KING COUNTY BOARD OF HEALTH
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Carolyn Edmonds, *Board of Health Chair*

KING COUNTY BOARD OF HEALTH MEETING PROCEEDINGS

April 19, 2002
King County Council Chambers

Roll call

- Richard Conlin
- Jan Drago
- Carolyn Edmonds
- Ava Frisinger
- Larry Gossett
- David Hutchinson
- Margaret Pageler
- Joseph Pizzorno
- Alvin Thompson
- Karen Van Dusen

Members absent: David Irons

Call to order

The meeting was called to order at 9:30 a.m. by Board Chair, Carolyn Edmonds.

Announcement of Alternates

No alternates in attendance. Chair Edmonds welcomed new Board member, Seattle City Councilmember Jan Drago.

Approval of March 15, 2002 Minutes

Discussion

Board Member Hutchinson observed the length of the meeting minutes and inquired about the Board's interest in revisiting the length, style and format of the meeting minutes. A discussion ensued about the pro's and cons of meeting minutes vs. meeting proceedings ie., time spent developing minutes; desire to have minutes that served as an archival record of Board proceedings.

It was noted that copies of the verbatim meeting transcript were available upon request in the following formats: electronic copy of WORD document, audiotape, and videotape.

The Board Chair made an executive decision as follows: Staff to develop meeting proceedings instead of minutes; Staff to make available copies of the audio transcript upon request to Board members and others.

Board Chair Edmonds requested that Board members contact her if the meeting proceedings did not appear to be satisfactory at which time the Board could elect to revisit the issue in a couple of months.

Motion: A motion was made to approve the minutes of March 15th, 2002. The motion was seconded and passed unanimously.

General Public Comments

There were no public comments.

Chair's Report - Carolyn Edmonds

Comments V-1:

Legislative update. House bill 1759 [needle syringe- reducing transmission of blood-borne disease]

Efforts to secure Governor's veto of "Hargrove" amendment were successful. Hargrove amendment, if it had been retained, would have placed physicians in the precarious position of being a needle exchange service. Senate Bill 6588 [food service rules] Efforts to secure Governor's veto of SB6588 were successful. Concerns remain and much work between sessions will be needed. The State Board of Health will be looking to update the State food code and Public Health Seattle and King County and the King County Board will support that effort. Chair Edmonds instructed staff to keep the Board apprised of any new developments and/or opportunities related to the development of food service rules.

Tobacco settlement - letter to the Governor: Per the request of the Board, Chair Edmonds wrote a letter to the Governor expressing displeasure with the securitization of the tobacco settlement funds. Chair Edmonds received a letter in response from Attorney General Gregoire.

Comments V-2:

Chair Edmonds reported on a WSAC [Washington Association of Counties] conference she and Board Member Lambert attended. Chair Edmonds filled in for Dr. Plough on a panel discussion about public health funding.

Comments V-3:

Meeting with Western Region FEMA Director: Chair Edmonds noted that, former legislative colleague, John Pennington, was now the FEMA Director for the Western region. Chair Edmonds announced that a meeting had been scheduled to meet with Mr. Pennington, Mary Selecky-Secretary of Health, Dr. Plough, and Chair Edmonds to discuss the distribution of FEMA funding in Washington State.

Comments V-4:

Letter of Support for Housing Grant: Chair Edmonds announced that the Department would be submitting an application to the Centers for Disease Control and Prevention for a community-based participatory prevention research grant. The stated purpose of the grant is to improve housing conditions, and to work with policy makers, tenants, landlords and other community partners to design guidelines for healthy housing. The Department had requested a letter of support from the Board of Health.

Discussion: Board Member Lambert called for inclusion of funding for interventions that teach basic skills in cleaning and maintaining housing. She advocated that a postscript be added to the letter to express support for basic cleaning skill development.

