

Executive Summary

Since 1891, the Washington State Board of Health (Board) has been responsible for providing suggestions for legislative action related to improving the public's health. The Board has been producing biennial State Health Report since 1977. The purpose of the report is to identify "public health priorities for the ensuing biennium and such legislative action as it deems necessary." RCW 43.20.100 requires the Board to produce the report in even numbered years for the Governor's review and approval. The 2020 report highlights key statewide public health policy initiatives that we believe deserve the Governor and Legislature's attention.

The Board's 2020 report focuses on recommendations that will:

- Help modernize and stabilize Washington's public health system;
- Reduce the burden of smoking and vapor products;
- Improve access and equity, and dismantle racism in state government;
- Make sure school environments are safe and healthy places for children to learn, play, and grow.

Strengthen and Transform Washington's Public Health System

The Washington governmental public health system is comprised of the Board, Washington State Department of Health (Department), 35 local health jurisdictions (LHJs) and sovereign tribal nations¹. The governmental health system has a unique and critical public safety role that is focused on protecting and improving the health of Washington's families and communities by providing Foundational Public Health Services (FPHS). FPHS are a defined and limited set of population-based programs and activities that are provided by the governmental health system, and are mandated by state or federal law. To have a fully functional public health system that can respond to disease outbreaks and emerging health threats such as COVID-19, FPHS (e.g., vital statistics, disease surveillance and food and drinking water safety) must be available in every community. In the 2017-2019 biennium, the Legislature made an initial investment of \$15 million in the public health system for the purposes of modernizing and stabilizing the system. In the 2019-2021 biennium, the Legislature made a \$28 million investment in the governmental public health system. More is needed to fully fund FPHS and protect the public's health and the state's economy. The Board recommends the continuation and expansion of this initial investment. The current gap in public health funding is estimated at \$450,000,000 per biennium.

Improve health by decreasing use of tobacco, nicotine, and vapor products

In 2019, Washington State lawmakers passed Engrossed House Bill 1074 raising the minimum age for purchasing tobacco and vapor products to 21 years. Smoking and tobacco product use is responsible for 17 to 19 percent of all deaths in Washington, and most adult smokers begin smoking before they turn 21.² This is a smart, evidence-based approach to reducing illness and death associated with smoking.

¹ 29 sovereign tribal nations and two urban Indian health programs. The American Indian Health Commission is a member of the FPHS steering committee, and serves on behalf of the tribal nations and urban Indian health programs. The Washington State Association of Local Public Health Officials serves on behalf of the 35 local health jurisdictions.

² Washington State Department of Health. [2018 Washington State Health Assessment](#). Accessed on 4/23/2018

However, the sudden rise in use of e-cigarettes and vapor products by youth and young adults reversed decades of progress reducing youth nicotine use.³ The Board recommends the Governor and Legislature prohibit the sale of flavored nicotine and tobacco products, including vapor products, to reduce the appeal and use of these products by youth and young adults.

Dismantle Racism and Improve Equity in State Government

The Board recognizes that racism and other forms of discrimination has been institutionalized and perpetuated through policies and practices that prevent meaningful community engagement and limit access and opportunity to important public services. Health equity means all people have the opportunity to attain their full health potential regardless of race/ethnicity, income, education, gender identity, sexual orientation, disability, or other socially determined circumstances.⁴ High-quality health care and education, food security, justice and a living wage are necessary for optimal health. Inequities persist because institutionalized racism has created barriers for Black, Indigenous and People of Color and other marginalized groups to accessing these basic needs. In order to achieve health equity, state government needs to have appropriate tools to identify and dismantle institutional racism.

During the 2020 legislative session, the legislature passed Engrossed Second Substitute House Bill 1783 creating the Washington State Office of Equity. The purpose of this office is to promote access to equitable opportunities and resources that reduce disparities for people in Washington and improve outcomes statewide across state government. The Office will facilitate state policy and systems change to promote equitable policies, practices, and outcomes by assisting agencies in applying an equity lens to agency decision-making. Unfortunately, due to the economic downturn resulting from the COVID-19 pandemic, Governor Inslee vetoed the funding for this important office. The Board believes that this Office will fill a critical need in helping state agencies identify and dismantle institutional racism. The Board recommends the Governor and Legislature fully fund the Washington State Office of Equity in alignment with the Office of Equity Task Force's final proposal.⁵

Make School Environments Healthy and Safe for Washington's Students

The COVID-19 pandemic has exposed the impacts of school environments on students, families and the economy. There are more than 1.2 million students that spend over 1,000 hours in public and private school facilities each year. Since 1960, the Board has had school environmental health and safety rules intended to assure that these facilities are clean and safe places for kids to learn, play, and grow. The Board modernized these rules in 2009, and that same year, the Legislature suspended the implementation through a budget proviso. Children are more vulnerable to toxics and hazards than adults. The suspended rules establish consistent minimum statewide standards that assure schools are designed, built, and maintained to protect children and help prevent illness and injury. Local health

³ Washington State Department of Health. [2018 Washington State Healthy Youth Survey Data Brief: Tobacco and Vapor Products](#). Accessed on 9/13/2020

⁴ Centers for Disease Control and Prevention. [Attaining Health Equity](#). Accessed on 4/16/2018.

