

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on February 28, 2001 in Room 210 Memorial Hall

All members were present except: Representative Geraldine Flaharty, Excused  
Representative Brenda Landwehr, Excused  
Representative Dale Swenson, Excused  
Representative Gwen Welshimer, Excused

Committee staff present: Dr. Bill Wolff, Kansas Legislative Research Department  
Renaë Jefferies, Revisor of Statute's Office  
June Evans, Secretary

Conferees appearing before the committee: Dr. Charles Magruder, Director of Community Health,  
Wichita

Others attending: See Attached Sheet

The Chairperson introduced Renaë Jefferies, Revisor of Statute's Office, replacing Norman Furse as she has been working the bills in the Senate.

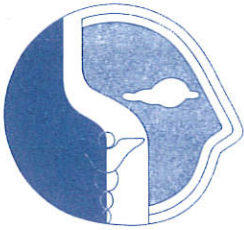
The Chairperson introduced Dr. Charles Magruder, Director of Community Health, Wichita-Sedgwick County Department of Community Health, Wichita, who briefed the committee on bioterrorism. There is a threat of bioterrorism and the local health departments are clearly unable to respond adequately. Without special preparation at the local and state levels, a large scale attack with variola virus, aerosolized anthrax spores, a nerve gas, or a foodborne biological or chemical agent could overwhelm the local and perhaps national public health infrastructure. Detection and surveillance are important because the initial detection of a covert biological or chemical attack will probably occur at the local level, disease surveillance systems at state and local health agencies must be capable of detecting unusual patterns of disease or injury, including those caused by unusual or unknown threat agents. Capable health departments are the most essential components for a successful response to biological terrorism. No local health department in Kansas possesses the necessary infrastructure to manage this responsibility.

Additional funding will be required to develop this essential infrastructure. An essential step on completing the process of being ready for an attack has been identified by Secretary Graeber and he has appropriately identified this proposal as his number one priority – increase State Formula funding for local health departments (Attachment 1).

The Chairperson announced there would not be a full committee meeting tomorrow, March 1, enabling the sub-committee on licensing to meet during the allotted time.

The meeting adjourned at 2:30 pm. and the next meeting will be March 5.





January 29, 2001

Garry Boston  
United States Representative  
300 SW 10<sup>th</sup>, Room 156-E  
Topeka, KS 66612-1504

Dear Representative Boston:

I am sending this letter to provide additional information regarding the threat of bioterrorism to our communities. Please note the enclosed article that was published in the July 2000 *Journal of Public Health Management and Practice*. You will note that it describes local response to potential exposure of a biological agent (anthrax) that can be used as a terrorist weapon.

This incident occurred approximately three months after my arrival in Wichita to begin work as the Health Officer/Director of the Wichita-Sedgwick County Health Department. As you can see from this article, our local Health Department was clearly unable to respond adequately. Fortunately, this threat turned out to be a hoax. If it had been real, numerous people may have died unnecessarily because we have not been able to adequately prepare for these types of circumstances.

Since 1998, the Wichita-Sedgwick County Health Department has made considerable progress in enhancing our capabilities, but a great deal of work remains. An essential step in completing this process has been identified by Secretary Graeber, and he has appropriately identified this proposal as his number one priority – increase State Formula funding for local health departments (enclosure 2).

I strongly urge you to make this a top priority for your legislative agenda. The health and safety of thousands of Kansas citizens may be at stake. We have an opportunity to make a difference now before it is too late.

Thank you for taking the time to consider this important area. Please contact me with any questions (316-268-8391 / [cmagruder@wscdch.org](mailto:cmagruder@wscdch.org)). I will be pleased to provide further information or make presentations as desired.

Sincerely,

Charles Magruder, MD, MPH  
Director of Community Health

CM/lj  
Enclosures

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H&HS  
2-28-01  
Atch #1

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# Taking the Terror Out of Bioterrorism: Planning for a Bioterrorist Event from a Local Perspective

Larry C. Garrett, Charles Magruder, and Craig A. Molgard

*There is a growing concern in the public health community over the potential for domestic biological and chemical acts of terrorism. These types of events do not respect city limits, county lines, or other geopolitical borders and pose a unique challenge for local health departments that have a critical role in detecting, preparing for, and responding to such events. Because direct support for most public health service, including bioterrorism preparedness, occurs primarily at the local level, this is the logical starting point for all planning activities.*

