2022 State Health Report – Working Draft

Executive Summary

Since 1891, the Washington State Board of Health (Board) has been responsible for providing recommendations for legislative action related to improving the public's health. The Board has produced a 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 Board's 2022 State Health Report focuses on:

- **Improving public health's response to health inequities through data reform.** Recommendations include:
    - Providing adequate funding to the Office of Equity to lead a community-centered process aligned with Washington's pro-equity and anti-racism (PEAR) plan and playbook to develop enterprise-wide standards for the collection, analysis, storage, and protection of disaggregated demographic data, starting with race and ethnicity data.
    - Directing and providing funding to state agencies to enhance interoperability of data systems to facilitate the collection, analysis, storage, and protection of uniform, disaggregated demographic data.
    - Actively monitoring and participating in opportunities to advocate for improvements in federal standards for interoperability and disaggregated demographic data collection.
- **Removing barriers to health care insurance and care coverage.** Recommendations include:
    - Expanding access to health insurance for individuals at least 19 years of age who are income-eligible, regardless of immigration status.
    - Employing strategies identified by the Tubman Center for Health and Freedom to ensure access to the type of health care services that members of marginalized communities most rely on, including but not limited to: requiring insurers to cover to cost of health care utilized by Washington communities, including complementary and alternative medicine (CAM), employing health care providers from the communities they are serving, incentivizing providers who use the health care that communities who have been historically or are currently marginalized prefer to use, and removing systemic barriers to care, such as cost and insufficient provider networks, so that communities can access timely, culturally based care.
- **Improving access to culturally and linguistically appropriate health services.** Recommendations include:
    - Expanding culturally and linguistically appropriate health care services, including but not limited to prescription information translation and increased access to interpretation services for medical appointments.
    - Provide funding to establish a task force made up of public health, health care, community-based organizations, and appropriate state agencies to conduct an assessment and develop a baseline report regarding the provision of culturally and linguistically appropriate and accessible formats for communities served, as well as recommendations for improvement as applicable.
- **Making school environments healthy and safe**. Recommendations include:

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- Removing the budget proviso that prevents revision and implementation of the Board's school environmental health and safety rules.
- Requiring the Department of Health, local health jurisdictions, OSPI, and the Board to work together to conduct a school environmental health and safety review and needs assessment to inform updates to the K-12 School Health and Safety Guide as well as future rulemaking.
- Prioritizing funding for K-12 school HVAC system maintenance and necessary upgrades to minimize transmission of contaminants and communicable diseases.
    - Actively monitoring and participating in opportunities to advocate for federal indoor air quality standards in the built environment.

- **Decreasing youth use of tobacco, nicotine, and vapor products.** Recommendations include:
    - Prohibiting the sale of all flavored nicotine and tobacco products to the public, including vapor products, to reduce the appeal and use of these products by youth and young adults.
    - Considering the regulation of flavored combustible and vapor cannabis products to reduce the appeal and use of these products by youth and young adults.
- **Strengthening Washington's public health system through continued investments**. Recommendations include:
    - Prioritizing continued and expanded foundational public health investments in the 2023-2025 biennium as well as future biennia to ensure Washington's governmental public health system can continue to 1) assess and control communicable diseases and enhance environmental public health services and 2) improve services over the life course and improve business capacities.

It should be noted that the 2022 report highlights some issues and recommendations that were highlighted by the Board in prior reports. This is because these issues were not adequately addressed in previous biennia.

While there are numerous topics that deserve to be highlighted in this report—mis- and disinformation and trust in the public health system; the impact of structural racism, sexism, and ableism on the public's health; effects of climate change in Washington; injury and violence prevention; and substance misuse and prescription drug overdose, to name a few—the 2022 report highlights actionable, statewide public health policy initiatives and recommendations deserving of the Governor's and Legislature's attention over the next biennium.

Acknowledgments

We would like to thank the community groups and public health partners that Board staff met with to understand their public health priorities. Where applicable, their voices have been incorporated into this report.

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Improving public health's response to health inequities through data reform

Health equity exists when all people can attain their full health potential and no one is disadvantaged from achieving this potential because of their skin color, country of origin, level of education, sex, gender, sexual orientation, age, religious or spiritual beliefs, job, neighborhood, socioeconomic status, and disability.[1] Data are core to making visible the longstanding inequities in our health care system and their impacts on our communities, particularly Black and Indigenous communities and communities of color.

Lack of data collection capacity, particularly disaggregated data, erases and further harms groups that have been most impacted by inequities. The Board and the Governor's Interagency Council on Health Disparities have heard from communities for years that they feel invisible. For example, advocates for finer data collection and reporting of Asian populations (e.g., Filipino, Indonesian, Japanese, Lao, Pakistani, Vietnamese) often feel completely unseen and unheard in the data when they are lumped into the broad "Asian" reporting category. Often these populations share many of the health inequities experienced by other groups, as well as unique health experiences not typically reported, but they are not seen when the data are aggregated into one broad category. Among other harms, this impedes their ability to apply for and receive grant funding to address the inequities in their communities. Communities have consistently asked us to collect data in a more disaggregated way.

Disaggregated data that reveal inequities across and within groups are instrumental for public health efforts related to preventing and controlling other diseases and conditions. However, collection of demographic data in Washington is currently decentralized and inconsistent, often working within the parameters of outdated federal data standards.

