in a peer reviewed for publication process has ties to activities that could inappropriately influence his or her judgment whether or not the judgment is in fact defective." The editor of the Journal of Forensic Sciences in Chicago, Dr. Gainsling, tells me there's no evidence that Harruff ever disclosed that his article on intra-oral shotgun wounds was directly influenced by the Kurt Cobain case. That constitutes scientific fraud.

Mr. Nickels thanked Mr. Lee, saying that he had received Mr. Lee's letter and that he will be responding to it. Upon Mr. Lee attempting to ask a question, Mr. Nickels indicated that Mr. Lee had given his testimony and that the Board would move on to other business. Mr. Lee asked if Mr. Nickels will defer all judgement to Dr. Plough on this. Mr. Nickels stated again that he would be responding to Mr. Lee's letter. Mr. Lee said that he would advise against doing that because that would be just a little bit too cursory.

Chair's Report

Mr. Nickels thanked Harborview for allowing us to use this facility for the Board meeting. It's of particular interest to the Board of Health because Harborview obviously plays a very strong role in our health care system and serves the same populations that the Public Health often provides service to. It is also of interest because this fall the County Council is considering a bond issue for Harborview that would deal with some seismic and earthquake issues in our trauma center. This building will be torn down because it is so unsafe in the event of an earthquake. Mr. Nickels doesn't want anyone to feel nervous about that, but this building and the one on the south side of the main tower are both very questionable in the event of a major earthquake. The building on the north side of the main tower, which is where half of the surgical suites, the burn unit and most of the hospital beds are these days, would probably be damaged to the extent that it would have to be closed. It would not be good, in the event of a major earthquake, to have the trauma center closed. The Council is

considering a very substantial capital plan that might be on the ballot in September, so our visit here is very timely.

Cancellation of August Meeting.

Mr. Nickels asked if there was any objection to canceling the August meeting of the Board. Seeing none, Mr. Nickels announced that the August meeting would be canceled and that there will be a September meeting unless there is not enough business.

Board of Health Survey & Meeting Evaluations.

In April, the staff reported the results of the survey that was conducted to get feedback from boardmembers. The final copy of that report has been distributed to members, and the findings were used to consider how to improve the Board's renewal ordinance.

Board of Health Renewal Ordinance.

The Board's renewal ordinance passed 12 to 1 on Monday. Mr. Nickels explained the changes that were made. The first change allows the third health professional to act as an alternate if one of the other health professionals is not present. The second change has the suburban members now being appointed by the County Executive based on nominations from cities, either individually or jointly. The issue related to that change was that currently a member of the City of Bellevue Council is not currently able to serve if he/she has an interest. Now, the City of Bellevue or any group of cities might nominate and then the County Executive will make an appointment based on those nominations. The third change is in the sunset clause, which we've had since the creation of the Board in 1996. The sunset is in four years, so we don't have to go through this process again for four years. Mr. Nickels believes the Council was very supportive and very pleased with the results of the last renewal, which shrunk the size of the Board and has allowed us to be very effective.

Briefing on National Tobacco Settlement Fund Allocation and the Tobacco Prevention and Control Plan.

Attorney General Gregoire negotiated a national tobacco settlement in 1998. Significant funds from that settlement are available, and this year the Legislature allocated a portion of those funds for the first time. We're going to hear a little bit about where those are going and how they're going to benefit our County. Mr. Nickels is very interested in this because he had a very heart to heart conversation with his daughter this week about the evils of tobacco use, for a specific reason. Mr. Nickels introduced Greg Hewett, Program Manager of Public Health's Tobacco Prevention Program, to present the briefing.

Mr. Hewett stated that we know quite a bit now about what we can expect and how this will affect King County. Last year, a $100 million control fund was established, to be spent over the next ten years on tobacco control. The first year, $15 million was allocated out of that fund, and this will be distributed to the 39 counties in the State. For the past year, the Department of Health and others created components to a tobacco control plan. The Department of Health requested $26 million to support the plan, and the Legislature approved $15 million retaining the plans major components. Mr. Hewett stated that we'll just have to downscale the funding. The main components of the tobacco control plan include community grants, schools, a "quit line", a media campaign and the evaluation.

Mr. Hewett wants to make sure the Board understands what the responsibilities the State will take and what the counties will be expected to do. The state will handle the "quit line", which

will be contracted out. Anyone in the State who needs assistance to stop smoking can call this number 1-800 number. The number will be available within two weeks after the contract has been announced. The next component the State will handle is the media campaign. The campaign will include television, radio and bus ads. King County will benefit greatly from this because most of the media and radio stations they will use will be in King County. The school contract will be handled by the State, contracting with the ESD's to do tobacco prevention in the schools. The State will also handle the evaluation components and the grants to the tribes. The counties will be expected to handle the grants to the communities. There are approximately $2.6 to 3 million that will be distributed among the 39 counties. Mr. Hewett confirmed for Mr. Nickels that the State will have $11 - $12 million. Mr. Nickels asked if the bulk of that would go into the school districts. Mr. Hewett responded that, although it's not been publicly announced, approximately $2.1 million will go into the school districts through the contract. Mr. Nickels asked for the amount going into the media campaign, to which Mr. Hewett responded approximately $6 million. Mr. Hewett confirmed for Mr. Nickels that the media campaign is the largest single component of the plan. Ms. Miller asked what kind of work the tribes would be doing and if this is through the tribal schools. She asked if they would be for working with their schools or doing other things. Mr. Hewett answered that the statement of work is being developed by the Department of Health, and the Department will be contracting out to the agency that handles the regional tribal district for Washington State and Oregon. That agency will contract with the individual tribes. This will include working with the schools within the reservations and the smoke shops to help with youth access issues. Ms. Miller asked if it would be doing work similar to that which we've done in trying to educate them about consistently carding minors. Mr. Hewett confirmed that the work would include those efforts. Ms. Miller indicated that the other issue with the smoke shops is taxation, which is a federal issue. Mr. Hewett agreed. Ms. Miller asked if they will be focusing this on their total population or mainly their youth population. Although Mr. Hewett had not seen the completed statement of work for the tribes, believes that it will primarily target youth. Ms. Miller requested to see the statement of work when it was complete. Regarding the $6 million media campaign, she would be very concerned if it wasn't primarily directed at preventing tobacco use. Ms. Miller assumed the quit line is for adults who have tried and want more assistance, but she thinks the only way to start making progress on this is by preventing kids from starting. That kind of advertising is very unique. We're going to have to do something that will appeal to kids ranging in age from 11 to 18 or 19. Peer pressure is part of the problem and the vast majority of what happens is pressure from the groups. So somehow the advertising needs to demonstrate peer pressure on the other side from their peers that this is not a good thing, is addictive and hurts your health in the long run. You may not see real damage early but later on in your life, and that it's not cool. Mr. Hewett was pleased to hear that for the media component, the State is required to use the youth council that's representing tobacco prevention to help produce these ads. So, the peer pressure understanding and messages are going to come from the youth themselves in these ads. Ms. Miller believes they should come from the youth. No adult can tell them not to smoke. But she also believes that there's a lot of peer work that's going on in the high schools and the junior highs. They're involving the students themselves. So we might do the kind of things that they're doing for alcohol and cigarette use and anger management. They mediate their own disputes. Ms. Miller thinks that if the message is from the kids to the kids. That's what's going to be successful.

Mr. Hewett continued. A lead agency has been appointed from each of the 39 counties. For King County the lead agency is Public Health - Seattle & King County. These agencies are asked to take advisement from their tobacco councils, and in King County the Tobacco Prevention Council has been in operation since 1996 and has developed a tobacco control plan toward which the King County allotment of dollars will be spent. On the Council there are 32 non-profit government agencies working together to develop this tobacco control

effort. The plan was devised in the past two years by listening to the concerns of the community. The Council has worked with the Board of Health as well, and together they've come up with a wonderful plan. In fact, much of the State tobacco control plan is based on the King County plan and there are a lot of similarities between the two.

Mr. Hewett explained that while we don't have the exact dollar figures yet, the final fund allocation plan will be known as early as next Tuesday or Wednesday. We have been given a conservative figure, but there are last minute details in working out the final dollar amount.

The Tobacco Council of King County would like to see the money support its tobacco control plan with 45 percent of the dollars to build upon and support the tobacco prevention efforts of Public Health. That includes staffing, the overhead and the required grant monitoring of the community grants the will be awarded. Fifty-five percent of this money will go directly to community grants, and the Council chose four areas in King County that applications for this money must apply to. The four areas are: smoking and pregnancy, cessation efforts, youth prevention and special populations. We're one of the few counties so far that will take 25 percent of the total dollar amount and direct it to special populations to assure the necessary funding to those communities to bring down heavy smoking rates.

Mr. Nickels asked Mr. Hewett, in terms of order of magnitude, what are the dollars that we're going to see in the County for our program compared to historic levels. Mr. Hewett responded that the tobacco settlement dollars will exceed the combined amount of the three tobacco funds that we receive yearly. In other words, put together all the funding every year for the past five years and that which we receive through tobacco licenses, for instance, and the tobacco settlement will exceed that. Then Mr. Nickels asked if we could have, at one of our meetings maybe this fall around October, some representatives of the Tobacco Council and some of the advocacy groups to come in and tell us what's going on nationally. Mr. Nickels wants to know if there are things we can pick up on from other communities and how they're using these dollars. He thinks other communities have looked to us for that kind of leadership, and he thinks that's been a very effective way to advance this effort.

