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

KING COUNTY BOARD OF HEALTH
MEETING PROCEEDINGS

April 20, 2001
9:30 AM to 12:00 PM
King County Council Chambers

Roll call

- Greg Nickels
- Nick Licata
- Margaret Pageler
- Kent Pullen
- Dan Sherman
- Les Thomas
- Dwight Pelz
- Joseph Pizzorno
- Rob McKenna (for David Irons)
- Richard Conlin
- Alvin Thompson
- David Hutchinson
- Alonzo Plough

Call to order

Chair Greg Nickels called the meeting to order at 9:47 AM.

Announcement of Alternates

Chair Nickels acknowledged Mayor Ava Frisinger from Issaquah as an alternate to Board Member Dan Sherman.

Introduction of new Board Administrator

Chair Nickels announced that Council Member Les Thomas had been appointed to the Board of Health, replacing Council Member Louise Miller. Chair Nickels acknowledged County Council Member Rob McKenna as an alternate to Board Member Irons. Chair Nickels noted that Board Member Thompson would have voting privileges in the absence of Board Member Van Dusen.

Adoption of the Minutes

Chair Nickels noted that a quorum was met and called for a motion to adopt the minutes of the March 16th meeting. Minutes were moved and seconded as presented. Chair Nickels called for additions or corrections.

Board Member Thompson stated that he had two corrections; one an editorial correction. He directed the Board Members to his remarks on page 2, fourth paragraph from the bottom. Board Member Thompson stated that an essential question he had raised in the context of the discussion on breast cancer treatment was not reflected in the Minutes. Specifically, "Is mammography always accompanied by clinical breast examination." Board Member Thompson noted that the correction had been noted, but he called for an additional correction to include the answer to the question posed. He stated that the answer was "Yes, clinical breast examination must always accompany mammography. It's the standard of care." He wanted to emphasize this point because he stated his belief that the major cause of malpractice action was failure to diagnosis cancer, failure to diagnose breast cancer. He asked that the answer to his question be included in the correction to the minutes, specifically, that the answer was, "Yes, clinical breast examination must always accompany mammography."

Board Member Thompson further stated that he believed this to be important because in his experience Public Health establishments as well as HCFA (Health Care Finance Administration) had not recognized that the two go together. He stated that this was at a time when HCFA was mandating mammography but would not pay for clinical breast examinations.

Chair Nickels asked that the minutes be corrected to include the response to Board Member Thompson's question. Chair Nickels inquired about additional corrections or additions.

Board Member Thompson indicated he had an additional correction and directed the Board to page 12, third paragraph from the top. Board Member Thompson stated that the word "possible" was transmogrified to the word "impossible". He indicated that the sentence should read," that it was possible without legislation for mental health professionals to change the threshold on which they recommend treatment." He further stated that the threshold was a professional rather than legislative judgment. He stated his belief that this was extremely important, so important he had in the past and would again today request a presentation by Mental Health professionals on this subject about what their criteria was. Board Member Thompson indicated that he was told that the Board would have such a presentation and that he would surely like to have it.

Board Member Thompson indicated that he suspected that another one of the Board Members would have something to say on that matter.

Chair Nickels instructed that the correction be noted.

Board Member Sherman was acknowledged by the Chair.

Board Member Sherman stated that he was the "other Board Member", Board Member Thompson had referenced. Board Member Sherman expressed his concern about the criteria. He stated that he wasn't sure that they had a resolution of that issue. He indicated that the earliest time at which an intervention could be made was before the police were needed. Board Member Sherman stated that there were cases where the Mental Health system had interacted and had not taken action to provide help to these people. He stated

that the balance always legislatively was freedom; the freedom of the person, and that as a member of the ACLU he cared about this. Board Member Sherman stated that on the other hand it had to do with what happened to these people, given that they're not really free and they were not able to think clearly.

Chair Nickels stated that the purpose of this discussion was not to solve the policy debate but to assure that Board Member Thompson's comments were accurately reflected in the minutes.

Chair Nickels indicated that the Board would be returning to this issue, not just once, but on numerous occasions in future meetings. Chair Nickels called for additional corrections or additions to the Minutes. There were none.

The Minutes of March 16, 2001 Board of Health meeting were approved with corrections as noted.

General public comment

No public comments requested.

Chair's Report

Chair Nickels directed the Board's attention to the Board packets, specifically the follow up correspondence to Mr. Steven Richmond regarding his testimony at the March 16th Board meeting. Chair Nickels summarized Mr. Richmond's concerns about what he perceived as public health indicators in the greater SeaTac area.

Chair Nickels updated the Board on future agenda items. He noted that on May 18th the Board would be hearing from representatives of the Family Planning Advisory Board. He further noted that on June 15th, the Board would be hearing from the Management Coordinating Committee of the Local Hazardous Waste Management Program. He referenced the previous presentation by representatives of County departments and organizations involved in local hazardous waste. He indicated that the June meeting would involve a broader presentation on that subject. He also mentioned that in June the Board would hear information about asthma, specifically the prevalence, hospitalization trends and local control of that chronic disease.

Chair Nickels stated that he wanted to update the Board on a regulation that the Board adopted several years ago designed to control and regulate outdoor tobacco advertising. He recalled the United States Court of Appeals for the District had set aside Pierce County's regulation that was almost identical to King County. He noted that the regulation was not based on free speech but based on a preemption that they perceived existed in Federal law. At about the same time a district court in New England upheld a local regulation and said that it was not preempted. He noted that that case had been appealed and was believed to be coming before the Supreme Court the following week.

Chair Nickels further stated that at the same time, the Board had decided not to take away the regulation that was adopted, but simply to put it in abeyance until the Supreme Court had made its ruling. He indicated it was still on the books but was not being enforced, and by resolution of this Board, was not being enforced. He stated his observance of his own neighborhood and the area adjacent to the elementary school where outdoor tobacco advertising was beginning to reappear. He noted that it appeared to a fairly coordinated

campaign, starting very small, very unobtrusive and now there were a few more. He stated his belief that there was a marketing effort underway to try and reintroduce this. He stated his belief that this was an unfortunate form of pushing tobacco, particularly around schools where children were walking and exposed to that advertising.

Chair Nickels announced that he wanted the Board to know, not in his capacity as Chair, but as an individual, that he was going to be working with a number of people to organize some protests around some of the more intrusive of those spots, particularly right around elementary schools. He indicated that if other Board Members wanted to participate he would be happy to get the information to them.

Chair Nickels introduced his next item, the EMS Staff awards. Chair Nickels announced that the King County Emergency Medical Services (EMS) Division staff and partners presented at the 19th Annual EMS Today Conference in March. He noted that one presentation and one poster session received top honors in their respective categories and each prize included a $500 cash award for continuing research efforts. Both presentations were entered in the pre-hospital care research forum. The first was a scientific paper entitled "Appropriate Destination and Patient Treatment Project - ADAPT". It was written by Michelle Plorde, from the EMS Division, Craig Peiguss, a Lieutenant from the Kent Fire Department and Dr. John Murray from the EMS Division.

Chair Nickels stated that "ADAPT" was a joint project carried out by the Kent Fire Department, the Maple Valley Fire and Life Safety, King County EMS and Urgent Care Clinics, including Health South, Multi-Care Maple Valley, Premera, Group Health and the Department of Social and Health Services. The purpose of the project was to evaluate the effectiveness of caring for patients with minor illnesses and injuries in a clinic setting rather than the Emergency Department. The data presented showed that Urgent Care Clinics and health care insurers could be organized to facilitate care of basic life support, that EMTs could accurately identify patients for referral to clinics and medical outcome were satisfactory and patient satisfaction was high.