Key words: *bioterrorism, epidemiology, public health, surveillance*

## Introduction

There is a growing concern in the public health community over the potential for domestic biological and chemical acts of terrorism. These types of events do not respect city limits, county lines, or other geopolitical borders and pose a unique challenge for local health departments that have a critical role in detecting, preparing for, and responding to such events.<sup>1</sup>

The bombing of the World Trade Center in New York City and the Alfred P. Murrah Federal Building in Oklahoma City have forced Americans to face the reality that terrorism is not something that occurs only overseas. According to U.S. intelligence agencies, conventional explosives continue to be the weapon of choice for terrorists, while chemical and biological materials are less likely to be used because they are more difficult to weaponize and the results are unpredictable.<sup>2</sup> However, nations and dissident groups exist that have both the motivation and access to skills to selectively cultivate some of the most dangerous pathogens and to deploy them as agents of terrorism or war.<sup>3</sup>

There have already been several troubling incidents. In 1984, for example, 751 people became ill after two members of an Oregon sect produced and

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distributed *Salmonella*, an intestinal organism, in restaurants to affect the outcome of a local election. One year later, four members of an anti-government militia group were convicted of planning to use ricin to kill government workers. Ricin, one of the most poisonous substances known to man, is derived from the common castor bean. Also in 1995, the Japanese cult, Aum Shinrikyo, released the nerve agent Sarin in the Tokyo subway and had plans for biological terrorism; included in its arsenal were botulinum toxin and anthrax cultures. In November 1995, an alleged member of a white supremacist group pled guilty to possession of three vials of *Yersinia pestis*, the organism that is capable of causing bubonic, septicemic, and pneumonic plague. In December 1998, the Federal Bureau of Investigation (FBI) and U.S. Army biological warfare experts raided a farm in Arkansas and found 130 grams of ricin, enough to kill 30,000 people if properly dispensed.<sup>4</sup>

This article summarizes the events surrounding the alleged threat of anthrax in a local office building in Wichita, Kansas, in August 1998. In addition, the authors review the response of the local health department and apply the lessons learned from this incident to bioterrorism preparedness activities. It must be noted that because this case is still under criminal investigation, the authors did not have complete access to all of the official data and timelines, making some of the information presented subject to change.

## Background

On August 18, 1998, several hundred workers were evacuated and a four-block area of downtown Wichita was cordoned off after a suspicious white powder was found in an office building. The evacuation began around 11:00 AM when the substance was found spread on several stairwells and elevators in the building. The office for Social and Rehabilitation Services, one of the many government agencies housed in the building, had received a threatening letter in a manila envelope stating the substance was anthrax.

Local emergency medical services (EMS), hazardous material units (HAZMAT), health department, and law enforcement officials detained nearly 200 people who may have been exposed: all persons in the area where the white powder was found and in

the office that had received the letter were considered possibly exposed to *Bacillus anthracis* spores. Overall control of the operation was directed by the FBI, with support from the Department of Defense (DoD) because the two are lead agencies involving biological acts or threats of terrorism. Because the local authorities had limited expertise with biological threats, the DoD assumed the primary role in the sampling and identification of the substance at the scene.

HAZMAT personnel responded in full protective gear with self-contained respirators to assess and contain the area. The air-handling system in the building was turned off to reduce the potential spread of *Bacillus anthracis* spores. Evacuation of the building was completed and the detained individuals were placed on air-conditioned buses near the building to ensure their comfort and keep them at the scene while the validity of the threat was assessed. The desktop where the letter was opened was washed with a 5 percent hypochlorite solution after collection of evidence by the FBI.

Five hours after the substance was found, most of the detained individuals were allowed to leave. This decision was made following a conference call coordinated by the FBI in which experts determined that it was very unlikely the substance was *Bacillus anthracis* due to its physical properties and lack of an effective dispersal method. The contributors to this decision included specialists from the Centers for Disease Control and Prevention (CDC), the DoD, and the Kansas Department of Health and Environment (KDHE). Before departing, contact information for follow-up was collected by public health officials and arrangements were made for counseling. Each person received detailed instructions to shower and double bag their clothes in plastic when they returned home. A handful of people who came in direct contact with the substance were decontaminated in a temporary shelter provided by McConnell Air Force base using soap, water, and a dilute bleach solution.

The DoD completed the on-site testing of the alleged *Bacillus anthracis* using an Enzyme Immuno Assay testing procedure (similar to a rapid strep test) known as a "Smart Card." The definitive testing of the substance was conducted by the United States Army Research Institute for Infectious Diseases, DoD, in Fort Detrick, Maryland where direct fluorescent antibody testing and culture were negative.

Within 24 hours after the initial threat, lab results showed the substance posed no chemical or biological threat.

