WASHINGTON STATE BOARD OF HEALTH

Notice of Public Meeting

Wednesday, August 10, 2022
9:30 a.m. – 2:25 p.m.
Virtual Meeting via ZOOM Webinar
(hyperlink provided below)

Proposed Final Agenda

Time	Agenda Item	Speaker
9:30 a.m.	Call to Order & Introductions	Keith Grellner, Board Chair
9:35 a.m.	1. Approval of Agenda—Possible Action	Keith Grellner, Board Chair
9:40 a.m.	2. Approval of June 8, 2022 Minutes – Possible Action	Keith Grellner, Board Chair
9:45 a.m.	3. Announcements and Board Business	Board Executive Director
10:05 a.m.	4. Department of Health Update	Umair A. Shah, Secretary of Health Tao Sheng Kwan-Gett, Chief Science Officer and Secretary's Designee Kristin Peterson, Chief of Policy Lacy Fehrenbach, Chief of Prevention
10:45 a.m.	5. Public Comment	Please note: Verbal public comment may be limited so that the Board can consider all agenda items. The Chair may limit each speaker's time based on the number people signed up to comment.
11:05 a.m.	Break	
11:20 a.m.	6. Update – Strategic Plan Status Report – Possible Action	Keith Grellner, Board Chair Board Staff
11:45 p.m.	7. Update – Per- and Polyfluoroalkyl Substances (PFAS) Rule Implementation and Related Issues – Group A Public Water Supplies, Chapter 246-290 WAC	Keith Grellner, Board Chair Department Staff
12:30 p.m.	Lunch	
1:30 p.m.	8. Emergency Rule – Notifiable Conditions, COVID-19 Reporting, WAC 246-101-017 – Possible Action	Stephen Kutz, Board Member Board Staff
1:45 p.m.	9. 2022 State Health Report – Possible Action	Keith Grellner, Chair Board Staff
2:05 p.m.	10. Board Member Comments	

Time	Agenda Item	Speaker
2:25 p.m.	Adjournment	

- **To access the meeting online and to register:**
  https://us02web.zoom.us/webinar/register/WN_-vKo3YQiR4ul_o6QIEm-lQ

- **You can also dial-in using your phone for listen-only mode:**
  Call in: +1 (253) 215-8782 (not toll-free)
  Webinar ID: 843 7806 7031
  Passcode: 940121

Important Information to Know:

- Times are estimates only. We reserve the right to alter the order of the agenda.
- If you need special accommodation, please contact Melanie Hisaw, State Board of Health Executive Assistant, at (360) 236-4110 or by email melanie.hisaw@sboh.wa.gov by July 29, 2022.
- To request this document in an alternate format or a different language, please contact Kelie Kahler, State Board of Health Communication Manager, at 360-236-4102 or by email kelie.kahler@sboh.wa.gov

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WASHINGTON STATE BOARD OF HEALTH

Draft Minutes of the State Board of Health
June 8, 2022
Electronic meeting via ZOOM Webinar

State Board of Health members present:
Keith Grellner, RS, Chair
Bob Lutz, MD, MPH
Elisabeth Crawford
Temple Lentz, MOL
Stephen Kutz, BSN, MPH
Patty Hayes, RN MN
Umair A. Shah, MD, MPH
Kelly Oshiro, JD
Melinda Flores
Socia Love-Thurman, MD
Tao Sheng Kwan-Gett, MD, MPH, Secretary's Designee

State Board of Health members absent:

State Board of Health staff present:
Michelle Davis, Executive Director
Melanie Hisaw, Executive Assistant
Kelie Kahler, Communication Manager
Stuart Glasoe, Health Policy Advisor
Samantha Pskowski, Health Policy Advisor
Kaitlyn Donahoe, Health Policy Advisor
Nathaniel Thai, Communications Coordinator
Cait Lang, Health Policy Analyst
Tracy Schreiber, Health Policy Analyst
LinhPhung Huỳnh, Department of Health
Lilia Lopez, Assistant Attorney General

Guests and other participants:
Jeremy Simmons, Department of Health

Keith Grellner, Board Chair, called the public meeting to order at 9:31 a.m. and read from a prepared statement (on file). He then detailed operating procedure and ground rules for conducting a virtual meeting, and asked board members to introduce themselves.

1. **APPROVAL OF AGENDA**
   Motion: Approve June 8, 2022 agenda
   Motion/Second: Member Hayes/Member Crawford. Approved unanimously

2. **ADOPTION OF APRIL 13, 2022 MEETING MINUTES AND ADOPTION OF MAY 27, 2022 MEETING MINUTES**

   Motion: Approve the April 13, 2022 minutes, as amended by Member Lutz

Motion/Second: Member Kutz/Member Crawford. Approved unanimously

Motion: Approve the May 27, 2022 minutes
Motion/Second: Member Crawford/Member Kutz. Approved unanimously

3. **BOARD ANNOUNCEMENTS AND OTHER BUSINESS**

Michelle Davis, Board Executive Director greeted the Board and directed Board members to materials in their packets on page 25. Ms. Davis noted the biographies of the newest Board members who were appointed on April 19, and welcomed the new members. She said that Mindy fills the consumer position formerly held by Fran, Socia fills the health and sanitation position formerly filled by Tom, and Kelly fills the consumer position formerly held by Vazaskia.

Ms. Davis provided updates regarding Board staff. She announced the selection of a new policy intern, Mikayla, who is working with Hannah Haag, the Board's outreach coordinator. She shared Mikayla's background and said she would be with the Board through at least July.

Ms. Davis said Tracy Schreiber, health impact review analyst, has taken a position with the Department of Children, Youth and Family, and Thursday, and that June 9 is her last full day. She said Tracy joined the Board in October 2021 and worked with the HIR team to produce six reports for the Legislature on a broad range of topics. She described the work Tracy would be doing at DCYF and congratulated Tracy.

Ms. Davis announced that Sam Pskowski, policy advisor, will be taking a position on the Governor's policy staff. She said Sam's portfolio will include public health. She said Sam has served as a policy advisor for the Board since March 2020, and identified the numerous rules, projects and initiatives that Sam had brought to completion during her time with the Board. She said Sam's appointment to the Governor's policy staff is well-deserved and that she would be missed.

Ms. Davis described the remaining documents under announcements, including a letter from the Office of Equity that the Board onto along with seven other agencies. The letter is focused on the proposed Council on Environmental Quality's beta Climate and Economic Justice Screening Tool. She said the letter expresses concern that the tool fails to include race or ethnicity as indicators to identify "disadvantaged communities," and that information regarding the tool is limited to English.

Ms. Davis noted that staff have drafted a letter commenting and providing support for the FDA's May 4th, 2022 proposed rule which would establish a new tobacco product standard prohibiting the use of menthol as a characterizing flavor. She said the comment letter supports of the proposed rule, shares findings from past Health Impact Reviews detailing the health impacts of flavored tobacco products. She noted the letter wasn't finalized in time for the materials posting deadline, but staff would forward it to Board members after today's meeting.

Ms. Davis indicated the packet also included response letters to the petitions for rulemaking that the Board considered at its April meeting, as well as recent rule filings for the emergency rule regarding COVID 19 reporting, and the order of adoption for the Local Board of Health composition rules. She noted that staff continue to receive inquiries regarding the LBOH rules, and are updating the Frequently Asked Questions documents. Ms. Davis indicated that the materials also include the concurrence letter to OFM regarding foundational public health services funding for the 2021-2023 biennium, followed by the detail for the spending of those funds.

Ms. Davis indicated the last item under announcements are the EH committee meeting notes. She said the committee received general rule updates and helped prepare staff for today's meeting.

Tao Sheng Kwan-Gett, Board member and Secretary's designee, congratulated Ms. Pskowski on her new position. He said had the privilege of working with her on the TAG, which was very controversial. He said Sam was always professional and a pleasure to work with.

Patty Hayes, Board member commended Michelle on all the work happening and commended staff moving to new positions.

Elisabeth Crawford, Board member, echoed previous comments and congratulated Sam, especially with all her help in onboarding.

Keith Grellner, Board Chair commented when staff does such a great job and get offered other jobs and promotions.

Steve Kutz, Board Member commented on the volume and value of background work by staff, and the significant time required to do the work.

4. DEPARTMENT OF HEALTH UPDATE

Tao Sheng Kwan-Gett, Chief Science Officer and Secretary's Designee, discussed the current state of COVID-19 worldwide and in the United States. He shared information on case rates in Washington State, noting the post-peak trends of the Omicron variant. Dr. Kwan-Gett shared that case rates are significantly undercounted as are based on reported cases and don't include the vast majority of home tests. He shared information on hospitalizations in Washington and other factors influencing hospital capacity. Dr. Kwan-Gett noted the mortality rate has not risen at the rate as hospitalizations, potentially due to the spread of the current variant. He then shared an update on COVID-19 vaccination rates and noted that uptake in younger age groups is not what the Department would like to see. Dr. Kwan-Gett also shared concerns around recent data on childhood immunization rates for routine vaccine preventable diseases.

Umair A. Shah, Secretary of Health, discussed key public health challenges and measures to protect against COVID-19. Secretary Shah shared that the Department is working on developing agency strategic priorities beyond COVID-19 including health and wellness, environmental health, emergency response and resilience, global and

domestic health, and investment in health systems and infrastructure. He also discussed a number of other issues that public health is actively working on and monitoring, such as acute hepatitis in children, avian influenza, the infant formula shortage, and monkeypox. Secretary Shah said the likelihood of sustained transmission of monkeypox is very low. He thanked Chair Grellner for his work as the chair of the Board and public health generally.

Member Kutz thanked the presenters and asked whether we've seen any sustained domestic transmission of monkeypox. Secretary Shah said that the situation is evolving, but for the most part transmission is related to those who have had travel-related exposure. He reiterated that the risk to the public is extremely low at this time. Dr. Kwan-Gett agreed noted that Washington has only one confirmed case of monkeypox, and that individual had a travel history.

Member Kutz asked about the new COVID-19 variants and whether the new variants are less virulent generally or less virulent in the vaccinated and previously ill populations, with the same capacity for severe illness in the unvaccinated population. Dr. Kwan-Gett responded that it's a combination of both and explained some of the differences between the older and newer variants.
Member Kutz commented that the Department's update did not include information about the recent salmonella outbreak in JIF brand peanut butter. He said that he was one of the people to get sick and commented that there needs to be more clarification from the state on what people should do concerning foodborne outbreaks.

Member Love-Thurman commented that one of the biggest issues they are hearing concern from the community is related to gun violence. She asked if there was research or other things that the Board could discuss as it relates to gun violence in the state. Secretary Shah agreed with Member Love-Thurman and discussed public health invisibility and how important it is for public health to be at the table on these issues. He discussed the important role that public health has in injury and violence prevention and public health is often left out of the conversation. Dr Kwan-Gett agreed, just as response to pandemic has been strongest when we leave politics at the door, with gun violence, if we can leave politics at the door and look at evidence to see policies for reducing violence.

Chair Grellner asked Secretary Shah about the current COVID-19 emergency proclamations, noting the current state of emergency is set to expire at end of June. He asked if the Board can anticipate adjusting quickly to in-person meetings. Secretary Shah said the Governor has made it clear that he takes a number of factors into consideration and one of the most important is the health and safety Washingtonians. He shared that he doesn't have insight beyond that but that if the emergency ends there is some risk to federal funding for COVID-19 response.

5. PUBLIC COMMENT

(Note: Public Testimony on Item 10, Keeping of Animals, WAC 246-203-130, will begin at 1:30pm)

Jean Mendoza, asked to speak on KOA rule.

Ken Harp, thanked the board for consideration of Item 13, Rulemaking Petition – Chapter 246-105 WAC, Immunization of Child Care and School Children for Vaccine Preventable Diseases. He provided comments with concern for immunization records, Emergency Use Authorization (EUA), exemptions and waivers.

Chair Grellner, commented that the Technical Advisory Group (TAG) did evaluate COVID as an EUA, and did not approve it for school entry.

Nancy Callihan, agreed with the last public comment by Mr. Harp, saying the COVID vaccine is not safe and provided reasons. She said although the TAG recommendations did not support adding the shot, the Vaccine Advisory Committee (VAC) is still going after this issue strongly.

Denis Kieft, asked to speak on KOA rule.

Lisa Templeton, spoke in support of Mr. Harp's petition, and spoke in opposition to the COVID shot, saying she identifies as an ex-vaxer and she is helping others become risk aware.

Chair Grellner closed public comment at 11:07 a.m.

The Board took a break at 11:07 a.m. and reconvened at 11:22 a.m.

6. EFFECTIVE DATE – ENVIRONMENTAL AND SAFETY STANDARDS FOR PRIMARY AND SECONDARY SCHOOLS, CHAPTER 246-366A WAC

Keith Grellner, Chair, introduced Kaitlyn Donahoe, Board Staff, gave a brief overview of the issue including background information, prior Board action, recent legislative action, and potential future revisions for this chapter. Ms. Donahoe discussed next steps for the Board on this topic and shared that the current effective date of the rules is August 1, 2022. She advised the Board will need to file a new CR-103 to extend the effective date since the legislature has not removed the budget proviso prohibiting implementation of the rules.