Board Member Van Dusen stated that the grant represented a wonderful opportunity if it was financially viable, given the current budget climate. She noted that housing and health assessments were traditionally included in housing codes and that to her knowledge King County did not have a housing code. She stated that perhaps this grant application represented an opportunity to take a look at the need for a housing code.

Dr. Plough responded that the grant application did not require a match. Those grants that do require a match go through an additional level of review to assure budgeted funds are available for said match. Dr. Plough concurred that there was indeed no existing code that dealt with health impacts of housing. He indicated that this grant represented an opportunity to begin the dialogue about the importance and inter-relatedness of health and housing.

Motion: Motion made to submit a letter of support for the Department's application to the CDC with the proposed amendment offered by Board Member Lambert. Moved, seconded and passed unanimously.

Comments VI-1:

Regional preparedness – Bioterrorism

Dr. Plough introduced the Board briefing on regional preparedness related to bioterrorism and other public health threats and emergencies. Dr. Plough provided the following background information:

- Preparedness to public health threats and other emergencies is a significant local, regional and national issue;
- Recent federal funding represents the most significant infusion of money to public health in several decade;
- Application for funds developed along guidelines developed by the Centers for Disease Control;
- Application submitted by State Department of Health prior to the April 15th deadline.

Issues that arose, across the nation, in application development were related to the lack of specificity about how dollars would be allocated, particularly the role of local public health departments versus state health departments; coordination with hospital response; activation of a national pharmaceutical stockpile; and lack of guidance from federal government around the incorporation of risk, threat and population assessments necessary in the allocation of money to locals.

Following on the heels of productive discussions with the State - Public Health has been allocated about $2.25 million out of the total State allocation of $18.2 million, which will give the Department a down payment on certain elements of the plan. Future discussions with the State will be necessary regarding the next round of funding in order to assure that funding allocations recognize increased risk and complexity of certain counties/regions without compromising a certain level of preparedness across the state.

Overview of Department Plan: Presented by John Wiesman, Dr. Jeff Duchin and Byron Byrne.

A. Bioterrorism (BT) Background

Critical differences between bioterrorism and conventional terrorism. First responder community - fire and police - takes the lead in responding to conventional terrorist activity. Public health and health care providers are the first responders in biological terrorist events. Biological events include covert releases of agents, followed by individuals feeling sick, going to emergency rooms, seeking medical attention. Potential for thousands of casualties and for event to go unnoticed for some time depending on the type of biological agent released. Critical that public health is prepared, ready to control an epidemic, ready to identify it early on and take appropriate prevention measures.

Number of agents, including anthrax and smallpox; agents that are easily disseminated and transmitted from person to person and because of that are useful as weapons. Additionally, populations are susceptible to these agents because they are not agents that the average citizen has resistance or immunity to; therefore they cause a high degree of morbidity and mortality. Diseases not familiar to physicians; difficult to diagnose and treat; potential to cause panic, social chaos, economic disruption. Require special action for preparedness.

Most dangerous bugs that are thought to be likely used as bioterrorist agents include: smallpox, anthrax, plague, tularemia, botulism and viral hemorrhagic fevers. In addition, there are others-- acute fever or glanders, brucellosis and some toxins, ricin toxin, epsilon toxins, staphlococcus enterotoxin B --- that have been known to have been made into weapons that are quite easily and readily disseminated and would be very effective. An acute fever outbreak won't be as deadly as a smallpox outbreak, but would cause a huge degree of social and economic disruption and chaos in the community - fear and resultant ramifications. Some of more or less routine bugs that are in the environment can also be used as weapons - salmonella, shigella, e-coli, vibrio cholera, and cryptosporidium. Some agents that are less readily made into weapons but clearly have the potential to be used in that fashion include the hantavirus, multi-drug resistant tuberculosis, Nipah virus, encephalitis viruses, hemorrhagic fever viruses and yellow fever.