## Health Department Response

Immediately after the EMS and law enforcement officials were notified of the potential anthrax exposure, a health department environmental health staff member trained for HAZMAT response was called to the scene. Due to the large public health consequences of anthrax, the city manager directly contacted the director of the health department and requested that he personally respond. The director of environmental health and a nurse epidemiologist also reported to the scene. They were equipped with two-way radios and a cellular telephone enabling them to maintain contact with the health department for ongoing support and access to additional sources of information as needed. Health department staff gathered information on *Bacillus anthracis* and its health consequences via exposure through inhalation and established contact with the CDC's Emergency Response Center and KDHE's Office of Epidemiological Services.

The health department's nurse epidemiologist collected contact information for follow-up, including name, address, phone number, location in building, time in/out of the building, and if visiting the building, whom the person saw. This information was gathered to help the health department if it became necessary to treat this population prophylactically. Instructions were given to the potentially exposed individuals on the need to shower and the proper handling of personal belongings until the substance had been identified. The director of the health department requested a mental health team to come to the scene to provide needed support, particularly for those who could not return home immediately and had to go through the decontamination process.

At the health department, work was underway to find a source of appropriate antibiotics and anthrax vaccine. In addition, the staff was preparing for the delivery of the pharmaceuticals if the substance was found to be *Bacillus anthracis*. Contact was maintained with the CDC's Emergency Response Center and information was relayed to and from the scene via telephone and radio. The health department staff maintained a "cautionary vigilant" stance until the

substance was identified positively as a non-threat. The final role played by the health department was to provide notification to the exposed individuals that they were indeed safe and that the substance they were exposed to was of no threat.

## Lessons Learned

Many important issues became readily apparent pertaining to the health department's emergency response procedures. These included weaknesses with communication, lack of a functional information management system, and inadequate training for bioterrorism response.

### Communication

Communication became an immediate problem between health department personnel at the scene and support staff at the health department. The use of radios was difficult at times and not always accomplished. In addition, communication over open airwaves was not secure, making confidential discussion impossible. Further, the cellular telephone did not work adequately due to location and limited battery life. Part of the communication problem was due to the county not fully activating its Emergency Operations Center. This type of event was unforeseen in the county's Emergency Response Plan and resulted in a failure for the county to follow portions of its basic emergency protocol; this is an area that is being evaluated at this time.

### Information systems

The lack of access to an effective and flexible information system hindered the collection of the facts necessary to support the health department's operations. Up-to-date information on bioterrorism and anthrax became problematic as Internet resources at the health department were limited to only one computer. In addition, there was no previous planning or

*Communication became an immediate problem between health department personnel at the scene and support staff at the health department.*

training that had taken place at the health department concerning bioterrorism.

Other difficulties related to the lack of a flexible surveillance system. Currently, the health department relies on a statewide computer-based disease surveillance system. This system lacks flexibility and will not adapt to an event-driven incident and the individuals associated with it. In addition, the nurse epidemiologist was not familiar with standard CDC epidemiology programs (i.e., Epi-Info), making the use of computerized data collection impossible. This resulted in health department personnel using a paper-based system to collect relevant data and the double entry of the data before letters could be sent notifying the affected individuals that the substance they were exposed to posed no threat.

More importantly, a review of the data collected after the event revealed that core information such as phone numbers or addresses was missing, making contact with a significant proportion of this population virtually impossible. Problems such as these have potentially life-threatening consequences.

#### Training in bioterrorism response

A review of the county's and health department's Emergency Response Plans revealed there were no written plans or guidelines to respond to biological threats; this may have slowed notification of the proper authorities and perhaps delayed the actual identification of the unknown substance. The lack of specific training and preparation caused other problems as well, including the health department's environmental health responder with the HAZMAT crews not notifying the director of the health department of the potential public health disaster; having both the health department director and the director of environmental health at the scene simultaneously; and lack of a central point of control for all health department activities, including the management of incoming and outgoing information. A written response plan that all staff had reviewed and practiced in mock disaster drills beforehand would have removed some uncertainty surrounding the event.

#### Discussion

The majority of health departments across the U.S. do not have a plan to respond to a biological attack.

Because terrorists are opportunists by nature, as a nation, we are vulnerable to an attack. The potential spectrum of bioterrorism ranges from hoaxes to state-sponsored terrorism that employs classic biological warfare techniques designed to produce mass casualties.<sup>5</sup> Of particular concern are smallpox, anthrax, and plague.<sup>6</sup> The planning to meet these threats needs to start at the community level as local health departments are the first line of defense; too often, planning at the state and federal level neglects this important concept.