Member Hayes asked for clarification about the new budget proviso that requires a report from the University of Washington (UW) on school environmental health and safety and if there is a way for the Board to collaborate with UW on that work.

Member Kwan-Gett agreed that the rule is out of date and should be updated with the latest science.

Member Hayes said that it sounds like the legislature has asked UW to do a scan of the current state of school environmental health and safety but doesn't get to the bottom line of the capacity to implement the Board's rules. She asked how that work can be harmonized with the Board's desire to update and implement these rules.

Ms. Davis asked Ms. Donahoe to present the budget proviso language related to the UW study. She offered to reach out to the Department of Health, who manages the contract for the study, to make sure UW has information about the Board's rules. Ms. Donahoe read the proviso language. Chair Grellner commented that the scope of the UW study is not what they had hoped for but a step in the right direction. Ms. Davis said the recommendations from UW could highlight the need for clearer, modern standards.

Member Hayes said she recognizes the need to extend the effective date of the school rules but wanted to be clear on expectations from the report. She said it will be helpful for the Board to revise rule but does not address main issue of assistance for schools that need help meeting the standards.

Member Lutz reiterated the need to implement these rules and noted that schools don't always have the resources that they need. He referenced a recent Morbidity and Mortality Weekly Report from the Centers for Disease Control and Prevention on ventilation in schools and noted that, not surprisingly, there was an equity issue related to it. Member Lutz said the Board has to continue delaying, but cannot delay indefinitely, that that funding is required. Chair Grellner agreed and commented that his frustration is that there are two issues: aging schools, and newly built schools under old standards, which add to the cost in the long-term and the inventory of schools that will need updating.

Member Crawford reiterated Member Hayes's concerns and noted how disappointing that it has been so many years and the Board can't move forward. She asked Board staff to describe the conversations with OSPI and others, and whether there are feelings of concern or support moving forward. Director Davis shared one of the recommendations staff received is that now is a good time to start conversations with school superintendents about what the Board has learned in the last 10 years. She noted improved relationships at local level between schools and local health, and that COVID has highlighted the importance of good ventilation in schools.

Member Crawford asked how the new proviso for the UW study fits in with the suspended rule. Ms. Davis said the report is due at the end of December, right before legislative session, and anticipate the report would be considered over the course of session. She suggested the Board could ask UW to share their recommendations after the report is submitted.

Member Kutz noted that the Board has had this discussion for many years, and it's getting discouraging. He said we now have the potential for new information to broaden our understanding of the current state of schools and our next steps. He and Chair Grellner discussed the concept of new schools being built under old standards, and the equity issues involved.

Motion: The Board directs staff to amend the effective date of new sections of chapter 246-366 WAC and new chapter 246-366A WAC, as filed in WSR 21-14-056, by filing a new CR-103, Order of Adoption, to delay the effective date of the new rules to August 1, 2023. In addition, the Board directs staff to continue communication with OSPI, Department of Health, and the Legislature on the need for these rule revisions, and to

request a presentation from Department of Health and University of Washington after the release of their report in December 2022.

Motion/Second: Member Hayes/Member Kutz. Approved unanimously

7. RULEMAKING PETITION – THE BOARD HAS RECEIVED A PETITION TO REVISE FOOD SERVICE, CHAPTER 246-215 WAC

Patty Hayes, Board Member provided a brief background on the petition the Board received requesting changes to the chapter 246-215 WAC, and introduced Kaitlyn Donahoe, Board Staff. Ms. Donahoe discussed the provisions of the Administrative Procedures Act allowing for petitions, the Board's petition policy, and details on the petition received. She shared that the petitioner requested the Board adopt rules requiring food handlers to wear masks at all times citing the increase of assembly line style food establishments. Ms. Donahoe discussed the Board's authority for regulating food service in chapter 246-215 WAC and shared recommendations from the Department of Health.

Member Kutz thanked staff for the briefing and noted that in the past 40 years working in public health, he has never investigated a foodborne outbreak associated with respiratory illness. He said there may be a public perception of respiratory disease spread this way, but it fortunately does not.

Member Hayes said she thought this petition was a good exercise to begin considering respiratory illness transmission generally, particularly as we're talking about the phasing out of the pandemic. She said she likes the idea of having a briefing about respiratory illness transmission within all indoor spaces not specific to restaurants. Member Hayes said she does not see this as a restaurant-specific issue, but it does give us things to think about as a Board for all indoor spaces. She said she supports the recommendation from the Department of Health to decline the petition and further explore this topic.

Member Kwan-Gett thanked staff and said he understands the motivation of the petitioner but the scientific data supports denying the petition. He said that early in the pandemic there were concerns that COVID-19 could spread through the gastrointestinal tract, with some symptoms, but since then data has not supported a foodborne route for this transmission. Member Kwan-Gett agreed with Member Kutz that foodborne illness is not spread through this route recommends denying the petition.

Member Crawford expressed concurrence with the prior statements. She said she understands where the petition came from, but that is not warranted under this specific WAC. Member Oshiro noted the petition mentions the assembly line style spaces, like a Subway, and that she isn't not sure if the petition is conflating being in close proximity to transmission of bodily fluids. Member Oshiro agreed with Member Crawford on denying the petition.

Member Kutz said that handwashing and wearing gloves is important in food preparation, and people who are wearing masks are constantly adjusting those and touching with bare hands or gloves. He said having food workers wear masks could increase the possibility of transmission. Member Kutz also mentioned the cause of foodborne illness via food preparation in the home.

Member Love-Thurman said she is glad that this was brought forward, and agree with the denial for the reasons everyone has mentioned. She reiterated the importance of handwashing, and stressed the importance of ensuring the public has access to restrooms in food establishments so that they can also wash their hands prior to eating for added protection.

Member Flores agreed with the recommendation to deny the petition and said she empathized with the petitioner's concerns.

Motion: The Board declines the petition to initiate rulemaking to adopt a rule to require food service handlers to wear a mask at all times under chapter 246-215 WAC for the reasons articulated by Board members and directs staff to notify the petitioner of the Board's decision. The Board also directs staff to provide an educational briefing at a future meeting regarding current state, local, and tribal health authorities and mitigation strategies to prevent and control the spread of respiratory illnesses in indoor settings.

Motion/Second: Member Hayes/Member Kutz. Approved unanimously

8. **SELECTION OF BOARD VICE CHAIR**

Michelle Davis, Board Executive Director, said Article II of the Board's bylaws describe Board officer positions. She noted that the Chair is selected by the Governor. The Vice Chair is selected by the Board, and committee chairs are selected by the committees.

She commented on the need for the Board to select a Vice chair, and said the bylaws stipulate that a vice chair must be selected from the 8 remaining Governor appointees. She noted that the Secretary and their designee are not eligible for these positions. She said Tom Pendergrass was the Board's last vice chair, and his term with the Board ended April 18. Ms. Davis described the Vice Chair role and indicated that she had asked Board members about their interest in this role. She said that Kelly Oshiro expressed interest specifically in the Vice Chair position. She also said that that Steve Kutz and Patty Hayes had expressed an interest in serving as either vice chair or chair.

Chair Grellner said that two committees need leadership. He said that he has filled the EH Committee Chair position and Tom served as HP Committee Chair.

Member Kutz moved appointment of Patty Hayes as Vice Chair. Member Hayes confirmed her willingness to step into the Chair role after Keith's time is done. She noted this depends on the Governor, and she would go with the will of the board.

Member Crawford asked Member Hayes if the Board waits for the Governor's decision, if she would be ok with revisiting the decision? Member Hayes said yes, and she'd support the board in whatever decision. She said she was willing to serve and see what the Governor does, or elect a Vice Chair today.

Member Kutz asked for clarification and Ms. Davis confirmed the Governor selects the Chair, and the Board selects the Vice Chair.

Member Crawford said she is willing to serve as Vice Chair when the timing is right.

Chair Grellner said he did not apply for reappointment, but he offered to continue as Chair through the end of the year. He talked about his position and said it is time to let someone else have a chance, he's been on the board since 2011 and Chair since 2014. He said it may be beneficial for the Board to think about the Vice Chair so that there isn't a need to reappoint the position in August.

Member Crawford inquired about the motion, and Member Kutz withdrew his motion.

Motion: The Board selects Member Oshiro to serve as the Board Vice Chair.

Motion/Second: Member Crawford/Member Hayes. Approved unanimously

9. DISCUSSION OF 2022 MEETING SCHEDULE AND POSSIBLE JULY MEETING CANCELLATION

Michelle Davis, Board Executive Director, referred the Board meeting schedule (see materials on file) and said that the Board typically reserves a tentative July meeting slot on its schedule. She recommended the Board cancel the meeting to afford staff greater time to prepare for the August Board meeting.

Motion: The Board approves the cancellation of the July 13 meeting.

Motion/Second: Member Kutz/Member Crawford. Approved unanimously.

The Board recessed for lunch at 12:39 p.m. and reconvened at 1:30 p.m.

10. RULES HEARING – KEEPING OF ANIMALS, WAC 246-203-130

Stuart Glasoe, Board Staff introduced the agenda item, drawing attention to key documents in the meeting material packet and noting that the presentation included two recommended amendments added to the presentation after posting material the previous week. He mentioned the Board's authority and duty to adopt rules to prevent, abate, and control nuisance and health hazards regulating human and animal excreta and human and animal remains in RCW 43.20.050. He said the cover memo listed four optional motions for Board consideration at the hearing's conclusion. Mr. Glasoe then gave a presentation (on file) on the Keeping of Animals rulemaking, covering the project history, highlights of the 2018 background report, features and content of the proposed rule, public comment where staff did not recommend amendments, and public comment

where staff recommended amendments to rule language and the supporting rule analyses. Mr. Glasoe asked if Board members had any clarifying questions.

Member Kutz asked for clarification of the mistake in the supporting rule analyses. Mr. Glasoe explained that staff incorrectly exempted the proposed standard for odor/ pest control from the analyses, believing that it was an existing rule standard for waste piles in the solid waste rules, when in fact it is a permit condition in that part of the solid waste rules. If adopted, the rule analyses would be corrected to include and address the amended standard, intended to serve as a less rigid performance standard and better fit Right to Farm laws.

Chair Grellner read a statement and opened the hearing for public testimony at 2:04 p.m., allowing two minutes per person. People testified via Zoom Webinar and microphones were muted after the allotted time expired. The Board also accepted written comment throughout the rulemaking.

Lynette Borcherding requested that the rulemaking be withdrawn, citing concerns with health officials inspecting property. She said she wants privacy respected and would not welcome inspection of her small farm. People that raise animals are very respectful of the land where they live and raise food. It's overreaching, we don't want more regulation, and we can be responsible without the guidance of the Board of Health.

Jean Mendoza said the definition of stockpiling exempts manure lagoons and composting and asked the Board to remove the exemption. She said rules such as this are not relevant for 99 percent of the population. There is a law that says don't kill someone—99 percent of us don't need that law to know that it's wrong. Laws are written for the small percentage of people who are disrespectful, don't know human decency, and abuse their neighbors. In the Yakima Valley there is a nice rural home with a swimming pool for the grandchildren. A confined animal feeding operation (CAFO), a large dairy, bought land next to this home and they stacked manure next to the pool. The pool is gone. Nobody is going to go swimming in a pool next to a stack of manure. As currently written, this rule allows CAFOs to place a million-gallon manure lagoon or a 20-acre composting area right next to a family home. Laws are written to allow efficient and effective enforcement. If this rule is passed, when a person comes to a local health district with a legitimate complaint over something like this.

Mary Schactler said there is no open range in western Washington and asked if you are pasturing animals on ten-acre pastures and moving them around, is that all under the rule and not open grazing? I have a problem with that. Domestic animal waste is not the only source of hazardous waste. In the past two decades hundreds of acres of farmland have been put back into nature for the preservation of water quality for salmon, but invasive reed canary grass has gone unchecked that serves as a source of excess nutrients and refugia for rodents that have more dangerous fecal pathogens than domestic livestock. If preventing contamination by animal waste is in your steering house, how does this proposal correct this dangerous issue? The population of cats is .3 cats per person. Washington has an estimated population of 7.76 million people in 2022 and is increasing. The estimated number of cats is approximately 2.28 million—cattle a tenth of that, horses also a tenth. Domestic cat populations are greater in areas with non-porous surfaces and higher economic neighborhoods. Cattle and horse

manure is compostable, used with bark, and widely used in the nursery industry. At .3 cats per person the typical farm has 1-3 cats and in the country cat populations are kept in check by wild animals. Cats are usually working animals on a farm especially if there is hay or feed storage. How will you implement this rule in suburbia?

