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
Friday, September 17, 2004
King County Council Chambers
MEETING PROCEEDINGS

Members Present: Carolyn Edmonds, Julia Patterson, Tom Rasmussen, David Irons, Steve Hammond, Richard Conlin, Frankie Manning, Ava Frisinger, Kathy Lambert, Larry Gossett, and Jan Drago

Members Absent: David Hutchinson, Bud Nicola, and George Counts

Staff: Alonzo Plough and Lisa Werlech

I. Call to Order

The meeting was called to order at 9:42 a.m. by Board Chair, Carolyn Edmonds

II. Announcement of Alternates

Chair Edmonds: No alternates present.

III. Approval of Minutes

A motion was made to approve the July 16, 2004 meeting minutes. The motion was seconded and the minutes were approved.

IV. General Public Comments

None.

VI. Chair's Report

Chair Edmonds stated that she was unable to attend the State Board of Health meeting, but invited Board Member Manning, also a member of the State Board of Health, to brief the Board on the State's meeting. According to Board Member Manning, there were two primary rulemaking issues:

- WAC 246.215 - Revision to the food code brings Washington State in compliance with federal regulations and changes;

- WAC 246.260 - Transient accommodations were exempted from homeless shelters.

Benton County also gave an update regarding its food and fitness program.

Chair Edmonds discussed the September 15, 2004 Overweight Prevention Symposium, which was sponsored by the King County Board of Health, Public Health – Seattle & King County, and the University of Washington School of Public Health and Community Medicine. The symposium was attended by almost 200 individuals comprised of representatives from school districts, government, academia, transportation, urban planning, health, media, business, and food distribution. The symposium began with a plenary panel of four national experts:

- Dr. Deb Galuska, Center for Disease Control, provided an overview of the national obesity epidemic;

- Dr. Adam Drewnowski, University of Washington Nutritional Sciences Program, addressed a regional and economic perspective of obesity;

- Dr. Larry Frank, School of Community and Regional Planning, University of British Columbia, discussed community walking on population weight;

- Dr. Abigail Halperin, University of Washington, discussed applying tobacco cessation efforts to reduce diseases caused by poor diet and inadequate physical activity.

The plenary panel was followed by small, break-out sessions in which attendees discussed decreasing obesity. Recommended strategies focused on five topic areas: increasing physical activities for adults; increasing physical activity opportunities for children; promoting physical activity (land use); increasing access to healthy food for adults; and increasing access to healthy food for children, including promoting breast feeding.

Closing remarks summarized strategies created during the break-out sessions in which attendees formed coalitions committed to advancing physical fitness and obesity prevention. A follow-up symposium will occur in six months to review progress, as well as plan next steps in the overweight prevention movement.

Board Member Rasmussen questioned whether Public Health will assume a pivotal role in the countywide strategy for overweight prevention, to which Dr. Plough replied that Public Health is taking a leadership role by hiring a coordinator focusing on overweight prevention and activity promotion. However, involvement is required from many organizations utilizing different strategies; various sectors will contribute expertise. Public Health will facilitate cross-communication and establish performance measures to evaluate the success of the implemented strategies.

Chair Edmonds advised the Board that the first two-year term for each of the Health Professional Members will expire on December 31, 2004. A motion was introduced and seconded to renew the current three Health Professional Members for a second two-year term . Chair Edmonds commended the Health Professional Members for their dedication and contributions to the King County Board of Health.

VI. Board Members' Updates

Board Member Rasmussen was absent from the July 16, 2004 Board meeting, because he was attending a national conference on homelessness, an important issue that Board Member Rasmussen would like discussed in a future meeting. Chair Edmonds stated that the Board heard a briefing from the Health Care for the Homeless Program at the July 16, 2004 meeting and invited Board Member Rasmussen to recount what he learned at the national conference. Board Member Rasmussen indicated he would prepare a summary for a future Board meeting.

Board Member Lambert explained CDC's recently issued definition of Sudden Unexplained Infant Death (SUID), and requested the Board's support, as a rulemaking body, to inform the State Legislature regarding the importance of funding the Child Death Review Panel.