Chair Nickels noted that the second award, a poster presentation, was entitled "ECG Rhythm Recognition and Monitoring by EMTs-Ds." Chair Nickels acknowledged the authors: Dr. Jack Murray, James Scapini, a Bellevue EMT-D; Tom Agnew from the Shoreline Fire Department, an EMT and former paramedic with King County Medic One and manager of the EMT Defibrillation Program; Dan Anderson and Tony Cagle, EMS Division Staff; and Dr. Richard Cummins, formerly the Medical Director for the EMT Defibrillation Program. The project reviewed more than 200 cases where EMTs were using only manual defibrillators. Patient benefits of ECG monitoring had not previously been investigated. The conclusions draw were that EMT Defibrillator personnel could identify and record cardiac rhythms and that their ability to identify abnormal rhythms contributed positively to patient care in 71% of the cases.

Chair Nickels congratulated the authors. Chair Nickels invited the group to say a few words, noting that the Board would be spending a fair amount of time in the year ahead talking about Medic One. Chair Nickels relayed an experience in King County in 1997, where the County put on the ballot something called EMS and no one knew what it was. He further relayed his experience that morning in his carpool where a neighbor and he were talking about Medic One and EMS. His neighbor admitted to him that they had voted "no" because they had no idea what EMS stood for. Chair Nickels stated that they needed to spend time in the community being reminded of what was this thing called "EMS" and why was it important. Furthermore why it had been a ground breaking, life saving tool in this region, and how would it be expanded and improved upon in the future?

Chair Nickels acknowledged Dr. John Murray.

Dr. John Murray introduced himself as the Medical Program Director for EMS in King County and a cardiologist by training. He stated that the two efforts acknowledged by the Board were best characterized as a response to a previous strategic plan where the stated goal was to become more efficient and more conscious of the distribution of services. One of the discoveries made was that EMS was responding to a number of relatively minor, perceived emergencies. They considered ways in which they could they better manage perceived emergencies. Dr. Murray reflected on the press conference that referred to the telephone referral project. The telephone referral project directed minor emergencies to a nurse line where they are handled over the telephone. He also noted that another way would be to take some of the less severe complaints and have them seen closer to home in community clinics that are now open. He noted that in Kent in particular, this was an issue because it was quite a long way to Auburn and Renton, and that it was the Fire Department's money and time and patients' time as well.

Dr. Murray stated that under the leadership of the Chief from Kent they did the ADAPT program. It was successful and Michele Plorde presented this project in Baltimore at the annual conference. He further stated that another service element had been the use of rhythm monitoring by EMTs, who are at a training level below paramedics, and are not usually expected to record and recognize abnormal heart rhythms. He stated that they had been doing rhythm monitoring in the County for about 20 years because it was a by-product of their efforts to train EMTs to do defibrillation. He stated that they had not known how effective this was and what role it was playing in patient care. The poster that was made represented the study that was done at Kent, Renton and Mercer Island, where this activity was underway. He concluded his remarks by thanking the Board for their recognition.

Chair Nickels noted that today, Medic One had three parts. First, he noted, CRP trained people throughout city neighborhoods, second, basic life support; the fire truck or the aid car with the emergency medical technician who had a certain level of training and third and final was the advanced life support also known as the Medic One unit. Chair Nickels stated that it appeared that had been expanded to include defibrillation. Chair Nickels asked Dr. Murray how defibrillation worked in the system. Specifically he asked, "Tell me how and what we can expect to see in the next 5 or 10 years and what outcomes we might expect to start experiencing?"

Dr. Murray responded by stating that he thought of Medic One, invented by the Seattle Fire Department, as the brand name for pre-hospital care in King County and actually worldwide. He stated that it was more than just paramedics, more than just Seattle Fire and now included the broad spectrum which Chair Nickels had described. He noted that they now received 160,000 calls a year. It was their responsibility to get the right resources to the right place at the right time. Dr. Murray stated that some of the calls were extremely minor complaints. He cited the example of a Lego up a nose, and asked the rhetorical question, "do we need a fire truck and a paramedic for that?" His response was "no, I think we can handle that with less intensive care". He also referenced the resuscitations from cardiac arrest and severe multi-traumas on the other end of the call spectrum. He indicated that they needed to focus on those types of calls appropriately. He stated that in addition to citizen CPR they have added public access defibrillation. He noted that there were now almost 400 defibrillators placed in homes, places of businesses, offices, police departments, non-traditional places where the occupants were now trained to offer defibrillation to people who have suspected cardiac arrest. He informed the Board that they were the first in the world to have fire fighter EMTs who performed defibrillation. Dr. Murray indicated that Dr. Cummings

had started that project 20 to 25 years ago. He stated that they now had the largest community-based provider system for defibrillation as a purely private activity. He indicated that he turned out to be the medical director for these, but that people were doing this on their own in response to public education. He concluded by stating that King County EMTs are very experienced, very well trained, and could have broader scope of practice. He indicated he expected to see more changes in the future.

Chair Nickels turned to Dr. Plough for the Director's Report.

Director's Report

Dr. Plough announced that the first item on his report was the review of the King County Health Action Plan's Community Benefits Program. Dr. Plough indicated that the Health Action Plan had been in existence about 5 years. He described the Plan as a wonderful and unique public-private collaboration designed to look at steps that could improve the health care system, with an increased focus on the intersection of disease management and population health. Dr. Plough reminded the Board of the presentation two years ago wherein the Health Action Plan staff introduced the Community Benefits Program. He noted that the Community Benefits Program was a collaboration between private hospitals and health plans to align and make community benefit funding consistent with epidemiologic studies of need throughout the County. The Community Benefits Program targeted their charitable giving in those areas experiencing worsening health trends. Dr.Plough invited Susan Johnson and Susan Thompson from the Action Plan to lead the presentation and honor participants of the Community Benefits Program.

Ms. Johnson thanked the Board Chair and members of the Board for the opportunity to come back and visit with them. She noted earlier presentations to the Board on other issues and expressed her hope to return at a later date to update the Board on other successful programs under the umbrella of the Health Action Plan, specifically activities in the area of diabetes with Community Connections for Chronic Care Program. Ms. Johnson referenced a new project , Kids Get Care, which she indicated she would like to provide more information to the Board at a later date.

Ms. Johnson directed the Board's attention to the overhead slides. She provided background about the Plan's origins, started in 1995 with a basic charge to review what types of things could be done at the intersection of disease management and population health by managed care, public and private sector initiatives. She noted one activity that was on their "To Do" list in 1996 was to develop a Community Benefits Program. Since the Program's inception they developed a voluntary approach where health plans, health systems and medical systems in the area came together and looked at where money should be going based on documentation of health need. She noted that their mantra became. "Hard Data Driving Voluntary Action."

She further stated that the program received national attention in American Medical News noting the "one-of-a-kind effort" and calling for the program to be a model for other communities to follow. Ms. Johnson indicated her desire to continue to grow the program in their third and final year. Ms. Johnson introduced her colleague Susan Thompson and announced that she would provide an overview of specific programs that had been implemented.

Ms. Thompson began her presentation by remarking that in 1999, using Public Health data, the Community Benefits group identified three areas of worsening health trends in King County. The first was childhood asthma where the data showed that hospitalization rates for

children had risen 25% in King County. The second, diabetes in African-Americans where the data had shown that diabetes related death rates for African-Americans were significantly higher than they were for Caucasians in King County. The third and final area was breast and cervical cancer screening among Asian women where the screening rates were significantly lower, particularly for Vietnamese women as compared to average rates in King County.

Ms. Thompson indicated that after identifying these worsening health trends, the Community Benefits group selected four projects to direct their collective charitable contributions. She identified the first project as the Odessa Brown Asthma Outreach Project. She stated that this project provided primary asthma care for inner city children. She identified the second project as the Community Diabetes Initiative; a project that provided staff management support and diabetes education through a network of community health centers and community clinics in King County. She noted that the third activity, also related to diabetes was the African-American Elders Project; a project that provided outreach services to connect isolated and elderly and diabetic African-Americans to important health and social services. Ms. Thompson identified the fourth and final project as the Breast and Cervical Health Program at the International Community Health Services where outreach, culturally appropriate outreach services were undertaken to connect Vietnamese women and all Asian women to important cancer screening services.