Ms. VanDusen asked Mr. Hewett to define the special populations he was referring to. She also asked what the Legislature actually did with the money that the State received, if it all went into this fund or was some of it diverted. Answering the second question first, Mr. Hewett responded that Washington State's settlement dollars for the first year (received over a 2-year period) were $329 million. Every year afterwards there will be $149 million coming to the State for 25 years. Every year the Legislature will need to struggle and deal with $149 million dollars and where that should be allocated to. The $100 million tobacco control fund was set up from the initial $323 million, which is why Washington State stood out as a national leader in tobacco prevention. The rest of the funds were put into the Basic Health Plan. So health took priority with tobacco settlement dollars. Mr. Nickels added that we are the only state that put 100 percent of those funds into health. Ms. VanDusen commented that that was excellent. Ms. Miller stated that we had to really lobby. They wanted to move it many other places. The counties took a position on it very early and lobbied that the money should be going to health. We didn't specify the fund allocation, but we said it shouldn't be diverted to other kinds of programs. Dr. Thompson commented that California is doing very well with its smoking prevention advertising. However, Pete Wilson, for reasons probably having to do with the tobacco lobby, diverted a significant part of that money to child health, an admirable objective. But when that happened, the smoking cessation began to exacerbate again. Dr. Thompson thinks that's a trap with which one has to be very careful. Mr. Nickels agrees saying that is pitting different communities against one another. Mr. Gossett pointed out that they were focusing on kids, and Dr. Thompson said that it was very sly. Dr. Thompson thinks that all the tobacco industry cares about is that smoking increase.

If it means that they will distort the health budget one way or another, particularly as an attractive way of detracting from anti-tobacco advertising, they'll do that, too. We should not be conned as we congratulate ourselves on this going to the health budget. Ms. Miller suggested that Dr. Thompson come and lobby, because she spent weeks on it she thinks we have to be careful too. Understand that we lost money out of the health budget that would go for child immunizations and keeping our clinics open. Those are important, too and we can't lose them. Mr. Nickels asked if there was a bill to have two separate funds so that they're not competing for the same dollars, with funds going into the tobacco prevention area and other funds go into other health care. Ms. Miller answered that the first thing they wanted to do was eliminate that. Ms. Miller confirmed for Mr. Nickels that she meant that they wanted to eliminate that firewall.

Mr. Hewett then answered the remaining question Ms. VanDusen had asked which was for a definition of the special populations he referred to. The Tobacco Council of King County is currently working on that definition and will have it next two weeks. We're looking at the highest smoking rates right now of the minority communities. We know several special populations that will be included, but we want to make sure we capture the real picture in King County. Mr. Hutchinson asked Mr. Hewett to say something about the direct community grants, what those are and how they will work. Mr. Hewett explained that solicitations for community grant applications will be sent in late July or early August to providers that do tobacco control work and any interested agency. The grants will be available for work in one or more of the four focus areas to do tobacco prevention. Mr. Hewett verified for Mr. Hutchinson that the application will be sent to the cities so they may pass it on.

Outdoor Tobacco Advertising Regulations.

The Board had an executive session on the outdoor tobacco advertising regulations last month. The Department is going to be bringing a proposal to the Board to in July to respond to Ninth Circuit Court of Appeals decision. Mr. Nickels has asked the Department and the prosecutor to take a look at an approach where we do not repeal, but set aside our regulation recognizing the court decision and recognizing that either Congress or the court will need to act for us to be able to enforce our regulation in the future. That sends a different message, and Mr. Nickels would like to ask the Board to consider that approach.

Budget Workshop Wrap-Up.

The Board has been holding budget workshops since February and we have finished the formal presentations. The underlying issue of how we are dedicating our local resources to public health has come clear through those briefings. We will come back on occasion to help the Board track some of those issues and give advice to the City and the County in their budget processes and on federal funding, particularly in critical services such as public health nursing, communicable disease prevention and chronic disease and healthy aging. The Board will hear more about that in the future.

Public Health Opinion Polls.

In the Board packet there is information about some public opinion polls that have been conducted on public health. These illustrate the same issue that Mr. Nickels was trying to show in the briefings on the budget, that the public very highly values what we do in public health, but they do not attribute it to public health. They don't make that connection, and Mr. Nickels doesn't believe that's the public's fault. It's public health's fault that we talk in a jargon and in a manner that does not clearly communicate the basic services that we're providing. That was apparent in some of our budget conversations where Mr. Nickels saw light bulbs

going off above Boardmembers' heads as we talked about some of the specific services and what was happening to them. Fifty-seven percent of the respondents in one poll could not define public health as either protecting the population from disease or policies and programs that promote healthy living conditions for everyone. After hearing public health defined, most, again 57 percent of the respondents, rated the current system for protecting public health negatively. They did not feel it was doing an adequate job. Sixty-five percent of the respondents felt that more should be done to protect public health. Of road and highway building, missile defense, cutting taxes and education, only education was viewed as a greater priority for additional public resources. We have very basic services we're providing. We're perhaps not putting the local resources in that we need to, and yet the public is not connecting. We are not necessarily connecting those two factors either. Mr. Nickels indicated that we are on the right track with looking at the budget, breaking it down and making it more understandable for the public.

Report of the Ad Hoc Committee on Natural Medicine Integration with Public Health.

Mr. Nickels called on Dr. Pizzorno to give a report on what has happened since February. Dr. Pizzorno stated that the last months have been quite interesting. Between Dr. Plough and Dr. Pizzorno, they've held about eight major substantive meetings on this. The committee is currently composed of Dr. Pizzorno as Chair, Councilmember Pullen, Councilmember Maggi Fimia, public member Merrily Manthey, Dr. Plough, public member John Weeks, Dr. Dedra Buchwald, Department of Medicine - University of Washington, Dr. Ron Schneeweiss, professor of the Department of Family Practice - University of Washington and Dr. Adam Drewnowski, Department of Epidemiology and Medicine - University of Washington. The staff have been Cathy Gaylord, Kris Beatty, Dr. Gary Goldbaum and nutritionist Patricia Manuel. We've accomplished a lot over the last six months, and Dr. Pizzorno recognized Cathy Gaylord, in particular, who is unfortunately no longer with us but provided remarkable support. He also recognized Dr. Plough, who has been very innovative in his thinking and has provided excellent staff support, and Dr. Goldbaum, who wrote most of the proposal.

We now have completed a proposal, a copy of which we will provide you at the next meeting. We've done something that's quite innovative and exciting. The intent is to create an institute under the Director of Public Health. This institute will be focused on engaging in several areas to define the research that will be necessary to determine how to optimally integrate public health and natural medicine perspectives and then to develop a research agenda to facilitate this. We came up with two demonstration projects, as a way to do that research evaluation: selenium for prevention of cancer, with screening and intervention, and a nutritional intervention reversal of homocystinuria for the prevention of cardiovascular disease. We completed a basic budget and structure and we learned a lot. One of the things Dr. Pizzorno learned, which he's always thought in the back of his mind but never actually articulated, was the remarkable similarity between the philosophical bases of public health and natural medicine. The difference has been that natural medicine practitioners apply these principles to individuals, while public health applies them to population groups. That is the idea of prevention of disease, education, healthy living. All these things are what natural medicine practitioners do on a one-to-one basis, where Public Health does it on a large scale. So it's been a very positive experience.

So that's the good news. The tough news is that back in November Dr. Pizzorno told the Board that he had gotten very strong encouragement from Senator Harkin's staff about the probability of a federal appropriation for this project. In April, Bastyr University, under Dr. Pizzorno's direction, hired a lobbyist to help us work our way through the federal process, and we learned it was not going to be so easy. While we were strongly encouraged to take

that funding pathway, this pathway did not prove to be particularly successful. We are now using our networks, both through Public Health and Dr. Pizzorno's staff, to identify foundations and other public entities that would be receptive to this proposal. We are identifying possible funders and will be sending the proposal out to them. We determined that it would be a good idea to do this in full collaboration with the King County 2010 task force and with the Center for Traditional Community and Public Health that's being established. So we had the idea to get together and go to the National Center for Complementary and Alternative Medicine (NCCAM) for funding. Dr. Pizzorno has already talked with members of the advisory counsel for the NCCAM and the White House Commission on Complementary and Alternative Medicine and we've gotten very positive feedback from individuals in those various organizations. Our intent is to put the proposal out and see if we can find somebody to fund it. The basic plan would be for funding with a ten-year perspective, and we think that's doable. Dr. Pizzorno hopes that in a couple months we'll hit the jackpot. Mr. Gossett asked who is the sponsoring organization under which the proposal is being submitted. Dr. Pizzorno responded that it is the Department of Public Health and that Bastyr University is not formally part of this but we believe it's important and we're providing support resources to help make it happen. Ms. VanDusen asked if the School of Public Health and Community Medicine at the University of Washington was asked to be involved, particularly since it involves research, education, grants and community demonstration projects. Ms. VanDusen thinks that it might be more an academic approach rather than Department of Public Health approach. She asked if there was any connection made with that group. Dr. Pizzorno answered that we have attempted such.

Dr. Thompson's request to Board to examine the Criminalization of Mental Illness.

Last month, Dr. Thompson addressed the Board on behalf of the State Association of Black Professionals in Health Care on the criminalization of the mentally ill, and asked us to do an evaluation and resolution of the obstacles to the timely and appropriate treatment of the mentally ill. Mr. Nickels has asked staff to put together a panel presentation either at our July or September meeting so that we can begin. He doesn't think a simple response is called for, so we need to start it out with some information gathering with a panel. Mr. Nickels invited Dr. Thompson to offer suggestions of panelists. Mr. Nickels commented that he and Mr. Irons, as members of the County Council, were interested to see the Superior Court here, not realizing we had a courtroom here in Harborview Hall. They took a short tour of the court prior to the meeting. It's very interesting and very crowded. It is an involuntary commitment courtroom for persons who are believed to be a danger to themselves or to others. People in need of very intense hospitalization and care are going in and out of there every day in very large numbers. Dr. Thompson explained that the reason the court is here is because Harborview Hospital is the place for temporary involuntary commitment and therefore it facilitates a better disposition of these people.