VII. Director's Report

Dr. Plough discussed immunization rates in King County, promising a more comprehensive follow-up briefing by Public Health's Immunization program later in the year. Dr. Plough stated that King County's immunization completion rates fluctuate from year to year, ranging from a low of 72% to a high of 86%. The current rate of 83%, though below the 90% national goal, is one of the highest rates of completely immunized children among urban areas in the United States. Some of the countervailing issues that prevent King County from reaching the 90% national goal include: parents claiming exemptions from immunizations; lack of information and fear regarding immunizations; confusion regarding dosing; lack of access to health care; and a 147% increase in the costs of immunizations over the last few years.

Dr. Plough informed the Board of the unsettling spread of avian flu in certain parts of the Pacific Rim, indicating an early warning sign of potential pandemic influenza. Dr. Plough stated that Public Health developed a pandemic influenza plan and will update the Board regarding avian flu as noteworthy incidents occur. In a related matter, Dr. Plough discussed recent media articles reporting flu vaccine shortages. According to Dr. Plough, the federal government does not predict a shortage of vaccine, rather, delayed availability. Public Health anticipates receiving flu vaccine in October or November and the Health Department's website outlines guidelines for determining who should receive a flu shot. Board Member Lambert questioned Public Health's plan for a potential SARS outbreak and whether an immunization is available, to which Dr. Plough replied that Public Health's pandemic flu plan can be applied to other infectious outbreaks, including SARS; a vaccine is still in the investigational stages and unavailable for distribution. Dr. Plough offered to provide a future briefing regarding work that Public Health has done with first responders, in conjunction with other community organizations, to develop isolation and quarantine plans to control emerging diseases, while balancing the rights of individuals.

Dr. Plough advised the Board that he was recently forced to issue an order compelling isolation and involuntary quarantine of an individual with tuberculosis, a complex

disease requiring strict compliance with a defined treatment regimen. This is the first time in ten years that Dr. Plough has exercised his Public Health Officer authority, which is indicative of the tremendous success of the Tuberculosis program.

VIII. Subject Tuberculosis Control Program

Dr. Masa Narita, Tuberculosis Control program, provided an overview of tuberculosis (TB), a disease that is spread among humans via air exposure. Approximately 30-50% of those exposed acquires latent or dormant TB infections. Among those who acquire latent TB, there is an approximate 10% chance of developing active TB. Treating active TB involves multiple medications administered for six to nine months; 18- 30 months if the person has drug-resistant TB. Only those who develop active TB disease are contagious to others.

Dr. Narita informed the Board that two million people worldwide die of TB annually. One-third of the world's population is infected with latent TB; approximately 15 million individuals are infected with latent TB in the U.S. and roughly 100,000 people in King County. Dr. Narita explained that approximately 8,000 individuals are homeless in King County on any given night; an estimated 20,000 individuals are homeless in King County per year, a 45% increase since 1998. Overcrowding, residents in congregate settings, close proximity of bedding, weakened immune systems, malnutrition, and HIV infection, are all contributing factors to TB outbreaks in the homeless population. A high prevalence of mental illness and chemical dependency contributes to delayed recognition and treatment of TB.

In January and February of 2003, with assistance from CDC's EPI-Aid, Public Health developed a large contact database, to help prevent the spread of active TB, as well as track trends in the homeless population. Database development led to the diagnosis of 17 cases of TB; the screening effort was a community-wide approach involving the TB program, Health Care for the Homeless Network, Jail Health, labs, Harborview, community clinics, Indian Health Services, and homeless sites. Although treatment was initiated in these cases, many infected persons failed to comply with the prescribed treatment regimen because of underlying behavioral, social, and medical issues.

Currently, there is a new outbreak in King County affecting eight young East Africans and one commercial sex worker. There are several shared characteristics among these individuals: East African origin, male dominant, history of incarceration, majority have been recent assault victims (gunshot and fight); alcohol/illicit drug use, and chronologically young. DNA fingerprinting indicates that all nine cases were caused by a single strain of TB. This group tends to congregate in non-traditional areas for the East African population and are resistant to revealing contacts. Additionally, these individuals participate in "hotboxing," cruising in a closed vehicle while smoking illicit drugs in an environment fostering TB transmission. Overall, the outbreak appears to be behavior- related, rather than ethnic-related.

The Tuberculosis Control program employs various strategies to ensure completion of treatment:

- Case management;
- Observed patient ingestion of medication;
- Alternate medication delivery sites (homes, work, park benches, street corners, etc.);
- Outreach workers, interpreters, and bi-lingual staff;
- Enablers, such as housing, transportation, and referrals to substance abuse treatment;
- Incentives, including food, restaurant coupons, clothing, or other personal products and stipends.