The Federal Office of Management and Budget (OMB) established the current minimum standards for collecting race and ethnicity data in 1997. The OMB standard consists of two reporting categories for ethnicity (Hispanic or Latino, Not Hispanic or Latino) and five reporting categories for race (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White). OMB encourages additional granularity where it is supported by sample size and as long as the additional detail can be aggregated back to the minimum standard set of race and ethnicity categories.

Data disaggregation, collecting data in greater detail, is an essential part of identifying and eliminating health inequities, undoing institutional racism, and advancing equity within public health and the broader governmental system. Collection and analysis of disaggregated data helps the governmental public health system identify and address health inequities and prioritize resources to communities. Further, democratizing data and allowing communities to use their own data to mobilize for action and achieve transformative change in programs, policies, and services, is a crucial step in dismantling existing structures of power and returning control of data to the people that allow it to exist.[2]

COVID-19 shed a bright light on the systemic and structural inequities in the health care and public health systems. Collection and use of disaggregated data was, and continues to be, vital to identifying impacted populations. Together disaggregated data and qualitative data—stories from

[1] Definition is informed by the Department of Health's Health Equity Workgroup
[2] Data Democratization: The Unsung Hero of Health Equity. Health Leads, June 2020. Accessed July 2022.

disproportionately impacted communities—support effective public health responses, including partnering with communities on outreach, prevention, and access to care. Without these data, the public health system cannot effectively and equitably respond to a public health crisis.

As highlighted by the 2020 Office of Equity Task Force, the COVID-19 pandemic laid bare the inequities and contradictions in our systems. In the most devastating way, the pandemic has reinforced an undeniable truth: we can only be as healthy as our communities which are most marginalized and furthest from opportunity. As with other crises, the impact and burden have been disproportionately shouldered by tribes, communities of color, immigrant communities, communities with lower income and wealth accumulation, the LGBTQIA+ community, the disability community, and vulnerable labor forces. As a stark example, agricultural and food processing workers exist at the paradoxical intersection of being essential and underserved. This is not by coincidence—health inequities and barriers to information, testing, and health care are manifestations of systemic discrimination and institutional oppression that have long privileged some at the expense of others.[3]

In March 2021, the Board adopted revisions to chapter 246-101 WAC, Notifiable Conditions. Included among the many updates to this chapter of rule is the requirement for health care providers and facilities, laboratories, and local health jurisdictions to report patient-identified disaggregated race, ethnicity, and language data as standard reportable data components that must accompany a report of a notifiable condition to public health authorities. The rules, which go into effect January 1, 2023, include four reporting categories for the patient's ethnicity, 72 reporting categories for the patient's race, and 50 categories for the patient's preferred language.

Notifiable conditions reporting is one piece of a broader system of public health data collection. Public health and health care partners lack unified data standards that allow for timely, consistent collection and sharing of disaggregated data. Within existing data sets, there can be inconsistences (e.g., data are missing altogether) and inaccuracies (e.g., aggregating American Indian and Alaska Native identities into the white reporting category). Lack of consistency and standardization in data collection hinders data sharing and data integration – where information can be linked across data sets to give a more informative, meaningful picture of how people live their lives – and prevents public health from performing comparison analyses or longitudinal studies to address health inequities.

These data are only as good as the public health system's ability to receive and analyze them for meaningful use. Interoperability – the ability for systems to share and exchange data – of public health data systems must be prioritized. There is an urgent need to not only standardize the type of data collected but the way data are used and shared among public health agencies and programs. The Board recognizes the need to simultaneously assess all health-related data systems from an agency level and to work with community partners, other state agencies, federal partners, and tribes to identify next steps toward synchronizing the collection and protection of disaggregated demographic data across multiple data sources. The sheer scope and magnitude of this longer-term, systemwide effort is tantamount to data collection reform. Systemic problems deserve and require systemic solutions.

Community leadership and tribal consultation are critical to this work. Trusted messengers clearly communicated to the Board during its Notifiable Conditions rulemaking the need and urgency to collect

[3] Office of Equity Task Force Final Proposal. Governor's Interagency Council on Health Disparities, 2020. Accessed July 2022.

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demographic variables in health-related datasets that more accurately reflect communities in Washington. This requires going beyond more traditional data variables and response options (e.g., broad categories for race, ethnicity, sex, and language) to include variables such as housing status, country of origin, tribal affiliation and Indigenous background, veteran status, sexual orientation, gender, occupation, income, and disability status. Variables such as these can provide keen insight into the social and political determinants of health.

This requires centering community voice in decision making regarding the collection of detailed demographic data. Further, indigenous data sovereignty is the right of a nation to govern the collection, ownership, and application of its own data. It derives from tribes' inherent right to govern their peoples, lands, and resources.[4] Therefore, consultation with Washington's 29 tribes and two urban Indian health programs is essential to protect tribal data sovereignty.

The Board recommends the Governor and Legislature take action to:

- Provide adequate funding to the Office of Equity to lead a community-centered process aligned with Washington's pro-equity and anti-racism (PEAR) plan and playbook to develop enterprise-wide standards for the collection, analysis, storage, and protection of disaggregated demographic data, starting with race and ethnicity data.
- Direct and provide funding to state agencies to enhance interoperability of data systems to facilitate the collection, analysis, storage, and protection of uniform, disaggregated demographic data.
- Actively monitor and participate in opportunities to advocate for improvements in federal standards for interoperability and disaggregated demographic data collection.

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[4] United States Indigenous Data Sovereignty Network. Accessed July 2022.