Smallpox facts:

- World Health organization declared smallpox eradicated in 1980;
- One of diseases that is driving bioterrorism preparedness nationwide due in large part to the fact that the disease killed approximately 300 million people in the 20th Century alone;
- Unlike anthrax, is transmitted person-to-person and it kills an average of one-third of those it infects. In the very young, the elderly and patients with underlying underlying medical conditions it may kill up to 60% to 70;

- No effective treatment for smallpox. Immunizations halted in 1972.
- Vaccine has significant adverse effects such as death and permanent neurological sequelae in one to two per million. Other adverse effects such as dissemination of the vaccine virus. Estimates re: immunization of King County population would result in minimum of one to two deaths, one to two people with permanent neurological sequelae and ten or more patients requiring hospitalization for serious complications. Estimates based on immunizing a population that does not have the numbers of immunocompromised persons, or persons with cancer, or persons taking other drugs for arthritis that might suppress the immune system, or people who have HIV infection, that the King County population has today; therefore would expect the complication rate would be much higher today than it was prior to the time smallpox vaccine was discontinued.
- Single case is considered a global public health emergency for the above reasons.

Smallpox challenges:

- Training health care providers to recognize cases;
- Identifying facilities to evaluate, isolate and care for cases;
- Rapid identification of all contacts of cases;
- Quarantine of contacts and suspected cases;
- Immunization of at risk persons: health care providers, first responders, public health workers, contacts of cases;
- Follow up of immunized persons;
- Planning for societal chaos and disruption of essential services;
- Communication strategy to talk to the public, political leaders and to other health care providers about the disease rapidly, effectively and clearly.

Comments VI-1:

Regional preparedness - Bioterrorism

A. Bioterrorism (BT) Background

Questions:

Q: ***Degree of difficulty in diagnosing disease?***
A: An advanced case of smallpox should be readily recognized. The problem is by the time a case would reach that stage of disease it would have spread through several more generations. So the challenge is to identify the smallpox case early before they reach that terminal stage and the disease has been transmitted to several more generations of susceptible persons.

Q: ***Legal authority to quarantine people?***
A. The health officer does have the legal authority according to Washington Administrative Code to impose quarantine. Quarantine remains a challenge in that it has not been used in a very long time. In order to have mandatory quarantine for any reason need to work out ways to insure that should that need arise, the appropriate mechanisms are in place that it will happen smoothly and efficiently.

Q: ***Implications of risks associated with smallpox vaccine?***

A. There is a national debate going on about the risk of small pox re-emerging and the risk of the vaccine and weighing the cost benefit ratio therein. This debate involves the CDC, the Advisory Committee on Immunization Practices, representatives from the health care and hospital communities including infectious disease physicians, first responders, emergency room doctors, even down to the local medical society level.

In order to make a determination about whether or not to vaccinate need to secure information on: how likely we are to see smallpox in the future and whether or not we can selectively immunize portions of the population to give some degree of protection without the risk involved in immunizing the entire population.

Q ***What is the relative risk of exposure in King County versus a less populated area of Washington State?***

A. The risk in a densely populated urban area is very different than the risk in a more rural or less densely populated area. Urban areas have airports, seaports, large facilities that attract large numbers of people that could be exposed to a transmissible agent at the same time, leading to a rapid, explosive spread of any transmissible agent throughout the population. There is a lack of confidence that a smallpox case would be identified early. Physicians have not seen smallpox, nor has there been training of physicians in King County or elsewhere to recognize the disease or communicate effectively with public health. Related to smallpox, even in the absence of readily available health care personnel, such as is sometimes the case in more rural areas of the state, an person infected with smallpox soon becomes sick enough to seek medical attention.

Board members comments underscored the need for provider training in detection of smallpox as well as community education about the need to respond for the greater good if quarantine were required.