Mr. Gossett asked what is the question that is going to be put to this panel that Mr. Nickels is proposing. Mr. Nickels responded that the question was raised, and maybe Dr. Thompson would like to address it more directly, about the David Walker shooting, a gentleman who was mentally ill, and ended up losing his life in a confrontation with the police, and whether or not our mental health system is adequately providing treatment and our criminal justice system is adequately addressing the needs of those who are mentally ill and end up in that kind of situation. It's a very broad question that deals with both the mental health delivery and criminal justice systems. The King County Jail, night after night, is the third largest mental health institution in the State of Washington. We are all troubled by the appropriateness or the inappropriateness of that fact, but it still exists. Mr. Nickels indicated that the panel may address the systemic issues if there are things the Board can do to encourage more appropriate treatment. Dr. Thompson recommended that the Board read

the book Shadowland, by William Arnold. It speaks to abuses of the mental health system during the McCarthy days. One of the persons who was a target of that was Frances Farmer, a native Washingtonian. Mr. Nickels interjected that Frances Farmer was a West Seattle resident. Dr. Thompson said that this book describes some bad things that were going on and the politicization of the mental health system. So for that reason, the pendulum swung toward improving the civil rights of patients who were mentally ill. Dr. Thompson can tell the Board that with his son, for instance, over a period of five years about every month they'd have a mental health worker come out and talk to him, and he was clearly a menace to himself. He lost about 98 pounds, he was not wearing appropriate clothes in the wintertime and he clearly could be a target for victimization. But repeatedly they would say that he says he's all right, so they let him alone. We finally got someone to understand that he was a hazard to himself and he was brought to Harborview Hospital and subsequently had a hearing at the court here.

But what's happened now is the bar for determining the civil rights of an individual vis-a-vis their own health, and in the case of David Walker the health of the community, has been raised too high. And because it is too high, the only way to deal in an emergency situation, as perceived by the police, is to shoot people. This isn't the first case. There have been numerous cases before. Now there are new medications. Dr. Thompson's son is now taking medications and he's nearly normal, functioning very well and enjoys life. He's really not able to work, and lives with Dr. Thompson. But there are now medications available to markedly improve the health of these people, to remove the terrible anguish that they experience. There's probably no more anguishing circumstance than schizophrenia, much less to remove the possibility of their freezing out under a bridge somewhere or being shot. That was one issue that was totally a health issue. The other issue was, Dr. Thompson's group implored the police department to look at what its policies were toward handling the mentally ill, and he raised the question with the Board at the last meeting. Dr. Thompson asked how would you handle a ten-year old who had a gun, which is not an impossible situation. He asked further what would you expect the police to do. Dr. Thompson posed the fact that the job of the police is not only to protect the public, but to protect the helpless, not kill them. He got a letter from Mayor Schell, which he shared with the Board, which indicates that the Mayor is starting two task forces, one you're totally aware of, having to do with police policy about the shooting, and the second having to do with the policy toward handing the mentally ill. I think that there needs to be, frankly, some state involvement here in terms of legislation which will permit a consideration of the civil rights of individuals vis-a-vis the civil rights of the community. It requires a good deal of thought. But we can't go on like we are, because that situation with a ten-year old boy with a gun is going to happen.

Director's Report

Ms. Geving explained that we have included a written copy of the Director's Report in the Board handouts in response to board member feedback.

Visitors from South Africa.

The Department hosted public health and elected officials from South Africa who came and visited this past month. Interestingly, they learned about us through conversations with the CDC and also by looking at our web site, deciding that of all the places in the United States they would come they wanted to come here to King County. We very much want to thank Mr. Gossett and Mr. Pelz for making time to talk with these individuals about public and health policy.

Traveler's Diarrhea Outbreak on Local Cruise.

The Board has probably heard in the media recently about an outbreak of diarrheal activity on an Argosy cruise ship that affected about 100 people. The thing that makes this particularly interesting is that this is a strain of E. coli that we don't typically see here in the United States. In fact, it's a strain that is more associated with traveling abroad. It's called traveler's diarrhea and we normally see it outside of this country, so it was very unusual. Dr. Jeff Duchin, our chief epidemiologist, played an instrumental role in helping to identify the causative factor. From a policy point of view, it leads us to believe that we may have to change what agents we look at as potentially causing these kinds of problems.

Surgeon General's Report on Oral Health.

The Board has in its materials the report from the Surgeon General on the status of oral health in America. This is a critical piece of information, and something that the Board will potentially want to hear more about in the future. Public Health is also participating in the national conference this week on oral health care. Even though there have been very substantial improvements in the treatment of dental cavities and periodontal disease, and also the preventive success that has happened through fluoridation, there is still not a good integration or understanding that oral health care and general health care go hand in hand. There are access to dental health care and dental insurance issues, particularly for low income, certain ethnic groups and the elderly. Public Health does have its own dental clinics in which we provide services to low income individuals, predominantly children. Our key issues in the provision of dental care are the same, predominantly with a much greater proportion of adults who need dental care that we simply cannot serve. This report will probably, from a policy perspective, awaken a new sense about oral health care. We're looking to see whether there will be additional federal funding that will be made available for dental or oral health care grants, and we'll also be looking to see whether that will shift any of the federal government priorities for public health activities.

Dr. Thompson thought he knew the answer, but asked why the designation oral health as opposed to dental health. Ms. Geving believes that it includes not only the dental aspects, but also the whole craniofacial system, including the nervous system and all the parts that make up the facial features. Dr. Thompson thinks that the oral-pharyngeal concerns that are mentioned are important. Ms. Geving indicated that we are paying attention to the incidence of pharyngeal cancers. She confirmed for Mr. Gossett that those are related to the use of tobacco as many of the oral diseases are. Ms. Miller commented that it is related to chewing tobacco. Dr. Thompson clarified that chewing tobacco produces cancers in the mouth, and tobacco smoking is associated with pharyngeal and esophogeal cancers. Dr. Pizzorno commented that, as a nutritional oriented physician, he always looks in peoples' mouths, because the cells in the mouth are the most rapidly turning over cells in the body. When there are deficiencies, they typically show up in the mouth first. When we talk about these various kinds of conditions, they are often indicators of folic acid insufficiency, and a lot of these oral problems can be reversed. So Dr. Pizzorno wonders when we look at these various oral health programs, dental sealing makes sense, but also some pretty specific nutritional interventions can greatly improve health. Ms. Geving thinks that is an excellent point. There are actually some national dental sealant programs which are like an immunization program for teeth, when you think about it that way. She agreed that Dr. Pizzorno is right, the nutritional components of oral health are very significant. Dr. Thompson commented that when he came to this State in 1953, he was looking in the mouth of a 16-year-old and he saw snags and almost a dentureless state. It was absolutely astounding. That was the bad state, because the lucky kids had dentures at age 16 and 17. Dr. Thompson came from Washington, D.C. His mother had no cavities. And in his school you

didn't have cavities. It is absolutely astounding to look at kids' mouths and to see the enormous change that's happened from putting fluoride in the water. Dr. Thompson remembers when the King County Medical Society was meeting in this auditorium, and Dr. Exner was saying fluoride is bad stuff. But between putting fluoride in the water and using dental sealants and the economic, socioeconomic state of people rising, not just African Americans but a lot of poor folks before World War II, it made an enormous difference. Dr. Thompson believes that was one of the greatest triumphs of public health. Ms. Miller commented that now the wealthy are reversing the benefits of fluoridated water by buying bottled water because for some reasons they think their tap water isn't good enough. Ms. Miller would hate to tell them as a water commissioner that some of that bottled water came right out of the tap. Dr. Thompson stated that bottled water is dispensed at the Public Health Department which is in a new building. Ms. Miller said that they have bottled water in the Courthouse because the pipes are so old you need to have it. Ms. Pageler commented that it's really good to hear that, because at a State Board of Health meeting in Spokane last month she just was subjected to a group of people who testified at great length that fluoride in the water was the cause of all of the ills in the world such as allergies and so forth, and that it was a government plot. That perspective is still out there. Mr. Irons stated that there are any number of water commissioners in his district that will say the same thing, and their firm belief is that the absolute worst thing, heresy, as far as they're concerned, would be to tie into the Seattle water system and allow fluoride into their system. Mr. Gossett asked why. Ms. Miller said that they have rural water, but they can't get any more well water because the State isn't going to give them any. Mr. Irons stated that in those water districts, if you want to get thrown out of office, stand up and say that's a good idea. Ms. Geving suggested that maybe there's naturally occurring fluoride. Mr. Irons responded that they actually have to add other chemicals to their water because it's so hard it actually dissolves the copper pipes.

Healthy People-Healthy Communities Month.

Executive Sims proclaimed June as Healthy People Healthy Communities Month, and we are engaged in a series of media activities, getting back to the comments about the public's understanding of public health, addressing some of these issues. You will see billboards and bus boards, and a series of prevention oriented media releases throughout this month. It's a repeat of the media campaign that we did before, talking about public health and making a connection between public health and things that are good for you. The campaign also identifies safe summer activities.

Breastfeeding Webpages.

Ms. Geving announced the launching of the Public Health webpages on breastfeeding, copies of which are in the materials. Dr. Sherman expressed concern about the breastfeeding webpages which talk about how good breastfeeding is, which it certainly is, saying that breastfeeding is best for you and your baby. That's not always the case, and there is no disclaimer in this article explaining that if a woman is taking medications, even some natural medicines, it may not be good for her infant. Dr. Sherman believes there should be some kind of statement that indicates to women that they should consult with their doctor about the advisability of breastfeeding if they are taking any over-the-counter medicines or natural preparations. Ms. Geving said that she will report this back to the work group and ask that they make some revisions. Dr. Thompson commented that there's a reduced risk of ovarian cancer in women who breastfeed, which it states on the webpages, so there is some advantage to the woman as well as to the baby. Dr. Thompson suggested that some efforts should be directed, not just to the women, but to employers. He remembers 20 years ago, one of his young ladies got pregnant three times. And when she came back to work, she had a room where she could express her milk, and he always had a

refrigerator full of milk. What employers do makes a great deal of difference in these times when a great number of young women have to work. Mr. Pullen stated that this is probably one of the best steps we could take toward improving health, and helping in other ways as well. Breastfeeding has got to be one of the foundations of natural medicine. It's the start of the health for the child. Children who are breastfed are more intelligent, they're healthier, they have fewer allergic reactions and better health for the rest of their lives. Normally it takes a full year of breastfeeding, and the immune system has some final developments that usually occur about the eleventh month. So a whole year of breastfeeding, at least, is desirable. Productivity, as Mr. Thompson mentioned, goes up because the parents aren't so busy fussing around with ear infections in their children. Mr. Pullen asked how much time is lost to parents who have to spend so much of it dealing with ear infections in their children. That happens much less frequently, if at all, if the children are breastfed. The gains for society, the children and everyone are enormous. Mr. Gossett asked Mr. Pullen if he has seen a study with results showing a higher average IQ or intelligence ratio in children who were breastfed than children who were not breastfed. Mr. Pullen answered that absolutely there are scientific studies out now and he can get the data if Mr. Gossett is interested in it. It's statistically significant. Ms. Miller said, as the only person here who has breastfed, Dr. Sherman is right. Everything gets into the breast milk. Ms. Miller believes that balanced information is necessary so that people can make intelligent decisions on their own and with their physicians, whether they be a visiting nurse or a regular practitioner. She breastfed both her children and everything gets into the milk, so you need to be careful about what you eat. And some people just aren't successful. Working women have enough guilt trips as it is. We are very accommodating in our workplace, but it is still difficult for our young women to be able to pump the breast milk. It is very important to try to accommodate breastfeeding women, but it doesn't work for everybody. We should at least give people direction on our website in case they have any difficulties or doubts about it.