Cindy Alia, Citizen's Alliance for Property Rights (CAPR), said she agreed with some of the exceptions in the rule and suggested amending subsection four to say the pubic agent must coordinate with, not just try to talk to, the property owner and referred the Board to more information on the CAPR website. She said we cannot stand the idea that our privacy, proprietary situations, and safety for public agents to come onto private land because they are curious about the possibility of a problem when really what they should be doing is communicating directly with and getting authority from the property owner, even just for nothing else than their own safety. You cannot just walk onto a person's property, especially when there is livestock and other kinds of animals on the property. It would be unconscionable for the state to direct a local health officer to do such a thing. Secondly, I'd like to see the state address the elk problem, especially where elk have become protected herds so they are essentially domesticated and yet this rule does not address that whatsoever. Elk carry dangerous tapeworm, hoof rot, wasting disease, and other pathogens that they carry with them.

Ron Wesen said he's a fourth-generation dairy farmer and dairy nutrient management plans are required for dairy systems. This rule is not necessary and will create conflict and potential lawsuits involving neighbors. I've had EPA come onto our property and do inspections and one of the things that is really not helpful is not being able to say exactly what they are looking for ahead of time. What is the water quality problem you are trying to improve with these rules, what is the human health issue you are trying to save? As mentioned earlier with the elk herd, here in Skagit County we have over 12-15 hundred head of elk that are managed by the state yet they are allowed to wander all over the place. Who's responsible for that issue? The other thing is code enforcement. I don't want to see our health departments having to come in and deal with neighbor conflicts. A lot of time what happens is neighbors move into an area not realizing they are in an agricultural area and they want to make it look like a non-agricultural area. This is one way they can come in and use the health department regulations to try to close down the neighbor. If the neighbor is polluting the water the counties have authority to make sure the water quality/stormwater runoff is clean. Skagit County has the Clean Samish Initiative. We are doing a lot of water sampling, making sure we don't have pollution in the water. So I don't believe this proposal is needed. There are other regulations in place. I'll mention some other things. Right to Farm, you keep putting these rules in place you make it more difficult for people to keep the open space that everybody says they enjoy, but they don't want to hear the agricultural noise or the smells associated with that. They want to be able to drive through the beautiful park that the agricultural community provides.

Dan Wood, Washington State Dairy Federation, said all dairies are required to have nutrient management plans and are regulated under the Dairy Nutrient Management Act, some have CAFO permits, and some are involved in air emission programs with state or local agencies. We generally don't believe that a new rule is necessary. However, if there is adoption of a new rule by the Board of Health, it is very very important to be clear what we mean by more stringent standards in federal, state, or

municipal law. We appreciate the expanded language that Stuart has provided to the Board to clarify that in subsection 3 and would encourage you to include that if you do adopt rules.

Henry Benthem said he is a dairy farmer in eastern Washington and opposes the rule. We have to follow the Dairy Nutrient Management Act which covers everything you guys are trying to do. We don't want to have multiple agencies checking on each other and paying for stuff and coming on our property while we are doing our business. We already have rules for all the stockpiling and odor controls. We get inspected every other year. For our manure management we have to take samples of nutrients in the ground, nutrients we are putting on, so I think this is all double the work and we don't need it at all. The more people that get involve the only way we can get things fixed is by lawsuits, and we always have to pay for those. They are costly. I really don't think any of this is necessary.

Jodi Dotson said she is a domestic animal raiser and a concerned citizen that the Board of Health would get into deciding what we can and can't do with our own property. I too agree with the lady who suggested that it is probably not a safe thing if people who are unknown just come walking on your property without any notice to property owners deciding when and what is OK for you to do. I mean I understand if there is a visible problem that somebody needs to go and there's massive manure everywhere. I don't agree with the cats to the birds to the ducks to the goats to every animal known to man. How about if we work on all the pee and the poop that human beings lay all over our city streets that people have to walk in? I'm very concerned that nothing has been done about that. What about all the seagulls that poop everywhere? You guys are opening such nonsense. I can see to a point some rules but this is over the top. I think you need to step back and look at exactly where you are going with this and what your goal is. Is it to control people? Is it to tell people what they can and cannot do with their own property? If that's your goal then I'm really sad to say that is not a fair thing for one group of people to tell the whole state what they can and cannot do with their private property.

Mark Herke, Yakima/Klickitat County Farm Bureau, said he opposes the regulation and believes it is completely unwarranted. It is a third bureaucracy coming over the top of two other existing bureaucracies that are already closely regulating farming operations. This is completely unneeded. The Department of Health is untooled and unprepared to dive into this realm. It's never been in a rural setting and it should stay out of it. A little historical perspective, the Department of Health regulated manure and animal issues in urban settings while animals were still housed there prior to the industrial revolution, where they were used for transportation, people, and freight. In the cities, not in the country. The Department of Health has never been involved in rural or farm settings. Again, I repeat, farm and ranch confined operations are closely regulated over manure issues by Department of Ecology and WSDA. This is unwarranted and unneeded. The Department of Health entering into this area of regulation will only complicate an ag producer's ability to comply with pertinent laws. And I echo the lady's prior comments about the open range versus irrigated pastures. We need to be really careful that we're not setting ourselves up for thousand-acre ranges and then still coming back and regulating pastures. We need to be able to exempt pastures.

Denis Kieft said he lives in unincorporated Clark County with his wife and two kids. Our neighbors created a horse sacrifice area seven feet from our drinking water well. Recommendations say these areas need to be as far away from wells as possible. The well was present before the neighbors designed their fields. These neighbors run an illegal horse boarding business—about a dozen horses kept on less than three acres. The well existed before the neighbors designed their fields. Clark County codes and regulations have been in limbo for ten years because of strong pushback by the local equestrian community. We cannot rely on local health authorities in Clark County. They don't do any enforcement. They sent our neighbors an informational brochure which they ignored. After talking with the neighbors and after letters were sent by lawyers, they have chosen to ignore common sense rules. To spite us they left a horse on the sacrifice area closest to our well 24 hours a day for nearly three months. They have threatened to put pigs on our well. We have endured bullying by our neighbors and their boarding customers and have suffered online attacks on our reputation in the community. They attempted to file a harassment order against us. We spoke to local and state agencies, and while it's a bad situation there is no enforcement. We test our water three times a year and hope it stays clean. Two neighboring wells are contaminated with nitrates and coliform bacteria. Our youngest child has GI issues and is under the care of specialists. Clear common-sense rules need to be in place because it should not left to livestock owners to do the right thing or follow best practices. No animal should be within 100 feet of a drinking water wellhead, ever. The current situation should not be grandfathered in, otherwise more than half the state will still be stuck in 1920. Workgroups only cause delays. Wellheads and drinking water need to take precedence over a neighbor's hobby or, in this case, an illegal business, and should not infringe on a basic human right such as water.

Joe Marceau said there were many good things mentioned previously. In your role it doesn't say much about education. I live in Jefferson County and I think it is real necessary to encourage good behavior by education. In our county we have a conservation district, like many counties in Washington, and I just encourage that education is key in providing a good environment for our livestock and so on. And I wanted to ask all you guys on here, what makes you think you can do a better job than, say, the Environmental Protection Agency and on and on and on? There are other agencies and departments that are already doing this? So what makes you think you are going to do a better job?

Chair Grellner closed the public testimony portion of the rules hearing directed it back to Board members for questions and for discussion after a motion and second are on the table.

Member Kutz pointed out to staff that a slide still used the amended term "free-range" grazing and asked how to differentiate open range grazing from pasture grazing when problems can happen in all areas. To the first point, Mr. Glasoe clarified that slides showing edited language for the recommended amendments is embedded in proposed rule language, so slides with overlapping language could show proposed rule language involving a recommended amendment on another slide. To the second point, Mr. Glasoe said the matter is addressed in the response to comments and clarified that open-range grazing generally serves as an example of low density grazing and a diffuse source while pasture grazing can range significantly from large acreage, low density

grazing to much smaller lots with higher concentrations of animals and accumulations of waste that can be a problem.

Member Kutz wanted to clarify that the rule does not include regular inspections like some other rules/programs. Mr. Glasoe said Board material has tried to make it clear that the rule does not involve operational functions such as inspections, record keeping, and permitting of any facilities. He said an inspection would occur only in situations where there is evidence of a bad problem and staff would follow standard procedures and laws to contact and work with the property owner. The rule would not be implemented on an ongoing basis and instead is intended to serve as a backstop for bad actors, bad problems.

Member Kutz said he understood the many concerns and issues and said it's a balancing act figuring out how to balance and fit this rule with other existing regulations. He added that nothing is odor free in farming country and asked how a complaint would be handled for an operation that's following another regulation. Mr. Glasoe said he didn't see anything here that would change what's happening on a regulated operation and said that is largely the intent of the recommended amendment to give examples of other superseding laws and programs in the rule. Member Kutz said we have an existing regulation on the books no matter what. It needs to be clarified for local health to have the tools they need. He thanked staff for the years of work and listening to people, and said it is a rule that will never satisfy everybody.

Member Lutz thanked staff and reflected on the complexity of the issue and use of the terms "patchwork" and "piecemeal" in the presentation regarding the regulatory structure and the challenges of enforcement. He noted the example of the planning requirements of the Dairy Nutrient Management Act but said they may not be enforced. He mentioned the reactive nature of CAFO permits needing to prove discharges to waters. And he mentioned pollution problems of Hangman/Latah Creek near Spokane where 68 percent of dissolved inorganic nutrients come from groundwater and diverse pollution sources. He acknowledged the concerns expressed in the hearing. He said the rule gives local health the authority they need, said enforcement is difficult, agreed that local health would rely on other agencies to address problems where they can, and said it's a no-win situation all the way around.

Member Hayes also acknowledged the complexity of the issues and the challenge working across agencies. She said, as a complaint-driven process it occurs locally and as problems surface there need to be updated standards so, as much as possible, there's consistency across the state and local health has the guidance it needs. She emphasized that this is not a regulatory program where local health is going out doing inspections, but rather is a program where there are standards for response and how the agencies and statutes should work together. She also noted for the record follow-up from the Department of Agriculture clarifying its initial comment letter, saying that it is not opposed to the rule and wants to continue working together. She closed saying the rule sets a statewide framework that helps local health approach the work.

Chair Grellner said that he also supports the rule and addressed some comments and issues. He said the Board has authority and duty to address this issue in RCW 43.20.050. He said there is an existing rule, this is not new, this is a modernized rule.

The existing rule is vague and does not effectively serve parties on either end of the spectrum when addressing issues. This rule does not give government or local health jurisdictions any additional authority to trespass on private property. Local health has enforcement authority that follows established law and this rule adds nothing new. He said there are hundreds of examples of animal owners not meeting expectations properly caring for animals and animal waste across the state and used his county's efforts fighting shellfish downgrades and water quality violations to illustrate the point. People don't always take care of their neighbors and nobody has the right to cause problems for their neighbors. The rule sets clear expectations for animal owners and neighbors so it's easier to resolve issues. He closed by referencing support from statewide environmental health directors and noted that we are getting pressure from people on both ends of the spectrum saying we are not doing enough or saying we are doing too much—evidence that we are about as close as we can get. He called the question and thanked staff for their work.

Motion: The Board adopts the proposed revisions to WAC 246-203-130, Keeping of Animals, as published in WSR 22-08-003, with any revisions agreed upon at today's meeting. The Board directs staff to file a CR-103, Order of Adoption, and establish an effective date.

Motion/Second: Member Kutz/Member Hayes. Approved unanimously

11. STATE HEALTH REPORT

Chair Grellner, introduced Kaitlyn Donahoe, Board staff, who provided a brief overview of the statutory requirement for the Board to produce a State Health Report, described the topics in the most recent report, as well as the work done so far to compile the 2022 report. Ms. Donahoe shared the recommendations included in the draft distributed for Board review (see materials on file) and recommendations for next steps. She shared information regarding community and public health partner engagement to draft the report and asked the Board to allow staff additional time to complete the report for the Board's consideration at its August meeting.

Motion: The Board directs staff to continue to develop the 2022 State Health Report, in consultation Board members, public health partners, and community groups, and present a final draft for the Board's consideration at its August 2022 meeting.

Motion/Second: Member Hayes/Member Crawford. Approved unanimously

12. REVIEW OF BOARD COMPLAINT POLICY, 2015-001

Chair Grellner, introduced Sam Pskowski, Board Staff, who provided background on the Board's authority to receive complaints regarding certain local health officials. She said the Board's current complaint policy was last updated in 2015, and recommended revisions based on the Board's experience with recent complaints received. Ms. Pskowski explained that proposed revisions are intended to improve clarity and transparency in the process.

Member Oshiro provided additional proposed revisions for clarity and useability. She recommended including information regarding how individuals may appeal decisions made by an Administrative Law Judge.

Member Kutz asked how long it would take if the Board wanted to develop procedural rules for hearings conducted by the Board, and whether the Lilia Lopez, Assistant Attorney General, would recommend developing those rules. Ms. Lopez said it would be a good idea to have its own procedural rules for these types of complaints and adjudicative procedures. Ms. Pskowski stated that it may take one year to develop and implement such rules.