⁵ Once finalized, the Office of Equity Task Force's Final Proposal will be posted to the [Office of Equity Task Force webpage](#) on the Governor's Interagency Council on Health Disparities website.

jurisdictions play a key role in providing site plan review and pre-operation inspections for new schools. Regular health and safety inspections can help identify air quality issues, assess for toxins and other hazards that can help prevent illness and injury. Unfortunately, only twelve out of thirty-five local health jurisdictions have school environmental health and safety programs in their county. These programs vary by health jurisdiction and none are sufficiently resourced to regularly and fully inspect each school their county. In addition, school environmental health and safety programs have been negatively impacted by the pandemic as resources have had to shift from activities like school safety inspections to COVID-19 response. As school districts make the transition to and from distance learning to in-person instruction, it is imperative that schools are a safe place for Washington's students. The Board urges the Governor to remove the budget proviso that suspends the updated school environmental health and safety rules; prioritize funding for heating, ventilation, and air conditioning (HVAC) systems to improve indoor air quality and reduce COVID-19 transmission; and provide funding so every community has regular school environmental health and safety inspections.

Strengthen and Transform Washington’s Public Health System

Washington State has a fundamental responsibility to protect the public’s health⁶. The governmental public health system, comprised of the Board, Department of Health (Department), local health jurisdictions (LHJs), and sovereign tribal nations, has a critical and unique public safety role that is focused on protecting and improving the health of families and communities. As a system, we work to help people live healthier, longer lives. When our people are healthier, the economic health and vitality of our communities is improved.

As of April 2020, Washington’s population is estimated at 7,656,200. The state’s population grew 1.5 percent from the previous year. Seventy-six percent of Washington’s growth is due to people moving to the state, and 24 percent represents in state births.⁷ As our population grows, greater demands are placed on our public health system while funding for core services (such as disease surveillance and control, drinking water and food safety, chronic disease and injury prevention) has been declining for years. This leaves the public at increasing risk of unnecessary disease and even death.

Washington’s governmental public health system provides unique services to communities across the state. The public relies on and expects this system to identify disease outbreaks early and prevent them from spreading; keep our food and drinking water safe; and work with community partners to plan, prioritize, and implement services that meet the communities’ greatest needs and make the best use of resources. In order to achieve a fully functioning public health system that can provide these services, the state must fund the [Foundational Public Health Services](#) (FPHS) so they are available in every community. Figure 1 illustrates the core services provided by the governmental public health system.

⁶ RCW 43.70.512

⁷ Office of Financial Management. [State of Washington 2017 Population Trends](#) Accessed September 2020

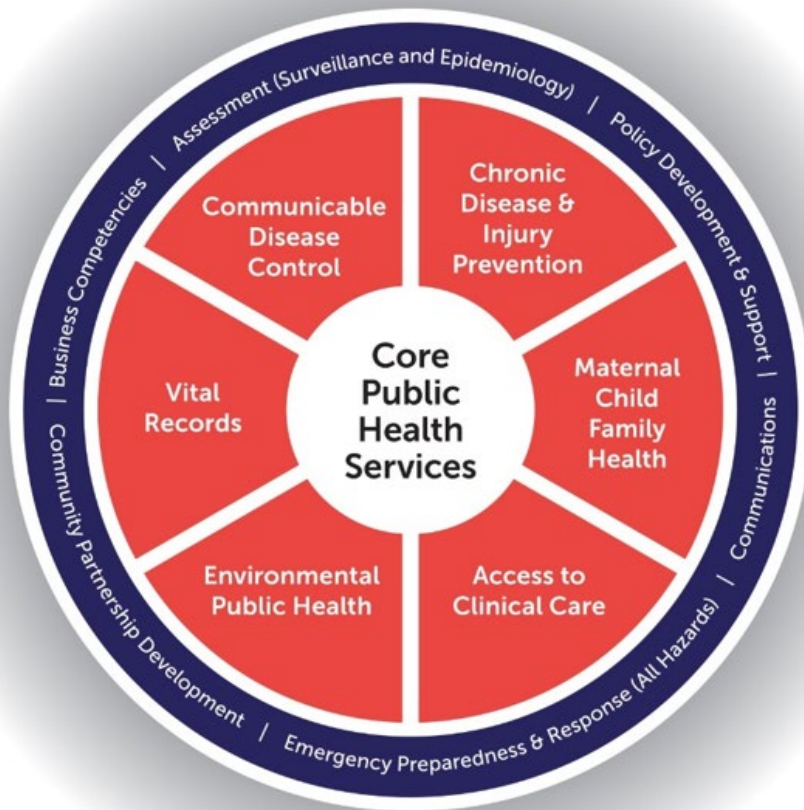


Figure 1

Unfortunately, the infrastructure that helps support the delivery of FPHS by the governmental public health system continues to be put at risk due to cuts in federal, state and local funding. The public health system is hard pressed to serve the diverse needs of our growing population and fulfill its basic statutory responsibilities. The COVID-19 pandemic has emphasized the need to adequately fund FPHS and shift focus from reactive, crisis-driven strategies to more proactive strategies to protect and preserve public health.