Food Services Establishment Fees.

Ms. Geving reminded the Board that at its November 1999 meeting, it made a decision to increase fees for the food protection program in order to cope with the changes that are going to be happening with the passage of I-695 and the loss of motor vehicle excess tax (MVET) funding. Ms. Geving introduced Public Health's Kathy Uhlorn, Manager of Administrative Services Division, Dr. Ngozi Oleru, Chief of Environmental Health Services, and Phil Holmes, Administrative Assistant for Environmental Health Services. Ms. Uhlorn began stating that in response to the passage of I-695, the Board of Health considered fee changes in the environmental health programs in November. Two levels of fee changes were considered. One was to replace the motor vehicle excise tax in programs in environmental health, and the second level was to replace the current expense or the county local support in the programs. The Board passed both of these levels of fee increases, and that resulted in full cost recovery of the permit activities. The Board adopted Rules and Regulations No. 99-07, which included the following changes. It increased fees to replace the MVET funding loss of $236,658 and to replace the CX funding of $567,012. This CX was then redistributed to other Public Health fund programs to help mitigate or offset the MVET losses in other Public Health programs. At the time of this decision, the Board of Health stated intent to reconsider fees in the food program if the State Legislature fully restored MVET funding for Public Health in King County. Ms. Beatty read the exactly the language from the rule, stating from Rules and Regulations No. 99-07, Section 2: "This amendment shall take effect on December 31st, 1999, provided that the Board of Health shall reconsider the restaurant fee increases in the event that the Legislature restores full funding for public health in King County." Ms. Uhlorn continued, stating that during the last Legislative session, the Board of Health worked with the State Legislature to restore public health funding statewide. In May of 2000 the State Legislature restored approximately 50 percent of the

MVET funding for the calendar year 2000 and approximately 90 percent of MVET funding for year 2001. We started out in the 2000 recommended budget in 1999 at a level of MVET funds in public health of $10,525,000. In the year 2000, the MVET replacement will be $5.2 million, and in calendar year 2001, the replacement will be $9.4 million, which is approximately 90 percent of the $10.5 million that we had previously.

Currently the Department is in the middle of its 2001 budget preparation. Ms. Uhlorn briefly discussed the many challenges the Department is facing so that the Board will have that information in making decisions. First, a factor for environmental health is regulatory uncertainty. The requirement of I-695 for fees to be approved by voters is in litigation. So the Board could not consider any fee changes at this time. Also, Initiative-722 would roll back fees adopted after July 1999. This would have the effect then of negating the fee changes that the Board made in November. The Department, unfortunately, has also been notified of a decrease in current expense at a level of about 8.4 percent, and that would be a reduction in the food program of $46,616. Ms. Uhlorn confirmed for Mr. Nickels that is the Executive's request to the Department in preparing its budget proposal. In 1999, the Department settled with Local 17, the largest bargaining unit in the Department, on wages to settle the class comp issues that had been outstanding for years. The good part is that staff are being paid at appropriate levels. The unfortunate part, from a budget concern, is that it increases the cost of the program. We have about a $400,000 challenge in this program for 2001 because of the labor settlement, rent and other inflationary costs of supplies and other operating expenses. There is also a county-wide class-action lawsuit in which the Department has been advised that our share is $775,000 for the year 2001 budget, which will have some impact on environmental health. We're in the process of trying to determine the allocation of those costs, but Ms. Uhlorn doesn't have that for the Board today. She will have it for you next month. Ms. Pageler asked if this is a labor issue and Mr. Nickels asked if the class-action litigation is also a labor issue. Ms. Uhlorn answered that it is the Clark class-action lawsuit by contract employees, employees that work under the Department in a contract situation. Ms. Pageler was familiar with the Clark lawsuit. Ms. Uhlorn explained that, unfortunately, the economic impact of these concerns may require environmental health to make service reduction proposals or additional local support will be needed to maintain current program levels. In responding to Mr. Nickels' request that we take an historic look over the last four years, Ms. Uhlorn prepared a chart which shows the full revenues for the food program budget, total program budget, the level of CX and local support. She corrected the chart saying that the CX line should also say "local support". It includes CX and MVET, and the percentages of funding for the overall program budget. It was 24.9 percent of the funding of the food program budget in 1997, and due to the actions that were implemented for full cost recovery. That is full cost recovery except for the fourth education visit for which the King County Council awarded funding during their deliberations at the end of November. Other than that educational visit that the Board of Health recommended and legislated two years ago, all of the other local funding was removed from the program. Mr. Nickels asked Boardmembers to hold their policy questions for afterwards and to ask only clarification questions during the presentation. Ms. Miller then asked, regarding Ms. Uhlorn's description of existing uncertainties that we need to worry about, if the Department had gotten a legal opinion from the Prosecuting Attorney's office that even a reduction in a fee would be subject to a vote of the people. It's not ever been clear to Ms. Miller that that would be the case, but it sounded like maybe that's what Ms. Uhlorn was saying. Ms. Uhlorn said that the Department has not received a legal opinion on that subject. Ms. Uhlorn confirmed for Ms. Miller that in trying to increase fees, the uncertainty is that the Supreme Court hasn't decided exactly how that will work.

For historical information, Ms. Uhlorn showed a color chart of the food protection program fee history with a different year in each colored column. It shows different classifications of

permit activities and the permit costs. Dr. Pizzorno commented on Ms. Miller's question saying that if indeed there is an issue about raising the fees, it seems like we could do an interim or one-year drop in fees and every year choose to drop the fees, while still allowing others the option to restore those fees. And maybe we need a legal opinion on that, because Dr. Pizzorno feels very strongly that when we agreed to raise these fees so much last fall, 50 to 400 percent, that it was with the clear understanding that it was not necessary, we were back where we were. Dr. Pizzorno guessed that the question is whether legally the Board can just do a one-year reduction and still leave the basic fee structure intact. Mr. Nickels said that we'll research that. Ms. Uhlorn confirmed that we had not asked that question before. Ms. Uhlorn noted that there is no change between 1997 and 1998, and that was a year in which it was decided that there would not be a fee increase, but there was an increase in local support. Dr. Sherman asked if there are other fees for the qualifying non-profit tax-exempt organizations in addition to the rightfully reduced fee for their one-time charitable events. It was brought to Dr. Sherman's attention by someone involved with a non-profit that for an event there are apparently are additional fees charged for serving hot food or something like that. He asked is that true, and if it is, are there any reductions given to qualifying non-profits for those fees. Mr. Phil Holmes responded that either temporary events that qualify under a 501(C)(3) IRS status or permanent establishments do receive a reduced fee permit. It's not the full cost permit that a profit making organization pays for a food establishment permit. Mr. Nickels asked if this is the only fee they have to pay. Dr. Sherman clarified that this is for temporary food establishments, so it would be for an event, and asked again if there are additional fees for serving hot foods and inspections for maintaining appropriate cooking temperatures. Dr. Ngozi Oleru offered that they receive reduced fees for a more permanent type establishment for 501(C)'s. But Dr. Sherman said he was talking about temporary. Mr. Nickels asked again if there is just one permit fee they have to get from Public Health. Dr. Oleru answered no. Mr. Holmes explained that there's a plan review fee as well, and there's no exemptions for the plan review fee. Dr. Oleru indicated that it is not for hot foods. The plan review fee, according to Mr. Holmes, is generally for any type of temporary event. Mr. Holmes answered Mr. Sherman's inquiry stating that the fee is $25 and should be on the schedule. Dr. Sherman asked for clarification that Mr. Holmes was talking about the one the Board raised to $30 and there should be no further fees for qualifying. Mr. Holmes directed Dr. Sherman to look at the very bottom of the list to see, of the fee schedule, third from the bottom is the listing for temporary establishment. That's a plan review fee for any temporary establishment. What Dr. Sherman is reading from in the middle of the page is the actual permit fee. Mr. Nickels gave a scenario where the Bite of Seattle brings in a plan that shows where water and washing facilities are available. Mr. Holmes explained that there is a fee for the Department's plan examiners to review and assure that the temporary establishment has met at the appropriate stipulations in the food code. Then the permit fee is the fee for the inspection during event. Mr. Holmes confirmed for Dr. Sherman that there are two fees adding up to $55 rung up as one cash register transaction.

Mr. Pullen stated that we can argue about the specific fees and the logic for how much they should be rolled back, but he doesn't think it matters whether we roll most of them back, over half of them back or all of them back, and whether we do a fee reduction equal to the MVET replacement, or equal to the CX replacement or to some other formula. It's essential that the Board commit to some significant reductions, because that is what the Board indicated it would do. That was the intent stated to the public, and the Board's honor and credibility is at stake with a lot of other things if fees aren't rolled back. A lot of taxpayer groups are now looking at health actions very carefully. There's a Harborview bond issue that may be on the ballot later this year, and it's very tenuous as to whether it's will pass or not. If word gets out that the Board is going back on its word, it jeopardizes a lot of other things as well. Mr. Pullen strongly suggested the Board work towards a significant fee reduction and avoid getting hung up on fee to fee details.