#### Local level capacity

In 1995, the National Association of County and City Health Officials (NACCHO) conducted a capacity assessment of local health departments throughout the nation. The study found that most local health departments are small and rely on limited staff, information systems, and financial resources. In addition, they found that there are serious deficiencies affecting the ability of local health departments to respond to public health emergencies. Moreover, local health department workers represent a wide range of occupations, including nurses, nurse practitioners, physician assistants, sanitation workers, and environmental health specialists.<sup>7</sup> There was a noted lack of trained epidemiologists and other public health professionals; these professionals are necessary to direct core public health activities including disease surveillance, communicable/infectious disease control, and other public health activities. These shortcomings create a risk for the entire nation, not simply selected cities or localities, especially when confronting bioterrorism events.

#### CDC funding

The CDC announced the availability of 40 million dollars in fiscal year 1999 to enhance public health preparedness and response for bioterrorism. A large portion of this cooperative funding agreement is to be used to develop local capacity. Specific areas of focus include preparedness planning and readiness assessment; expansion of surveillance and epidemiology capacity; increased laboratory capacity for chemical/biological agent identification; and the development of effective communication linkages and public health training capacity.



### Response strategies to bioterrorism

When planning a response strategy to bioterrorism, local health departments should identify key responders within their jurisdiction including EMS, law enforcement, and emergency management agencies. Defining the roles of each agency, including protection of first responders, is important.<sup>8</sup> Many of these agencies may already be working on their own programs and integrating the public health response within their plans may be an effective use of resources. Health department directors should familiarize themselves with the Nunn-Lugar-Domenici Act of 1997, which provides funding and federal support to enhance community response capability to biological and chemical events. Health officers also need to familiarize themselves with their local and state public health status and regulations, particularly those concerning isolation and quarantine of persons afflicted with infectious or contagious disease. The development of fact sheets on the most common biological and chemical threats should be considered for distribution to local medical providers to help them recognize the signs and symptoms of biological/chemical agents for inclusion in their differential diagnosis. The training of likely first responders (i.e., emergency department physicians) needs to be part of a comprehensive readiness plan.

### Casualties and capabilities

With few exceptions, treatment of a small number of individuals exposed to a chemical or biological agent is not beyond current medical capabilities; however, large numbers of casualties would overtax those capabilities quickly. Planning should include

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methods to enhance decontamination capabilities and supplementation of medical providers with personnel trained to respond to biological or chemical events. Assessment of local area hospitals on supplies of antidotes, drugs, ventilators, personal protective equipment, decontamination capacity, mass-casualty planning and training, isolation rooms for infectious disease, and familiarity of staff with the effects and treatment of chemical and biological weapons<sup>9</sup> are additional assessment and planning activities that must be conducted locally.

### Disease surveillance at the local level

Expanding disease surveillance and epidemiological capacity at the local level is an important component of bioterrorism preparedness. Not all acts of bioterrorism will be large-scale events and may involve only a small portion of a targeted population. This could be accomplished by dispersing pathogens in enclosed spaces or poisoning pharmaceuticals, prepared food, livestock, or crops. These types of situations may be missed or dismissed as background noise on a large state-based disease surveillance system but may be captured on a local one. For example, nearly all of the investigations that lead to the recognition of infectious disease outbreaks throughout the United States are initiated by local health departments,<sup>1</sup> and a local nurse or epidemiologist may be the first to identify a potential bioterrorism event through routine local disease surveillance activities; this is especially true if the pathogen is a "nontraditional" biological warfare agent (e.g., Salmonella). Local disease surveillance is an essential first step in preparedness and is important in helping law enforcement officials to react swiftly.<sup>5</sup>

### Types of incident categories

Surveillance systems at the local level must be able to capture and support three types of incident categories: (1) event driven, (2) disease specific, and (3) total counts. A bioterrorist or chemical incident is event driven and the surveillance system must be able to accommodate one to many individuals associated with the event; basic identification, demographic, and exposure data should be collected. A disease-specific event is where an individual is associated with a specific disease; this is the traditional



model of reportable disease surveillance. Total count is the ability to aggregate numbers of specific diseases without the need to capture personal identifiers or demographic data; total cases of gastroenteritis in a school district are an example of this type of capacity.