Despite these interventions, approximately 4% of TB patients are non-compliant.

Chair Edmonds questioned whether the East African patients were concerned about having TB, to which Dr. Narita responded that many of these patients were so ill that they submitted to medications. However, once the patients began feeling better, they discontinued medications despite several remaining months of the regimen. Symptoms of TB include prolonged cough, weight loss, fatigue, night sweats, and coughing up blood. According to Dr. Narita, a Public Health Nurse visits incarcerated patients in an effort to continue educating them while they are in a clean and sober state.

Board Member Rasmussen questioned whether the TB Control program works with shelters in regard to the ventilation and sanitation techniques that may reduce spread of TB in shelters. According to Dr. Narita, the TB Control, Health Care for the Homeless, and shelter representatives collaborated on guidelines addressing these environmental issues. These guidelines are available on the Public Health website.

Board Member Conlin questioned the TB Control program's annual costs to which Kari Tamura, Interim Prevention Division Manager, replied that the 2003 TB outbreak cost $700,000, and thus far in 2004, the cost is $400,000. Board Member Conlin stated that while Public Health struggles with continued funding issues, TB Control is a shining illustration of the importance of Public Health.

IX. Subject Institute of Medicine – Core Indicators

Dr. David Solet reiterated that core indicators are a component for ensuring population health, which was the emphasis of the Institute of Medicine's report, *The Future of the Public's Health in the 21st Century*.

According to Dr. Solet, an ideal core indicator set includes:

- Being as concise as possible;
- Data must be readily available and routinely updated;
- Data should be high quality and accurately measure a specific condition;
- Measures that affect a broad demographic;
- Health outcomes, as well as determinants of health;
- Practical and linked to interventions;
- Comparable to metropolitan areas similar to King County;
- Compelling information to mobilize community action.

Dr. Solet explained how Public Health's proposed core indicators were selected based upon available, quality of data, while also avoiding redundancy. He referred to a table organized according to various fields: indicator; measure; source; available demographics, etc. It is anticipated that data in the table will be interactive once it is posted on Public Health's website. Some of the data will be linked to visual aids, such as color coded maps. As an example, Dr. Solet discussed an important data set, diabetes-related mortality, because of its relationship to obesity. The data source is death certificates, which include most demographics and leads to an overview of what is known as diabetes-related mortality in King County. Upward arrows indicate an increase in trends, whereas, dashes symbolize no trend in the last five years. The overall long-term trend demonstrates increasing diabetes-related mortality at a rate per 100,000. Dr. Solet summarized that this is a measure of the variability of the rate in comparison to *Healthy People 2010*, an objective that is 45 per 100,000. It is clear that King County is far from that objective, but it is also clear that U.S. data for 1999 shows a rate of 77 per 100,000, and King County is well below that rate. Other interesting trends regarding diabetes-related mortality are based upon provisional data demonstrating an increase among Asian Pacific Islanders, whereas, there is no trend among other race groups, even in light of decreasing death rates in general. Dr. Solet highlighted a chart outlining diabetes-related mortality according to race, which showed higher death rates in African Americans than in other racial groups from 1992 to 2002. Linking data with visual aids also allows evaluating diabetes-related mortality by planning area, which is illustrated on a map of King County. The darker-shaded areas indicate higher rates of diabetes-related mortality in South King County and Central Seattle.

Dr. Solet cautioned that some characteristics may appear to be ideal core indicators, when in fact, there is unreliable, unavailable, or sporadic data. Domestic violence is one such example, because it is difficult to obtain a population base for measuring domestic violence and ensuring that the data sources are reliable. For instance, the Seattle Police Department has a check-off box for noting those occasions when police intervention involves domestic violence, however whether the box is checked depends upon how attuned the police officer is to identifying domestic violence, as well as how diligently the form is completed.

Dr. Solet informed the Board that the Health Department's Leadership Group is finalizing the core set of indicators, which will be conveyed to the Board of Health, with accompanying data, at a future meeting.

XI. Adjournment

Chair Edmonds adjourned the meeting at 11:16 a.m.

KING COUNTY BOARD OF HEALTH

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CAROLYN EDMONDS, CHAIR DATE