Ms. Lopez told Member Oshiro that the Board could include language in the policy about judicial review and appeal. She also said the appeal process would likely be described in the order from the presiding officer of the hearing. Member Flores asked clarification regarding Board members designated as a consultant or subject matter expert. Ms. Pskowski said the proposed language is related to Board member sponsorship to act as a consultant to staff for the project. Member Kutz expressed support of the proposed revisions and said the policy could be updated relatively quickly if the Board finds issues in the future. Member Hayes weighed the need to actively change policy as the Board learns with not feeling a huge sense of urgency to make changes right now. She said she likes these changes but thinks items like Board sponsorship and what it means needs to be formalized a little better. Member Flores and Member Love-Thurman agreed.

Member Kutz suggested tabling this item until the next Board meeting or until there is time for staff to work with Board members on additional revisions. Member Hayes expressed her willingness to sponsor this work and asked how to complete this work procedurally. Chair Grellner suggested standing up an ad hoc subcommittee.

Executive Director Davis described the process for establishing an ad hoc subcommittee for this work and mentioned the Board may want to consider taking a look at its bylaws to provide clarity regarding Board member sponsorship. Member Kutz added additional context regarding sponsorship relating to the Keeping of Animals rule. He and Member Flores volunteered to help draft additional revisions to the Board's complaint policy.

Motion: The Board directs staff to make additional revisions based on the discussion today by members and return with recommended revisions at a future meeting.

Motion/Second: Member Kutz/Member Hayes. Approved unanimously

The Board took a break at 3:10 p.m. and reconvened at 3:20 p.m.

13. **RULEMAKING PETITION – THE BOARD HAS RECEIVED A REQUEST TO AMEND WAC 246-105-070, DUTIES OF HEALTH CARE PROVIDERS OR ORGANIZATIONS**
Keith Grellner, Board Chair, introduced Samantha Pskowski, Board Staff. Ms. Pskowski introduced the topic, reviewed the Board's authority related to immunization

requirements for school entry, and described the petition for rulemaking. She said the petition requests specific changes to the Board's immunization rules to require providers to ensure informed consent is obtained when administering vaccines. Ms. Pskowski explained that the Board's rules do not extend to the practice of medicine, and that federal and state requirements already address consent for medical intervention.

Tao Sheng Kwan-Gett, Secretary's Designee, said that he understands and respects the intent of the petitioner regarding informed consent; however, the requirements the petitioner is seeking are not within the domain of this chapter of rule. He recommended denying the petition.

Member Kutz said that any school vaccinations given by a provider are already required to provide information about the vaccine. He said requiring information other information like what the petitioner suggests is not available to physicians, and that providers already have the appropriate information regarding the vaccines that are given routinely with each vaccination.

Member Love-Thurman agreed that informed consent is so important, and is outside the purview of the Board to weigh in on. She said medical providers do have those forms completed by the child's guardian consenting to vaccination and provide information to the guardians on the vaccine. Member Love-Thurman said it is important to keep medical practice consistent.

Member Hayes said she supports base concept of informed consent and echo the comments made by Member Kwan-Gett and Member Love-Thurman. She said this petition is out of scope and belongs with the various medical boards and commissions in our state. Member Hayes said the communication and enforcement around informed consent, as well as standards of practice, comes from those medical boards and commissions. She said she is excited to hear the medical commission recently addressed this and hope we can get the petitioner get in touch with the commission on this topic.

Motion: The Board declines the petition to initiate rulemaking to amend chapter 246-105 WAC for the reasons articulated by Board members and directs staff to notify the petitioner of the Board's decision.

Motion/Second: Kutz/Love-Thurman. Approved unanimously

14. REQUEST FOR EMERGENCY RULEMAKING — ON-SITE SEWAGE SYSTEMS, CHAPTER 246-272A WAC, PROPRIETARY PRODUCTS AND SUPPLY CHAIN SHORTAGE

Member Kwan-Gett introduced the Department of Health's request for emergency rulemaking, explaining that on-site sewage systems (OSS) have specific requirements for proprietary product components. However, some components have been hard to obtain because of supply chain shortages, necessitating regulatory flexibility for system maintenance and repairs. Stuart Glasoe, Board Staff, added that the cover memo included a motion for Board consideration.

Jeremy Simmons, Department of Health explained that OSS must be approved for use in Washington and designed to provide adequate treatment. This includes proprietary systems tested and approved for use in the state, and use of consistent replacement parts when repaired or maintained. During the pandemic there have been supply chain shortages, exacerbated Salcor's recent closure and shortage of its components. The shortages are a problem for OSS maintenance and are also a barrier to new construction and property transfers. He said the emergency rule language would allow manufacturers to develop a plan for use of alternate replacement parts based on department guidance and approval. Regarding a longer-term solution, he reminded the Board that permanent rulemaking is currently underway on the chapter and will allow further analysis of the issue.

Member Kutz highlighted the sensitivity of Puget Sound shellfish beds and asked to confirm that systems would be expected to perform as designed using an authorized, alternate component. Mr. Simmons said the approach would allow replacement of parts not originally tested but that should perform similarly. Member Kutz, asked if permitted systems not yet installed could use the alternate parts. Mr. Simmons again confirmed. Member Kutz asked how we will assure long-term performance and not cause pollution. Mr. Simmons, said the department will review data provided in the proposal to determine similar performance as the OSS was tested, and said long term it is likely manufacturers will retest systems with the alternate components to verify the data. Member Kutz asked if the department would deny a request if it determine a component was not a qualified replacement. Mr. Simmons said yes, manufacturers will have to provide data showing it is a suitable replacement.

Chair Grellner asked if homeowners will be allowed to use these approvals of temporary devices until the system fails and needs replacement. Mr. Simmons said it should be viewed as an approved system but it will be up to local health jurisdictions (LHJ) to decide how they want to permit systems. Department guidance will encourage use until a system fails and needs to be replaced. He added, down the line the tested devices should be about the same as the "emergency rule" systems. It shouldn't impact homeowners. That will be our guidance. Chair Grellner said homeowners should not be penalized for companies that can't get their parts and said department guidance should urge LHJs to honor those systems. If not, the cost of replacing a system should be borne by the company.

Chair Grellner next asked what happens when a manufacturer goes out of business, and they are not around to address the matter of replacement parts—is that being considered in the rule. Mr. Simmons said the rules do not address the question of the manufacturer of the entire system going out of business. Those systems generally get replaced when they fail and are maintained as well as possible until then. Chair Grellner said it's something we need to consider in the future, looking at the nexus of housing, safety, and looking out for the homeowner. He added that he thinks this is a good short-term solution for now.

Member Flores expressed concern that retrofitted systems set up people for a sales pitch for an upgrade. I'm not sold and feel it will set up the homeowner for additional costs because they don't have the part and a band-aid fix may or may not work, and then they upsell the homeowner. She illustrated her concern by recounting a recent

upselling experience with work on her furnace, and again expressed her skepticism. Mr. Simmons said he didn't think the emergency rule would be worse than not having it. He added that it may not work as a long-term fix but didn't foresee homeowners being required to upgrade systems. Mr. Simmons mentioned the important role proprietary systems play in allowing development on sensitive sites, and again said he didn't think the emergency rule would lead to upselling.

Member Kutz said these high-tech systems are usually in critical areas and emergency authorization of alternate components eliminates incentive for manufacturers to certify systems with the new components, creating concern for new installations. As a homeowner I would want some guarantee that the system is not going to fail. I can understand systems that are already in the ground, but new installations with unproven parts is a concern. Mr. Simmons said the existing rules require proprietary products to include a two-year service warranty built into the cost of the system. He said manufacturers have a vested interest in their reputations and systems not failing. He expects manufacturers will stand behind their products and fix problems if they come up. Member Kutz said his concern is that systems may not fail but may not treat sewage to the level needed to prevent pollution, which is why we probably should not allow this for new installs. Chair Grellner said it's a valid concern, adding that he understands the department's approach in this situation. He reminded people that emergency rules are good for only 120 days, so we have a guardrail for this, and added that rulemaking on the chapter will continue to address the issues. It seems to be a reasonable solution for a short-term fix addressing a market situation not really under our control.

Mr. Glasoe chimed in noting the distinction between the short-term emergency rule and ongoing work on the permanent rule. There will be opportunity to revisit the issue when staff return to the Board for subsequent emergency rulemaking until the permanent rule is adopted.

Motion: The Board finds that in order to protect public health, safety, and welfare, it is necessary to adopt an emergency rule to amend chapter 246-272A WAC to allow the Department to consider written requests from manufacturers of proprietary treatment products for retrofits to proprietary treatment product components that will allow systems to continue to function properly without negatively impacting treatment, operation, or maintenance during supply chain shortages. The Board directs staff to file a CR-103E, Emergency Rulemaking Order, to amend WAC 246-272A-0110 within chapter 246-272A WAC, which will become effective immediately upon filing with the code reviser. The Board further directs staff to consider the emergency changes in the permanent on-site sewage system rulemaking.

Motion/Second: Member Kwan-Gett/Member Hayes. Approved unanimously

15. RECOGNIZING BOARD MEMBER CONTRIBUTIONS

Member Oshiro, Board Vice Chair, recognized Chair Grellner and Member Kutz for their service and contributions to the Board. Vice Chair Oshiro read Resolution 2022-03 for Member Kutz for the Board's consideration.

Motion: Move to adopt Resolution 2022-03 Recognizing Stephen Kutz

Motion/Second: Chair Grellner/Member Hayes. Approved unanimously.

Chair Grellner, thanked Steve for being a peer and a mentor and said it's been an absolute pleasure to work with him.

Member Kutz challenged his fellow board members to consider serving on the Council (HDC) as he's treasured this opportunity to represent the board.

Member Hayes added her understanding for his departure and expressed her joy, appreciation and support for his leadership and future endeavors.

Member Kutz said his predecessor, Mel Tonasket, encouraged him to serve. He said serving on the Board has been one of the most rewarding experiences of his life and he hopes to continue and thanked those he's worked with.

Member Lutz said that Steve's an incredible person and remarked on his a storied history and incredible contribution to Public Health and the state. He said that Keith and Steve are the longest serving people he has worked in person with, and he wants to ensure we keep some institutional knowledge going forward.

Member Kwan-Gett added his congratulations and remarked on how Steve brings wisdom, experience and thoughtful questions to this process. He thanked him for his service.

Member Love-Thurman said she feels she's missing out to work with Steve in this space and she honored all the work he's done with indigenous communities. She hopes to work together more with him in the future.

Motion: Move to adopt Resolution 2022-04 Recognizing Keith Grellner

Motion/Second: Member Hayes/Member Kutz. Approved unanimously.

Vice Chair Oshiro, read Resolution 2022-04 for Chair Grellner, for the Board's consideration.

Member Kwan-Gett thanked Keith for his incredible career in public health and expressed his appreciation for the way he leads meetings with fairness and efficiency. He said that during public comment, Keith makes sure everyone is heard and feels heard, and this is important as a democratic institution and for our democracy.

Member Hayes added her thanks and appreciation for Chair Grellner's style and how he balances all his work and availability and leadership, including WSALPHO, FPHS steering committee, etc. She said she hopes he takes extended time when he is able because he deserves it.

Member Kutz, asked where to begin? He said he has enjoyed working together all these years, even before the board. Member Kutz said that Chair Grellner has set the bar high and he doesn't know anyone who's done it better. Member Kutz said the Chair ensures

fairness is always brought to the process, which is important to members and residents of WA and he thanked him from the bottom of his heart.

Member Flores said she feels like she has missed the opportunity to work together. She said she is impressed with his bio and glad to witness this today. She thanked the Chair, offering the best of luck. She thanked Member Kutz for supporting dental therapy and said she wants to grow and learn from their examples.

Member Lutz said he echoes all the statements. He said the Chair handled himself with such class during all the challenges and he set the bar high for his successor. He thanked Chair Grellner for being a leader at the local and state level.

Chair Grellner, thanked everyone, saying that Vice Chair Oshiro will do a great job. He said this has been a wonderful ride, we've been through huge challenges and what a pleasure it is to work with Michelle and staff. He said he's anxious to see everyone in person. He said the board is in good hands with phenomenal people and he feels privileged and honored to be a part of this team.

Member Lutz said Keith reminds him of those professors in college or grad school that knows all about the binders behind him. Chair Grellner said they are all the minutes and resolutions in Kitsap County that go back to 1943. They are from predecessors, such as Dr. Lindquist.

16. BOARD MEMBER COMMENTS

Keith Grellner, Board Chair called for any comments.

Member Flores, thanked everyone for a great meeting, including Kaitlyn, Samantha and Michelle for their guidance.

Chair Grellner, recognized Sam, saying she's done an amazing job and wants to thank her, congratulate her, and wish her all the luck in the world.

Michelle, thanked everyone, and extended gratitude on behalf of staff to Keith and Steve for their years of service. She said they are both incredible public health leaders and we are humbled to work with them. She gave a reminder for the July meeting cancellation and said we'll see folks in August.