Ms. Thompson announced that to date, the Community Benefits Program had contributed over $100,000 in support of these four projects. She stated that every year before a new funding cycle began, they had the projects come forward and report their outcomes to the Community Benefits group. She directed their attention to the list of outcomes noted on the slide.
She stated that the next slide identified the participating organizations in the Community Benefits Program. She paused in her presentation and asked that the representatives from each of the participating organizations to join her at the podium to receive their awards.

Chair Nickels and Dr. Plough joined the representatives to hand out the awards.

Chair Nickels read the inscription on the award, "King County Health Action Plan Communities Benefits Program Contributor, Year 2001."

The following recipients and their respective organizations were acknowledged: Melicient Whinston, Medical Director and Chief Medical Officer, Community Health Plan of Washington; Laura Rehrmann, President and CEO of Group Health Community Foundation; Sister Susanne Hartung, Vice President, Mission, Ethics and Community Relations for Swedish Health Services; Se'ev Young, Senior Vice President and Chief Medical Officer, First Choice Health Network; Chad Richardson, Quality Improvement Coordinator, PacifiCare of Washington; John Castiglia, Chief Medical Officer and Senior Vice President, Premera Blue Cross; Jean Chin, Director of Care Resources, Virginia Mason Medical Center.

Chair Nickels acknowledged Suzanne Peterson, Director of Community Government Affairs and Advocacy from Children's Hospital and Medical Center in absentia.

Chair Nickels recalled a workshop on prevention and early identification and intervention a number of years ago where the Board was informed about health trends that were of concern. He further recalled a speaker that told the Board that prevention was high on the list of the values for his particular organization. This speaker remarked that in the "good old days" they were able to focus on it more. Chair Nickels said he asked the speaker what the

"good old days" were and the speaker responded "six months ago". Chair Nickels reflected that when our health systems are stating that the "good old days" were only six months ago, then we were not looking at prevention and we were not looking at early intervention. He stated that those present and their respective organizations were focused on the long term health of the community. He expressed his thanks for their efforts.

A group photo was taken of the award recipients.

Chair Nickels requested that Board staff distribute a survey while the meeting participants returned to their seats. Chair Nickels noted that the survey was designed to ascertain the Board's interest in possible workshop topics for the Fall Local Boards of Health conference.

Dr. Plough continued his report with the next item on the agenda, an update on the STD summit. Dr. Plough noted that since 1998, sexually transmitted diseases and risky sexual behaviors had risen dramatically amongst men who have sex with men in King County. He noted that syphilis, a disease that had virtually been eliminated in terms of cases originated by 1995 to 1996 had re-emerged in 1997 and was now thought to be very extensive in the MSM population at levels almost 100 times the heterosexual population.

Dr. Plough indicated that the Department had been working on a report and strategies that would be presented today in partnership with community based AIDS organization. Dr. Plough introduced the presenters: John Wiesman, Prevention Division Manager, Dr. Hunter Handsfield, and Karen Hartfield from the Department's Prevention Division and Jim Holm, Co-Chair HIV/AIDS Planning Council.

Mr. Wiesman noted that the purpose of the presentation was to brief the Board of Health on an important infectious disease issue; the resurgence of sexually transmitted diseases in men who have sex with men, which he indicated would henceforth be referred to as "MSM. He indicated that the briefing would include, a report on the STD HIV Summit that was held on Worlds AIDS Day, the current efforts to implement Summit recommendations and an overall picture of the issues and process utilized at the Summit.

Mr. Wiesman noted that in the late '90's, the Public Health Surveillance System started showing concerning trends in MSM. Specifically, the reemergence of syphilis. He noted that the data showed that 70% of MSM with syphilis were also infected with HIV. He stated that they had also seen increasing rates of gonorrhea and chlamydia and HIV prevalence in the local STD clinic, and noted that similar trends were being seen in other North American and European cities. The Department's initial steps were to alert the MSM community and service providers of the reemerging STD problem and steps that could be taken to reduce risk. Mr. Wiesman stated that they also held an education event for providers of HIV infected MSM to educate them on the issues, and worked with the Centers for Disease Control and Prevention to implement a special study to investigate risk behaviors in this population. He stated that an obvious thing to the Department was that addressing this issue needed to be a community response, not just a Public Health Department response. Mr. Wiesman stated that Dr. Plough proposed a joint Public Health and community summit to address the ongoing STD increase. Dr. Bob Wood, the Department's AIDS control manager, began that effort by meeting with community agencies and gay community stakeholders to elicit their support for a summit. The result was the formation of a planning group of key stakeholders that developed a day long summit. The goals of the Summit were: (1) to engage community partners in revitalizing efforts to fight the STD/HIV epidemics and (2) to obtain input to assist Public Health in using our resources in the most effective way possible. Mr. Wiesman noted that the Summit recommendations fell into three broad categories. First was the need for improvements in clinical services. Second, a need for increased coalition building for better

uniform prevention efforts, that included mental health and substance use treatment providers. And third, a need for new community driven prevention messages.

Mr. Wiesman invited his colleague Dr. Hunter Handsfield, STD Program Director to describe more fully the data that had identified the need for some of the biomedical interventions that have been undertaken. Mr. Wiesman noted that following Dr. Handsfield's remarks, Karen Hartfield , HIVS/AIDS Planner, would go into more detail about the recommendations from the Summit and current efforts to implement those recommendations. Followed by Jim Holm, community partner and Co-Chair of the HIV/AIDS Planning Council, who would address the important role of the community and HIV infected persons.

Dr. Handsfield directed the Board's attention to the first slide in his presentation. He noted that the first slide provided a context for the problem. He pointed out that in the late '80's and early '90's there was a substantial local and national epidemic of syphilis which was primarily in heterosexual men and women. He pointed out that the rates of men and women were essentially identical at that time. By 1995 and '96, he noted that there were only six reported cases of syphilis in King County and all but one of those, including the single case in 1996, were acquired elsewhere but diagnosed in King County. He stated that syphilis was effectively eliminated in the County, which was in fact the case in many counties across the U.S. He then pointed out that in the late 1990's things changed and in 1997, noted that cases were equal in men and women, and then took off in men only.

Dr. Handsfield observed that the blue bar depicted in the slide showed cases in men who have sex with men and the yellow bar depicted heterosexuals. He noted that, as reflected by the sex ratio in 1997, it looked like the disease was reintroduced in the heterosexual population, but once it was introduced into a population of MSM, many of whom were behaving unsafely, it took off in epidemic fashion in that population. He stated that although the data for the current year was not shown, if you took what was known in the first quarter of 2001 and extrapolated to the rest of the year, things would continue along the same trend line. He stated as point of fact, that if anything, the rates were a bit higher in the first quarter of the current year than they were in the latter part of last year.

Dr. Handsfield indicated that if they took the data and divided it by the estimate of the number of men who have sex with men who resided in King County and the number of those who are HIV infected, and then calculated rates of infection; the rate in heterosexuals didn't even show up because it was less than 100,000. Therefore on the referenced scale it was essentially zero. He pointed out that on the national level the rate in heterosexuals was in the range of 2 to 3 per 100,000 nationally. He further noted that the rate in MSM in King County looked like it was in the range of 160 to 180 per 100,000. He indicated that since 70% of the MSM with syphilis were HIV infected, and only about 4,000 HIV infected MSM resided in King County, they had calculated that somewhere in the range of 1,000 per 100,000 was the rate of HIV infected MSM. He expressed that that amounted to an astounding 1% of HIV infected MSM acquired syphilis each year in King County, which was as high a rate as syphilis had ever been documented as far as he was aware in any population.

Dr. Handsfield referenced Dr. Plough's remark about seeing similar but less dramatic trends in gonorrhea and chlamydia infection. He noted on the next slide that the blue bars were chlamydia, the yellow was gonorrhea among gay and bisexual not attending the SDT clinic from the mid-90's through 2000.