Removing barriers to health care insurance and care coverage

Despite significant gains in health insurance coverage after the implementation of the Affordable Care and Patient Protection Act's (ACA) and subsequent Medicaid expansion in 39 states, about ten percent of Americans do not have health insurance.[5]

During 2019 and 2020, the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics observed that 14.4 percent of U.S. adults aged 18–64 years were uninsured. Among all race and Hispanic origin subgroups, those adults most likely to be uninsured were Hispanic (30.4%) followed by non-Hispanic Black (14.6%), non-Hispanic White (9.7%), and non-Hispanic Asian (7.8%) adults. Among the Hispanic origin subgroups included, those most likely to be uninsured were of Central American (42.2%) origin followed by Mexican or Chicano (33.6%) origin. Adults of Cuban (22.7%) origin were more likely to be uninsured than those of Puerto Rican (14.8%) and Dominican (12.9%) origin.[6]

In 2019, Washington's uninsured rate was 6.5%[7] and rates varied by county.[8] Although significantly higher than the recent lowest uninsured rates set in 2016-17, the 2019 rate is still lower than the state's uninsured rate before the implementation of the ACA major health coverage expansion components in 2014. Still, inequities remain. For example, the uninsured rate of the Hispanic population (16.8%) in 2019 was nearly four times as high as the uninsured rate for non-Hispanic Washingtonians (4.5%) that same year.[9, 10]

Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones.[11]

Health care costs are a key factor in deciding whether to seek care. About four in ten U.S. adults say they have delayed or gone without medical care in the last year due to cost, with dental services being the most common type of care adults report putting off due to cost.[12] Strategies to increase insurance

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[5] Health Insurance Coverage in the United States: 2020. United States Census Bureau, September 2021. Accessed July 2022.

[6] QuickStats: Percentage of Uninsured Adults Aged 18–64 Years, by Race and Selected Hispanic Origin Subgroup — National Health Interview Survey, United States, 2019−2020. MMWR Morb Mortal Wkly Rep 2022;71:834. DOI: http://dx.doi.org/10.15585/mmwr.mm7125a3

[7] Washington State Health Services Research Project: Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Research Brief No. 98, December 2020. Washington State Office of Financial Management. Accessed July 2022.

[8] 2012-19 County Uninsured Rates Chart Book: Washington State. Washington State Office of Financial Management Health Care Research Center, February 2021. Accessed July 2022.

[9] Washington State Health Services Research Project: Statewide Uninsured Rate Remained Unchanged from 2018 to 2019. Research Brief No. 98, December 2020. Washington State Office of Financial Management. Accessed July 2022.

[10] Note: more recent data on the uninsured rates in Washington State and nationally are challenging to interpret as the COVID-19 pandemic significant impacts on health insurance coverage due to high unemployment rates and underreporting.

[11] Healthy People 2020: Access to Health Services. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed July 2022.

[12] Americans' Challenges with Health Care Costs. Kaiser Family Foundation, July 2022. Accessed July 2022.

coverage rates are critical for making sure more people get important health care services, including preventive care and treatment for chronic illnesses.[13]

During the 2021 legislative session, Board staff conducted a Health Impact Review (HIR)[14] of House Bill (HB) 1191. The proposal would have required the Health Care Authority to extend Apple Health coverage by creating a new, state-only funded plan for all individuals, regardless of immigration status, who are at least 19 years of age, have a countable income equal to or below 133% of the federal poverty level, are not incarcerated, and are not eligible for categorically needy medical assistance as defined in the Social Security Title XIX State Plan. The HIR noted that evidence indicated that HB 1191 would likely increase access to health insurance for individuals at least 19 years of age who are income-eligible, regardless of immigration status, and that some eligible individuals may enroll in health insurance, which would likely increase access to and use of healthcare services, improve health outcomes, and decrease health inequities by immigration status.

Ensuring access to the full range of reproductive health care is critical in light of the Supreme Court's decision on *Dobbs v. Jackson Women's Health Organization*, in which the court held that the U.S. Constitution does not confer a right to abortion and effectively overruling both *Roe v. Wade* and *Planned Parenthood v. Casey*. In 2018, Board staff conducted a literature review on inequities in reproductive health care access. Staff identified 45 unique barriers to reproductive health care access, including insurance status and coverage, difficulty navigating the insurance system, cost of care and other associated costs, and limited language access and lack of culturally and linguistically appropriate services.[15] Many of the identified barriers still exist today --- a troubling reality given our national maternal mortality crisis.[16]

Section 1332 of the ACA permits a state to apply for a State Innovation Waiver (also referred to as section 1332 waiver) to pursue innovative strategies for providing residents with access to high quality, affordable health insurance while retaining the basic protections of the ACA. On May 13, 2022, Washington submitted a section 1332 waiver application that would allow anyone, regardless of immigration status to purchase insurance coverage through the Washington Health Benefit Exchange.[17] If approved, the Exchange expects a 1.1% to 1.4% increase per year in access to marketplace coverage as well as state-funded premium assistance for newly eligible individuals through the year 2033.[18] The Board supports efforts such as these to expand insurance coverage and access to health care for all Washington residents.