Ms. Uhlorn's next two charts showed options for a fee change in the years 2000 and 2001. This chart gives the Board information on the impact of the same levels of action that it took in November of 1999. We'd be looking at reducing the fee by the level of MVET support or reducing the fee by the level of local support (CX) for each year. Ms. Uhlorn pointed out that the program budget is at the top of the chart, which is the total program expenditures. The fee revenues are the CX, educational visit, CX replacement, MVET replacement, other funding that is in the program in the year 2000, and what the challenge will be to Public Health. When the Board increased fees, it was to make dollars available for other programs in Public Health. So there would not be service reductions in the year 2000. Mr. Nickels clarified that the level of CX support for Public Health is a decision of the King County Council, and that decision has not been made for 2001. Although the Executive will make the proposal and it will receive due consideration, that decision will be made by the County Council and is a balancing act between different priorities. Mr. Nickels indicated that it is not necessarily one the way Ms. Uhlorn is laying it out, as other program cuts within critical public health services. Ms. Uhlorn indicated that these are two or maybe three options to consider, but the number of options are probably endless. It could be given in a flat number or a percentage, but this is giving the Board the information for this year and next year at the levels of action that it took last November.

Ms. Uhlorn described the information on the next chart. For the 2000 column, the budget is in balance and with no change in fees. All of Public Health's budget should stay intact, but this would be a decision by the County Council. Now that we have notification of our appropriation for MVET replacement, the County Council will make the final decisions as to where that funding will be allocated. Conceptually, there are sufficient revenues from the MVET replacement so that if those funds go back into the same programs there would be no service reductions for either Public Health or the community program. The next column is an option to roll back the fees by the amount of the MVET that was in the recommended budget. That would be $236,000, for the year 2000. The next column is to roll back fees by the amount of CX that was taken out of the food program and distributed elsewhere in the Department. That was $567,000. The last column is combining both options 2 and 3. Ms. Uhlorn confirmed for Mr. Nickels that $803,000 would totally roll back the increase. That would totally roll back the actions that the Board took in November. It would be a challenge then to other programs in the Department how we would pick up that funding. Dr. Pizzorno asked if that is the amount of money we're getting from the State, or is that the total amount that the fees would be reduced. Ms. Uhlorn answered that it was the latter. Ms. Uhlorn clarified for Dr. Pizzorno that the State gave us half of the MVET amount, but not any CX replacement. For 2001, following the same kind of pattern, we have what the program would look like with no fee reductions, if the Board took no actions to change the fees. We would have a revenue gap of $446,000 because of the costs that Ms. Uhlorn talked about earlier, of which labor is the predominant cost factor. For 2001, we reduce the amount of MVET replacement that we will be getting in 2000, which is $212,000, because we only got 90 percent, not 100 percent. The next 2001 column would be the CX replacement, and that would be a reduction of $567,000. The last column shows the impact for the 2001 budget as we know it today if the Board reduced fees by the amount of MVET and CX replacement.

Mr. Nickels stated that he agrees largely with Mr. Pullen's comments. When the Board adopted these fees, it did it in an emergency fashion. The Board did it because of what it perceived to be a crisis in our ability to provide a food protection program and some other services that met the needs of the community. We had gone through an extensive analysis of our food safety program as a result of the E. coli outbreaks and the Kingdome issues that were raised, and we determined that we felt the food protection program needed to meet federal Food and Drug Administration standards. We raised fees in 1999 to accomplish that.

In the year 2000 budget, we had the dual challenge of the County Executive cutting current expense funds that he proposed to go into the food program significantly, and I-695 cutting the motor vehicle excise tax. When the Board adopted the fee on the food protection program, we stated in the rule that we would revisit that. In our debate, we talked about what we meant by revisiting it. It meant that we might roll it back totally, consider a partial rollback or not roll back at all, but we would in good faith return to the issue and give it further deliberation. That's the purpose of our discussion last month and the briefing this month. Mr. Nickels proposed that the Board consider a proposed rule on those fees at its next meeting. Mr. Nickels would like the Board to consider a couple of issues on this. One, in the year 2000, the motor vehicle excise tax restoration is only 50 percent. We are not made whole this year. Next year we are largely made whole, it's 90 percent, but because of administrative reductions that the County Council took in the Health Department budget we are largely made whole. And because of the budget discussions we've had around this table and at the County Council, we are attempting to take a look strategically at how we are investing those local resources and not necessarily accepting that dollars are going to go exactly back to where they have been in the past. We're looking at public health nursing, chronic disease and contagious disease programs, and whether or not those critical areas are being adequately addressed. The issue of the current expense and the prioritization for it is a very delicate one. The budgeting issue is one that the County Council deals with in its annual budget. The point that we have seen in our deliberations over the last several months on budget indicates that our local investment in Public Health has been going down, and we are at risk as a result of that. Mr. Nickels doesn't accept as a fait accompli that current expense support will be cut in this area or any other area of Public Health. That's a debate that is yet to occur. But this does give a sense of the challenge that the Department is facing as they put their budget together. The Council will face it, and the Board will face it as policy makers in public health. That being said, Mr. Nickels believes that the Board has made a commitment to the public. He will be supporting some rollback of that fee, at least for the year 2001, when we have the substantial motor vehicle excise tax revenue restored. That's an important issue for our debate next month and potentially at our September meeting. Mr. Hutchinson wanted to know whether the MVET funding replacement was for two years or whether we are going to get funding beyond two years. Ms. Uhlorn responded that it will be determined in each legislative session. It's not an ongoing funding source, but it is now at least in their base budget. Ms. Uhlorn confirmed for Mr. Hutchinson and Mr. Nickels that it's in the base budget for 2000 and 2001, but not 2002 or any year thereafter.

Mr. Conlin stated that he very much respected the concerns that Mr. Nickels has raised, and the recommendations and suggestions that he made. He suggested that the Board ought to seriously consider an alternative of not taking any action until after the review is done. Mr. Conlin gave his reasons for this. First, there's a general principle that the Board ought to consider, which is the approach that he was taking when the Board looked at these fees. That is that a regulated business ought to pay the cost of the inspections that are being required in order for that business to carry out its business safely. That's the general principle we use in a lot of fees and policies that we've decided are important in order to protect public health and safety. It's what we do, for example, in worker safety, WISHA inspections, things of that nature. That's the basic philosophy. So Mr. Conlin's thought, when the it reviewed the food inspection fee, was that the Board ought to think about that principle as a long range aim for how to assess these fees. It's a cost of doing business. Mr. Conlin's not sure how burdensome it is to a particular proprietor, and that's certainty something we ought to consider very carefully, but it's something that the Board ought to consider as a principle. The other principle that Mr. Conlin is concerned about is that there are so many public health needs that do not lend themselves in any way to charging a fee to the proprietorship or person who is actually involved in the public health concern. Those programs, in turn, will have to be funded out of other sources, such as the CX or whatever

appropriations come from the State. From a public health priority standpoint, that's the kind of principle that Mr. Conlin would be looking at applying. Then examining what we're aiming for, Mr. Conlin believes it's important the Board reconsider what it said it would, in the event the Legislature restores full funding. It's true the Legislature has restored most of the funding, not technically full funding. That's okay. Mr. Conlin does believe it's appropriate for the Board to reconsider under these circumstances, but that reconsideration should be very carefully and thoughtfully done. As Mr. Nickels said, Mr. Conlin doesn't think it in any way implies that the Board made a commitment to roll back these fees, only that it would take a look at them. The final reason that Mr. Conlin thinks the Board should be very cautious in approaching this is because of the mammoth uncertainties that we're faced with in the future in regards to this. First of all, public health funding is uncertain. We don't know what's going to happen with the County's budget. We certainly don't know what's going to happen with the State budget beyond 2001. We need to be very careful about that, considering the need to cut funds for other public health priorities. Mr. Conlin doesn't think we can act on 2000 fees because it would be inequitable to roll back the fees for some entities in 2000 and not those who have already paid it. Mr. Conlin doesn't know if those have been paid at the beginning of the year or if it's spread out through the year. Ms. Uhlorn interjected that they've been paid. So, Mr. Conlin rejoined, 2001 is the only year the Board needs to address. In addition to those uncertainties there's also the legal uncertainties we have to face. We don't know the fate of I-695 in the Supreme Court. The question is, if we roll these fees back now and then look at further program expenditures in 2002, is this something we want to consider putting on the ballot, or should we reserve ourselves at least some capacity for the possibility of future expenses. Of course, if I-722 goes on the ballot and those fees are rolled back or put into litigation for another year or two that would be a further uncertainty. The prudent thing is to conserve our resources at this point, so we can reevaluate and look at it very carefully. But Mr. Conlin doesn't think there should be any commitment at this point to rolling back, and he would be very cautious about doing so. Dr. Sherman asked when the Court is taking up the I-695 matter, to which Mr. Conlin responded that he thinks the Supreme Court's hearing is in about a month. Mr. Nickels said that it was another week, that they're hearing it around the 28th and then they will take it under advisement. Mr. Conlin said that we have no idea when they'll issue a ruling. Mr. Nickels said that we might know at the July or September meetings. Ms. Pageler stated that we might not know for a year.

Dr. Pizzorno indicated that he thinks there are three significant themes here, and they all have merit. Number one is that we need to prioritize our public health dollars, based on what we perceive are the current needs rather than anything in the past. The second is that organizations and individuals should largely pay for the costs of our having to ensure the public safety, but not totally, because there is a public responsibility here, not just the a private responsibility. And third, we do indeed need to honor our commitments to the public, and Dr. Pizzorno thinks the Board was pretty clear. The representatives of the Small Well Owners Association come to Dr. Pizzorno's mind. These retired Americans have worked hard over the last several years to keep the Board educated. It bothers Dr. Pizzorno that we raised their rates 400 percent. It is not in this proposal to deal with that. Dr. Pizzorno not only wants to deal with this issue but indicated the Board has to look back at those, which he thought were egregious, and deal with them as well. Ms. VanDusen wished to reinforce what Dr. Pizzorno said, as she agreed with everything he said. Ms. VanDusen's feeling would be to try to honor some of that commitment, but the part that bothers her most as we talk as a Board about ways and policies and statements we may want to make to the County budget, is the fact that the local portion of public funds continues to be reduced in this area, and I'm assuming in public health in general. We see it in the proposal for next time, $46,000. So it continues to undermine, and this is an important public piece. Certainly the folks who prepare and serve the food and have a business have to pay a fee for that and inspection costs and the plan reviews. Ms. VanDusen can understand that, but that isn't the whole cost

of that program. One of the things the Board may want to consider is what isn't getting done in protecting the public from the avenue of food contamination and food borne illnesses. This outbreak on the Argosy cruise ship is a prime example, another agent, and we continue to have emerging agents that are food borne. We look to another part of the food protection program, the epidemiology and that ability to do the investigations of the illnesses. We thought that was abysmally underfunded. It was horrible to see that. Some of the most common ways by which those things occur is through food, and they can be transmitted secondarily through other ways. We have to take a hard look at the funding for public health. Ms. VanDusen would support a reduction in the fees, but when things settle out we need take a hard look at local funding and we've got to replace it. Money has got to be put back into the system from a centralized public funding base. Otherwise, we will get farther behind on one of the most critical ways to control public health, and that's the environmental controls.