### "Buy in" from locals

The analysis of surveillance data is, in principle, quite simple. Data are examined by measures of time, place, and person.<sup>10</sup> Surveillance systems at the local level do not have to be elaborate to meet these needs, but they must be inclusive. It is important to seek "buy in" from local hospitals, clinics, and other health care providers in the local area as they are the providers of data. If a state is using an electronic disease surveillance system, efforts must be made to integrate the local system with the state system to facilitate bi-directional flow of data without the need to reenter data. By strengthening local surveillance capacity, the overall capacity of the state increases as well. Multiple points of entry into the surveillance system are important, and the development of electronic data capture while simultaneously accepting telephone and paper reports should be encouraged. It is important to provide feedback to the providers of surveillance data in the form of reports, updates, and other pertinent information. This will help assure them that the data are used for appropriate public health surveillance activities.

### Developing local capacity

Developing local epidemiological capacity is vital for increased bioterrorism preparedness. There are many ways to increase this capacity, including the use of distance learning programs provided by the CDC and a variety of summer and special training programs offered by universities and schools of public health around the country. The merits of updating a surveillance system without having staff trained with basic epidemiological skills should be considered carefully.

### Identification of support laboratories

While the expansion of laboratory capacity for the identification of chemical and biological agents is vital to the overall success of bioterrorism preparedness, generally it is beyond the scope of all but the largest health departments and therefore should be a

state-based activity. However, local health departments need to be aware of their state's capacity and be able to identify the nearest laboratory to be used for biological and chemical identification. In some instances, particularly for potential biological material, capacity may be limited to a handful of labs in the entire country.

### Modern systems and skills

To address bioterrorism threats effectively, local health departments must be given modern information systems and staff equipped with advanced, regularly updated professional skills. Unfortunately, most local health departments are forced to rely on outdated communication and information systems and many of their workers lack access to required training. A 1996 study conducted by NACCHO<sup>11</sup> revealed that many health departments have no access to the Internet or other essential on-line data and communication services; one-half of all local health departments did not use electronic mail (e-mail); computers are scarce commodities for many health workers and staff in 70 percent of the departments had "little or no expertise" in using on-line health data and services available from the CDC, state health departments, and other authoritative sources.

As local health departments attempt to overcome their lack of computer and telecommunications infrastructure, the initial challenge facing them will be how to transcend the surface appeal of computer technology and harness its power to improve the health of populations. Simply building an e-mail system with access to the Internet is not sufficient. Serious consideration needs to be given to systems integration. Traditionally, integration efforts have been attempted at the state or regional level and most ran out of resources before reaching the operational stage.

Because direct support for most public health service—including bioterrorism preparedness—occurs primarily at the local level, this is the logical starting point for all integration activities. However, this approach is nontraditional, may face "political" opposition, and will take several years to plan, develop, and implement. Because not all health departments have large staff or resources, grouping together and sharing scarce resources, expertise, and services may help ease the development of integrated public health information systems. These groupings also

may help in the development of effective bioterrorism response plans. Many local health departments do not have the staff or expertise to develop their own plan while a regional grouping of health departments can share resources and responsibilities and can form synergistic relationships that will benefit the entire public health community.



Given the current state of biological and chemical bioterrorism preparedness at local health departments throughout the country, the staff at the Wichita-Sedgwick Department of Community Health did an excellent job. Their action and flexibility represent the true spirit of public health and dedication to protecting the health of the community. The alleged use of *Bacillus anthracis* in Wichita should be used as an opportunity to assess local public health officials' actions and strengthen their response, for they may not be as fortunate in the future. Preparation and an increase in the capacity of local health departments are the keys to ensure an organized and successful response to this sinister public health threat.

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#### REFERENCES

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**Kansas Association of Local Health Departments  
Legislative Session 2001 Statement**

Public health services are an essential component of the quality of life in Kansas. The Kansas Association of Local Health Departments supports a strengthening of the partnership between the state and local governments in providing the necessary resources to ensure that all Kansans have access to core public health functions. Specifically, KALHD recommends state funding increases to two areas:

- 1.) A \$2.8 million increase in the FY 2002 General Health Programs funds from the state general fund
- 2.) A \$400,000 increase in the FY 2002 Local Environmental Protection Program (LEPP) from the Water Plan Fund.

**General Health Programs Funds**

KALDH supports a \$2.8 million dollar increase in the FY2002 budget for General Health Program funds. These funds appear in the Aid-to-Local portion of KDHE's budget and are state general fund dollars. The state dollars are distributed in accordance with the formula outlined in KSA 65-242. In 1980, a legislature-directed study recommended a general formula funding of \$1.9 million for local health departments. This study further recommended that state financing support an adjustment for future inflation. The 2001 General Health Program funding level is \$2.2 million, an increase of \$300,000 over a twenty year period. Local governments have clearly shouldered the increased costs due to inflation over this period of time.