For the last nine years, the Board has worked as a part of the governmental public health system with state and local public health leaders and tribal representatives to better understand the challenges that the system faces to rebuild and maintain a fully functional public health system that is capable of meeting its legal mandates to protect the public's health. In the 2017-2019 biennial budget, the Legislature made an initial one-time \$15 million investment to support efforts to improve and transform

the governmental public health system. The Legislature also provided a one-time appropriation of \$3 million to implement the Governor's lead directive in the 2017-2019 biennial budget.

After this initial investment, a statewide FPHS [baseline assessment](#) was conducted to identify the degree to which FPHS is currently implemented and operating, estimated costs and funds needed for full implementation, and services most likely to benefit from possible new service delivery models.⁸ The baseline assessment determined that no foundational program or capability is fully or significantly implemented across all responding agencies. This suggests that FPHS in Washington State do not currently meet the condition of "must exist everywhere, to work anywhere."⁹ There was wide variability in service gaps across agencies and statewide system. The current gap in public health funding is estimated at \$450,000,000 per biennium.

A portion of the 2017-2019 biennial budget funds appropriated by the Legislature were invested in new service delivery models by funding four shared service demonstration projects. These projects focused on sharing staff, expertise, and technology across LHJs to deliver specific FPHS in communicable disease and assessment. Project descriptions and one-year evaluation results can be found in the [Service Delivery Demonstration Projects Year 1 Evaluation](#) report.

Of the \$450,000,000/ biennium needed, the FPHS Steering Committee identified the highest priority "fund first" FPHS services including communicable disease, environmental public health, assessment (e.g., epidemiology, disease surveillance, and community health assessment), and the capabilities that support them to include in the decision package that totaled \$296,000,000/ biennium. The Legislature allocated an additional \$28 million for FPHS In the 2019-2021 biennial budget. The public health system has used these dollars to expand upon the original demonstration projects and invest in infrastructure, new service delivery models, reinforcing capacity, and tribal FPHS. These investments have also contributed to increased effectiveness in our COVID-19 response. The following are examples of how these investments have been used in the community.

- **Island County Health District.** The Island County Health District received \$46,238 that was invested in communicable disease investigations. These additional funds have allowed the district to maintain back-up staff to support and improve response time for case investigation and staff the office five days per week.
- **Spokane Regional Health District.** Spokane Regional Health District received \$450,485 which has allowed the hiring of additional staff for communicable disease investigation and treatment; collaboration with schools, health care providers, and community partners to increase immunization rates; and COVID response, including case investigations, contact notifications, business consultations, and community testing coordination.

The Board recognizes that to achieve this goal Foundational Public Health Services will need stable consistent funding implemented over the course of multiple biennia. By investing a small amount in

⁸ Note: Tribes were not included in the baseline assessment as they were engaged in a tribally-driven process to define FPHS delivery framework, costs, and gap analysis.

⁹ Washington State Public Health Transformation Assessment Report, BERK Consulting, September 2018. Accessed September 2020.

FPHS over the past two biennia, the legislature has begun addressing the chronic underfunding and resulting detrimental effects on people, communities, and state's economy.

The COVID-19 pandemic has illustrated the importance of a fully funded and functional public health system. While investments from previous and current biennia have made some critical improvements that positioned the public health system to respond to COVID-19 better than it would have without these funds, chronic underfunding of FPHS resulted in the system continuing to play catch up in response to a global pandemic. There is necessary work that remains unfunded.

COVID-19 has disproportionately impacted communities of color and low-income communities. Structural inequities have contributed to underlying health, social, and economic disparities that put these communities at greater risk of infection during the pandemic. A key defense against any public health crisis is investing in core public health services, including the ability to address social determinants of health and reduce health disparities through culturally and linguistically appropriate services.

COVID-19 has also demonstrated the importance of collection, analysis, and regular reporting of detailed demographic data. Early on, demographic data were not consistently reported for cases, hospitalizations, and deaths related to COVID-19. The collection and regular public reporting of demographic data by race, ethnicity, sex, gender identity, age, primary language, socioeconomic status, disability status, county, and other demographic information of cases, hospitalizations, and deaths are essential during health emergencies.¹⁰ This disaggregated data are vital to identifying impacted areas and partnering with communities on outreach, prevention, and access to care. Without these data, the public health system cannot equitably respond to a public health crisis, such as COVID-19. And this requires additional staff. In addition, up to date information systems and technology must be in place and functional to facilitate collection and transmittal of data. These data are only as good as the public health system's ability to receive and analyze it for meaningful use. Interoperability of public health data systems must be prioritized.