Ms. Pageler commented that her instincts are with Mr. Conlin's. We deal a lot with regulatory programs that are required to pay for themselves. But looking ahead to the kind of contingencies we face, Ms. Pageler would like to see an option developed that provides some sort of equivalent to that MVET replacement. If the County Council wants to give more of a break, then the County Council needs to figure out how it's going to provide its dollars to appropriate them through CX. Mr. Nickels clarified that the fee decision is the Board's alone. Ms. Pageler responded that though the fee decision is the Board's decision, we have to know what resources we have. The resources that we know we have are the MVET dollars, and so those are the resources that Ms. Pageler thinks ought to be applied. She would not say a fee reduction, but some sort of rebate, because we don't know what the Supreme Court's going to do to us, what I-722 is going to do to us, and we do know that the costs of the program are increasing. Ms. Pageler would limit it that way, and would structure it not as a change in the fee, but as an interim based on this replacement of MVET dollars. She doesn't know whether it would be done for this year or just next year. Mr. Nickels asked if Ms. Pageler sees us collecting the money and rebating it back in some fashion. Ms. Pageler offered that it could be done all on the same form, giving an example of a fee of $125, less a $25 rebate and being paid $100 by check. It would be structured legally if the Legislature doesn't come through with that money in the next year. Mr. Nickels reiterated that then legally we have that fee in place. He said that that is similar to the question that Dr. Pizzorno asked and said that that option would be researched. Ms. Pageler added that it would respond the MVET replacement dollars. Dr. Sherman stated that he supports that concept because that also could result in a rebate for this year as well, for when they apply next year for their licenses. That's one of the issues we're trying to deal with, that the costs of trying to send money back this year is prohibitive in terms of the value you get. Dr. Sherman likes the idea of a rebate instead of anything permanent, because we don't know what's permanent. It's also in keeping with the position that the Board took with our contract with the public that if we got money back, we were going to return it. Mr. Hutchinson said that he would also associate himself with that arrangement. Mr. Nickels indicated that we will bring back this issue at our July meeting, that he will take the comments that we've had here and work with staff to formulate a proposal for the Board to consider. Mr. Nickels is unsure whether the Board will be able to act on it in July. We're going to need to massage it and see if it hits the mark, and then probably bring it back in September for action.

Mr. Nickels reopened General Public Comments with the Board's approval.

Mr. Kit Hawkins is a lobbyist for the State Restaurant Association. His normal duties are lobbying the Legislature in Olympia and not King County, so in a sense he's parachuting into this hearing. There are 10,000 eating and drinking establishments in the State. Close to a third of those are here in King County. This fee increase has caused anger and consternation, as you might well imagine. The Restaurant Association's phone in Olympia basically melted in the wake of the increase and we still continue to get calls. You have in front of you faith in government involved here. The fee before the increase must have borne some relationship to the cost of providing the inspections and that aspect of protecting the public health that does involve food service in restaurants. Our owners completely understand that. They also completely understand the obligation to protect the public health, and have no objections to fees that cover the cost to the extent that restaurants are involved in food service and have that obligation to protect public health. Mr. Hawkins has been listening carefully to the comments. We've all been around the block as being involved in government, and we know what can happen once a fee increase is in place. We know what can happen with dedicated sources of funds that do not come out of a general fund with the voters. It's far easier to tax us than it is to tax the voters. And as a matter of faith with the restaurant owners of King County we urge that the fees be rolled back appropriately. We're not interested in causing major budget reductions that were beyond your control, but we all know the basic parameters of this thing. The restaurant operators in King County strongly urge you to roll back the fees as soon as it can be done, fiscally appropriately, and to the full extent. Mr. Hawkins heard about new areas of concern, and a concern that those fees do cover the true costs of the program. In theory we have no legitimate objection to that, provided we have a voice and have some confidence that those fees only do that, and are not used as a source of funds for other programs. Mr. Nickels added a note that when the Board raised fees in 1999 to provide the fourth educational visit, the Association supported those increases and worked with us on that program. Mr. Gossett asked what the Association means that it wants to roll it back to the fullest extent, if that meant to the 1999 level. Mr. Hawkins responded the 1999 level would be the ideal, but the Legislature only restored 90 percent of the funds. The Association does not presume to be experts in the fiscal flows in King County. They believe there's room for reasonable people to arrive at a reasonable solution to this. Mr. Hawkins didn't want to come testify and make a rigid statement that would just make it more difficult for the Board vis-a-vis the extent the Board can take their views into account. Mr. Conlin commented that one of the things that he's still not completely clear on is what is how we determine what the actual cost of the inspections are. He asked if that's something that we can get further detailed information on, because that will help him in figuring this out.

(Continuation of Director of Health's Report)

Resolution No. 00-303 Supporting the Decision of the Seattle Metropolitan Area Waterfowl Management Committee to Invite the USDA - Wildlife Services to Control the Population of Canada Geese.

Mr. Nickels stated that this was an item that was brought to us in a letter from Ms. Pageler and Mr. Conlin. We received a substantial briefing in July of 1999 from the Seattle Department of Parks and Recreation and others. We also brought this issue up in April. In May we had a panel of experts come and review that information for us and explain the USDA process involved. The folks who were on that panel are all here today to answer any questions that members have. Mr. Nickels asked Roger Woodruff with the USDA Wildlife Services to tell the Board the latest news. Last time when we took this up there was a court case before a federal district judge having to do with a temporary injunction to halt the

controls. Mr. Woodruff confirmed for Mr. Nickels that the court case has been resolved. The preliminary injunction was denied by the district court last week, and our program is ready to move ahead in the Puget Sound area. To Mr. Nickels' question of what happens next, Mr. Woodruff stated that entities or agencies, individuals, and businesses that are experiencing damage with wildlife, geese in particular, contact their agency and request assistance. They provide a broad range of assistance with a lot more depth than just removing geese. They address all the non-lethal measures that can be adopted and advise the people to contact them on what those measures are. They work with people to resolve their goose problem, and in areas particularly of high priority health and safety where geese would have to be removed, then they would comply with that request. The cooperating entity has to pay for the service, because their agency doesn't have adequate funding in the field to provide assistance without it. That is the standard operating procedure. Mr. Nickels asked what effect, if any, would this Board of Health resolution have on the process. Mr. Woodruff responded that they are intending to move ahead, based on the findings of the court and based on the environmental documentation that they already have.

Mr. Nickels indicated that he was in the position where he had to postpone action on this due to a lack of an adequate number of boardmembers to act on this. Ms. Beatty suggested that the action be postponed temporarily to see if a quorum has not truly been lost, that members may return to the meeting. Mr. Gossett asked how many more members are needed, to which Ms. Beatty answered one. Mr. Nickels agreed to hold this for a few minutes to see if Ms. Pageler, Ms. VanDusen or Mr. Pullen return. Upon Ms. VanDusen returned to the meeting, Mr. Nickels indicated that there was a quorum so that Resolution 00-303 could be taken care of. Mr. Conlin moved to adopt the Resolution, and Mr. Hutchinson seconded the motion. Mr. Conlin spoke to his motion saying that we spoke fairly extensively about this at our last meeting, and again, this is not something that anybody is excited about doing. It's not something that we think is a great thing to do, but it appears that we have created this problem, and we need to address the issue of how to handle this unfortunate situation in our ecosystem. There are clear public health and environmental health effects here, and Mr. Conlin thinks it's something that we need to do. Mr. Thompson asked if a clear solution to the disposition of the carcasses has been announced, and if the Board's vote is moot. Mr. Woodruff responded that his agency is going to send some carcasses out for testing for heavy metals and pesticides. Until the results of those tests are back, they won't be donating any carcasses for public consumption. If the carcasses prove to be clear then they will attempt to make donations to any charitable organization that would like to receive the processed carcasses. Mr. Nickels addressed Dr. Thompson's question of whether the action is moot. He thinks it's more of a policy question. Mr. Woodruff has said that they're moving ahead in their process. This was requested by the City. Mr. Conlin responded to Mr. Nickels' inquiry of whether he still feels that this support is still something that he wishes to have, saying that it's still helpful, particularly if there is continuing litigation. Mr. Conlin thinks it's helpful for the Board to have taken a position.

Mr. Hutchinson asked what is the cost of processing the food for purposes of donating it. Mr. Woodruff answered that it's rather expensive. There's only about a pound of meat on a Canada goose at this time of year, which is a surprise, and the cost of processing ranges from five to ten dollars per bird, depending on who will do it, not including transportation costs and other things.

Mr. Nickels made a couple comments. He's going to vote yes, but he is a bit uncomfortable with this. When the Board has taken policy positions in the past, it's looked at the science, and then made its policy judgment based on that information. The science of this, in terms of public health, not in terms of other issues, are that Canadian geese provide a source of swimmer's itch, which is a public health issue, and annually we end up seeing beaches

closed, but the indication of more serious public health ramifications is much more speculative. Despite that, Mr. Nickels will support this resolution because he believes that, even though it is only speculative, there are potentially other public health problems down the road if we do not take some corrective action. One of the pieces of information that we've received was a graphing of the population trend among the resident Canada geese. It's a pretty alarming trend and a relatively severe action now would prevent a much more drastic action perhaps in the future. Mr. Nickels believes this is a reasonable preventive action. He does, despite that, continue to have some misgivings about the program. Dr. Thompson stated that he too is uncomfortable about killing the birds, but on the other hand, he thinks that it is irresponsible to allow the increasing fecal contamination of water, lawns and playgrounds to persist, and the Health Department has to advocate for preemptive action. Mr. Hutchinson would like to separate out and comment on the extravagant cost of processing the geese for food. Mr. Conlin and Mr. Nickels indicated that the motion does not call for the geese to be used as food. Mr. Hutchinson asked if the Board can do something to state an opinion about the costly processing the geese as food. With $5-$10 a bird you could buy chickens or something else for a lot less and provide that food to those people. It's taxpayers money, and Mr. Hutchinson feels it's irresponsible. Mr. Hutchinson consented that it was sufficient to have the minutes reflect his comment. The Board adopted Resolution 00-303 with a vote of seven in favor and none opposed.