Dr. Handsfield noted that in looking at a few of the population characteristics that had influenced their attempts to deal with these epidemics, they had noticed that among men

with syphilis, men who have sex with men with syphilis, that the median age was 35 years. Stated another way, half of all MSM with syphilis are age 35 and above, and only half are below that age. For gonorrhea and chlamydia the median age was somewhat lower but still more than half are 30 and up. He pointed out that the race ethnicity distribution was more or less reflective of the County as a whole. That not very many men were bisexual and as had already been pointed out , over two-thirds of those with syphilis were also HIV infecte; smaller but substantial portions of those with gonorrhea and chlamydia.

Dr. Handsfield indicated that they had preliminary data that suggested that HIV was on the increase in Seattle/King County. He stated that there was clear documentation of rising HIV rates in MSM in San Francisco. He further stated that the behavioral trends that were driving the STD rates, and the fact that it was known that STD had biologically enhanced the efficiency of HIV transmission made it hard to imagine that these trends could be occurring without increased risk of HIV transmission.

Dr. Handsfield stated that STD had increased substantially over a four year period and continued in the current year. He noted that there were many cities throughout North America and Europe where similar trends had been identified. This could only be attributable to adverse changes in sexual behavior. He indicated that they were better explained by sexual safety relapse than in people who were formerly safer than they were by failure of younger, newly sexual active MSM to adopt safer sex practices. He mentioned that undoubtedly some of the latter was going on, but the age distribution alone suggested that it was not solely the introduction of newly sexual active men into sexually active population.

Dr. Handsfield asked the rhetorical question, "So why is this happening?" To which he responded, "there seems little doubt that improvements in HIV therapy are responsible, but the first one, the perception that AIDS is curable is probably overemphasized in this slide. When in fact, we now think that's probably a minor consideration. Most MSM are smarter than that. They realize that AIDS is still a very big deal and they want to avoid HIV infection." Dr. Handsfield went on to say that he believed that improved therapies have resulted in essentially healthier populations, and healthy people were more sexual than people who were not healthy. He stated that he thought that there was probably a psychology that reduced confrontation with lots of sick people in the environment due to dramatic therapeutic changes that had occurred. Epidemic fatigue, safer sex burnout, the fact that any behavioral change, whether it was weight loss or smoking, was hard to maintain for long periods of time. And there might also be some influence of substance abuse trends.

Chair Nickels interjected and asked Dr. Handsfield to comment on some trends seen a few years ago in Vancouver that he remembered was related to the introduction of injectable cocaine.

Dr. Handsfield commented that the trends appeared to be closely related to substance abuse and sexual behavior around substance abuse. He stated his belief , based on a review of the data, that increased frequency of the use of particular drugs, such as crystal methamphetamine, continued use , but even increased use in inhaled nitrites which were believed among many MSM, to enhance the sexual experience or prolong erections and permit more continued sexual activity, were believed to be associated.

Dr. Handsfield referred to the next slide and noted that the Department had not been inactive for the past several years in trying to address this issue. He mentioned enhanced screening in various settings for STDs among MSM. He mentioned that efforts to expand the partner notification were not terribly successful because so many of these men had anonymous

partners who were hard to identify. He mentioned that neurologic analyses had been undertaken to try to understand some of the behavioral epidemiology behind these changes.

Dr. Handsfield summarized his final slide with references to information sharing with other affected areas and their participation in a national symposia. He specifically mentioned that Seattle/King County's guidelines for standardized screening and testing of MSM was to be published in a national journal. He further referenced the CDC (Center for Disease Control) position paper which they had participated in that was designed to create awareness on a national level around these issues. Dr. Handsfield noted that Public Health had been looking carefully at the current structure for HIV/AIDS prevention and the bottom line is that STDs/HIV programs are moving toward a more collaborative, closer working relationship in response to this epidemic.

Chair Nickels acknowledged Board Member Thompson.

Board Member Thompson directed attention to page 3, the top graph. He indicated that it appeared to an inversion of the histogram incidence of gonorrhea and chlamydia that he was used to seeing in the monthly reports where chlamydia far outweighed all other STds. Board Member Thompson asked if that was because chlamydia was less transmissible with MSM.

Dr. Handsfield stated that it was not entirely clear. He indicated that there were some interesting scientific issues which he indicated he would not go into today, but that begged the question. He stated that the bottom line was that they didn't see as much chlamydia infection in MSM as they did in heterosexuals. He stated that this particular rising trend was actually fascinating from a biological standpoint and was stimulating a whole range of other research among some colleagues of his at the University of Washington because heretofore chlamydia had been more unusual in MSM than it had become recently.

Karen Hartfield introduced the next part of the presentation. Ms. Hartfield stated that she was going to talk about the community Summit and share some of the recommendations that the Summit participants made. She also mentioned that a copy of the complete report was available.

Ms. Hartfield stated that the data presented clearly demonstrated the need to revitalize Department programs. She stated that Public Health's 20-year HIV prevention history had shown them that community ownership of problems and solutions was most effective. She indicated that they felt the need to assure that the community understood the problem and was given the opportunity to think creatively about it. With this in mind, they planned the Summit in close collaboration with community-based organizations and representatives. She stated that it remained their belief that community driven solutions would have the greatest impact.

She restated the goals of the Summit, made reference to the fact that community-based organizations or AIDS Service Organizations, were committed to revitalizing their own prevention efforts and creating agendas to address the STD/HIV epidemic.

Ms. Hartfield noted that the gay community was diverse and that they needed to assure broad representation in order to generate the kind of dialogue they felt was needed. A planning committee was convened including about nine community and Public Health representatives to develop the agenda and the participant list. She noted that participants from all of the key HIV/AIDS community based organizations, local, state and federal public health staff, gay community business leaders and gay community media as well as grassroots leadership. She also noted that representatives from all communities of color as

well as men who have sex with men who identify themselves as bisexual and transgender were in attendance.

Ms. Hartfield briefly outlined the Summit agenda, noting that seven data presentations on community perspectives clarifed the epidemiologic and social context of the current disease reemergence. She noted that these presentations also provided a common language and knowledge base for all of participants. She stated that community presenters spent their time updating participants on how gay men are perceiving HIV and STD 20 years into the epidemic.

Ms. Hartfield reviewed the questions posed to the groups and their corresponding recommendations. The first group was asked to discuss issues related to STD screening, testing and treatment, HIV counseling and partner management services. They were asked to look at whether or not services were adequate, accessible? How they could be improved to attract MSM? She pointed out that each work group was facilitated by a trained facilitator and that all of the questions were generated in advance.

Chair Nickels asked for clarification about the group size, to which Ms. Hartfield responded that there were about 12 people in each group. She further noted that in each group was a recorder.

Ms. Hartfield stated that the recommendations for the STD/HIV work group were, first of all, to develop and disseminate the screening guidelines. Second, to identify and select appropriate clinic services based on qualitative data and then discuss these with the community. Third, to implement the new approaches to service delivery.

Ms. Hartfield stated that the second work group explored issues related to emotional health and recreational use of substances in conjunction with sexual activity. This topic was generated from the fact that there were high levels of substance use in the population and many believed that substance use both altered judgment around risk behavior and also may have been a surrogate marker for low self-esteem, depression and other emotional health issues which might be related to risk behavior. Due to the historically limited collaboration between mental health and substance use treatment and prevention for HIV negative gay men, the group recommended that they work hard to develop new or revamped programs to emphasize emotional health issues and substance use. The group felt strongly that community driven approaches were critical using Public Health as a catalyst.

Ms. Hartfield noted that they felt they needed to identify more collaborative partners such as alcohol companies to help fund programs. There was a consistent theme through all the work groups that people perceived that there was a lack of funding. She stated a point of fact that funding had been decreasing over the years so they were trying to think of creative ways to get more money.

Chair Nickels inquired as to whether they were really driven to the point where they had to seek help from alcohol companies to deal with the Public Health issue?

Dr. Handsfield responded by stating that they had tremendous underfunding of substance abuse problems. He indicated that it was being recognized more and more and referred to a new bill introduced into the Senate by Senator Barbara Boxer from California to quadruple the federal spending on drug treatment. He stated that this dynamic played out at every level.