However, those who are covered by health insurance are not immune to the burden of health care costs. About one-third of insured adults worry about affording their monthly health insurance premium,

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[13] Healthy People 2030: Health Care Access and Quality. U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed July 2022.
[14] A Health Impact Review (HIR) is an objective, non-partisan, evidence-based tool that provides the Governor and Legislators with information about how proposed legislation may impact health and health equity.
[15] Report to the Legislature: Literature Review on Inequities in Reproductive Health Care Access. Governor's Interagency Council on Health Disparities, January 2019. Accessed August 2022.
[16] Gingrey JP. Maternal Mortality: A US Public Health Crisis. Am J Public Health. 2020 Apr;110(4):462-464. doi: 10.2105/AJPH.2019.305552. PMID: 32159977; PMCID: PMC7067092.
[17] Washington Section 1332 Waiver Application. Washington Health Benefit Exchange, June 2022. Accessed July 2022.
[18] Ibid.

and 44% worry about affording their deductible before health insurance kicks in.[19] Further, inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to health inequities.

Mainstream insurance coverage typically does not cover complementary and alternative medicine (CAM) services such as massage therapy, acupuncture, herbal medicine, or traditional or indigenous medicine – services that may be more sought out by communities who have been historically or are currently marginalized. Discrimination in health care settings (e.g., unfair and disrespectful treatment by a health care provider, or discrimination based on ability to pay, type of insurance, ability to speak English, racial/ethnic background, and gender) has been significantly associated with the use of herbal medicines.[20] Among Black adults, racial discrimination was associated with greater CAM use, regardless of institutional setting. In other words, discrimination in any institutional context (settings such as work, education, law enforcement, and the service sector) has an important effect on health care behavior of Black adults, including the choice to look beyond conventional sources of health care.[21]

In 2021, the Tubman Center for Health and Freedom (TCHF), in partnership with Byrd Barr Place and other community-based organizations around Puget Sound, conducted a mixed method research survey to examine the ways in which the communities that are most often marginalized by the mainstream medical system tend to and care for the health and wellness of themselves and their family members.[22] The Wellness Equity by Lifting-up Local Under-reported Solutions (WELL US) study highlights a lack of insurance coverage for preferred care modalities, overall sense of dissatisfaction with health insurance coverage, and major barriers to seeking medical attention including cost, racism or harassment, fear of discrimination, inability to find a provider, and language barriers. The study also found that BIPOC, disabled and LGBTQIA+ community members utilize significant amounts of what is considered "alternative" medicine[23] and that vitamins and supplements are widely used to support health in marginalized communities.[24]

Expanding insurance coverage and ensuring that coverage meets the needs of Washington's diverse communities are essential to improving the health and wellness of our residents and reducing health inequities.

The Board recommends the Governor and Legislature take action to:

- Expand access to health insurance for individuals at least 19 years of age who are income-eligible, regardless of immigration status.

[19] Americans' Challenges with Health Care Costs. Kaiser Family Foundation, July 2022.
[20] Thorburn S, Faith J, Keon KL, Tippens KM. Discrimination in health care and CAM use in a representative sample of U.S. adults. J Altern Complement Med. 2013 Jun;19(6):577-81. doi: 10.1089/acm.2012.0586. Epub 2013 Jan 11. PMID: 23308362; PMCID: PMC3673613.
[21] Shippee TP, Schafer MH, Ferraro KF. Beyond the barriers: racial discrimination and use of complementary and alternative medicine among Black Americans. Soc Sci Med. 2012 Apr;74(8):1155-62. doi: 10.1016/j.socscimed.2012.01.003. Epub 2012 Feb 18. PMID: 22386637; PMCID: PMC3341177.
[22] Wellness Equity by Lifting-up Local Under-reported Solutions (WELL US) Study. The Tubman Center for Health & Freedom. Accessed July 2022.
[23] TCHF's study recognizes that CAM or "alternative" medicine is not alternative for all communities, and that CAM is only referred to as "alternative" in comparison to mainstream medicine.
[24] Wellness Equity by Lifting-up Local Under-reported Solutions (WELL US) Study. The Tubman Center for Health & Freedom. Accessed July 2022.

- Employ strategies identified by TCHF to ensure access to the type of health care services that members of marginalized communities most rely on, including but not limited to:
  - Requiring insurers to cover to cost of health care utilized by Washington communities, including CAM.
  - Employ health care providers from the communities they are serving.
  - Incentivize providers who use the health care that communities who have been historically or are currently marginalized prefer to use.
  - Remove systemic barriers to care, such as cost and insufficient provider networks, so that communities can access timely, culturally based care.

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Improving access to culturally and linguistically appropriate health services

Adequate health insurance alone cannot remove every barrier to care, and regardless of coverage, culturally and linguistically appropriate services (CLAS) must be provided to all patients.

In 2004, the U.S. Department of Health and Human Services' Office of Minority Health (OMH) developed CLAS Standards to advance health equity, improve quality of services, and work toward the elimination of health disparities. Standards were updated in 2013. The principal standard of CLAS is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.[25]

OMH evaluated national CLAS implementation and found that CLAS activities such as hiring skilled interpreters; training staff; and collecting race, ethnicity, and language data can be costly to organizations. However, it is more costly not to implement the Standards because of adverse patient outcomes and the financial burden of errors and inefficiencies that CLAS can reduce.[26]

Research has consistently demonstrated the persistent gap in the provision of culturally and linguistically appropriate care and the impact on equity and health outcomes.[27] The absence of culturally and linguistically appropriate care can impact the quality-of-care delivery for limited English proficiency (LEP) patients by increasing time to treatment, reducing quality of patient-provider communication, increasing risk of adverse events, and increasing hospital lengths of stay.[28, 29, 30]

During the 2022 legislative session, the Board conducted a Health Impact Review (HIR) of ESHB 1852. The proposal would have required the Pharmacy Quality Assurance Commission to adopt rules establishing requirements for the translation of prescription drug labels and prescription information. The HIR noted that evidence indicated the proposal would have the potential to result in more pharmacies providing translated prescription drug labels and other prescription information, improving access to culturally and linguistically appropriate services for some people with limited English proficiency (LEP), which would likely improve health outcomes and decrease health inequities. The bill passed the House and died in the Senate.