ADJOURNMENT

Keith Grellner, Board Chair, adjourned the meeting at 4:51 p.m.

WASHINGTON STATE BOARD OF HEALTH

_____

Keith Grellner, Chair

To request this document in an alternate format or a different language, please contact Kelie Kahler, Washington State Board of Health Communication Manager, at 360-236-4102 or by email at kelie.kahler@sboh.wa.gov TTY users can dial 711.

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WASHINGTON STATE BOARD OF HEALTH

Jo-Ann Huynh
Administrative Assistant

Jo-Ann Huynh joins the SBOH team as an Administrative Assistant 2 supporting Melanie Hisaw. She graduated with a Bachelor of Arts in Psychology in 2020 from Brown University, where she was also involved in Asian feminist, student of color, and immigrant communities. She resides in Olympia and most recently worked in program coordination at a local behavioral health hospital. Jo-Ann is a proud daughter of Vietnamese immigrants, which informs her passions for care access, equity, and community development. She is excited to support the Board's work and to get to know what brings everyone to the table.

RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: June 24, 2022
TIME: 9:56 AM

WSR 22-14-021

Agency: State Board of Health

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) 08/01/2023 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☒ Yes ☐ No If Yes, explain: Restrictions imposed by the 2009 legislature on the implementation of new or amended school facility rules are retained in the 2021-2023 supplemental state operating budget, prohibiting implementation of the rules through June 2023.

Purpose: This filing delays the effective date of new sections of chapter 246-366 WAC, Primary and Secondary Schools, and new chapter 246-366A WAC, Environmental Health and Safety Standards for Primary and Secondary Schools, one year due to legislative direction in the supplemental state operating budget (Engrossed Substitute Senate Bill 5693) prohibiting implementation until the legislature acts to formally fund implementation. The rules provide minimum environmental health and safety standards for schools.

New sections of chapter 246-366 WAC, Primary and Secondary Schools, and new chapter 246-366A WAC, Environmental Health and Safety Standards for Primary and Secondary Schools, were adopted by the State Board of Health (Board) on August 12, 2009 filed as WSR 09-14-136. The Board filed a Rule-Making Order (CR-103), WSR 10-01-174, on December 22, 2009 setting the effective date of the rules as July 1, 2010. However, in advance of the Board's actions, the 2009 Legislature adopted a proviso in the state operating budget (Engrossed Substitute House Bill 1244) suspending implementation of the rules until the Legislature acts to formally fund implementation. The proviso has been included in all subsequent state operating budgets, including the 2021-2023 supplemental state operating budget (ESSB 5693). In response, the Board has taken the following series of actions to delay implementation of the rules:

Voted on March 10, 2010 to file an amended Rule-Making Order, filed as WSR 10-12-018 on May 21, 2010, to delay the effective date to July 1, 2011;
Voted on April 13, 2011 to file an amended Rule-Making Order, filed as WSR 11-10-080 on May 3, 2011, to delay the effective date to July 1, 2013;
Voted on March 13, 2013 to file an amended Rule-Making Order, filed as WSR 13-09-040 on April 11, 2013, to delay the effective date to July 1, 2015;
Voted on March 11, 2015 to file an amended Rule-Making Order, filed as WSR 15-09-070 on April 15, 2015, to delay the effective date to July 1, 2017;
Voted on June 14, 2017 to file an amended Rule-Making Order, filed as WSR 17-14-055 on June 28, 2017, to delay the effective date to August 1, 2019;
Voted on June 12, 2019 to file an amended Rule-Making Order, filed as WSR 19-14-107 on July 2, 2019, to delay the effective date to August 1, 2021; and
Voted on June 9, 2021 to file an amended Rule-Making Order, filed as WSR 21-14-056 on July 1, 2021, to delay the effective date to August 1, 2022.

Action by the Board in June 2022 extends the effective date of the new rules to August 1, 2023. The Board will continue to monitor the state budget and budget proviso suspending implementation of the new rules in the coming legislative sessions for possible implementation in 2023.

Citation of rules affected by this order:

New: None
Repealed: None
Amended: None
Suspended: None

Statutory authority for adoption: RCW 43.20.050

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 09-14-136 on 07/01/2009 (date).

Describe any changes other than editing from proposed to adopted version: See WSR 10-01-174.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: Kaitlyn Donahoe
Address: P.O. Box 47990, Olympia WA 98504-7990
Phone: 360-584-6737
Fax: N/A
TTY: 711
Email: kaitlyn.donahoe@sboh.wa.gov
Web site: www.sboh.wa.gov
Other: N/A

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	0	Amended	0	Repealed	0
Federal rules or standards:	New	0	Amended	0	Repealed	0
Recently enacted state statutes:	New	0	Amended	0	Repealed	0

The number of sections adopted at the request of a nongovernmental entity:

	New	0	Amended	0	Repealed	0

The number of sections adopted in the agency's own initiative:

	New	0	Amended	0	Repealed	0

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	0	Amended	0	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	0	Amended	0	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	0	Amended	0	Repealed	0

Date Adopted: 06/08/2022	**Signature:** 
Name: Michelle A. Davis	
Title: Executive Director, Washington State Board of Health	

RULE-MAKING ORDER
EMERGENCY RULE ONLY

CR-103E (December 2017)
(Implements RCW 34.05.350 and 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: June 15, 2022
TIME: 4:22 AM

WSR 22-13-101

Agency: State Board of Health

Effective date of rule:

Emergency Rules

☒ Immediately upon filing.
☐ Later (specify)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: WAC 246-272A-0110, Proprietary treatment products - Certification and registration. Under the current rule, manufacturers of proprietary treatment products used in on-site sewage systems must test their products with the National Science Foundation (NSF) and register their products with the Department of Health (department) based on the NSF test results before the product is allowed to be permitted or installed in Washington. This allows the department to ensure that products used in on-site sewage systems can provide the appropriate level of treatment needed to protect public health and the environment such as drinking water sources and shellfish sites. Proprietary treatment products are required to be installed and operated as they were tested and registered to ensure they continue to perform as needed.

The State Board of Health (board) has amended the existing rule to allow manufacturers to make a written request to the department to substitute components of a registered product's construction in cases of a demonstrated supply chain shortage or similar manufacturing disruptions that may impact installations, operation, or maintenance. The request must include information that demonstrates the substituted component will not negatively impact performance or diminish the effect of the treatment, operation, and maintenance of the original registered product. Supply chain disruptions have made it difficult for manufacturers and owners to comply with the current requirement. For example, some manufacturers have incorporated disinfecting ultraviolet (UV) light systems into their products to achieve higher treatment performance required for sensitive sites. These disinfecting UV light systems require routine maintenance that requires replacement supplies. Salcor Inc., the manufacturer of a disinfecting UV light system incorporated into several proprietary treatment products sold and currently used in Washington, has recently ceased operation. This has created a sudden shortage of Salcor supplies that are needed for operation and maintenance for on-site sewage systems currently in operation. Without these supplies, the on-site sewage systems that use Salcor products do not operate as registered and may not completely treat sewage. This may impact sensitive sites near these on-site sewage systems. This same supply shortage is also currently preventing home sales when maintenance of these devices is noted on home inspections for property transfers because replacement parts are unavailable. New construction is likewise impacted as many active or pending permits include on-site sewage systems using Salcor products. There are other manufacturers of disinfecting UV light systems that can be substituted into the proprietary treatment products that use Salcor products. This emergency rule will allow the department and local health jurisdictions to consider such projects.

In 2018, the board filed a CR-101, Preproposal Statement of Inquiry, WSR 18-06-082, to initiate permanent rulemaking and update the on-site sewage system rules. That rulemaking is still underway and is expected to conclude in 2023. The board has directed staff to consider this emergency rule amendment to WAC 246-272A-0110 to be incorporated into the permanent rule.

Citation of rules affected by this order:

New: None
Repealed: None
Amended: WAC 246-272A-0110
Suspended: None

Statutory authority for adoption: RCW 43.20.050 (3)

Other authority:

EMERGENCY RULE

Under RCW 34.05.350 the agency for good cause finds:

☒ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding: The board finds that in order to protect the public's health, safety, and welfare, it is necessary to adopt an emergency rule to amend WAC 246-272A-0110 to allow the department to consider written requests from manufacturers of proprietary treatment products for substitutes to proprietary treatment product components that will allow systems to continue to function properly without negatively impacting performance or diminish the effect of the treatment, operation or maintenance during supply chain shortages.

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	0	Amended	0	Repealed	0
Federal rules or standards:	New	0	Amended	0	Repealed	0
Recently enacted state statutes:	New	0	Amended	0	Repealed	0

The number of sections adopted at the request of a nongovernmental entity:

	New	0	Amended	0	Repealed	0

The number of sections adopted on the agency's own initiative:

	New	0	Amended	1	Repealed	0

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	0	Amended	0	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	0	Amended	0	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	0	Amended	1	Repealed	0

Date Adopted: 06/13/2022	**Signature:** 
Name: Michelle A. Davis	
Title: Executive Director	

AMENDATORY SECTION (Amending WSR 05-15-119, filed 7/18/05, effective 9/15/05)

WAC 246-272A-0110 Proprietary treatment products—Certification and registration. (1) Manufacturers shall register their proprietary treatment products with the department before the local health officer may permit their use.

(2) To qualify for product registration, manufacturers desiring to sell or distribute proprietary treatment products in Washington state shall:

(a) Verify product performance through testing using the testing protocol established in Table I and register their product with the department using the process described in WAC 246-272-0120;

(b) Report test results of influent and effluent sampling obtained throughout the testing period (including normal and stress loading phases) for evaluation of constituent reduction according to Table II;

(c) Demonstrate product performance according to Table III. All ((~~thirty-day~~)) 30-day averages and geometric means obtained throughout the test period must meet the identified threshold values to qualify for registration at that threshold level; and

(d) For registration at levels A, B, and C verify bacteriological reduction according to WAC 246-272A-0130.

(3) Manufacturers verifying product performance through testing according to the following standards or protocols shall have product testing conducted by a testing facility accredited by ANSI:

(a) ANSI/NSF Standard 40—Residential Wastewater Treatment Systems;

(b) NSF Standard 41: Non-Liquid Saturated Treatment Systems;

(c) NSF Protocol P157 Electrical Incinerating Toilets - Health and Sanitation; or

(d) Protocol for bacteriological reduction described in WAC 246-272A-0130.

(4) Manufacturers verifying product performance through testing according to the following standards or protocols shall have product testing conducted by a testing facility meeting the requirements established by the Testing Organization and Verification Organization, consistent with the test protocol and plan:

(a) EPA/NSF—Protocol for the Verification of Wastewater Treatment Technologies; or

(b) EPA Environmental Technology Verification Program protocol for the Verification of Residential Wastewater Treatment Technologies for Nutrient Reduction.

(5) Treatment levels used in these rules are not intended to be applied as field compliance standards. Their intended use is for establishing treatment product performance in a product testing setting under established protocols by qualified testing entities.

(6) Manufacturers may make written request to the department to substitute components of a registered product's construction in cases of supply chain shortage or similar manufacturing disruptions that may impact installations, operation, or maintenance. The request must include information that demonstrates the substituted component will not negatively impact performance or diminish the effect of the treatment, operation, and maintenance of the original registered product.

TABLE I

Testing Requirements for Proprietary Treatment Products	
Treatment Component/ Sequence Category	**Required Testing Protocol**
Category 1 Designed to treat sewage with strength typical of a residential source when septic tank effluent is anticipated to be equal to or less than treatment level E.	ANSI/NSF 40— Residential Wastewater Treatment Systems (protocols dated between July 1996 and the effective date of these rules)
Category 2 Designed to treat high-strength sewage when septic tank effluent is anticipated to be greater than treatment level E. (Such as at restaurants, grocery stores, mini-marts, group homes, medical clinics, residences, etc.)	EPA/NSF Protocol for the Verification of Wastewater Treatment Technologies/ EPA Environmental Technology Verification (April 2001)
Category 3 Black water component of residential sewage (such as composting and incinerating toilets).	NSF/ANSI Standard 41: Non-Liquid Saturated Treatment Systems (September 1999) NSF Protocol P157 Electrical Incinerating Toilets - Health and Sanitation (April 2000)
Total Nitrogen Reduction in Categories 1 & 2 (Above)	Protocol for the Verification of Residential Wastewater Treatment Technologies for Nutrient Reduction/EPA Environmental Technology Verification Program (November, 2000)

TABLE II

Test Results Reporting Requirements for Proprietary Treatment Products	
Treatment Component/Sequence Category	**Testing Results Reported**
Category 1 Designed to treat sewage with strength typical of a residential source when septic tank effluent is anticipated to be equal to or less than treatment level E.	Report test results of influent and effluent sampling obtained throughout the testing period for evaluation of constituent reduction for the parameters: $CBOD_5$, and TSS: □ Average □ Standard Deviation □ Minimum □ Maximum □ Median □ Interquartile Range □ 30-day Average (for each month) For bacteriological reduction performance, report fecal coliform test results of influent and effluent sampling by geometric mean from samples drawn within ((~~thirty-day~~)) 30-day or monthly calendar periods, obtained from a minimum of three samples per week throughout the testing period. See WAC 246-272A-0130. Test report must also include the individual results of all samples drawn throughout the test period.