Chair Nickels acknowledged Board Member Pageler. Board Member Pageler stated how she thought it would be interesting to invite a show of hands for those Board members that had not had an alcoholic beverage in the last month. She stated that it was this group who thought they were using alcohol responsibly, and it was not the same issue as tobacco. She stated that she thought they ought to be calling on alcohol companies to assist in funding Public Health. She referenced one alcohol company that had a major ad campaign about stopping drunk driving and noted that this issue was something that mattered to the industry.

Ms. Hartfield stated that she thought consideration should be given to different media approaches. She stated that drug companies have often underwritten prevention campaigns for HIV.

Ms. Hartfield went on to describe the third recommendation; to convene a community coalition to focus on integrating emotional health and substance use.

She stated that the third group discussed the role of bathhouses and other public sex venues in HIV prevention. She noted that Public Health and community-based organizations had been providing outreach clinic services and education in these venues for a number of years, but participants believed that they needed to enhance and revitalize these efforts. Of particular importance was increasing the distribution of risk reduction supplies such as condoms and increasing the outreach presence in clinics. The three recommendations by this group included an expanded bathhouse coalition to include other venues and also bar owners and that this coalition should specifically recommend prevention agendas and specific programs to be implemented. Furthermore that Public Health needed to increase funding to expand prevention services in bath settings.

Ms. Hartfield stated that the fourth group looked at the importance of community leadership in media and how it influenced normative behavior in the gay community. This group had clear consensus that the gay community lacked visual leadership with some people noting that many of the leaders had actually died of AIDS and others had not stepped up to replace them. The group did not feel that the gay media has taken a leadership role in recent years. They mentioned specifically that norms have changed over time and that new norms should be promoted. In particular, norms around disclosure of one's HIV status to potential partners was seen as critical. This groups' three recommendations fell out along these lines targeting HIV positive and negative men with messages around the importance of disclosing one's status to potential partners. Coordinating messages across agencies was seen as critical because there were many different agencies providing many different programs. Additionally acknowledgement that community norms had shifted. Universal condom use was no longer the norm and it wasn't helpful to continue promoting an old norm.

Ms. Hartfield stated that the last group was charged with discussing ways to increase or stabilize resources for HIV prevention and ways to enhance collaborations between agencies and institutions. This group felt strongly that funding should be targeted more strategically as it had decreased and that a more compelling case for funds needed to be made now that HIV was viewed by some as a chronic manageable disease. They also felt strongly that prevention efforts should focus on HIV positive men in order to maximize the impact. This groups' recommendations were to: protect and maintain current HIV funds; review and realign current programs with evidence based practices; convene a broad-based coalition to develop funding proposals; and work with the HIV care system to assure that HIV care resources were used to target HIV positive men with prevention messages. Ms Hartfield concluded her remarks and turned the balance of the presentation over to Mr. Jim Holm.

Mr. Holm began his remarks by stating that it was time that HIV positive gay and bisexual men took charge of the rising tide of risky sexual and needle sharing behaviors. He stated that the recent STD Summit focused constructively on risk behaviors bringing forth recommendations that would revamp and revitalize efforts to eradicate STDs and HIV. He indicated he wanted to make three points: First, that the conference was a collaborative effort. Top gay leaders were involved in planning and implementation. He noted that it was refreshing to see 60+ persons of the MSM community focused on resurgent STD and HIV transmission. Critical University of Washington researchers provided relevant data that was used to formulate recommendations. Participants showed much interest in pursuing necessary steps. Action coalitions were initiated. The groups would pursue concerted coordinated messaging to focus upon HIV positive men who had sex with men and to promote renewed community norms. Norms needed to be focused upon compassion for others, community health and individual health. As an example, "HIV stops with me" was the theme now being discussed in some community circles. He stated that his community's organizations had extensive histories in molding community norms and that they must redouble their efforts.

Mr. Holm stated that his second point was that the gay community was behind what needed to be done. Key leaders expressed emerging concern over the data presented. Representatives from groups were as varied as Washington Mr. Leather, the Imperial Court of Seattle, PAWS Seattle, the Seattleite Support Group, Life Line AIDS Alliance, and People of Color Against AIDS Network contributed to the dialogue. The gay media generously covered the press conference held by Executive Ron Simms and community leaders. Mr. Holm noted that his community organizations stood poised for action.

Mr. Holm stated his third point as follows: that the Seattle HIV/AIDS Council was taking the issue seriously. He further stated that the Positive Voice and Care Prevention Collaboration Committees had recommended targeting HIV positive men for prevention messages. Positive Voice in particular had reversed prior community positions that treated all men the same out of fear of creating pariahs of positive men and splitting the community. Instead this fear was being eclipsed by concern over new high incidence rates of sexually transmitted diseases. He stated that future messages must be crafted with care to minimize potential harm while promoting needed behavior change. Mr. Holm informed the Board that the Planning Council Prioritization Committee would be adopting proposals to increase efforts toward HIV positive men and their partners. New funds and energy would be dedicated next year.

Chair Nickels acknowledged Board Member Thompson.

Board Member Thompson thanked the panel for their excellent presentation. He noted that it appeared that monogamy might be an approach, not a solution, but an approach to the problem. He inquired as to the status of monogamy and what was the possibility of promoting it effectively within the gay community?

Mr. Holm responded by stating that there was a growing movement in the gay community for creating legal partnerships and that this went along with a major coupling happening in the gay community in which at least serial monogamy had been taking place. He indicated that he thought that this would be one of the issues that they would be looking at in devising the messages.

Chair Nickels acknowledged Board Member Pizzorno.

Board Member Pizzorno commented that they had mentioned risk calculus in a slide but had not talked about it. He asked if the panel could tell them more about what was meant by risk calculus.

Ms. Hartfield responded that the group felt pretty strongly about the apparent thought process gay men undertook when they were faced with a potential encounter. This thought process ended with a decision based on a number of factors such as what the person looked like, what sort of job did he have, how old was he, where did they meet, was he under the influence at the time? Questions, whose answers, helped the person calculate the risk or determine whether that person was negative or positive and whether he might be an appropriate partner. She noted that the calculus shifted depending on who the person was. She said that what they needed to acknowledge that this reasoning occurred and it represented the norm. Thus it would be helpful to assist the individual to think this through effectively rather than just promoting the use of condoms because it wass known that people were not doing adhering to that message.

Dr. Handsfield also responded to the question on risk calculus as well as the monogamy question. He stated that in theory individuals in Public Health would like to always go to the root causes or problems and address those root causes. He noted that although monogamy may be an idea, it wasn't achieved for an awful lot of people, gay or straight. He stated that the idea to promote monogamy had merit, but that if we stopped there, we were not going to get anywhere.

Dr. Handsfield stated that understanding the psychological and sociological motivations for unsafe behavior, for disclosing or not disclosing, was really key. He mentioned that the profession was at the beginning of their understanding of behavior and how to influence it. He noted that while they learn how to do those things, they also need to undertake those things that they know work..

Board Member Pizzorno inquired about whether or not there was anything being done to try to document the accuracy of various judging parameters to at least get feedback to the community about if this is indeed is an accurate way of doing it?

Ms. Hartfield stated that to her knowledge she didn't know of anything specifically. She noted that there was a lot of research going on in terms of people's attitudes and behaviors, but did not know if it was being correlated with actual incidents of new HIV.

Dr. Handsfield stated that they did not know how accurate these personal calculuses were. He indicated that in some cases, it was known that people making the risk calculus often made the wrong decision. He mentioned that in the STD clinic, and not just among MSM, they have seen people who have had only four lifetime sexual partners and yet had been in and out of the clinic three times with gonorrhea or chlamydia over the course of 18 months. On the other hand, they have seen people who have had many, many, many partners come in repeatedly to get rechecked and never have gotten gonorrhea or chlamydia. He indicated that there might be differences in how those people go through their calculuses. He stated that ultimately behavioral research would provide some of those answers, but at this point they were only starting to scratch the surface.