Washington State Trauma System: Role of Harborview Medical Center.

Mr. Nickels introduced Dr. Scott Barnhart, Medical Administrator for Harborview Medical Center. Dr. Barnhart explained that the presentation will focus on Harborview, its role in the public health system and, in particular, on its role as part of the much larger trauma system in the State of Washington. He introduced his co-presenter Johnese Spisso who is Harborview's Chief Operating Officer. She is a national expert on trauma systems and has surveyed many trauma systems. The two of them will give an overview of Harborview, where it sits in the public health system and really focus in on the trauma system here at Harborview and within this central region. Harborview is a public hospital owned by King County with a very strong mission to serve as a safety net, both in the area of trauma, but also for all patient populations. Within that we play a very key role within the public health system in King County with a very strong focus as a Level I trauma center for this region, but really throughout a four-state region. In terms of the public health mission, a key component of what we offer is access to very high quality care. We do that from a public health perspective at the levels of primary, secondary, and tertiary prevention. Dr. Barnhart gave some examples. In conjunction with the trauma center we have the Harborview Injury Prevention Center, which takes data looking at accident rates such as bicycle accidents. In primary prevention mode, we looked at bicycle helmets as a way to reduce head injuries to obviate the need to have all the complex trauma support. In the area of secondary prevention, we have a number of programs, but the area of diabetes is a particularly good one. We all know that by managing diabetes well you can avoid many of the long-term complications such as renal failure. We are working here and with the community clinics to develop much tighter diabetes management programs. In the tertiary prevention area, as a Level I trauma center, we maintain a full team of specialists who are here on a 24 hour a day, 7 days a week schedule, 365 days a year. Our mission here at Harborview is a broad one, but it includes trauma and burns, care of the medically indigent and care of incarcerated patients.

Dr. Barnhart noted the Board's earlier discussion around the King County Jail and mental health. Mental health is a major component of what we do with the crisis triage unit, inpatient as well as outpatient facilities here. As was mentioned, we have the County Prosecutors here with the courthouse, so we really try and provide a broad set of coordinated services.

We serve the immigrant and refugee population. We have specialized centers ranging from sexual assault to domestic violence, and in the area of sexually transmitted disease. Our other missions include teaching, and we are one of the primary educators of medical professionals, ranging from medical students, in-house staff to nurses, respiratory therapists, pharmacists. Many of the health professionals throughout this region have trained at Harborview within this environment, and that has two important parts to it. One, there's very high quality care which is provided here, which sets a high standard of care for the community. But more importantly, there's a very important message that's sent out by the citizens of King County and the County Council saying that the Harborview is really here to serve the citizens, and that permeates all that we do. For the trained health professionals, it's an important message they take on.

Next is the area of research. We have a number of high quality research programs. One of the best programs is the Center for Age Research. In looking at the public health model, this Center addresses primary prevention, with areas such as behavior modification. Looking at the Center for AIDS Research, on a primary prevention level, there are research programs looking at behavior modification, clearly identifying the risk factors for transmission so that we can stop the epidemic before it even gets started. For secondary prevention, there's a very sophisticated clinical trials unit here. A good example of what they do is study a lot of combination therapies that we hear so much about. It's changing AIDS from a diagnosis that 15 years ago meant you only had 18 months to live, a quickly mortal disease, to one that is becoming a chronic illness. For tertiary prevention, there's a lot of research to determine the best treatment for those patients who have onset on complications of AIDS.

Harborview is truly a partnership. It's owned by the citizens of King County, and it's managed by the University of Washington. The County has generously funded bricks and mortar. This has been absolutely key to our providing a first-rate facility to meet these very broad public needs. As some of you know, there is a potential bond issue under consideration by the County Council right now. In addition, the University supplies the management and the faculty and there is a publicly appointed Board that oversees the operations of the Medical Center. We are a key safety net provider in the community. We are by no means the only one, but in terms of overall size and in dollars, we play a very key role within the County. Regarding the medically indigent, there are about 7,000 admissions, outpatient is about 200,000, inpatient mentally ill 3,000, but for the outpatient it's 100,000. These are large volumes of patients for whom Harborview clearly is able to provide a lot of expertise in its medical care. Dr. Barnhart confirmed for Mr. Hutchinson that was an annual figure. We go into a lot more detail, with trauma, about 45,000, sexual assault, 5,600. Dr. Thompson asked what numbers there are for inpatient pay. Dr. Barnhart responded that it depends on how you break it down. For commercial insurance, it would be about 38 percent, and that's because as the Level I trauma center we end up attracting a strong mix of patients, and that's very important to the overall financial stability of this Medical Center and its ability to provide for these very broad safety net purposes. Dr. Thompson concluded that it isn't really just the indigent who benefit from Harborview, but everybody does. Dr. Barnhart confirmed that, saying that it's really a broad range of the community that comes here. Anybody from any part of this County can be at Harborview and be in a clinic or be in a patient care room. You could have a top executive next to someone who may not have a roof over his/her head. We try and provide a single standard of care for all the patients and we really try and provide care that meets or exceeds community standards. As a Level I trauma center we have unique services that are not able to be replicated elsewhere. Looking at trauma as a public health program, this is an area where Dr. Barnhart thinks the public health model is a very important one. This is not just an area for which we should look at a single individual that's been injured, but one we should view more broadly as a public health model especially among the young. Trauma is a leading cause of death, but also as one ages, you are much

more vulnerable to trauma. So looking at good outcomes as people age is extremely important. Overall we see 15,000 who are triaged in the emergency room. About 4,500 are admitted. For trauma, Dr. Barnhart thinks about how this dialogue should go forward. Clearly there ought to be a focus on clinical outcomes. The outcomes are clearly related to having appropriate expertise, which is very important. Ms. Spisso will speak to that as she explains the trauma center. Expertise in trauma is clearly volume dependent. This is no different than many other areas. With cardiac surgery, for example, you don't get your open heart surgery at a hospital that's doing ten a year, where the surgeon is doing two a year. You want to go to the place that is doing very high volumes. So the outcomes are very much oriented towards that. Because trauma happens in the field, triage in a very organized and integrated system that identifies the patients' injuries, assesses them and gets them to the right level of care is very important. Dr. Barnhart turned it over to Ms. Spisso.

Ms. Johnese Spisso gave a quick history of the Washington State trauma system. Washington has a statewide system. Certain states have a statewide system such as Oregon, Tennessee and Pennsylvania. Other states have no formal organization and still other states have the authority delegated at county levels. The latter is the situation in California, which is why you see certain counties there having very robust trauma systems and other counties not having a process for designation. The model in Washington State, when you look across the country, is one of the most inclusive model systems, because we designed different levels of trauma centers so that every hospital can participate in some way. In a state like Pennsylvania, the only type of facility you can designate is a Level I or Level II. Oregon has Levels I, II and III because of the unique needs and the vast rural population. In Washington State, the system was designed to accommodate five levels of facilities. Mr. Nickels asked if a Level I in Pennsylvania is the same as a Level I in Washington. Ms. Spisso responded that standard Level I's and Level II's are in nearly every organized system and are the same because they were all based on the original criteria developed by the American College of Surgeons Committee on Trauma. Where you get into differences are on the III's, IV's and V's.

The Washington State trauma system began in 1990 with the passage of the Washington Trauma Care Systems and Planning Act, and Washington was one of 19 states that received development grants to initiate a trauma system. Out of that they set up the Washington State Department of Health, Division of EMS and Trauma, which was established for oversight responsibilities of the system, looking not only at care in the hospital but also in the three-hospital area. This was a separate division than the Department of Health Licensing Division that we work with just to accredit our facility as acute care hospitals. Between 1991 and 1993 there was an extensive consensus building process that was used to establish the rules for the provision of designated trauma services in this State. Again, it was based on the American College of Surgeons guideline with a lot of modifications made to that to reflect the unique resources in the State. With this process, the rules are reviewed and updated every two to three years through this same public process. We have extensive subcommittees of the Governor's Trauma EMS committee that do a review every year. The committee includes people from all the hospitals in Washington as well as pre-hospital and also some consumer groups.

The different trauma center levels that came out of our original planning for adult facilities are I, II, III, IV and V. There is a level V, for example, that is the clinic on Friday Harbor, which is not really well staffed, as far as the ability to handle complex medical care, but they have either a PA or a nurse practitioner that's on duty there. If someone is injured there, the PA or nurse practitioner could provide a quick screening and determine how to get that patient then to another designated center. That's the value of a participatory system. We now have 75 facilities in the State of Washington designated at some level. It really sets up

our network of having the Level III's, IV's and V's keep the type of patient that they can handle and then send the really critical patients with what we call major trauma to a Level I center, in this case Harborview, or the Level II in Spokane in eastern Washington. That model, as shown in some of the national data, of getting the right patient to the right hospital will continue to reduce the number of preventable deaths in Washington State. It's already had a very big impact.

The next category is pediatric. Because the numbers of injuries in children are a lot smaller, we felt that a hospital should be at least a Level III if it were going to see any type of child. In a three-hospital system, instead of getting someone to the closest hospital, they get them to the closest designated hospital. For pediatric patients, the State model includes only up to the Level III designation.