The investments in FPHS, first with one-time funding and subsequently with ongoing funding is an important step forward. The small amount of funding is a small step in the right direction. More is needed to fully fund FPHS and protect the publics' health and the states' economy. The Board recommends the continuation and expansion of these initial investments in future biennia to ensure comprehensive and stable funding for assessing and controlling communicable disease and enhancing environmental public health services. The current gap in public health funding is estimated at \$450,000,000.

¹⁰ [What we are learning from COVID-19 about being prepared for a public health emergency](#). Trust for America's Health. Accessed September 2020.

Improving health by decreasing use of tobacco, nicotine, and vapor products

Smoking and tobacco products are the leading cause of preventable disease, disability, and death in the United States. Tobacco use is responsible for approximately 17-19 percent of all deaths in Washington. About 95 percent of adult tobacco smokers began smoking before they turn 21.¹¹ In 2015, the Institute of Medicine released its report Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products,¹² which concluded that raising the minimum age of legal access to tobacco products to 21 will prevent or delay initiation of tobacco and nicotine use by adolescents and young adults and therefore lead to a “substantial reduction in smoking-related mortality.” The Board recognizes exposure to all forms of inhaled products, including tobacco, vaporized nicotine products with electronic devices, and cannabis smoking have an adverse effect on health, which worsens with long-term use.

In 2019, the Washington State Legislature passed Engrossed House Bill 1074 (Chapter 15, Laws of 2019), which raised the minimum age of purchase for tobacco and vapor products to 21 years. The Board completed a Health Impact Review of the bill, in which staff evaluated the scientific evidence to determine its strength (i.e., Not Well Researched, A Fair Amount of Evidence, Strong Evidence, or Very Strong Evidence). The Health Impact Review of HB 1074 found a fair amount of evidence from other states and local jurisdictions that changing the minimum purchase age would likely decrease use of tobacco and vapor products among youth and young adults.¹³ It also found very strong evidence that decreasing the use of tobacco and vapor products among youth and young adults will likely improve health outcomes for those youth as well as for others who would have been exposed to secondhand smoke or smoking in utero. The new law went into effect January 1, 2020. Continued monitoring and evaluation of the impacts on use of tobacco, vapor products, and cannabis use will be necessary to identify the effectiveness of the law and to suggest other ways to decrease these products.

Despite decreasing use of tobacco products generally among middle and high school students from 2011 to 2017,¹⁴ the use of e-cigarettes, or vapor products, by these age groups increased dramatically.¹⁵ Results from the 2018 Washington State Healthy Youth Survey indicate the prevalence of current (i.e., past 30-day) vapor product use among 6th graders (3%), 8th graders (10%), 10th graders (21%), and 12th graders (30%) significantly increased from 2016.¹⁶ E-cigarettes are now the most commonly used tobacco and nicotine product among youth. The Department of Health reports, “The vaping epidemic has reversed decades of progress reducing youth nicotine use.”¹⁵ Research consistently shows that flavors, and associated advertising, contribute to the appeal, initiation, and use of tobacco and nicotine

¹¹ Washington State Department of Health. [2018 Washington State Health Assessment](#). Accessed on 9/13/2020

¹² IOM (Institute of Medicine). 2015. Public health implications of raising the minimum age of legal access to tobacco products. Washington, DC: The National Academies Press.

¹³ Washington State Board of Health. [Health Impact Review of HB 1074](#). Accessed on 9/13/2020

¹⁴ Wang T.W., Gentzke A., Sharapova S., et al. Tobacco Product Use Among Middle and High School Students--United States, 2011-2017. *Morbidity and Mortality Weekly Report*, Centers for Disease Control and Prevention. 2018;67(22):629-633.

¹⁵ Surgeon General's Advisory on E-cigarette Use Among Youth [press release]. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2018.

¹⁶ Washington State Department of Health. [2018 Washington State Healthy Youth Survey Data Brief: Tobacco and Vapor Products](#). Accessed on 9/13/2020

products, including vapor products, particularly among adolescents and young adults.^{17,18,19} In 2009, the Family Smoking Prevention and Tobacco Control Act banned flavored combustible cigarettes (except menthol and tobacco)^{20,21} specifically as one strategy to reduce the use of cigarettes among young people. Meanwhile, estimates suggest there are over 460 brands and 8,000 flavors of e-cigarettes on the U.S. market.^{22,23} JUUL Labs, which has more than 70% of the U.S. e-cigarette market share,²⁴ reported 85% of its sales are from mint and other flavors.²⁵