Chair Nickels acknowledged Board Member Sherman.

Board Member Sherman expressed his interest in following up on a statement made by Board Member Thompson related to monogamous relationships. He referenced Dr. Handsfield's comment about attempts to get to the root causes of problems. He wanted to

know what the Department was doing to promote long term, stable, monogamous relationships in the gay community. He further stated that there had been issues in the legislature about legalizing gay, long-term relationships. He indicated that he didn't believe these conversations had gone anywhere. He inquired about what was being done or could be done to promote that at the start?

Dr. Handsfield responded in two parts. He stated that first there was a limit to what government could do because it would be construed as paternalism. He stated that the whole reason that community involvement was needed was that if they were going to get those ideas across, they were going to have to come from the community. He went on to say that they did include abstinence and/or formation of permanent mutually committed monogamous relationships in all of their HIV and STD prevention messages. He noted that they didn't stop there because they recognized that for many people that would not be sufficient, but that it was always a prominent part of what they have done and what they have said.

Ms Hartfield responded that they did fund community-based organizations such as Gay City and Life Long AIDS Alliance to sponsor groups and workshops for gay men around dating and relationships and skill building. She indicated that she thought a lot of gay men felt like they had not been in a culture that was teaching them how to have good, healthy relationships. Part of the prevention effort included going a little bit further to help people develop meaningful relationships that would reduce risky behaviors.

Chair Nickels invited Dr. Plough to continue his Director's Report.

Dr. Plough announced that Tom Hearne would be providing a report on Medic One. Dr. Plough noted that many Board members had participated on two different task forces over the past three years where they reviewed a wide range of operational and funding options around Emergency Medical Services. He noted that at least 12 different funding options had been explored in the course of the task force deliberations. Dr. Plough informed the Board that Tom Hearne was going to present a brief overview of that planning process and provide a summary of some of the work leading up to recommendations recently forwarded to the County Council and the six suburban cities.

Mr. Hearne indicated his gratitude for the Board's recognition of EMS staff and their respective accomplishments. He stated that he took this as a sign that even after 30 years of leadership from Seattle and King County they were still able to generate work that was groundbreaking and important. He stated that it illustrated the close working relationship that existed with the fire department and paramedic service providers.

Mr. Hearne recalled the last time he had come before the Board of Health back in June of 1997. He noted that a few months after that presentation the EMS levy failed to reach the 60% majority and caused a huge financial and operational crisis for the entire system. Since that time, two different task forces made up of elected officials have looked at the financial and operational aspects of Medic One.

Mr. Hearne indicated that he wanted to present a brief overview of Medic One, how it was organized and who it treated. He also indicated that he would describe the process that the task forces used and the recommendations that had gone forth to the King County Council and the six suburban cities. He noted that the recommendations were included in the report that was available to the Board.

Mr. Hearne gave an overview of Medic One commencing with groundbreaking work of the late '60's and early '70's in the City of Seattle that was then replicated across King County throughout the late 1970's. He noted that what was truly unique about the system was that it included a very committed citizenry. He noted that the County had the highest rate of people trained in CPR, speculating that about a third or more of King County citizens had received CPR training. He mentioned the county-wide 911 access and dispatch protocols that triaged calls so that they are sent both to local fire departments and paramedic providers across the County. He stated that the first level in the tiered system was the basic life support, provided by the fire departments ranging from fully staffed urban departments to volunteer rural departments. Mr. Hearne stated that the system also included eight medical control hospitals that provided field ties with the paramedics and served as trauma hospitals in the system.

Mr. Hearne further stated that within the Department's EMS Division a number of EMS programs provided training, as well as the medical control that was directed by Dr. Murray, regional planning and a number of other services. He stated that the EMS system was truly unique and had developed and evolved over the past 30 years.

Mr. Hearne summarized data related to the volume of calls and characteristics of EMS in the County up through and including 1999. He noted that in 1999 they had almost 143,000 basic life support calls, ones that would be responded to by the local fire departments. On a population basis, that worked out to be about 8% of the population annually requesting EMS services. He noted that these calls ranged all the way from minor injuries or illnesses to the most severe life threatening kind of calls.

Mr. Hearne talked about response times across the system, ranging from the very fast BLS (basic life support) where it varied depending on whether they were included in the City of Seattle or in King County. He noted that BLS response times were about 4 minutes in Seattle and a little longer in King County. He stated that of the 143,000 BLS calls, they had nearly 50,000 paramedic calls or advanced life support service calls in 1999. He noted that these calls typically arrived on the scene a few minutes later than the BLS crews. He further noted that there were a few paramedic units that were more geographically and strategically deployed and they were a scarce resource that they tried to use only when truly necessary.

Mr. Hearne went on to say that the major response categories in Seattle and King County were separated into those that the fire departments responded to, which are all the calls, and those that paramedics responded to. He referenced overheads that illustrated the types of calls each type of provider responded to.

He noted that trauma calls occurred primarily in younger people who sustain injuries. For paramedics cardiac was a major category. He noted that about 30% of paramedic calls were cardiac related, but that there was a small number of trauma calls. He stated that this represented a kind of ecology in the system where they responded to all calls that came in through 911, but through the judicious use of paramedic services they sent them out on only the most critical ofcases.

Mr. Hearne noted the age distribution of paramedic calls and basic life support calls, directing the Board's attention to the graphs depicted in the overheads. He noted that the graph showed that as the population got older, the relative response with paramedics got higher. He noted that the next slide showed the breakout of calls by time of day, with peak times of 5:00 and 6:00 a.m. through 11:00 or 12:00 at night for EMS. He also pointed out a peak mid day period when most of the BLS responses occurred. Mr. Hearne stated that this information was used when planning for additional services targeting peak periods.

Mr. Hearne indicated that over the last 4 years they had looked at a number a number of EMS strategic initiatives that were included in the strategic plan. He stated that the strategic planning process was aimed at developing a number of strategic initiatives that would attempt to manage, in a safe and responsible way, the growth in calls that they had experienced. One of these strategic initiatives was the ADAPT project, which looked at EMT's directing people to clinics rather than to emergency departments. Mr. Hearne briefly summarized other options that were being looked at such as review of criteria for dispatching paramedic units, referring non-urgent calls to a nurse line rather than have a BLS crew from the local fire department, and the institution of a regional EMS purchasing program.

He also mentioned an initiative to develop new plans for vehicle replacement and doing medical quality management. He noted their interest in responding to concerns from one of the task forces about rapid collection of data and the development of a strategic initiative about regional data collection. He also mentioned the institution of an EMS Advisory Committee of physicians and paramedic and fire department responders whose purpose was to advise the EMS Division.

Chair Nickels acknowledged Board Member Conlin:

Board Member Conlin shared a conversation he had had with some of the EMS delivery people in the City. He mentioned that the people he talked with indicated that were three types of calls. He characterized the calls as: (1) really important to respond right away, (2) calls where it turned out that maybe it wasn't that important, but it was marginal enough that it was okay to call, and then (3) those calls that came in that were really not appropriate for EMS. He further stated that those calls in the latter category came from a relatively small number of people; that they were often people who called repeatedly. He wondered if there was a way to figure out how to handle those situations. Board Member Conlin said that it sounded like strategies were being considered and that it was really important to address this group of repeat callers given the growth in calls. He indicated that there might be some argument to suggest that the growth was being driven by that third category; distracting resources that should be used for more important things and not a particularly good use of those resources.

Board Member Conlin inquired as to whether there was a collaborative process that involved other health care providers.

Mr. Hearne indicated that they were actively exploring this. He noted that the ADAPT project looked at the practicality of transporting patients to clinics rather than to emergency departments. He stated that it required them to have a whole set of discussions with health care providers that EMS traditionally had not done.

Dr. Murray stated that the "frequent flyer" problem had been recognized since the onset, and that they were trying to deal with this on a local basis and engage the local physicians and other care givers. He concurred with Board Member Conlin's assessment of the third group, noting that fortunately it was not a large group and they were able to deal with them.