From September 2013 through August 2015, the Governor's Interagency Council on Health Disparities received a grant from the federal Office of Minority Health to raise awareness and promote adoption of

[25] Think Cultural Health: National Culturally and Linguistically Appropriate Services Standards. U.S. Department of Health and Human Services. Accessed July 2022.
[26] Awareness, Knowledge, Adoption, and Implementation of the National CLAS Standards in Health and Health Care Organizations Evaluation Project: Summary of Key Findings. U.S. Department of Health and Human Services, Office of Minority Health. Accessed July 2022.
[27] Ethn Dis. 2020 Autumn; 30(4): 603–610. Published online 2020 Sep 24. doi: 10.18865/ed.30.4.603
[28] Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care. 2007;19(2):60-67. 10.1093/intqhc/mzl069
[29] John-Baptiste A, Naglie G, Tomlinson G, et al.. The effect of English language proficiency on length of stay and in-hospital mortality. J Gen Intern Med. 2004;19(3):221-228. 10.1111/j.1525-1497.2004.21205.x
[30] Lindholm M, Hargraves JL, Ferguson WJ, Reed G. Professional language interpretation and inpatient length of stay and readmission rates. J Gen Intern Med. 2012;27(10):1294-1299. 10.1007/s11606-012-2041-5 10.1007/s11606-012-2041-5

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the CLAS Standards. During the two-year grant period, Council staff provided information, resources, technical assistance, and training on the CLAS Standards to several state agencies and other public and private health-related organizations.[31]

In addition to these training modules, there have been a variety of tools designed to ensure culturally and linguistically appropriate care. For example, the U.S. Department of Health and Human Services' Office of Minority Health houses a variety of free continuing education and e-learning programs for health care administrators, providers, and other personnel; the American Academy of Pediatrics has developed a Culturally Effective Toolkit for providers; the Cross Cultural Health Care Program based out of Seattle provides training and consulting on culturally competent communication and practices across cultures and languages in health care; Washington State managed care plans have cultural awareness plans and committees to guide their work; community health boards are employing initiatives to provide culturally relevant information to their communities; and the Department of Health is currently implementing Engrossed Substitute Senate Bill 5229 (Chapter 276, Laws of 2021) which requires health professions to adopt rules to require their licensees to complete health equity continuing education training at least once every four years.

Despite the abundance of training resources available, there is currently no indicator to measure levels of access to CLAS in health care and public health throughout Washington State. The Board believes that understanding the current provision of CLAS across the state by major health care and hospital systems, independent health care providers, public health clinics, community-based organizations, and more, is key to improving patient experience and health outcomes as well as reducing health inequities.

The Board recommends the Governor and Legislature take action to:

- Expand culturally and linguistically appropriate health care services, including but not limited to prescription information translation and increased access to interpretation services for medical appointments and emergency room visits.
- Provide funding to establish a task force made up of public health, health care, community-based organizations, and appropriate state agencies to conduct an assessment and develop a baseline report regarding the provision of culturally and linguistically appropriate health care services for communities served, as well as recommendations for improvement as applicable.

[31] CLAS Standards Training and Resources. Governor's Interagency Council on Health Disparities. Accessed July 2022.

Making school environments healthy and safe

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 would establish consistent, statewide standards to help assure that schools are designed, built, and maintained to protect children and help prevent illness and injury. That same year, the Legislature suspended implementation of the rules, citing concerns with the financial impact of the new rules, through a budget proviso:

The department of health and the state board of health shall not implement any new or amended rules pertaining to primary and secondary school facilities until the rules and a 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 statute.[32]

Unfortunately, suspension of rule implementation has been included in each state operating budget since the 2009-2011 biennium. With the budget proviso in place, the Board can neither implement the 2009 rules, nor can it update these rules to address environmental health factors such as indoor air quality, climate change, and more with the most up-to-date science.

During the 2021-2022 school year, 295 public school districts[33] served 1,091,429 students[34] and 758 private schools served 104,426 students[35] in Washington. In a typical school year, students spend over 1,000 hours in school facilities, not including after-school activities. Children are disproportionately impacted by changes in their environment, and these impacts are often amplified by racial inequities that further drive health inequities.

Environmental public health professionals play a critical role in helping identify risks, potential problems, and solutions to improve health and safety. Regular health and safety inspections can help identify air quality issues and assess for toxins and other hazards to help prevent illness and injury. Prior to the COVID-19 pandemic, only twelve of Washington's thirty-five local health jurisdictions had established school environmental health and safety programs. These programs have been negatively impacted by the pandemic as resources have had to shift from activities like school safety inspections to COVID-19 response.

Indoor air quality is a key component of student health and performance. However, 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

[32] Engrossed Substitute Senate Bill 5693, Section 222(1); Chapter 297, Laws of 2022
[33] About School Districts. Washington Office of Superintendent of Public Instruction. Accessed July 2022.
[34] Washington State Report Card: State Summary, 2021-2022 School Year. Washington Office of Superintendent of Public Instruction. Accessed July 2022.
[35] Best Washington Private Schools (2022). Private School Review. Accessed July 2022.

sources, results in improved student performance. Board staff completed a review of literature in October and November 2021 related to air quality and academic performance.