During the 2020 Legislative Session, the Board conducted Health Impact Reviews of Senate Bill 6254 and House Bill 2454.²⁶ The original proposals would have prohibited the sale of flavored vapor products or any product that is known or reasonably should be known to be used with or in a vapor product to create a flavored vapor product. The Health Impact Reviews found very strong evidence that prohibiting the sale of flavored vapor products is likely to decrease initiation and use of vapor products among adolescents and young adults and use of other tobacco products among these age groups. There is also very strong evidence that decreasing the use of vapor and tobacco products among adolescents and young adults will improve health outcomes. For example, a large body of recent research found that solvents and flavor chemicals in e-cigarettes cause harm at the cellular level and are cytotoxic.^{22,27,28,29} Moreover, evidence shows that flavor chemicals are cytotoxic in both e-liquid and aerosol forms.^{27,28} It was unclear how and to what extent the bills would affect initiation and use of other flavored tobacco products by adolescents and young adults. We remain in this precarious situation since neither bill passed during the 2020 Legislative Session.

¹⁷ Huang L. L., Baker H. M., Meernik C., et al. Impact of non-menthol flavours in tobacco products on perceptions and use among youth, young adults and adults: a systematic review. *Tob Control*. 2017;26(6):709-719.

¹⁸ Garrison K. A., O'Malley S. S., Gueorguieva R., et al. A fMRI study on the impact of advertising for flavored e-cigarettes on susceptible young adults. *Drug Alcohol Depend*. 2018;186:233-241.

¹⁹ Goldenson N. I., Kirkpatrick M. G., Barrington-Trimis J. L., et al. Effects of sweet flavorings and nicotine on the appeal and sensory properties of e-cigarettes among young adult vapers: Application of a novel methodology. *Drug Alcohol Depend*. 2016;168:176-180

²⁰ Family Smoking Prevention and Tobacco Control Act, 123 (2009). <https://www.govinfo.gov/content/pkg/PLAW-111publ31/pdf/PLAW-111publ31.pdf>

²¹ Courtemanche C.J., Palmer M.K., Pesko M.F. Influence of the Flavored Cigarette Ban on Adolescent Tobacco Use. *American Journal of Preventive Medicine*. 2017;52(5):e139-e146

²² E-cigarettes linked to heart attacks, coronary artery disease and depression [press release]. American College of Cardiology. 2019.

²³ Gerloff J., Sundar I. K., Freter R., et al. Inflammatory Response and Barrier Dysfunction by Different e-Cigarette Flavoring Chemicals Identified by Gas Chromatography-Mass Spectrometry in e-Liquids and e-Vapors on Human Lung Epithelial Cells and Fibroblasts. *Appl In Vitro Toxicol*. 2017;3(1):28-40.

²⁴ Kaplan Sheila, Hoffman Jan. Juul Suspends Selling Most E-Cigarette Flavors in Stores. *The New York Times*. 13 November 2018, 2018;Health.

²⁵ Kaplan Sheila. Trump Administration Plans to Ban Flavored E-Cigarettes. *The New York Times*. 11 September 2019, 2019

²⁶ Washington State Board of Health. [Health Impact Reviews of SB 6254 and HB 2454](#). Accessed on 9/13/2020

²⁷ Hocharoen Chanalee. An evaluation of potential harm of electronic cigarette aerosol exposures and directions for research and regulation. In: Taft D, ed: ProQuest Dissertations Publishing; 2015.

²⁸ Behar R. Z., Wang Y., Talbot P. Comparing the cytotoxicity of electronic cigarette fluids, aerosols and solvents. *Tob Control*. 2017;27(3):325-333.

²⁹ Omaiye E. E., McWhirter K. J., Luo W., et al. High-Nicotine Electronic Cigarette Products: Toxicity of JUUL Fluids and Aerosols Correlates Strongly with Nicotine and Some Flavor Chemical Concentrations. *Chem Res Toxicol*. 2019;32(6):1058-1069.

One of the arguments used against the legislation to remove flavored products pertains to the potential for e-cigarettes to be used by adults to quit smoking combustible cigarettes. Currently, e-cigarettes are not approved by the U.S. Food & Drug Administration (FDA) as an aid to quit smoking.³⁰ The U.S. Department of Health and Human Services stated that, “so far, the research shows there is limited evidence that e-cigarettes are effective for helping smokers quit.”³¹ Vapor product manufacturers may apply to have their product reviewed by FDA for approval as a cessation option which could include flavors. A continuing concern is that adults who use e-cigarettes are continuing their addiction to nicotine and at higher doses than when they used combustible tobacco.

The Board believes that the potential reduction in morbidity and mortality by banning flavored nicotine and tobacco products, including vapor products, could greatly improve the health and welfare of people in Washington, particularly youth and young adults. Local governments are restricted by preemption from prohibiting or restricting flavors within their jurisdictions. Therefore, the State needs to take this action to protect future generations from a lifetime of nicotine addiction. The Board recommends the Governor and Legislature prohibit the sale of flavored nicotine and tobacco products, including vapor products, to reduce the appeal and use of these products by youth and young adults.