Q. ***Discuss the concept of "circle of immunizing"?***

A. The ring vaccine strategy was used to eradicate naturally occurring smallpox from the 1950's through the 70's and 80's. The ring vaccine strategy involves the vaccination of one case and all the contacts of that case very rapidly. The ring vaccine strategy is the preferred CDC strategy, although there is debate about its merits. The other alternative is to pre-immunize the entire population. In the absence of a community-wide outbreak it is not necessary to pre-immunized at this point in that first responders are no more likely to come into contact with smallpox than anyone else is. Should there be a community-wide outbreak, first responders would be among the very first to be immunized.

Q. ***Comment on the symptoms of smallpox?***

A. The symptoms of early smallpox can be mistaken for other diseases like chickenpox or other types of diseases that have rashes. There are about four or five other things that could be mistaken for smallpox in a differential diagnosis.

Q: ***Is there consideration being given to training and education of first responders?***

A. Education and improving relationships with the first responder community is very high on the Department's agenda.

Q: ***In regards to the proposed model legislation developed at the federal level, would the model law address concerns about quarantine and other issues?***

A. Relative to the model law the State had convened a group to review the model law and made a preliminary decision that it would not apply here in Washington State. Work will continue related to the legal framework for quarantine both at the State level and in King County.

Q: ***How long does it take before the vaccine's effective?***

A. Immunization against smallpox within three or four days of exposure would be beneficial and effective.

B. Public Health Role

Detection and evaluation of biological disaster:

- Rapidly identify population at risk;
- Adequate number of designated, trained staff;
- Backup staff [cross-trained, recall mechanism];
- Surveillance - traditional and new methods;
- Need complete, timely reporting from hospitals and clinics;
- Epidemiology/disease investigation and control plans;
- Ability to augment resources - staff, equipment, space.

Response - facilitate medical management of exposed persons:

- Provide information on diagnosis, treatment, prophylaxis and infection control issues;
- Local drug and vaccine stockpiles;
- National Pharmaceutical Stockpile management;
- Mass treatment and/or vaccinations;
- Identify reservoir of volunteer staff and medical professionals;
- Communication with hospitals and other medical caregivers;
- Quarantine;
- Public health law.

Emergency Management and logistics:

- Integrate BT response into existing disaster plans;
- Facilitate hospital preparedness: biological disaster planning and response;
- Medical professional credentialing and privileges;
- Mass casualty plan including triage and medical care;
- Mortuary capacity;
- Psychological support.

Information and communication:

- Provide information, education and training to health professionals, government leaders and the public;
- Emergency Operations Center;
- Public Information Officer - media relations ready made information sheets, web site, internet access, broadcast fax;
- Augment phone capacity and trained staff to take inquiries;
- In-service training.

Questions:

Q. ***In an incident of bioterrorism in the State, would that fall under the jurisdiction of the State Patrol, the National Guard or others?***

A. If it crossed jurisdictions, then incident response responsibility would fall to the State. The Governor has the authority to declare an emergency and if a biological disaster or a large outbreak, intentional or otherwise, crossed County lines, the Governor could invoke his powers to declare an emergency at which time the State Emergency Response Plan would kick in.

Q. ***If there was an onslaught of patients to area medical care facilities we could expect a corresponding increase in the amount of biohazardous waste generated. Do the plans address issues related to infectious waste?***

A. The volumes of waste would skyrocket. The truly dangerous type of waste could be adequately taken care of onsite through washing with a certain concentration of bleach and/or disinfectant and through infection control procedures. It isn't necessary to invoke new or unusual types of waste management procedures and will not be one of the areas that would be severely stressed because there are some readily available disinfectants that could be used. However, supply of these disinfectants may be strained.