Test Results Reporting Requirements for Proprietary Treatment Products	
Category 2 Designed to treat high-strength sewage when septic tank effluent is anticipated to be greater than treatment level E. (Such as at restaurants, grocery stores, mini-marts, group homes, medical clinics, residences, etc.)	Report all individual test results and full test average values of influent and effluent sampling obtained throughout the testing period for: $CBOD_5$, TSS and O&G. Establish the treatment capacity of the product tested in pounds per day for $CBOD_5$.
Category 3 Black water component of residential sewage (such as composting and incinerating toilets).	Report test results on all required performance criteria according to the format prescribed in the NSF test protocol described in Table I.
Total Nitrogen Reduction in Categories 1 & 2 (Above)	Report test results on all required performance criteria according to the format prescribed in the test protocol described in Table I.

TABLE III

<table>
<tr><th colspan="7">Product Performance Requirements for Proprietary Treatment Products</th></tr>
<tr><th>Treatment Component/Sequence Category</th><th colspan="6">Product Performance Requirements</th></tr>
<tr><td rowspan="9">Category 1 Designed to treat sewage with strength typical of a residential source when septic tank effluent is anticipated to be equal to or less than treatment level E.</td><td colspan="6">Treatment System Performance Testing Levels</td></tr>
<tr><td rowspan="2">Level</td><td colspan="5">Parameters</td></tr>
<tr><td>$CBOD_5$</td><td>TSS</td><td>O&G</td><td>FC</td><td>TN</td></tr>
<tr><td>A</td><td>10 mg/L</td><td>10 mg/L</td><td>——</td><td>200/100 ml</td><td>——</td></tr>
<tr><td>B</td><td>15 mg/L</td><td>15 mg/L</td><td>——</td><td>1,000/100 ml</td><td>——</td></tr>
<tr><td>C</td><td>25 mg/L</td><td>30 mg/L</td><td>——</td><td>50,000/100 ml</td><td>——</td></tr>
<tr><td>D</td><td>25 mg/L</td><td>30 mg/L</td><td>——</td><td>——</td><td>——</td></tr>
<tr><td>E</td><td>125 mg/L</td><td>80 mg/L</td><td>20 mg/L</td><td>——</td><td>——</td></tr>
<tr><td>N</td><td>——</td><td>——</td><td>——</td><td>——</td><td>20 mg/L</td></tr>
<tr><td colspan="6">Values for Levels A - D are 30-day values (averages for $CBOD_5$, TSS, and geometric mean for FC.) All 30-day averages throughout the test period must meet these values in order to be registered at these levels.
Values for Levels E and N are derived from full test averages.</td></tr>
<tr><td>Category 2 Designed to treat high-strength sewage when septic tank effluent is anticipated to be greater than treatment level E.

(Such as at restaurants, grocery stores, mini-marts, group homes, medical clinics, residences, etc.)</td><td colspan="6">All of the following requirements must be met:

(1) All full test averages must meet Level E; and
(2) Establish the treatment capacity of the product tested in pounds per day for $CBOD_5$.</td></tr>
<tr><td>Category 3 Black water component of residential sewage (such as composting and incinerating toilets).</td><td colspan="6">Test results must meet the performance requirements established in the NSF test protocol.</td></tr>
<tr><td>Total Nitrogen Reduction in Categories 1 & 2 (Above)</td><td colspan="6">Test results must establish product performance effluent quality meeting Level N, when presented as the full test average.</td></tr>
</table>

State Board of Health: Sponsorship

Board members serve as sponsors for rulemaking projects and other Board tasks or projects as appropriate. Sponsorship of a particular rule project or other work is voluntary. Board members may request to serve as a sponsor for a particular topic, or Board staff may reach out to Board members to request they serve as a sponsor. Time commitment and responsibilities are dependent on the rule or project.

Sponsor responsibilities and expectations include, but are not limited to:

- Working closely and providing guidance to Board staff throughout the duration of the project. This may include regular check-ins, review of documents or proposed rules, attending meetings, and ad-hoc consultation as needed.
- If necessary for the project, participate in and serve as chair or co-chair for technical advisory groups or committees.
- Introducing related agenda items and facilitating discussion at Board meetings. Board staff will work with the sponsor in the development of presentation materials and provide talking points or supplemental materials as needed.

Current Rulemaking Projects

As of July 2022, the Board has the following chapters open for rulemaking:

Chapter of Rule	Board Sponsor	Anticipated Rulemaking Milestones*			
		CR-101	CR-102	CR-103	Effective Date
Newborn Screening – OTCD Chapter 246-650 WAC	Bob Lutz	February 2022	TBD	TBD	TBD
Notifiable Conditions Chapter 246-101 WAC	Stephen Kutz	July 2021	TBD	TBD	TBD
On-Site Sewage Systems Chapter 246-272A WAC	Keith Grellner	March 2018	January 2023	April 2023	April 2024
School Environmental Health & Safety Chapters 246-366 & 246-366A WAC	Keith Grellner	October 2004	July 2009	December 2009	August 2023**
Sanitary Control of Shellfish Chapter 246-282 WAC	Patty Hayes	February 2022	TBD	TBD	TBD
Water Recreation Chapter 246-260 & 246-262 WAC	Keith Grellner	December 2016	TBD	TBD	September 2024

* Estimated milestones subject to change due to COVID-19 and other factors. Staff will continue to monitor and update project timelines.

** The effective date of the School Environmental Health and Safety rules is dependent on any changes to the budget proviso restricting implementation.

Department of Health Updates

Washington State Department of Health

www.doh.wa.gov

State Board of Health Meeting

August 10, 2022

@WaDeptHealth
@WaHealthSec

Speakers

MPV & COVID-19 Response

Umair A. Shah, MD, MPH

Secretary of Health

MPV & COVID-19 Epidemiology

Tao Sheng Kwan-Gett, MD, MPH

Chief Science Officer

988 Suicide & Crisis Lifeline

Lacy Fehrenbach, MPH

Chief of Prevention

Strategic Plan

Kristin Peterson, JD

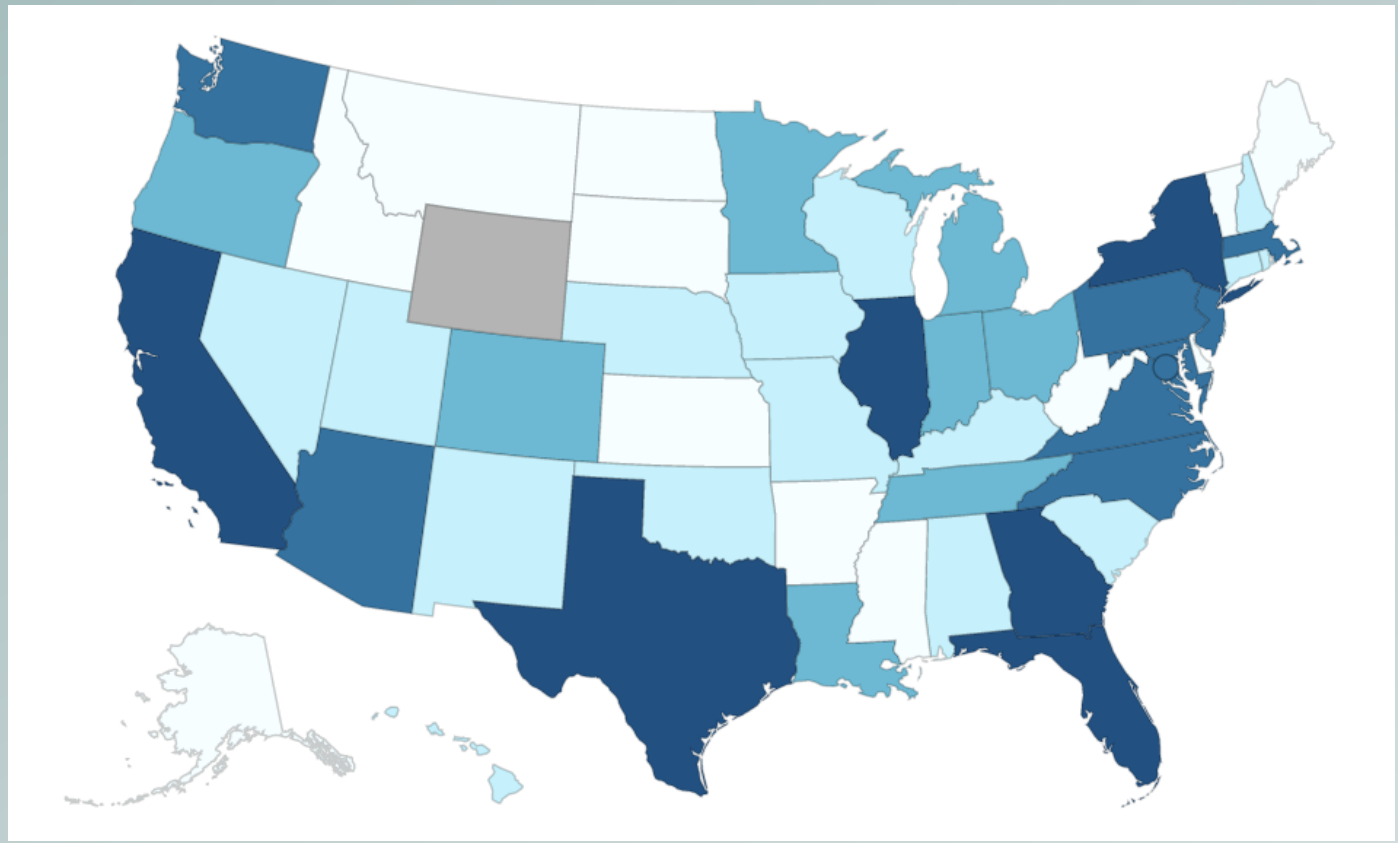
Chief of Policy


Health
Where Equity,
Innovation,
& Engagement
meet.

MPV
(Monkeypox)

MPV Cases in US

8,934 Confirmed and Probable Monkeypox Cases



Top 10 US Jurisdictions with Monkeypox Cases (as of 8/8/22)		
1	New York	1,960
2	California	1,310
3	Florida	936
4	Texas	702
5	Illinois	672
6	Georgia	625
7	District Of Columbia	303
8	New Jersey	243
9	Pennsylvania	234
10	Maryland	215
11	Washington	183

MPV Response Timeline

May 23rd

1st probable case in WA

May 25th

WA DOH Launches MPV Readiness Team

May 27th

1st confirmed case in WA

July 22nd

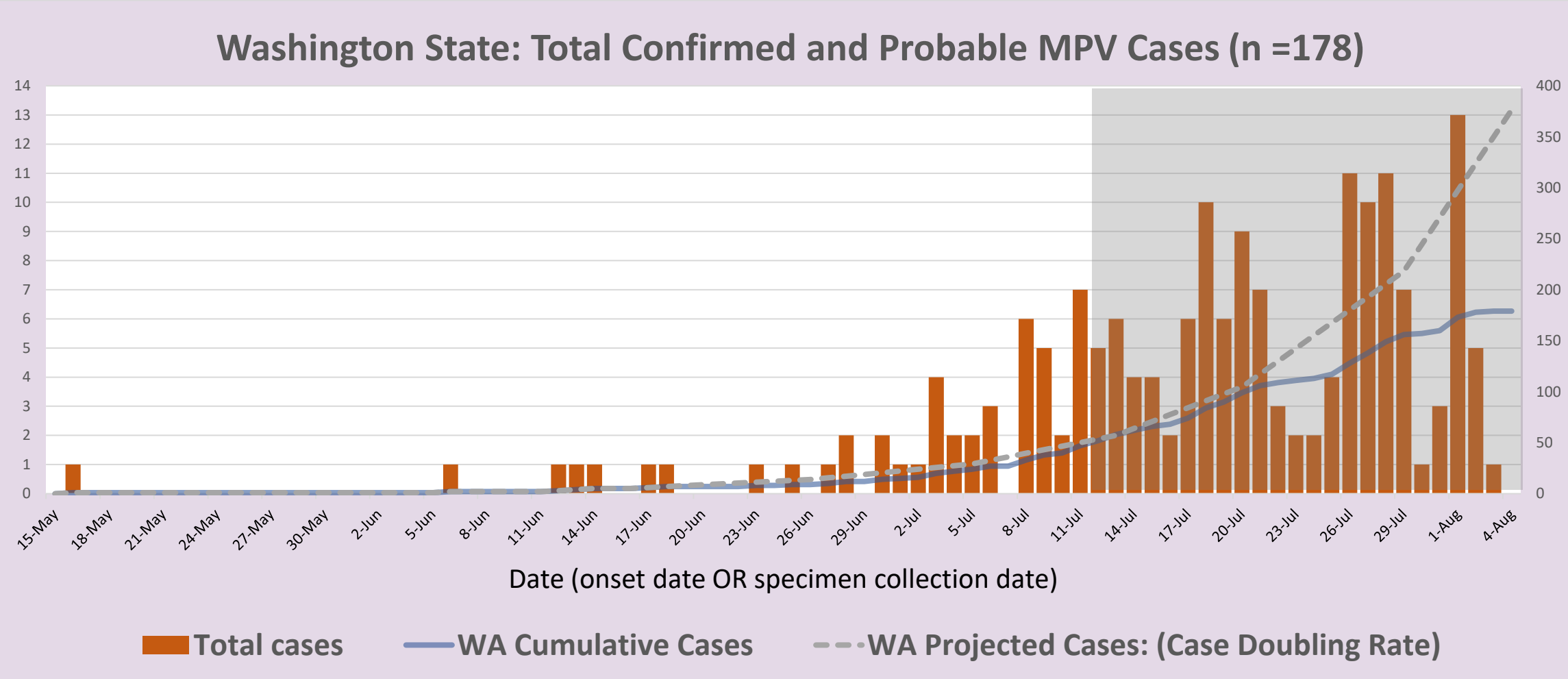
WA DOH activates MPV Response Team (formal ICS activation)