³⁰ Ghinai Isaac , Navon Livia , Gunn Jayleen K.L. , et al. Characteristics of Persons Who Report Using Only Nicotine-Containing Products Among Interviewed Patients with E-cigarette, or Vaping, Product Use-Associated Lung Injury -- Illinois, August-December 2019. *MMWR Morb Mortal Wkly Rep.* 2020;69

³¹ What we know about electronic cigarettes. 2019; Available at www.smokefree.gov. Accessed 9/9/2019

Dismantle Racism and Improve Equity in State Government

Health **starts** where we live, learn, work, and play. That statement has become a mantra in the public health community. It highlights that our health is determined by so much more than what happens in a doctor's office. Far more than health care, our health is influenced by the level of our education, our jobs, our income, and our environment, and these are all influenced by systemic racism and oppression. Unfortunately, because we are not all **starting** from the same place, we do not all have the same opportunities to achieve optimal health.

Health equity is defined as all people having the opportunity to attain their full health potential regardless of social position, race/ethnicity, income, education, gender identity, sexual orientation, disability, or other socially determined circumstances.³² The coronavirus pandemic has dramatically illustrated adverse impacts of this crisis, including increased risk of disease, hospitalization, and death among Black, Indigenous, and People of Color (BIPOC) and marginalized communities. The pandemic has also shown that the economic impacts of crises impact these communities more severely.

In August 2020, the Washington State Department of Health released a report that showed the significant disproportionate impacts that COVID-19 has had on Washington's communities of color. With regard to COVID-19 cases, Native Hawaiian or Other Pacific Islander people (NHOPI) and Hispanic people have age-adjusted rates approximately seven times higher relative to White people. Hospitalizations are eight times higher for Hispanics and twelve times higher for Native Hawaiian or Other Pacific Islanders relative to Whites. Hospitalization and case rates for Black people are approximately three times higher than those of Whites. American Indian and Alaska Native (AIAN) case rates are two and half times higher and hospitalization rates are three times higher compared to whites. Among COVID-19 deaths, there is a similar trend although not as extreme, with rates over five times higher for NHOPI, four times higher among Hispanic, and over three times higher among AIAN compared to Whites³³.

The burden of COVID-19 disease among Black, Indigenous, and People of Color (BIPOC) and other marginalized communities is not unique to this pandemic. Health inequities have resulted from past pandemics and emergencies. They predictably stem from systemic barriers that impact all parts of our lives. Historically, systems and institutions have been designed to exclude, marginalize, and erase certain populations. Privileges and burdens are distributed unevenly across society, so that marginalized communities experience the worst impacts of every crisis. Communities still feel the reverberations of the Great Recession (2009), and the coronavirus pandemic has compounded and intensified these struggles.³⁴

The coronavirus pandemic has disproportionately impacted BIPOC communities, who face greater financial difficulties than their White counterparts. A recent national poll by NPR, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health found that among households participating in the poll, the pandemic's financial impacts are severe. These impacts include difficulties paying for housing, utilities or car payments, affording medical care, paying credit cards or other debt, affording food, or depleting savings. For Black respondents, 40% say they are struggling to pay rent or mortgage, and 43% say they are having trouble paying utilities. For Latino households that lost income,

³² Washington State Department of Health. [Health Equity](#). Accessed on 9/24/2020.

³³ Washington Department of Health [COVID-19 Morbidity and Mortality by Race, Ethnicity and Language in Washington](#) State August 26, 2020

³⁴ Once finalized, the Office of Equity Task Force's Final Proposal will be posted to the [Office of Equity Task Force webpage](#) on the Governor's Interagency Council on Health Disparities website.

46% say they are struggling to pay mortgage or rent. About a third of both Black and Latino respondents who lost household income said they are struggling to pay for food. Seventy-two percent of Latino and fifty-five percent of American Indian respondents say their households are facing serious financial problems compared with 36 percent of Whites³⁵.

The Board acknowledges and supports the important pandemic response efforts Governor Inslee has carried out to help address some of these inequities. For example, as part of the pandemic response, Washington now has a statewide [language access plan](#), requiring all cabinet agencies to translate vital COVID-19 information into the top 36 languages spoken in the state. As a result, in-language landing pages are available on the [Washington State Coronavirus Response website](#). Grant funds are being issued to community organizations for the purpose of reaching those communities hardest hit by the pandemic. The Governor has also worked to expand access to broadband for rural and under-served communities improving telemedicine opportunities and remote learning opportunities for students. These strategies need to extend beyond the COVID-19 pandemic, and become normalized across state government.

The 2019-2021 biennial operating budget, ESHB 1109 (section 221, subsection 7), included a proviso that directed the Governor's Interagency Council on Health Disparities to convene and staff an Office of Equity Task Force. The Task Force was established to develop a proposal for the creation of a state office of equity. The Office of Equity is intended to promote access to equitable opportunities and resources that reduce disparities, including racial and ethnic disparities, and improve outcomes statewide across all sectors of government. In its draft final report, the Task Force identified key roles and responsibilities of an office of equity, that would guide and support state government's efforts to address the disparities experienced by vulnerable and marginalized communities.