- Indoor air quality in school settings may impact student performance through multiple pathways, including through impacts to respiratory health outcomes and absenteeism. Available evidence also suggests that indoor air quality in school settings may impact student performance directly.
- Math and reading scores are significantly impacted by a number of indoor air quality metrics, including the type of HVAC system, particulate counts, carbon dioxide concentration, and ventilation rates.
- School location and outdoor air quality may also contribute to indoor air quality, which could exacerbate existing educational inequities.

The COVID-19 pandemic continues to highlight the importance of ventilation to reduce transmission and spread of respiratory illnesses. The U.S. Department of Labor's Occupational Safety and Health Administration (OSHA) maintains standards about ventilation and standards on some of the air contaminants that can be involved in indoor air quality problems, but there are currently no federal minimum standards for indoor air quality or the broader built environment.[36]

As we attempt to emerge from the pandemic, we must prioritize indoor air quality and ventilation. Although billions of federal dollars were made available to assist schools during the pandemic, early rounds of COVID-19 relief funds did not prioritize indoor air or ventilation infrastructure in K-12 schools. The Board is pleased that additional federal support will be provided to schools through in the American Rescue Plan Act (ARPA). The ARPA includes providing technical assistance to schools, including a Clean Air in Buildings Checklist that all buildings can use to improve indoor ventilation and air filtration, as well as the opportunity for schools, public buildings, and state, local, and tribal governments to make ventilation improvements and upgrades using ARPA funds.[37]

Climate change will worsen existing indoor environmental problems and indoor air quality, and it may introduce new problems as the frequency or severity of adverse outdoor conditions change. Warmer temperatures and shifting weather patterns have led to more frequent and severe wildfires, and Washington has experienced a significant increase in poor air quality days due to wildfire smoke. Children, particularly those with pre-existing diseases such as asthma and diabetes, are especially at risk for experiencing adverse health effects from smoke exposure.[38]

Children also suffer directly from the increased severity and duration of heat waves. Studies performed in multiple countries have shown an increase in child morbidity and mortality during extreme heat events. There is a >90% chance that by the end of the 21st century, average summer temperatures will

[36] Indoor Air Quality. United States Department of Labor, Occupational Safety and Health Administration. Accessed July 2022.
[37] National COVID-19 Preparedness Plan. The White House. Accessed July 2022.
[38] Which Populations Experience Greater Risks of Adverse Health Effects Resulting from Wildfire Smoke Exposure? U.S. Environmental Protection Agency, November 2021. Accessed August 2022.

exceed the highest temperatures ever recorded in many regions across the world, putting children and their families at increasing risk of heat injury.[39]

Climate change is also increasing the frequency and severity of other extreme weather events, such as extreme precipitation, flooding, and storms, which can result in damage to buildings and allow water or moisture to enter indoor environments. Increased indoor dampness and humidity can lead to increases in mold, dust mites, bacteria, and other biological contaminants indoors. Extreme weather events can also create conditions that support increases in and the spread of pests and infectious agents that can make their way indoors.[40]

Schools are a community hub that provides shelter from adverse weather events and wildfire smoke, and protecting the health and safety of students, faculty, and administrators is a key component to protecting the broader community. Ensuring our state's minimum standards for school environmental health and safety are up to date and reflect the best possible science are critical to equitably identifying and addressing the most common environmental causes of injuries and illnesses in Washington schools in a rapidly changing climate.

The Board recommends the Governor and Legislature take action to:

- Remove the budget proviso that prevents revision and implementation of the Board's school environmental health and safety rules.
- Require the Department of Health, local health jurisdictions, OSPI, and the Board to work together to conduct a school environmental health and safety review and needs assessment to inform updates to the K-12 School Health and Safety Guide as well as future rulemaking.
- Prioritize funding for K-12 school HVAC system maintenance and necessary upgrades to minimize transmission of contaminants and communicable diseases.
- Actively monitor and participate in opportunities to advocate for federal indoor air quality standards in the built environment.

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[39] Paulson, J. A., et al. Global Climate Change and Children's Health. Pediatrics, 136(5), 992–997. 2015. https://doi.org/10.1542/peds.2015-3232
[40] Indoor Air Quality and Climate Change. United States Environmental Protection Agency, December, 2021. Accessed July 2022.

Decreasing youth 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. Cigarette smoking in particular is responsible for more than one in five deaths per year the United States[41] and Washington State.[42] 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.

Youth and young adults under age 18 years are far more likely to start using tobacco than adults; nearly 9 out of 10 adults who smoke started by age 18. According to the U.S. Surgeon General, there is a strong association between the use of e-cigarettes, cigarettes, and the use of other burned tobacco products by young people.[43]

Despite decreasing use of tobacco products generally among middle and high school students in recent years, e-cigarettes, or vapor products, have been the most commonly used tobacco product among youth since 2014.[44] Nationally, about one out of every 35 middle school students, and about one out of every nine high school students reported current (i.e., past 30 days) use of e-cigarettes.[45]

The 2021 Washington State Healthy Youth Survey found that vapor products are the most common nicotine product used by youth. The prevalence of current (i.e., past 30-day) vapor product use among 6th graders (3%), 8th graders (5%), 10th graders (8%, and 12th graders (15%) significantly increased from 2018.[46]