The General Health Program Funds are a significant source of funding for local health departments and provide support for basic public health services such as immunizations, maternal and child health programs, and communicable disease investigations. These are the only non-categorical funds distributed to local health departments. This allows the dollars to be directed to the specific public health needs of each county. As needs vary in the 105 counties across the state, it is important to retain the flexibility of the General Health Programs Fund.

<b>General Health Program Formula Funds Recommendations</b>	<u>Recommended Level</u>	<u>Current Level</u>
1. Increase Funding	\$5 million	\$2.2 million
2. Increase Minimum Level Funding per County	\$14,000	\$7,000
3. Retain existing language in KSA 65-242 (distribution formula and maintenance of effort requirements) with exception of minimum funding amount.		
4. Retain local flexibility to designate use of funds to meet public health needs of the local community.		

**Local Environmental Protection Funds**

KALHD supports a \$400,000 increase in the LEPP funds from the Water Plan Fund. The funds are distributed to counties on a per capita basis in accordance with KAR 28-66-22. The proposed increase is recommended by the Kansas Water Authority. The LEPP funds provide support for basic environmental pollution prevention activities including sanitary code development, revision and enforcement in all areas of on-site wastewater

management and private water supplies. These activities not only protect public health in our local communities, they also protect both surface and ground water quality.

Local health departments are faced with new water quality program requirements. Across the state, KDHE is conducting Total Maximum Daily Load Studies (TMDL). These studies look at stream segments where the designated uses are impaired as defined by state's water quality standards. Pollutant loads are then allocated to the various sources in the watershed. Communities will need to respond with corrective actions to remove the use impairment. Local health departments will be involved in developing the community response. This will be a new program for local health departments. The increased funding will provide assistance in this area while allowing continued support of important existing environmental protection such as sanitary code enforcement and management of on-site wastewater systems.

**Local Environmental Protection Program Funds  
Recommendations**

	<u>Recommended Level</u>	<u>Current Level</u>
1.) Increase LEPP Funding	\$2.2 million	\$1.8 million
2.) Continue existing preventive programs as well as new TMDL responsibilities		

**Partnerships with other Groups**

The increased funding recommended in this Legislative Statement is consistent with the legislative platform of the Kansas Association of Counties. The KAC 2001 Legislative Priorities include "Increased State Participation in Local/State Partnership for Safe and Healthy Communities". The platform recommends:

"The State of Kansas, as a partner with counties in creating and ensuring healthy and safe communities, should assume it share of the financial responsibility for our shared goal. With shared responsibility, counties should enjoy shared financial participation from the State."

The proposals outlined in this Legislative Statement are a positive step in addressing the priority issue identified by the Kansas Association of Counties. The KALHD Legislative Committee will work closely with KAC to provide consistent and united support for the proposed increased financial assistance to local communities.

KALHD will also work with KPHA and KAS in support of these issues.

Through the initiative of Secretary Clyde Graeber, there is a renewed effort to strengthen the public health partnership between the state and local governments. This partnership is critical if we are to be successful in meeting the challenges of delivering quality public health services throughout Kansas. KALHD fully supports Secretary Graeber's initiative and looks forward to working with the Kansas Department of Health and Environment in meeting our common goals.





# Biological and Chemical Terrorism

*The Perspective of a  
Local Health Department*



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## Basic Outline

- Background
- Key Focus Areas – CDC Recommendations
- The importance of local public health

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## Vulnerability

- Vulnerability of U.S. civilians to chemical and biological agents recognized\*

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## Background

### *Vulnerability of U.S. Citizens*

- Known Terrorist Activities
  - Use of nerve gas (sarin) in a Tokyo subway\*

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## Use of Sarin in Tokyo



CNN

- Unsuspecting riders killed
- Unprepared responders killed
- Ill-equipped hospitals overwhelmed and contaminated
- Community paralyzed by terror

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## Background

### *Vulnerability of U.S. Citizens*

- Known Terrorist Activities
  - Use of nerve gas (sarin) in a Tokyo subway
  - Outbreak of salmonellosis due to intentional contamination of restaurant salad bars

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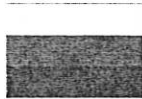
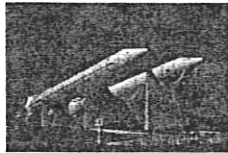
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## Background