Board Member Conlin relayed an incident where a woman called in to request an ambulance to transport her to the clinic. The response given to her was that she should contact a taxi for transportation to which she responded that it was her right to have an ambulance.

Mr. Hearne interjected that they were looking at other options for providers such as referring some non-urgent calls to a nurse line, having BLS providers take these individuals to clinics, and at the paramedic level, trying to reduce the number of times that they get sent out so-

called code greens. He noted that the "frequent flyer syndrome" also offered an opportunity to identify people that could be linked with other parts of the Health Department for additional support.

Board Member Conlin observed that it was his impression that a number of the repeat callers might also need mental health services and that was really the root of the problem.

Chair Nickels acknowledged Board Member Thomas.

Board Member Thomas asked who actually made the determination about whether the call required BLS or ALS ?

Mr. Hearne responded that dispatch centers, county wide, used a set of protocols and that dispatchers were trained in the application of these protocols.

Board Member Thomas sought further clarification by using an example of a 3-year-old calling 911 and stating 'My daddy's fallen and I think he's broken his leg.' Compared to 'My daddy, is having a heart attack." He asked if that information was what got differentiated.

Mr. Hearne responded by stating that the dispatchers were very conservative, so in the event there was any uncertainty, there might be a tendency to send paramedics. He stated that this related to a point made earlier, in which there were some people that needed to be seen but might not need to be transported by paramedics.

Chair Nickels acknowledged Board Member Thompson.

Board Member Thompson asked how they dealt with "the issue of predetermined futility of life support, as what might occur with people in hospice, people with advance directives, or folks who were in nursing homes where nursing homes really didn't want people to die there, and yet that's not an untoward outcome?"

Dr. Murray stated that this was a contentious issue. He stated that there was one legal mandate that existed in the state; the state DNR (do not resuscitate) bracelet. He stated that they have encouraged providers to be very thoughtful and judicious in their decisions when they arrived on the scene. He stated that if it looked like a clear-cut indication of end of life and that it appeared to be the family's decision and the patient was nearly in that state, they might often not institute life support. On the other hand, if there was any question at all, then they did institute the resuscitation efforts, and sometimes learned later that that wasn't necessarily the desire of the patient. He stated that it was a very difficult situation that providers encountered.

Chair Nickels acknowledged Board Member Pizzorno.

Board Member Pizzorno noted that one resource he didn't see referenced in the materials was home health services. He indicated that it seemed like a lot of less life-threatening situations and the frequent callers could be handled by those groups at a far lower cost. He inquired as to whether or not there had been any conversation with those providers about being a part of the team?

Mr. Hearne responded in the negative. He noted that Board Member Pizzorno's point was an excellent one but that they had not explored that possibility as yet.

Dr. Murray indicated that a number of their patients already had home health services and that they tended to pick up where that failed. Then the patient was stabilized and referred back again through the hospital and the physician. He indicated that he thought there needed to be an understanding that EMS was the safety net in that most of their patients had health care, they had lots of resources being expended on them, and when that failed they called 911.

Mr. Hearne went on to provide background on the funding for the EMS system in the Seattle and King County area. He summarized the first levy and the interim levy that was approved in February of 1998 that was set to expire at the end of the year.

Mr. Hearne noted that in 1998 there had been a Financial Planning Task Force set up whose main job from the County Council was to look for more permanent, stable funding sources and to look at alternatives to the property tax funding. The Financial Planning Task Force recommendations reaffirmed the importance and effectiveness of the regional medical system for EMS, and especially for the regional planning and use of paramedic services. They reviewed about 15 funding options. All of their funding recommendations either required an extensive change in state law in order to have EMS use them, or did not provide adequate funding for a regional system. The Financial Planning Task Force recommendations had three options for further analysis. One was to continue the levy to look at additional funding from King County from the current expense fund, the CX fund, and then to implement fees for paramedic transports.

Mr. Hearne further elaborated by stating that in 1999, the County Council appointed a new task force that was charged with coming up with an inter-jurisdictional agreement on strategic plan update for operations and a funding package. The task force recommendations were a six-year levy with a 25 cent per thousand assessed valuation. Mr. Hearne noted that the current levy was passed by voters in 1998 at 29 cents. Mr. Hearne further noted that the task force recommendations included a review of fees for paramedic transport as an initiative to be reviewed during the 2000 to 2007 strategic plan.

Mr. Hearne summarized the implications of the task force recommendations of 25 cents. He stated that future paramedic needs, effective in 2002, included the addition of a half-time unit in Seattle, a half time unit in Evergreen in the Bothell area and expanding the service on Vashon Island to a higher level. He stated that over the last 20 years, there had been two paramedics who had provided paramedic service on Vashon. He noted their obvious dedication, but emphasized the need for additional funding in order to give them a day off and provide additional service in an area where there have been increased calls. In 2003 it is planned to move a unit that's now a peak time unit in the Issaquah area to 24 hour service. Seattle is planning to add one unit. And then in 2004 and 2006, if needed, adding services in South King County.

Chair Nickels acknowledged Board Member Thompson.

Board Member Thompson asked, with respect to fees for paramedic transport, whether or not there were any socioeconomic correlations of calls that might affect fees charged.

Mr. Hearne noted that there had been articles that appeared in cardiology journals that indicated that there were some barriers to people seeking care if charges for service were indicated. The concern was what would be the effect on people seeking care if fees were being charged? He noted that some of the other concerns had to do with administrative problems and the rate at which fees would be collected and the reimbursement rates for Medicaid and Medicare. He noted that since this was a fairly complex field, from the

financial, administrative and care side, he thought that the task force wanted this carefully studied before any recommendations went forth about whether fees should be charged for transport.

Board Member Thompson asked if there was any data on the socioeconomic epidemiology of calls to which Mr. Hearne replied that in terms of whether people had insurance or not, that they really didn't have very good data.

Board Member Thompson observed that there was data on zip codes and the socioeconomic implications of this data.

Mr Hearne responded by asking if Board Member Thompson meant demographic data to which Board Member Thompson responded in the affirmative.

Mr. Hearne responded that they did have a lot on that. He referenced a slide depicting where they had paramedic services currently and where paramedics' workloads were heaviest throughout the County. He noted that location of paramedic units was associated with where calls occurred. He further stated that where calls occurred depended on a number of things, socioeconomics included. He said it also depended on where people lived, how people moved around the County to work, to shop, and to engage in recreational activities. He stated that they had looked at all of those things in preparing their recommendations for paramedic services. He noted for example, that they had looked at the residential population density across the County to see, first of all, where people lived. They also looked at where people worked as an important factor, and although not reflected on his charts, he pointed out the transfer of population during the day to work places. He noted that the Seattle Fire Department probably had the best data on where their patients came from. He noted that about half of their calls for paramedic services came from outside the city of Seattle. Mr. Hearne inquired of Board Member Thomspon about whether or not he had responded to his question.

Board Member Thompson indicated that yes he was looking at socioeconomic factors as creating a greater burden of disease as opposed to disease and accidents. He said he wondered whether that was factored into any possibilities of fee for service.

Mr. Hearne indicated that they had not factored it in so far in any review of fees for service. He indicated that he was sure that that would be part of the analysis that was done during the upcoming period.

Mr. Hearne continued his description of the EMS levy by stating that the second area funded was basic life support to the fire departments. He stated that currently this amounted to about $ 8.3 million dollars a year. He noted that the fire departments provided a very integral and important part of the provision of EMS in the County. He further noted that they would be using the same funding formula for distributing those funds as was used currently, which was based on population, the assessed valuation, and the number of calls that occurred in the areas.

Mr. Hearne indicated that if the proposal was accepted, they would be getting an estimated assessments of about an average of $54 million dollars a year for both Seattle and King County. He stated that he thought that about 26 percent of that would go for support of Fire Department First Response, 62 percent to paramedic services, 11 percent to regional support, [activities that the EMS Division and the Seattle Fire Department provide for training, planning, medical direction], and then one percent for the strategic initiatives designed to assist them in managing the rate of growth in calls.