August 4th

United States declares federal public health emergency

MPV Response - Public Health in Action

MPV Epi Curve in Washington State

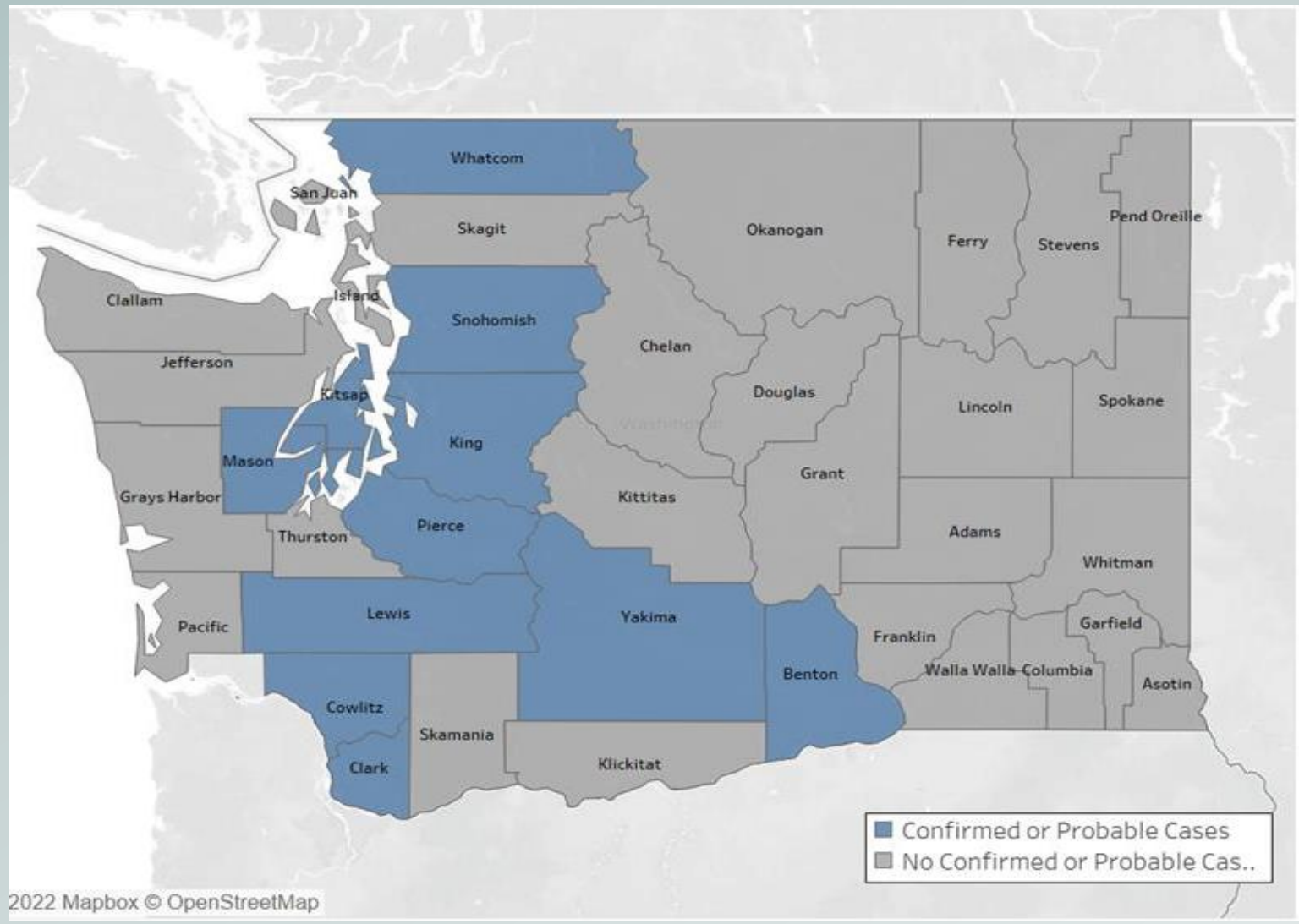


As of 8/5/22: Current doubling rate is 6.83 days

54 cases in the last 7 days

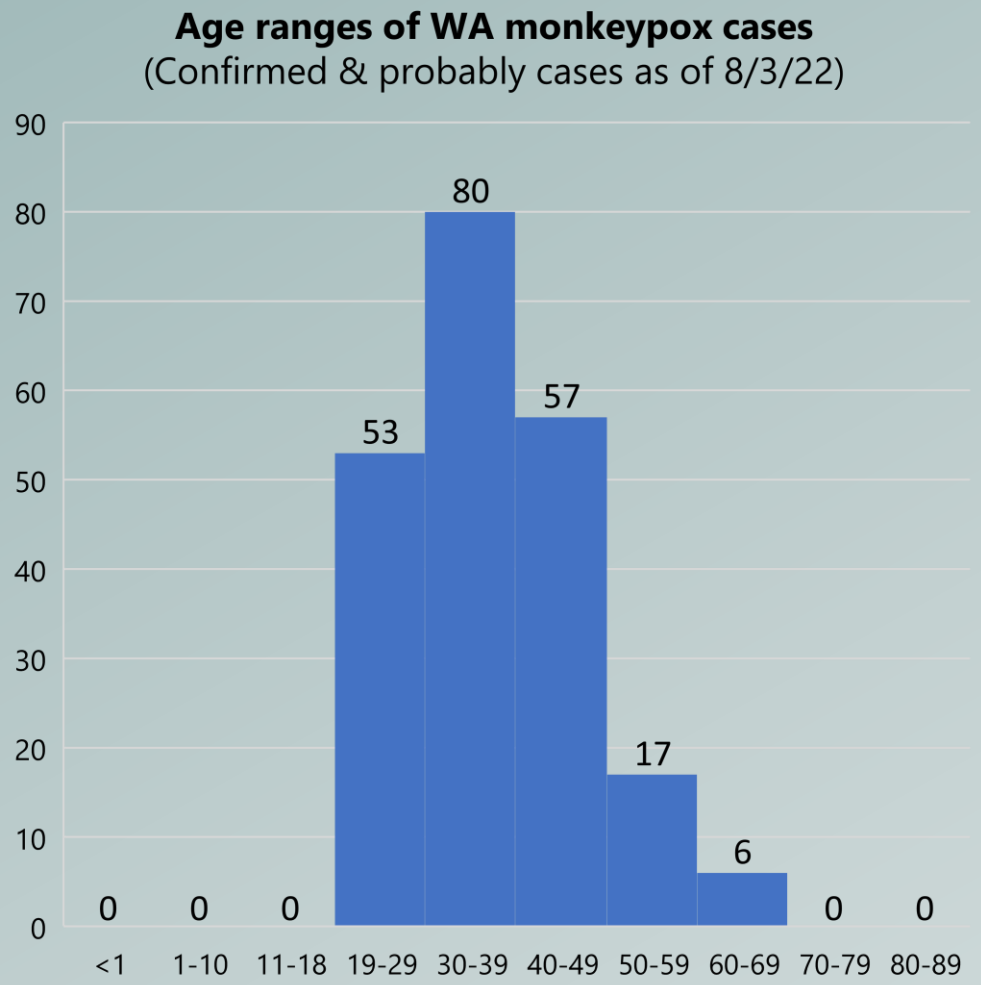
Cases by County in Washington State

Reported Cases by County as of 8/5	
Total cases	212
King	180
Pierce	11
Snohomish	5
Benton	1
Clark	3
Cowlitz	1
Kitsap	2
Lewis	1
Yakima	4
*Mason	1
Non-WA Resident	2
*Whatcom	1



As of 8/5/22: 11 counties

Cases Demographics in Washington State



Race/Ethnicity Demographics of Cases*		
	#	Percent
Cases with any ethnicity data reported:	**77**	**36%**
Hispanic, any race	19	25%
Non-Hispanic	58	75%
Cases with any race data reported:	**67**	**31%**
American Indian/Alaska Native	*1*	*1%*
Asian	*1*	*1%*
Black	*4*	*6%*
White	51	76%
Native Hawaiian/Pacific Islander	*1*	*1%*

*Note: Data are incomplete and based on initial report to DOH. DOH is following up with LHJs to obtain updated race/ethnicity data after case interviews are completed.

MPV Vaccines

JYNNEOS Allocations to Washington State

Phase 2A	Phase 2B	Phase 3A
2,710	3,660	6,900

96% of allocated vaccines have been ordered and distributed

Jynneos Alternative Dosing Regimen

MPV Risks

Spread into general population including those at high risk for severe disease (children, pregnant women, those with immune deficiency)

Stigma against MPV infected individuals and LGBTQ+ communities

Perception that MPV response is less vigorous because it disproportionately impacts gay and bisexual men

Stigma & Misinformation

Misinformation Is Worsening the Monkeypox Crisis and Fueling Homophobia

Kylie Cheung - Jul 26

Marlena Sloss for The Washington Post

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SGN

SEATTLE'S LGBTQIA+ NEWS & ENTERTAINMENT WEEKLY SINCE 1974

VOLUME 50 ISSUE 31

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Home / Local

A human virus, not a Gay virus: Community leaders convene to address MPV misinformation, course of action

by A.V. Eichenbaum, SGN Managing Editor | Friday August 5, 2022

Jeenah Moon/Getty Images

Monkeypox Is Not an STD. Calling It That Isn't Just Misleading—It's Dangerous.

Misinformation surrounding this virus is going to create even bigger problems

Lead With Community

COVID-19

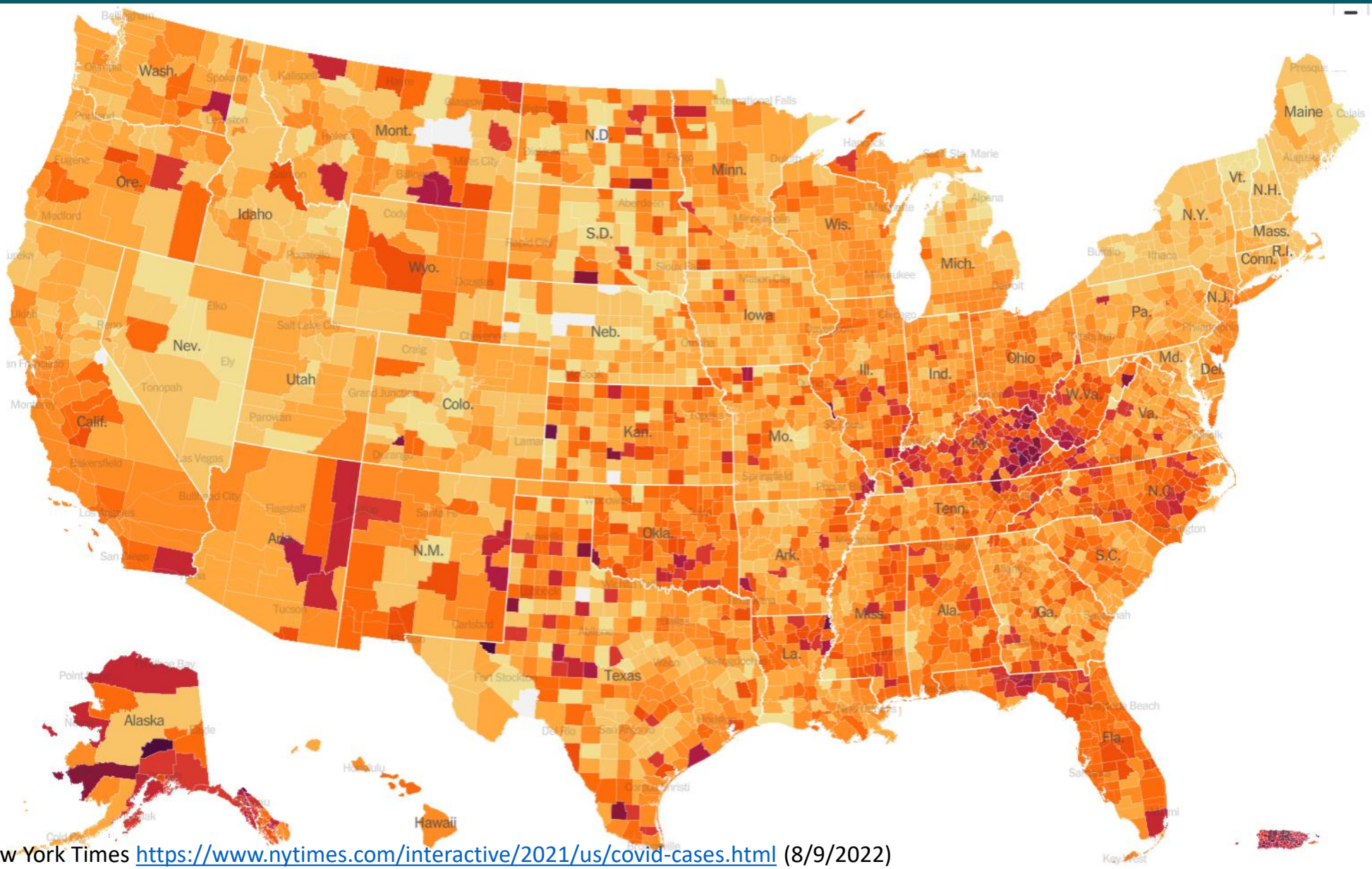
Washington State Department of Health

Mask Up, Washington.