State agencies have a statutory duty to serve all people in Washington. As a system state agencies must examine practices, policies, and services to identify and dismantle institutional racism. State agencies need assistance to develop and implement successful strategies to eliminate systemic inequities. The Office of Equity will assist state agencies in applying an equity lens to decision making, providing barrier-free access to services, increasing opportunities for participation, and improving outcomes statewide across sectors. The Office will help state government break down systems of racism and oppression and re-envision and rebuild systems of equitable opportunity.

During the 2020 legislative session, the Legislature passed ESSHB 1783 (Chapter 332, Laws of 2020), which establishes the State Office of Equity within the Governor's Office. This office is intended to provide a unified vision around equity for all state agencies, and assist agencies in promoting diversity, equity and inclusion in all aspects of their decision making including services, programming, policy development, budgeting and staffing. Unfortunately due to the severe economic downturn due to the coronavirus pandemic, funding to run this office was eliminated from the 2021-2023 biennial budget³⁶.

The pandemic has disproportionately impacted Washington's communities of color. They experience a higher rate of disease, and bear a greater burden of its economic consequences. The impacts of this pandemic are cumulative and will undoubtedly persist for many years. Jan Olmstead and Dr. Ben

³⁵ [The Impact of Coronavirus on Households by Race/ Ethnicity](#) September 2020 NPR/Robert Wood Johnson Foundation/Harvard TH Chan School of Public Health

³⁶ [ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1783](#) (Chapter 332, Laws of 2020) Partial Veto

Danielson co-chaired the State Office of Equity Taskforce, and commented on the impacts of inequity. “We all pay for inequity. In terms of diminished dignity, deferred opportunities, and decreased health. Pragmatically, we all also pay for inequity financially. In terms of compromised work productivity, higher public service needs and healthcare costs. An investment in equity is a cost-saving venture, by any measure.³⁷ “

The Board recommends the Governor and Legislature provide adequate and sustainable funding in alignment with the Office of Equity Task Force’s Final Proposal.³⁸

³⁷ 2020 Office of Equity Proposed Final Report

³⁸ Once finalized, the Office of Equity Task Force’s Final Proposal will be posted to the [Office of Equity Task Force webpage](#) on the Governor’s Interagency Council on Health Disparities website.

Make School Environments Healthy and Safe for Washington’s Students

During the 2019-2020 school year, there were over 295 public school districts serving 1,147,573 students³⁹ and 795 private schools serving 108,545 students⁴⁰ in Washington. In a typical school year, students spend over 1,000 hours in school facilities, not including after-school activities. RCW 43.20.050(2)(d) requires the Board to adopt rules for environmental health and safety in all schools, and the Board has done so since 1960. The Board initiated rulemaking in 2004 in response to significant public comment that [chapter 246-366 WAC, Primary and Secondary Schools](#) was outdated and needed to be modernized to address issues related to indoor air quality, drinking water safety, and safety in areas such as laboratories and playgrounds. In July 2009, the Board adopted an updated set of rules, [chapter 246-366A WAC](#), Environmental Health and Safety Standards for Primary and Secondary Schools. That same year, the Legislature suspended implementation of the rules through a budget proviso.

The proviso reads:

The department of health and state board of health shall not implement any new or amended rules pertaining to primary and secondary school facilities until the rules and final cost estimate have been presented to the legislature, and the legislature has formally funded implementation of the rules through the omnibus appropriations act or by statute⁴¹.

The suspension of rule implementation has been included in each operating budget since the 2009-2011 biennium. Upon lifting the suspension, Chapter 246-366A WAC will supersede Chapter 246-366 WAC and establish consistent statewide standards that will help assure that schools are designed, built, and maintained to protect children and help prevent illness and injury.

The suspended rules are intended to address the most common environmental causes of injuries and illness at schools. For example, the suspended rules assure that: playground equipment meets national consumer safety standards; that laboratories and shops have basic safety equipment such as eyewash stations, showers, and emergency shut offs for gas and electricity; heating and ventilation requirements are modernized and consistent with best practices to prevent contaminants such as pesticides, herbicides, or vehicle exhaust from being drawn into the building or ventilation system; and internal building temperatures are regulated to prevent temperature extremes and to facilitate a comfortable learning environment so that all children have the chance to succeed.

Environmental public health professionals play a critical role in helping identify risk and potential problems and solutions to improve health and safety. Only twelve of Washington’s thirty-five local health jurisdictions have school environmental health and safety programs. Ensuring schools are designed, built, and maintained to protect student’s health requires regular, ongoing inspections and technical assistance. School environmental health and safety is a foundational public health service, and must be available in every community. In order to provide basic health and safety protections for all school children across the state, school environmental health and safety inspections local health jurisdictions must have sufficient resources and capacity to carry out this work. The Washington State

³⁹ Office of Superintendent of Public Schools, [Washington State Report Card](#), Accessed August 2020

⁴⁰ [Private School Review](#) (Washington Private Schools) Accessed August 2020

⁴¹ Chapter 357, Laws of 2020, Sec. 221 (1)

Department of Health (Department) estimates the cost to ensure each community has adequate resources for regular school inspections is \$6.2 million per biennium for 30 FTEs.