### *Vulnerability of U.S. Citizens*

- Known Terrorist Activities
- Arsenals of Military Bioweapons\*



Russia

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## Background

### *Vulnerability of U.S. Citizens*

- Arsenals of Military Bioweapons
  - *Military use against civilian targets*
  - *Terrorists could steal the weapons*
    - Serious concern as:
      - Sophisticated delivery mechanisms
      - Engineered for mass dissemination

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## Background

### *Vulnerability of U.S. Citizens*

- Known Terrorist Activities
- Arsenals of Military Bioweapons
- Increasing Availability of Sophisticated Technology
  - *Recipes for preparing agents*
  - *Other instructions available on the internet*

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## Background

- Vulnerability of U.S. Civilians
- Coordinated U.S. Response
  - Nunn-Lugar-Domenici Act



Former Senator  
Sam Nunn



Senator  
Richard Lugar



Senator  
Pete Domenici

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## Background

### *Coordinated U.S. Response*

- Nunn-Lugar-Domenici Act
- Presidential Directives
  - DOD efforts
  - DOJ support
  - HRSA →MMRS

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## Key Focus Areas – CDC Recommendations

- Preparedness
- Detection and Surveillance
- Characterization of Biological and Chemical Agents
- Response
- Communication Systems

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## Preparedness

- Basic Concern
  - "Without special preparation at the local and state levels, a large scale attack with variola virus, aerosolized anthrax spores, a nerve gas, or a foodborne biological or chemical agent could overwhelm the local and perhaps national public health infrastructure."

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## Preparedness *CDC Priorities*

- Development of coordinated bioterrorism plans and protocols
- Establish a distance-learning system that provides biological and chemical terrorism training
- Disseminate guidelines and performance standards on biological and chemical terrorism preparedness planning

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## Detection and Surveillance

- Importance
  - "Because the initial detection of a covert\* biological or chemical attack will probably occur at the local level, disease surveillance systems at state and local health agencies must be capable of detecting unusual patterns of disease or injury, including those caused by unusual or unknown threat agents."

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## Detection and Surveillance

### *Overt versus Covert*

- Overt
  - Consequences immediate and obvious
  - Will usually involve a chemical agent
- Covert
  - Delay between exposure and illness
  - Usually involves a biological agent



*e. coli* bacteria

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## Detection and Surveillance

### *CDC Priorities*

- Strengthen state and local surveillance systems for illness and injury
- Develop new algorithms and statistical methods for searching medical databases on a real-time basis for evidence of suspicious events
- Establish criteria for epidemiologic investigation and notification of law enforcement

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## Characterization of Biological and Chemical Agents

### *CDC Priorities*

- Establish a multilevel laboratory response network for the identification of critical biological agents
- Establish regional laboratories that can provide diagnostic capacity during terrorist attacks involving chemical agents
- Establish around-the-clock capability at the CDC for diagnostic support and to expedite molecular characterization of critical biological agents

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**Response**  
*CDC Priorities*

- Assist state and local health agencies in organizing capacity to rapidly deploy in the event of overt or covert attacks
- Ensure rapid mobilization of CDC response teams to provide local assistance
- Establish a national stockpile to provide medical supplies in the event of a terrorist attack

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**Communication Systems**  
*CDC Priorities*

- Establish an electronic infrastructure for exchange of health information
- Implement a plan that ensures rapid dissemination of health information to the public during actual or potential acts of bioterrorism
- Create a website that disseminates bioterrorism preparedness, training and other information

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**Actions at the Local Level**  
*The WSCDCH Experience*

- Needed actions
  - Develop basic IM capabilities
  - Enhance basic epidemiologic capabilities
  - Implementation of the KDHE bioterrorism grant
  - MMRS proposal implementation\*

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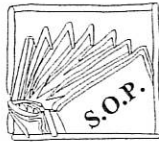
MMRS Proposal  
*Relation to CDC Key Focus Areas*

- Preparedness\*

Training...the first step in disaster preparedness



Nebraska Emergency Management Agency



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MMRS Proposal  
*Preparedness*

- Develop SOPs with other local agencies and the state
  - Patient management
  - Laboratory support
  - Public affairs
- Create additional training opportunities
- Work with KALHD and KDHE to develop additional health department standards for these efforts

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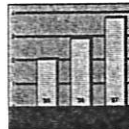
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MMRS Proposal  
*Relation to CDC Key Focus Areas*

- Preparedness
- Detection and Surveillance\*



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## MMRS Proposal

### *Detection and Surveillance*

- Create a strong health surveillance program
  - Geographic boundaries to be determined
  - Collaboration with many entities
    - ER's
    - Hospital labs
    - Schools
    - Coroner's office
    - Vet. facilities
    - Other clinics
- Work with KDHE to develop standard methods for data collection and analysis