C. Foundation for BT Response

Foundation for a bioterrorist response:

- On-call coverage 24 hours a day - 7 days a week - 365 days a year;
- Comprehensive emergency response plan;
- Incident command structure so as to communicate across jurisdictions during times of emergencies;
- Strong communicable disease program;
- Qualified staff on-site at emergency operation centers [King County Emergency Operation Center, Seattle Emergency Operation Center, and Public Health Emergency Operation Center.] Coordination, planning and deployment of staff is done out of the Public Health Emergency Operation Center;
- Strong relationships with many diverse community partners ie., pre-established relationships with law enforcement and medical providers and community-based organizations;
- Informed policy makers. Policy makers are going to be faced with needing to make certain decisions along with public health. When do you vaccine and when do you not vaccine? Quarantine - how are we actually going to implement that if we actually need to do that?
- Prepared medical and public safety systems;
- Robust communicable disease disaster response capacity;

- Well trained surge capacity workers.

Questions:

Q. ***Is there a protocol regarding who needs to make what decisions?***
A. The answer is "yes" related to many of the general emergency issues. The Department continues to educate people around the specific issues related to bioterrorism. There is a clear communication protocol with the executive offices and branches related to BT response and this communication protocol is reflected in the General Emergency Plan.

Planning priorities:

- Coordination of county medical, first responder and disaster management resources and response protocols;
- Continue to engage hospitals and medical professionals as well as community organizations in BT preparedness planning;
- Coordinate and engage local state and federal resources;
- Increase capacity for providing education, training and information.

Anthrax Outbreak - 2001:

Locally, 250 and 260 suspicious powder incidents that required a response. Twenty-five of those were based on information that Public Health deemed to be credible threats and were sent on to the Public Health Lab for testing - none of them were actually positive for anthrax, but 260 events that the County had to respond to. Resulting flood of calls, e-mails; need to quickly develop protocols and training around safe mail handling. The Department accelerated Department-wide planning through the establishment of 12 work groups as well as formal engagement of the Washington Hospital Association.

SeaTac Smallpox Scare: December 7, 2001, 4:00 p.m.

- Incoming passenger reported to have smallpox;
- On-scene response coordinated by Port of Seattle Fire/Hazmat and Public Health Communicable Disease Team
- DOH, CDC and Washington, DC notified;
- Plane quarantined, individual interviewed by law enforcement and physical exam by paramedics and public health physician.
- Press Conference, 6:00 p.m.
- Evening - confirmed hoax.
- Follow up with CDC, individual tracked throughout duration of stay.

Resource Impacts – Public Health

- September 11 - October 14, 2001: 2,450+ staff hours
- [61 40-hour work weeks]
- September 11 - December 31, 2001: $350,000+ in personnel and other expenses redeployed BT response efforts.

D. Usual demands

Since 9/11 Communicable Disease section investigated 3,035 disease reports:
- 66 outbreaks
- 578 enteric disease reports
- 420 foodborne illness complaints
- 360 general communicable disease reports
- 1,677 hepatitis reports

Current BT preparedness:

- WTO surveillance system ---syndromic surveillance system: an automated, electronic surveillance, from hospital emergency departments in King County.
- Biological Emergency Response Team {BERT}
- King County Hospital "CEO/Medical Director Outbreak Response Work Group"
- Pharmacy coordination and mutual aid;
- Joint protocols with first responder agencies.
- WA State Terrorism Response Plan - management of National Pharmaceutical Stockpile and distribution plan;
- Enhanced communication with Emergency Department and Infectious Disease professionals via listserves;
- Public Health bioterrorism website;
- Collaborations with University of Washington: training, clinical response, surveillance system;
- CDC collaborations - smallpox and Division of Quarantine

Federal Grant:

Regular print = funding to support;
Italics = commence work, but no resources allocated.

Area A: Planning and Readiness assessment

- Establish a regional BT response planning advisory committee.
- Assess current response capabilities, identify desired improvements and establish implementation timelines;
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- Develop regional response plans with Pierce, Kitsap, Snohomish and DOH.
- *Coordinate and develop a smallpox response plan and pandemic influenza response plan.*
- *Further develop and exercise mass treatment and immunization plans.*
- *Identify appropriate facilities in KC for potential isolation and quarantine.*
- *Train public health staff to assist DIH in NPS push pack distribution.*
- Participate in planning for TOPOFF II {Top Officials} and exercising of plans.