The effects of nicotine exposure during youth and young adulthood can be long-lasting and can include lower impulse control and mood disorders. The nicotine in vapor products can prime young brains for tobacco use and addiction to other drugs.[47] Preventing youth initiation of tobacco and other nicotine use is critical to stem the tide of tobacco-related mortality, morbidity, and economic costs.[48]

Research consistently shows that flavors, and associated advertising, contribute to the appeal, initiation, and use of tobacco and nicotine products, including vapor products, particularly among adolescents and

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[41] Smoking & Tobacco Use Fast Facts. Centers for Disease Control and Prevention, June 2021. Accessed July 2022.
[42] Tobacco and Vapor Products Data and Reports. Washington State Department of Health. Accessed July 2022.
[43] Fact Sheet: E-Cigarette Use Among Youth and Young Adults, A Report of the Surgeon General. U.S. Department of Health and Human Services, Office of the Surgeon General. Accessed August 2022.
[44] Smoking & Tobacco Use: Youth and Tobacco Use. Centers for Disease Control and Prevention, March 2022. Accessed July 2022.
[45] Gentzke AS, Wang TW, Cornelius M, et al. Tobacco Product Use and Associated Factors Among Middle and High School Students — National Youth Tobacco Survey, United States, 2021. MMWR Surveill Summ 2022;71(No. SS-5):1–29. DOI: http://dx.doi.org/10.15585/mmwr.ss7105a1
[46] Washington State Healthy Youth Survey 2021 Results. Accessed July 2022.
[47] Know the Risks: E-Cigarettes and Young People. U.S. Department of Health and Human Services, Office of the U.S. Surgeon General. Accessed August 2022.
[48] Ibid.

young adults.[49, 50, 51] According to the National Youth Tobacco Survey, among students who reported current use of any tobacco product, 79.1% (high school: 80.2%; middle school: 74.6%) reported using flavored tobacco product(s) in the past 30 days.

At the request of members of the Legislature, Board staff have conducted multiple HIRs in recent years that found evidence that prohibiting the sale of flavored vapor products is likely to decrease initiation and use of these products among adolescents and young adults. Most recently, HIRs of the following legislative proposals introduced during the 2020 legislative session.

House Bill 1932, Concerning vapor products. [52]	**House Bill 2454**[53] **and companion Senate Bill 6254**[54]**, Relating to protecting public health and safety by enhancing the regulation of vapor products.**
Among other requirements, this bill would have prohibited the sale of flavored vapor products and flavored cannabis vapor products and regulated vapor product advertising.	Among other requirements, these bills would have banned the sale of vapor products containing vitamin E acetate and flavored vapor products, other than tobacco flavored products.
Strong evidence • Prohibiting the sale of flavored vapor products will likely decrease initiation and use of vapor products among adolescents and young adults • Decreasing initiation and use of vapor products among adolescents and young adults will likely decrease initiation and use of tobacco products among these populations. Very strong evidence • Decreasing use of vapor products among adolescents and young adults will likely improve health outcomes • Decreasing use of tobacco products among adolescents and young adults will improve health outcomes.	Very strong evidence • Prohibiting the sale of flavored vapor products will likely decrease initiation and use of vapor products among adolescents and young adults • Decreasing initiation and use of vapor products among adolescents and young adults will likely decrease initiation and use of tobacco products among these populations • Decreasing use of vapor products among adolescents and young adults will likely improve health outcomes • Decreasing use of tobacco products among adolescents and young adults will improve health outcomes

[49] 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.
[50] 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.
[51] 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
[52] Health Impact Review of HB 1932, Concerning vapor products (2019 Legislative Session). Washington State Board of Health, September 2019. Accessed July 2022.
[53] Health Impact Review of HB 2454, Relating to protecting public health and safety by enhancing the regulation of vapor products (2020 Legislative Session). Washington State Board of Health, January 2020. Accessed July 2022.
[54] Health Impact Review of SB 6254, Relating to protecting public health and safety by enhancing the regulation of vapor products (2020 Legislative Session). Washington State Board of Health, January 2020. Accessed July 2022.

There has been promising movement to limit or prohibit youth use of tobacco, nicotine, and vapor products in recent years. 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. This law went into effect January 1, 2020.

In April 2022, the State of Washington settled a lawsuit against JUUL Labs, Inc., which controls more than 70% of the U.S. e-cigarette market share, for allegedly violating the Consumer Protection Act and Washington's vapor products legislation (RCW 70.345) by marketing flavored vapor products to youth. As a result of the settlement, JUUL must pay Washington $22.5 million, stop advertising that appeals to youth – including most social media promotion – accurately market the nicotine content and effects of the nicotine in its products, and implement a robust secret shopper program and online purchase age verification.[55] Additionally, the U.S. Food and Drug Administration issued marketing denial orders to JUUL for all their products currently marketed in the United States. The FDA cited JUUL's premarket tobacco product applications lacked sufficient evidence regarding the toxicological profile of the products to demonstrate that marketing of the products would be appropriate for the protection of the public health.[56]

Furthermore, the Board supports the FDA's proposal to prohibit menthol as a characterizing flavor in cigarettes as described in Docket No. FDA-2021-N-1349, *Tobacco Product Standard for Menthol in Cigarettes*. As articulated in the proposed rule, research shows that restricting the range of flavored tobacco products benefits youth tobacco prevention efforts. In 2009, Congress prohibited the use of characterizing flavors (except tobacco and menthol) in cigarettes due to the appeal of those products to youth. Following passage of this law, while overall smoking rates decreased, the use of menthol cigarettes increased, suggesting that the remaining flavor continued to hold appeal to youth and adult smokers.[57] The proposed rule prohibiting menthol closes this loophole and removes the only remaining flavored cigarette (except tobacco) available in the United States.