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## MMRS Proposal

### *Relation to CDC Key Focus Areas*

- Preparedness
- Detection and Surveillance
- Characteristics of Biological and Chemical Agents\*



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## MMRS Proposal

### *Characterization of Biological and Chemical Agents*

- FBI has established agreements with lab in KC and Missouri Department of Health
- Other labs will develop capabilities in the near future
- Will develop further protocols for specific circumstances

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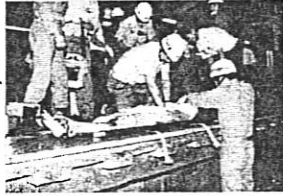
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### MMRS Proposal

#### *Relation to CDC Key Focus Areas*

- Preparedness
- Detection and Surveillance
- Characterization of Biological and Chemical Agents
- Response\*



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### MMRS Proposal

#### *Response*

- Enhancement of HAZMAT capabilities
  - New equipment for identification of chemical substances after an overt attack
  - Increased role in environmental sampling, defining impact and extent of contamination, and support of decontamination of patients and environment

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### MMRS Proposal

#### *Response (2).*

- Enhancement of HAZMAT capabilities
- Increased epidemiologic responsibilities\*

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MMRS Proposal  
*Epidemiologic Response*

- Overt attack
  - Support EMS at scene
  - Provide key information to hospitals
  - Collaborate with HAZMAT team
- Covert attack
  - Maintain functioning health surveillance program
    - Sound alarm in timely manner
  - Coordinate needed interventions

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MMRS Proposal  
*Relation to CDC Key Focus Areas*

- Preparedness
- Detection and Surveillance
- Characterization of Biological and Chemical Agents
- Response
- Communication Systems\*

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MMRS Proposal  
*Communication Systems*

- Work with KDHE to see how this program can provide further support for development of the Health Alert Network
- Develop infrastructure for an appropriate website

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### WMD Process

*Some Benefits of Local Health Department Involvement*

- Health Surveillance Program that will provide infrastructure for other public health needs
- Health Department develops and enhances key relationships that will help program development in other areas
- Obtain training and equipment that will improve skills and capabilities of Health Department staff

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### Final Comments

- Capable health departments are the most essential components for a successful response to biological terrorism
- No local health department in Kansas possesses the necessary infrastructure to manage this responsibility

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### Final Comments (2)

- Additional funding will be required to develop this essential infrastructure
- Secretary Graeber has championed an effort that would enable us to start building this infrastructure – increase in State Formula funding for local health departments\*

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Secretary Graeber's Proposal  
↑ *State Formula -- Methods*

- State general fund
- Senate Ways and Means subcommittee proposal
  - 1¢ sales tax on cigarettes
  - Fantastic idea
  - Should consider increasing

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Final Comments (3)

- Additional funding is necessary for infrastructure development to adequately address bioterrorism, but this development will benefit other areas as well\*

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Health Department  
*Infrastructure Development -- Additional Benefits*

- Other surveillance capabilities
  - Emerging infectious diseases
    - West Nile fever
    - Denge fever
    - "A plane ride away"
  - Increasing antibiotic resistance

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### Health Department

#### *Infrastructure Development – Additional Benefits (2)*

- Other surveillance capabilities
- Ability to monitor immunization status
  - Kansas not doing well
    - 75.1%\* vs. 79%\* nationwide
  - Sedgwick County is worse
    - Only 70.8%\*

\* = % 2-year-olds appropriately immunized by kindergarten/first grade

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### Health Department

#### *Infrastructure Development – Other Benefits*

- Other surveillance capabilities
- Ability to monitor immunization status
- Enhanced maternal and child health programs\*

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### Infrastructure Development

#### Enhanced Maternal and Child Health

- Health departments could implement a program that involves traditional public health initiatives (ex. Home visiting) that rigorous research has shown to be effective in reducing many significant health and social problems in a cost-effective manner – Nurse Family Partnership (formerly called Olds Model).\*

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**Nurse Family Partnership**  
*Some Benefits*

- Healthier mother and babies
- Decreased child abuse
- Less juvenile delinquency
- Fewer welfare costs
- Decline in childhood injuries
- Substance use in women, children and adolescents lessened

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**Conclusion**

- With a relatively small investment, local health departments can make many great things happen for Kansas. Protecting Kansas citizens from the deadly consequences of bioterrorism is only one potential benefit

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