Rehab is the very newest component that was added to the trauma system in 1997. If a facility keeps trauma patients for the rehab component of their care, it has to go through a formal designation process to validate that it has the resources available to do that level of service, that is Levels I, II, III, IV, adults and pedes. In rehab care, because the elements are very focused, there are four Level I rehab facilities in the State. One of the goals with rehab is to reintegrate the patient back into the community. We looked at hospitals with strong rehab programs that could apply for the highest level of designation so the patient can be near their family when they're having a very long rehab course. Family is an active part of that rehab team. For our State rules, in the WAC there is currently a maximum of one Level I adult and one Level I pediatric trauma center for the State. That was based on the overall population of the State, the overall incidence of major injury, the patient flow and the system resources. As Dr. Barnhart mentioned, that's been one of the critical success factors. In a number of other states there have been issues both on quality of care and viability of institutions in the trauma system. That's because there was too much duplication of resources, too many Level I's in one metropolitan area, and no one was seeing enough patients to stay proficient. When the original guidelines were being written by the American College of Surgeons, they recommended that you see at least 500 major trauma patients a year. Each year since that document was originated in 1993, the levels have gone up, and now the latest document is calling for about 1,200 major trauma patients a year.

Dr. Thompson asked if the Cascade Mountains provide a significant barrier, sufficient that there ought to be a Level I east of the mountains. Ms. Spisso answer no, that there are two Level II's in Spokane each of which can see the same type of patient as a Level I. The only difference is the teaching and research components that Level I's are required to provide as well as burn care. For burns, because of the air medical transport that we have in this State in the northwest and with a lot of private carriers, we have enough rotary resources to get those patients to definitive care quickly enough.

Ms. Spisso described more specifically these various levels of designation and the key differences between them. A Level I is a facility that provides the highest level of definitive care and comprehensive care for patients with complex multi-system injuries. A Level I trauma center has to be available 24 hours a day, seven days a week, waiting for that patient to come in. All the different types of physician, nursing, surgical and surgical specialists need to be in-house and available. You can see why it gets very expensive, and the only way to make that proficient is if you have enough of these serious people coming in. Level I's are also responsible for research, professional and community education and prevention and for providing community outreach, not only to the local community that they serve, but to all the other trauma centers in the State. That's a key part of our role here at Harborview. Level II's can also provide care for the most complex patients. The exceptions would be burns and some multi-system trauma that gets into some of the more rare injuries.

Physicians and nurses are in-house and available to the trauma patient within five minutes. The surgical specialists, though, in this State are on-call and available within 20 minutes, so they don't have to be in-house. Then a range of specialists are also on-call within 30 minutes. In this State, we use Level III centers for stabilization and evaluation. If a Level III does the initial evaluation and rules the patient out for major injuries and have to admit them for more than transportation, it's perfectly fine to do that. A Level III can handle simple injuries, but if it's something that requires more specialized care, they phone and transfer the patient to the Level I. With the Level III's, physicians and nurses are available, but surgeons and most of the specialists are on-call and not immediately present. Ms. Spisso confirmed for Ms.VanDusen that there are a total of 75 trauma centers and that those aren't necessarily Harborview centers, but are designated by the State. Ms. Spisso continued saying that Washington is divided into eight regions for the purposes of trauma care. Each region sets the minimum and maximum numbers. In the central region, which is Seattle and King County, we have seven designated centers. Harborview is the Level I, and then we have three Level III's and four Level IV's. Our Level III's are Overlake, Valley and Evergreen. Our level IV's are Highline, St. Francis, Northwest and Stevens. Those facilities decide what level designation they want to apply for. Level IV's are found more in the rural areas. Cascade Valley Hospital in Arlington is a Level IV hospital, as are a lot of the smaller rural hospitals. They provide initial evaluation and have trauma trained nurses available in their ER. Some of them don't even have ERs, but use stabilization areas, and physicians are on-call. A lot of Level IV's use nurse practitioners or PA's to substitute the medical role, and the level V's are the same way. The clinic on Friday Harbor is an example of a Level V. Mr. Nickels asked what relationship, if any, do hospitals like Swedish or Virginia Mason have to the system. Ms. Spisso responded that Swedish and Virginia Mason are in the central region. Every three years when we open up the designation process, they have a chance to apply. If they choose not to apply, the three-hospital triage system in this area just doesn't deliver any patients to their door. That's been the nature of the way they want to continue in their business. Every three years they can reevaluate and if they want to come into the business, and then based on the number of minimum and maximums to be met, there can be opportunities for new hospitals to be designated. In the designation process, the State gets an external review team who are experts in the field from other states to come in and review facilities, medical records and outcomes, and validate that all the necessary services are available. The team makes the recommendation to the State as to whether the entity should be caring for trauma patients or not. Ms. Spisso answered affirmatively to Mr. Hutchinson's question of if it is the State who manages the trauma system. She further explained that the Governor's Steering Committee for Trauma and EMS is the guiding committee and there are subcommittees for hospital, day, pre-hospital and others. It's a very organized system.

Ms. Spisso recapped the history of the designation in Washington stating that in December of 1993 Harborview was the first facility designated. The roles were available and Harborview came up first as the adult Level I. Between 1993 and 1995, other facilities in the State were designated in this region as III's, IV's and V's. In November of 1995, the separate rules for pediatric care were written. Harborview worked collaboratively with Children's Hospital. We didn't want to duplicate services, so we said to Children's that we are very comfortable with providing all the care at Children's from emergency visit through resuscitation, OR and acute care. We've always worked closely with them to provide the rehab care. They agreed that they wanted to apply using a partnership model. So right now, the pediatric surgeons with Children's are consultants to our surgical team here. The rehab team from Children's Hospital does rounds every day on all of our injuries children, and once they're stable and their acute care needs are met, we transfer them over to Children's for rehab. Harborview doesn't provide pediatric rehab because there was no need for us to duplicate. We have a fantastic program over there. It's worked very nicely. After

implementing that model starting in 1995, other hospitals in the State have looked at a joint designation. The Level II's in Spokane share resources by rotating with one hospital being the Level II one week, and the other being the Level II the next week. Every three years we're re-reviewed and designated, and we just had our review in 1998. We were accredited as meeting all the standards for a Level I adult and pediatric trauma, and that will occur again in 2001.

In looking at Harborview's volume, the total numbers of injured patients triaged to its ER from the pre-hospital who are brought in private vehicle, is about 15,000. About 10,500 of those have an extensive evaluation in the ED, are seen by all the specialists, ruled out for injuries and later either discharged to home, jail, detox, psych or transferred from a lower level of care. We admit about 4,500 major trauma patients, which is a very brisk volume, but we think it's what's needed to maintain our expertise. Those patients go directly from the ER, they're all admitted to the hospital, and they go either to OR, ICU, acute care or they are people who died within the first 24 hours. Fortunately, there are not too many of those. Mr. Nickels asked over what portion of Harborview's admittance to the hospital 4,500 represents. Ms. Spisso answered that admissions and short stays, are about 17,000.

Dr. Barnhart took over to describe the strengths of the trauma center. He came back to the issue of patient volume. When you look at that 4,500, there's a range of trauma from fairly minor injuries such as a fractured wrist from a skateboard fall to a full-blown multiple organ failure. The studies indicate that your best outcomes are when you are seeing close to, somewhere between 500 and 1,000 of those very critically injured patients. Within the County, there are about 800 in terms of overall volume. For having an aggregation of the very sickest coming to a center, we're right at that point where we are able have enough aggregate expertise. Were we to begin to split that off into two or three, it's very likely we would drop below that, and there's evidence from around the country that outcomes begin to drop off. For Harborview's role as a trauma center, trauma is a vital component. It's a core mission of the hospital. There is a very substantial aggregation of clinical expertise here. Not only can we take care of people in the first few hours, such as many emergency rooms can do, but we have people with the expertise to take those patients to the operating room and do a lot of the very complex reconstructive surgery, whether it's facial fractures or pelvic fractures, we have that expertise here. There's a very strong commitment from the administration, the medical staff and from the Board to continue to make sure that we provide the cutting edge care for the patients here in King County. We're also blessed with some very strong components, including a state-of-the-art facility and technology. We're able to provide a full range of care. There has been a long history, now 15 years old, of a linkage between the Harborview Injury Prevention and Research Center and the trauma center. This way there's real time monitoring of the patients that are coming through and there's a system to begin to learn who those people are and think about how to improve outcomes. There are projects from bicycle helmets to looking at automobile crashes and what happens in an automobile crash and what can we do in terms of the out of hospital field assessment. A medic may look not only at the patient, but at the car, identifying the speed of the car and determining that there's a high probability, even though it can't be seen, that the spleen or the liver is ruptured in this situation. Similarly, we're saying if we're going to have cars with the air bags, we know air bags are great if you're Dr. Barnhart's size, but air bags are not great if you're 100 pounds. Harborview is looking at those much more complex issues to move into a prevention mode. There's a unique collaboration with Children's and Harborview has worked as a leader but in a collaborative manner with all the other Level designations throughout Washington State and even a broader region. Mr. Nickels asked if the relationship with Children's is helped by the fact that both part of the University of Washington teaching system. Dr. Barnhart said that, yes, even though Children's has a somewhat separate status from a faculty standpoint and throughout the whole academic

medical center, they work in an integrated way, and there's a lot of value to that. Whether it's patient care or investing in information systems, we can get a lot more sort of bang for the buck in pediatric intensive care. They provide us with a pediatric intensive care. We can provide that round-the-clock coverage for critically ill children in the pediatric intensive care unit here. If Harborview were to try to build and staff that on its own, it would be a much more expensive model. So there are real economies that we get from that relationship.

In closing, the key is that we at Harborview really want to optimize clinical outcomes. That is the framework from which all of this ought to be viewed. This is a good trauma center that looks at outcomes and employs quality assurance committees that look at how people do with these injuries in a very standardized facility. It's an area where information technology is really informing our judgments much better. We want to be very careful not to dilute volumes, because that's going to result in diluting expertise and will likely lead to a drop-off in the outcomes. It's very important that the issue of appropriate triage be looked at, because those early decisions in a trauma patient are very important. Finally, to have all this in a quality improvement program, so that there is a clear review, as there is in the trauma center, of the clinical outcomes to make sure that we're providing the very best care, not just here but throughout the whole trauma system in King County.

The meeting was adjourned at 12:32 PM.

KING COUNTY BOARD OF HEALTH

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s/Greg Nickels/s, Adopted July 21, 2000