Questions

Q. ***What is TOPOFF II?***
A. TOPOFF II is a follow-up from TOPOFF I which was staged about two years ago. It's a national exercise involving multiple sites. TOPOFF 2 will occur May of '03, and the players at that moment include Chicago and the State of Illinois, and Seattle, King County, and the State of Washington. The exercise will be a comprehensive real time exercise for the most part. It'll take place over a number of days. There will be a

scenario that will pose issues for local first responders, health care providers, and public health. Because of the focus on Top Officials, it will also involve your local elected officials to a degree that they haven't been involved in an exercise of this scale before. The scenarios will be somewhat interrelated. The particular scenario has not been decided. The exercise is run under the Department of Justice and is being largely funded by federal monies.

- *Develop Environmental Health (food, air, water) prevention and response plans;*
- *Exercising plans.*

Area B: Surveillance and Epidemiology Capacity

- Develop investigation and response protocols with computerized databases.
- *Develop and train rapid response teams capable of conducting field investigations, rapid needs and exposure assessments and response activities.*
- *Ensure sufficient epidemiologic staffing capacity to manage routine workload with the reportable disease surveillance system*
- *Educate and provide feedback to health care providers about notifiable disease and diagnosis of BT related diseases.*
- Collaborate with DOH on developing a secure web-based communication and reporting system;
- *Further develop fact sheets and educational materials.*
- Educate policy makers regarding public health investigation, response and disease control.
- GAPS: Assessing timeliness and completeness of reportable disease surveillance system.

Area C: Laboratory Capacity - Biologic Agents

- Collaborate with DOH and train Public Health Lab staff to test for BT agents and safely package and handle specimens.
- Add biological safety cabinet and improve security of lab.
- Implement electronic laboratory reporting.
- GAPS: courier services

Area E: Health Alert Network

- *Collaborate with DOH to implement electronic alert systems with public health, hospitals, laboratories, health care providers and first responders.*
- Assess backup notification systems.
- GAPS: assessing electronic infrastructure and testing security systems, acquiring and implementing wireless broadcast technologies, redundant electronic communication systems for EOC.

Area F: Risk Communication and Health Information Dissemination

- Develop communication strategy in case mass treatment or immunization is required.
- *Develop public awareness and community education campaigns for BT preparedness and response.*
- *Develop fact sheets tailored to key audiences.*
- *Create Public Health Emergency Operations Plan to mobilize call-up rosters.*
- GAPS: Conduct assessments of communication needs with special populations (e.g. limited English speaking, refugee, immigrants, homeless, mentally ill and people with

disabilities), development of a call-in center for public information, triage and follow up, exercising of plans.

Area G: Education and Training

- *Assess needs and develop training programs for Public Health Staff and community agencies*
- Create a training database to monitor progress in completing and maintaining community training.
- GAPS: distance learning equipment, speakers' bureau, first responders training and other community partner training.

Regional preparedness - Bioterrorism

First Steps

- Create Emergency Management unit in the Director's Office responsible for overseeing and implementing general and BT preparedness
- Hire additional communicable disease epidemiologists
- Hire Environmental Health planner
- Hire Microbiologist
- Hire Health Educator
- Hire a communicable disease Public Health nurse
- Begin upgrades to Public Health Emergency Operations Center
- Increase safety of the Public Health Lab

Benefits

Preparedness for biological terrorism will improve our response to inevitable, naturally occurring outbreaks including biological disasters and other health threats.

Pandemic influenza - a real thing and it's coming up. We have outbreaks of disease all the time; Outbreaks of recognized diseases (E-coli 0157:H7, Meningococcal meningitis, pertussis); New emerging infections {West Nile Virus, Hantavirus);

Other disasters requiring coordination of resources and mass casualties.