In recent years, Washington has experienced a significant increase in days of poor air quality due to wildfire smoke. Wildfire smoke is a contributor to poor air quality, and Washington is at risk for more intense, severe wildfires due to climate change.⁴² Children, particularly those with pre-existing diseases such as asthma and diabetes, are especially at risk for experiencing adverse health effects from smoke exposure. The Department maintains [guidance](#) for canceling or moving outdoor children's activities and closing schools when smoke may be a health threat. School districts, typically in consultation with their local health jurisdictions, decide whether to close schools due to poor air quality. The Department recommends school closure if particles less than 2.5 micrometers in diameter (PM_{2.5}) exceeds 150.4 unless indoor air can be kept cleaner.⁴³

Ventilation rates in most schools are below recommended levels, and growing evidence shows positive impacts of outdoor air ventilation. Improved indoor air quality, from either outdoor air ventilation or removal of pollution sources, results in improved student performance. Children in classrooms with high outdoor ventilation rates tend to achieve higher scores on standardized tests in math and reading compared to those in poorly ventilated classrooms.

As the COVID-19 global pandemic requires school districts to re-evaluate their typical cleaning and operating procedures to prevent spread of the coronavirus disease, implementation of the suspended rules are more important now than ever. Local health jurisdiction school environmental health and safety programs have also been impacted by the pandemic as resources have had to shift from activities like school safety inspections to COVID-19 response. When school districts make the transition from distance learning to in-person instruction, it is imperative that schools are a safe place for Washington's students.

Indoor air quality is a key component of school environmental health, and should be prioritized to maintain a healthy indoor environment in schools and help reduce transmission of SARS-CoV-2 (the virus that causes COVID-19), regardless if schools are open or closed.

Higher ventilation rates reduce the transmission and spread of respiratory illness.⁴⁴ To help minimize SARS-CoV-2 transmission, the American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE) recommends regular inspection, maintenance, and regular repairs of heating, ventilation, and air conditioning (HVAC) systems as well as adequate ventilation to dilute indoor contaminants.⁴⁵ These measures are considered a first line of defense against aerosol transmission of SARS-CoV-2 in school facilities.

⁴² Washington State Department of Ecology, [Climate Change Increases the Risk of Wildfires](#), Accessed October 2020

⁴³ Washington State Departments of Health and Ecology, [Summary Guidance: Wildfire Smoke](#), Accessed October 2020

⁴⁴ U.S. Environmental Protection Agency, [Evidence from Scientific Literature about Improved Academic Performance](#), Accessed September 2020

⁴⁵ American Society of Heating, Refrigeration, and Air Conditioning Engineers, [Guidance for the Re-Opening of Schools](#), Accessed September 2020

Protecting the health and safety of students, faculty, and administrators from the spread of COVID-19 is essential to protecting the broader community. Some states are leveraging COVID relief programs and funding to make necessary changes to school HVAC systems. In June 2020, Vermont's Legislature established the [School Indoor Air Quality Grant Program](#), funded through the federal Coronavirus Relief Fund. The program is designed to help improve indoor air quality and health in schools as they prepare to re-open for the 2020-2021 school year. Funding is intended to assist Vermont schools with projects such as repairing, maintaining, and upgrading HVAC systems aligned with guidelines from the CDC and ASHRAE. To ensure Washington's schools are in compliance with recommended guidelines for indoor air quality, we encourage prioritization of funding for HVAC repairs and upgrades to meet indoor air quality standards and COVID-related recommendations as the Legislature considers funding for school capital projects.

The Board recommends the Governor and Legislature:

- Remove the budget proviso that suspends amendment and implementation of the school environmental health and safety rules. The Board believes that the school rule is needed to provide consistent statewide standards for operating and maintaining schools.
- Allocate \$6.2 million for 30 FTEs in the upcoming biennial budget to fill gaps in school environmental health and safety programs across the state, ensuring each community has adequate funds and support for regular school inspections.
- Recognize that school health and safety inspections are a Foundational Public Health Service and provide funding to local health jurisdictions so all schools receive regular health and safety inspections and have access to technical assistance to improve environmental health and safety.
- Prioritize funding for HVAC systems to ensure schools are meeting indoor air quality standards and minimizing transmission of SARS-CoV-2.
- Require Office of Superintendent of Public Instruction and the Department to work with schools and local health jurisdictions to update the school health and safety guide. This guide has not been updated since January 2003. It is an important resource that complements the school rules and provides the most up-to-date information and guidance regarding best practices for operating and maintaining schools.