The tobacco industry aggressively targets its marketing to certain populations, including young people, women, and racial and ethnic minority groups, particularly Black people. These groups are more likely to smoke menthol cigarettes compared to other population groups.[58] The tobacco industry strategically and aggressively targeted the Black community with menthol cigarettes for decades, including placing more advertising in predominantly Black neighborhoods and publications, and appropriating culture in marketing.[59] Non-Hispanic Black or African American people who smoke cigarettes, regardless of age, are more likely to smoke menthol cigarettes than people of other races or ethnicities who smoke

[55] AG Ferguson: JUUL must pay Washington $22.5 million over its unlawful advertising practices. Washington State Office of the Attorney General, April 2022. Accessed July 2022.
[56] FDA Denies Authorization to Market JUUL Products. U.S. Food and Drug Administration, June 2022. Accessed July 2022.
[57] 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.
[58] Menthol Smoking and Related Health Disparities. Centers for Disease Control and Prevention, June 2022. Accessed August 2022.
[59] Why tobacco is a racial justice issue. Truth Initiative, August 2020. Accessed August 2022.

cigarettes.[60] It is estimated that approximately 40% of excess deaths due to menthol cigarette smoking in the U.S. between 1980 - 2018 were those of African Americans.[61]

Washington legalized the sale, purchase, and use of recreational cannabis for people 21 years of age and older in in 2012. Per the 2021 Healthy Youth Survey, approximately 1% of 6th graders, 3% of 8th graders, 7% of 10th graders, and 16% of 12th graders have reported using cannabis in the past 30 days.[62] Given the well documented role of flavors in encouraging tobacco use among youth and young adults, the Board believes emerging cannabis control policies should consider lessons from tobacco control to prevent youth cannabis use. In a 2019-2020 survey of eight Northern and Central California public high schools, a substantial proportion of adolescent cannabis users are choosing flavored cannabis products, including both combustible and aerosolized products.[63] Researchers acknowledge restrictions that prohibit sales of any characterizing flavors, such as recent local and state restrictions on the sale of flavored tobacco products could help address rising adolescent interest in new tobacco products and cannabis use.[64]

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 take action to:

- Prohibit the sale of all flavored nicotine and tobacco products to the public, including vapor products, to reduce the appeal and use of these products by youth and young adults.
- Consider the regulation of flavored combustible and vapor cannabis products to reduce the appeal and use of these products by youth and young adults.

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[60] Menthol Smoking and Related Health Disparities. Centers for Disease Control and Prevention, June 2022. Accessed August 2022.
[61] Ibid.
[62] Washington State Healthy Youth Survey 2021 Results. Accessed July 2022.
[63] Werts M, Urata J, Watkins SL, Chaffee BW. Flavored Cannabis Product Use Among Adolescents in California. Prev Chronic Dis 2021;18:210026. DOI: http://dx.doi.org/10.5888/pcd18.210026external icon
[64] Ibid.

Strengthening Washington's public health system through continued investments

Washington State has a fundamental responsibility to protect the public's health.[65] The governmental public health system, comprised of the Board, Department of Health, local health jurisdictions, and sovereign tribal governments, 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.

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 adopt and fund the Foundational Public Health Services (FPHS), so they are available in every community.

In 2018, 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.[66] 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."[67] There was wide variability in service gaps across agencies and statewide system. The baseline assessment estimated the total cost to implement FPHS statewide was nearly $600 million, with a funding shortfall of approximately $225 million.

The legislature has begun addressing the chronic underfunding and resulting detrimental effects on people, communities, and the state's economy. Over the past few biennia, the legislature allocated funds toward FPHS infrastructure with historic investments during the 2021-2023 biennium:

Biennium	**Amount**
2017-2019	$18 million[68]
2019-2021	$28 million
2021-2023	$125 million

A portion of the 2017-2019 biennial budget funds appropriated by the Legislature was invested in new service delivery models by funding four shared service demonstration projects. These projects focused

[65] RCW 43.70.512
[66] 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.
[67] Washington State Public Health Transformation Assessment Report, BERK Consulting, September 2018. Accessed July 2022.
[68] $15 million for FPHS, $3 million to implement the Governor's lead directive.

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on sharing staff, expertise, and technology across LHJs to deliver specific FPHS in communicable disease and assessment.

Investments during the 2019-2021 biennium provided much needed capacity for the governmental public health system to pivot and rapidly respond to the COVID-19 pandemic. 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. 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.

Most recently, FPHS funding in the current biennium has helped expand capacity and services provided by the governmental public health system. Examples include environmental public health data, planning, land use, and inspections; cross-cutting capabilities such as information technology, emergency preparedness, surveillance, and community partnership; and communicable disease data, planning, and investigations; public health lab investments, and promoting immunizations.

The investments in FPHS, first with one-time funding and subsequently with ongoing funding is an important step forward. However, even with historic investments by the legislature, more is needed to fully fund FPHS and protect the public's health.

The Board recommends the Governor and Legislature prioritize continued and expanded foundational public health investments in the 2023-2025 biennium as well as future biennia to ensure Washington's governmental public health system can continue to 1) assess and control communicable diseases and enhance environmental public health services and 2) improve services over the life course (e.g., chronic disease, injury prevention, maternal and child health) and improve business competencies (e.g., technology, leadership, facilities and operations).

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