Questions:

Q. ***What is the Department doing to address the needs of staff whom are in the role of first responders?***

A. The Department does not have anything formal in the current plan. The Department hopes to hire additional staff so that current staff can afford to take time off. The expanded plan would allow for additional medical epidemiologists, so that the Department has more surge capacity and real time support and backup.

Q. ***What would the Board of Health's role be in the event of a future emergency?***

A. In the short term the Department needs to work with the Board to assess the level of preparedness capacity as it relates to the overall budget and the mission. In addition the Board is key insofar as rulemaking to assure that those scenarios that might evolve are adequately addressed in the context of rules and regulations. Chair Edmonds added that the Board's role, as public health leaders, is to be the stewards of the health of King County residents by becoming educated, informed, and

knowing the answers to questions. As well as taking on the responsibility of mitigating public panic when it starts to occur or begin to take the steps to prevent public panic should it become apparent that that might also occur.

Q. ***What is the probability of any of the 15 agents showing up on in King County? What is the process they would have to go through to create these agents that would be a problem, how would they distribute it and then also how fragile are they?***

A. Dr. Duchin to respond in writing to these questions.

Q. ***When looking for those settings or places where people with a communicable disease can be taken, is the Department looking at both sides of Lake Washington?***

A. Yes, the Department is looking throughout the County.

Q. ***Regarding the smallpox hoax, when the man was interviewed coming off the airplane were the first responders in hazmat uniforms?***

A. Initially the responders were fully suited in maximal protective gear and as more was learned they removed layers of protective gear.

Q. ***Where is the State Lab located?***

A. In Shoreline.

Q. ***Is the Department coordinating in any way with the State Toxicology Lab?***

A. The Department is tied in with the State Toxicology Lab only because most of the things discussed in the briefing are infectious agents and the bacteria and viruses. The type of toxins that the Toxicology Lab would be assaying for, wouldn't be the type that the Department would be concerned about within this context. The Department would rely exclusively on the State Toxicology Lab should there be a scenario that would be appropriate for toxicology testing.

Q. ***Does the Department plan to do any training of local officials so that they will be able to step in to assist with such activities such as staffing phone banks?***

A. The regional health officers will be engaging local elected folks to determine roles and to provide the education piece. The Department has training objectives in the grant proposal that were not funded. Training of public officials wasn't funded in the State plan adequately, so at this point the Department has some excellent resources readily available on the website.

Q. ***Are there materials available for Board members to use in educating the public, aside from the actual broadcasts of the meetings?***

A. The meetings are broadcast and there is information available through the Department for Board member's use.

Q. ***What are the details of the communications protocol that connects the emergency operation centers, the three centers that are potentially operable, and then the connections back to public officials and the role that the Board might need to take on in this kind of a situation?***

A. (answer not available)

Q. Does this present an opportunity to bring in private partners who might be interested in doing some public service work, particularly in the marketing and communications field in helping out on this kind of communication?

A. Communication with the public is a formal part of the Department plan; to educate the public formally about smallpox, about some of these agents, about what types of response the public would need to do about quarantine. What is it? What might we need to do it? What's it all about? so that people are comfortable with these concepts should the Department need to use them. Something that might be useful to the Board would be to provide some of the debriefings from the first TOPOFF exercise, and another similar exercise called "Dark Winter." Board members might be interested in reading some of the critiques of what happened with the involvement of public officials and where the stumbling blocks were, and that would probably be very useful in the context of understanding what to expect with TOPOFFII.

Other Business

June meeting will focus on communicable diseases. Staff is exploring the possibility of holding the meeting at the Public Health Lab. Also slated for the June meeting is recognition of the King County Health Action Plan Community Benefits Program members, an overview of the Health Action Plan's "Kids Get Care Program", and the public hearing on on-site septic system (OSS) fee package.

KING COUNTY BOARD OF HEALTH

Carolyn Edmonds, Chair