Mr. Hearne concluded by noting a number of deadlines that they were attempting to meet. He noted that the strategic plan recommendations were transmitted to the County Council on the 16th of April. He further stated that there were six cities with populations over 50,000, which by state law had to approve the measure in order for it to go on the ballot. Those cities were Renton, Shoreline, Bellevue, Seattle, Federal Way, and Kent. He indicated that they had targeted June 30th as the date for approval by the cities and the end of July as the target for the County approval. He then said it would appear as a ballot measure in November.

Chair Nickels inquired as to whether there were any additional questions. He acknowledged Board Member Sherman.

Board Member Sherman asked if the proposed 25 cents per 1,000, was a fixed amount. He asked if valuation of homes went up, then more money would come in.

Mr. Hearne indicated that Board Member Sherman's statement was correct. He indicated that in giving very conservative estimates about the growth in assessed valuation of homes through 2007 that the effective rate of the levy could be around 22 cents by 2007. He stated that they were limited in terms of the amount that they could grow every year and future initiatives, tax initiatives, might limit them as well.

Board Member Sherman asked if the proposal amount was a fixed amount per thousand?

Dr. Plough responded that it was a cap and could drop.

Board Member Sherman restated Dr. Plough's statement to which Mr. Hearne confirmed that it could indeed drop.

Board Member Sherman asked if there was a formula for how it would drop?

Mr. Hearne stated that there wasn't a formula for how it could drop. He indicated that the County Council reviewed their financial plans every year, and could reduce the amount if growth was very high and it looked like they didn't need the money that they were generating through the levy.

Board Member Sherman asked about the potential for billing for services, further inquiring about whether Medicare and most insurance companies covered at least ambulance services? He asked if they billed for those services stating his belief that they were covered in some insurance plans.

Mr. Hearne responded that they did not bill for those services. He stated that at this point, if an individual got a paramedic transport, for BLS transports, many patients were actually transported now by private ambulance companies and they did submit bills for that. In some areas of the County, some of the fire departments would transport patients if they were close to hospitals. He noted that so far, there was only one fire district in the County that actually billed for that transport.

Board Member Sherman inquired as to why they weren't billing for this transport, which could generate funds?

Mr. Hearne indicated that it wasn't clear, for paramedic services, that that they were going to be able to recover enough money to provide the revenue that they needed to operate on in

their levy amount. He stated that it was one of the issues that was going to be considered in their review of paramedic transport fees.

Chair Nickels asked for clarification regarding recovery of funds to cover the administrative cost of the billing system.

Dr. Murray stated that paramedics transport mostly Medicare recipients. He further stated that HCFA had price fixed, and was now in the process of reducing the reimbursement for ambulance transport, and that you had to provide documentation along with all the other administrative issues with HCFA.

Board Member Sherman inquired if Dr. Murray was saying that the federal government, in the federally funded Medicare program, did not reimburse for ambulance transfer, the actual cost of administering the billing?

Dr. Murray responded that HCFA provided a fixed fee reimbursement, which might not cover the full cost of providing the service.

Board Member Sherman stated that as a physician he saw Medicare patients, and yes, he did get paid less often from Medicare than from other sources, but that they do pay more than just the administration costs.

Dr. Murray suggested that if you included your service in the amount, they might not in fact cover the costs of the service and the administration.

Board Member Sherman stated that he was not suggesting a complete substitution for a levy, but if there were funds available that they were simply not asking for that come through insurance, that would not be palatable to him. He stated that if they were going to the public to ask them for money for a levy, why weren't they getting money that was legally justified and due them? He noted that all that was needed was to put the billing system in place. As a physician, he stated that if you're talking about only billing insurance companies or Medicare, then they are going to complain because you're are not billing private parties. In those cases sliding scales can be worked out, which are things that doctors and hospitals do all the time.

Dr. Murray indicated that he believed Board Member Sherman was correct and that the same point had been made by a number of the members of the task force.

Chair Nickels acknowledged Board Member Pelz.

Board Member Pelz noted that the amount of money they were talking about was per thousand. He indicated that if they could recover this money from insurers, the rate might drop from what to what? He stated that they had always gone out for $0.25 and now they were at $0.29.

Mr. Hearne stated that it was in fact just the reverse of Board Member Pelz' statement; that the amount used to be at $0.29 and would be reduced to $0.25.

Board Member Pelz stated that before that they were at $0.25 and then they inched up to $0.29 and now they were coming back down to $0 25. He stated that they could probably charge $0.25 if they didn't recover through billing and they might get it down to $0.24 if they did recover. He pointed out that the choice of whether to bill or not to bill was about insurance. He stated that they have socialized insurance across all parties for EMS. He clarified his use of the word "socialized" as a verb and not an adjective. His intent was that

they have elected to spread the cost across the population. He stated that if you owned a $200,000 dollar home you paid $2.00.

He further stated that the options were to either charge the two dollars for your $200,000 house or they were going to try to recover through billing. He went on to say that if they did elect to bill than they would have to hire people to collect from insurance agencies or Medicare. He stated the fundamental question was do we charge people a penny per thousand dollars, and therefore $2 a year on a house, or do we hire public employees who chase paper all day? He stated that a part of the question was what made for efficiencies in the health care insurance business? One form of efficiency people looked to was to hire thousands and thousands of billing clerks and by hiring more billing clerks they could drive down healthcare costs in America. Other people think that to pay billing clerks as part of the healthcare system in America was in fact a waste of money. He stated that that was the debate about healthcare in America. He concluded by saying that he thought there were some broader issues than whether or not we could recoup this from some willing payer somewhere.

Chair Nickels acknowledged Board Member Hutchinson.

Board Member Hutchinson asked if they would speak about permanent funding.

Mr. Hearne indicated that he thought the desire of many providers would be to seek permanent funding. He noted that the state law actually provided for an option of providing permanent funding under the EMS levy. He stated that he thought that the reason that a permanent levy was not taken on was that many of the task force's elected officials felt it was good to have periodic reviews of taxpayer approved levies. Another option that was discussed was the alternative of having the County take that on as a part of their regular budget, and he stated his belief that that idea went away with the combination of Initiative 695 and the CX issue that was before King County. The task force discussions didn't really have an the option to have a permanent funding source, either from County CX or through the permanent levy arrangement. He noted that there had been a lot of discussion about whether it should be a six year levy or a ten year levy, and the recommendation was for six years.

Chair Nickels thanked Mr. Hearne and Dr. Murray for their presentation.

Dr. Plough wrapped up his Director's report, briefly referencing the legislative update included in the Board's packet. He noted that there were 240 bills in Olympia that dealt with healthcare in some way. He noted that he thought the major impact on public health was in the Governor's budget and in the Senate budget. He noted that the I695 backfill for the motor vehicle excise tax remained at 90%. Dr. Plough stated that the as yet to be released House budget might not put in the growth factor that the other two budgets had.

Dr. Plough directed the Board's attention to the final piece of business, a letter from the Cedar River Council in reference to questions raised by Board Member Irons about Cedar Grove Mobile Home Park, and whether the Department was monitoring the on-site systems in this mobile home park. Dr. Plough indicated that there was a copy of the letter in the Board packets. He summarized the response that would be forthcoming to the Cedar River Council. He noted that the Department had reviewed their questions and that the park had submitted an on-site plan to the department that was currently under review. Dr. Plough stated that there were not any current violations but that they were closely monitoring the park. He stated that a lead staff person had been assigned to oversee the project. He

indicated that he had crafted a response back to the Cedar River Council and would update the Board again and include a copy of his response in the Board packet next month.

Chair Nickels inquired about the legislative update and the number of bills that successfully made it through. Dr. Plough indicated that only about 60 bills of the original 240 crossed over to the opposite house.

Chair Nickels inquired about the restaurant smoking bill. Staff informed Chair Nickels that that particular bill had not survived.

Chair Nickels called for additional questions. Hearing none, he called for adjournment.

KING COUNTY BOARD OF HEALTH

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s/Greg Nickels/s