Visit www.doh.wa.gov

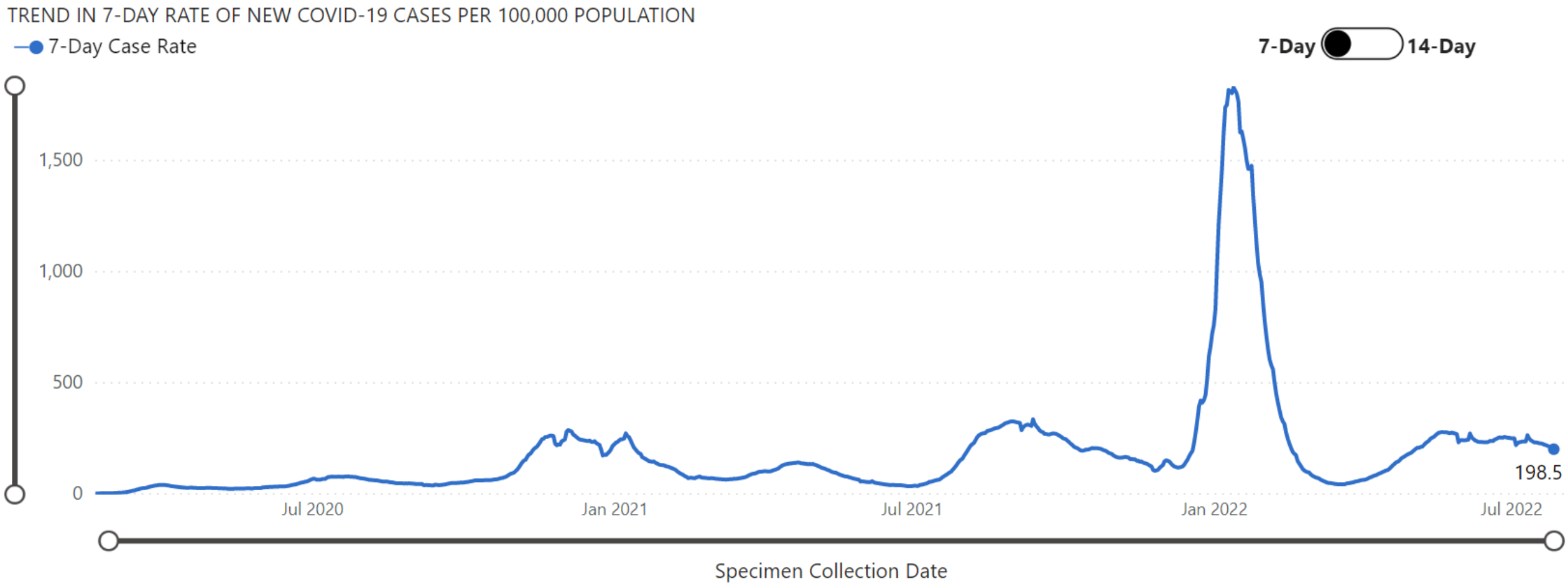
@WaDeptHealth
@WaHealthSec

August 2022 – U.S. COVID-19 hot spots



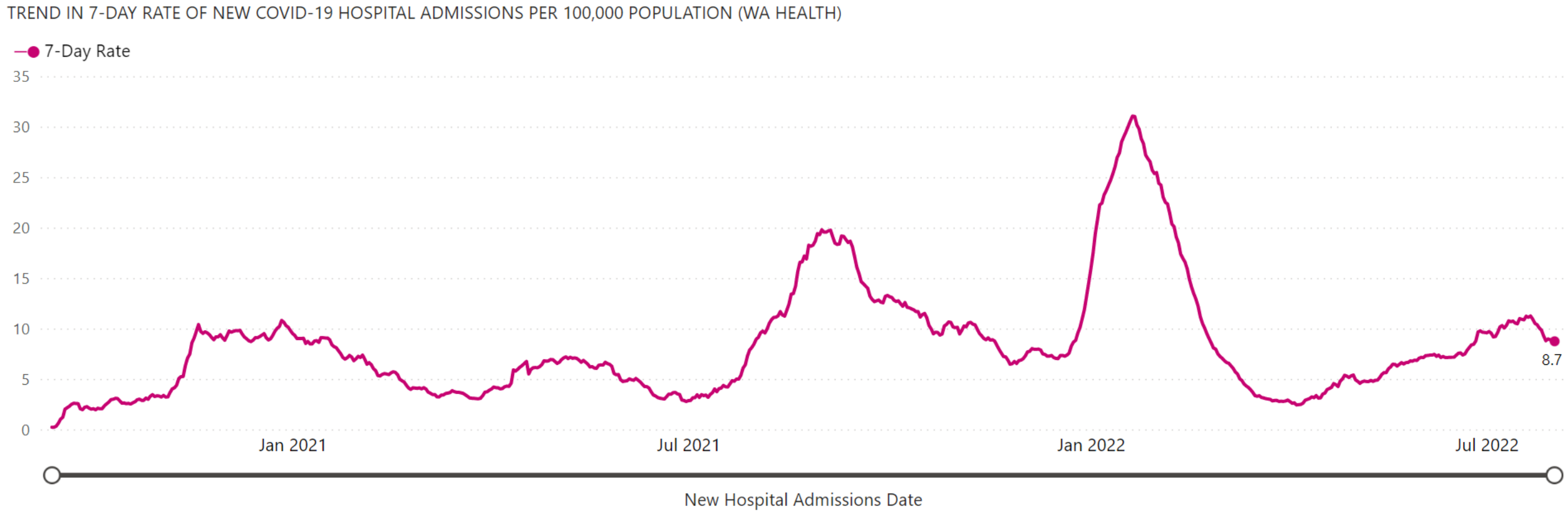
Source: The New York Times https://www.nytimes.com/interactive/2021/us/covid-cases.html (8/9/2022)

COVID-19 Cases in Washington State



Source: DOH COVID-19 data dashboard https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard (8/9/2022)

COVID-19 Hospitalizations in Washington State



Source: DOH COVID-19 data dashboard https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard (8/9/2022)

Test to Treat Expanded for All Washingtonians

HAVE YOU JUST TESTED POSITIVE FOR COVID-19?

Do you have mild or moderate symptoms that started in the past 5 days?

Are you immunocompromised or high risk for severe illness or hospitalization from COVID-19?

THERE ARE TREATMENTS THAT MAY BE RIGHT FOR YOU

COVID-19 Bivalent Booster Dose

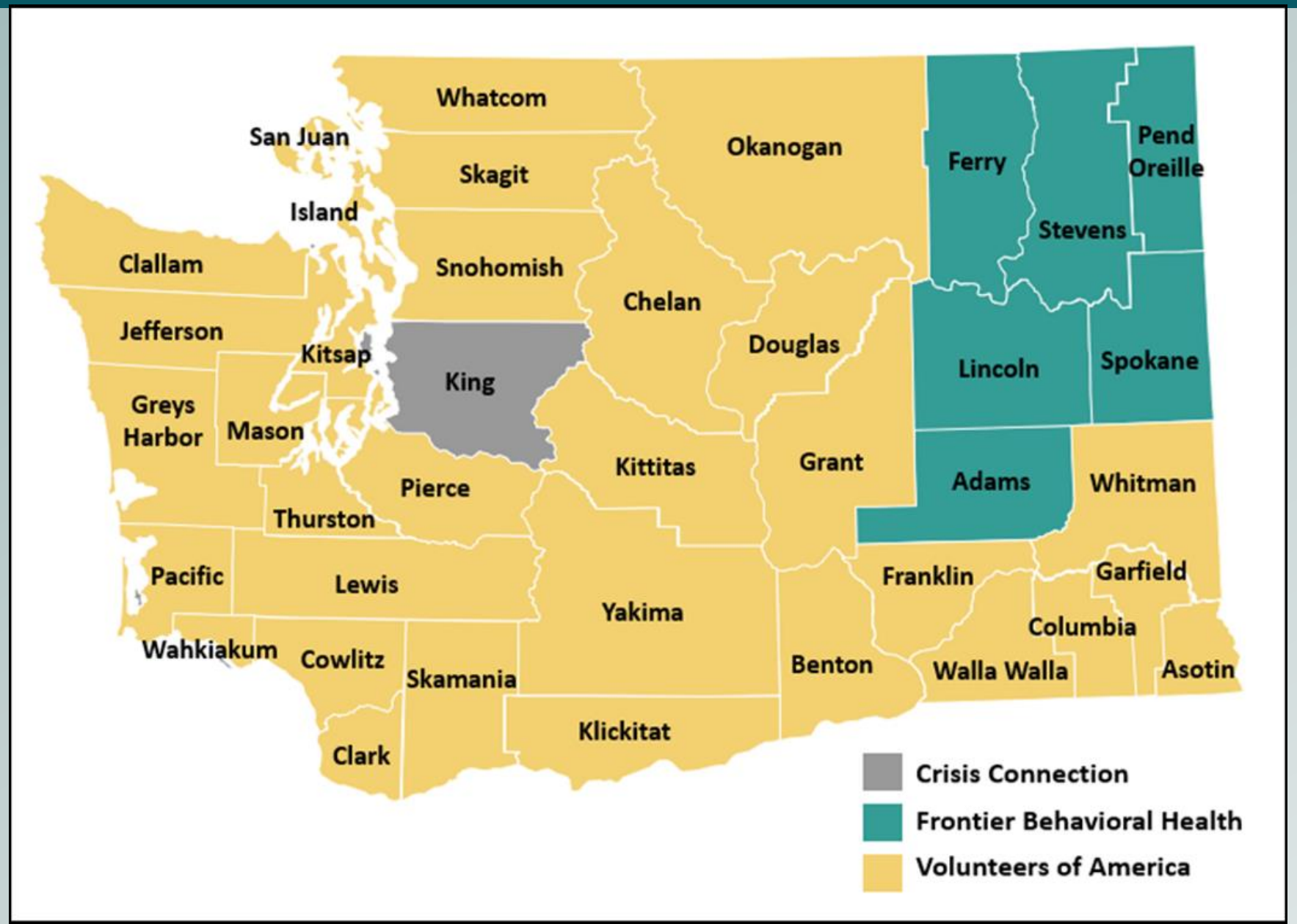
988 Suicide & Crisis Lifeline

State Rollout

Crisis Centers in Washington

988
24/7 Crisis & Support

Washington 988 Call Centers



Native and Strong Lifeline

We all make us all strong.

Our connection helps make us who we are. It protects us, too.

NativeAndStrong.org

Resources

Washington Indian Behavioral Health HUB
988 Suicide and Crisis Lifeline
Lifeline Partner Toolkit
Substance Abuse and Mental Health Services Administration
Crisis Response Improvement Strategy committees
E2SHB 1477
Campaigns in partnership with tribal communities:

- it starts with one
- Suicide Prevention

Transformational Plan

Commitment to Washington

WASHINGTON STATE DEPARTMENT OF HEALTH

TRANSFORMATIONAL PLAN

A VISION FOR HEALTH IN WASHINGTON STATE

CORNERSTONE VALUES: EQUITY • INNOVATION • ENGAGEMENT

VISION: EQUITY AND OPTIMAL HEALTH FOR ALL

PRIORITY I. HEALTH AND WELLNESS

PRIORITY II. HEALTH SYSTEMS AND WORKFORCE TRANSFORMATION

PRIORITY III. ENVIRONMENTAL HEALTH

PRIORITY IV. EMERGENCY RESPONSE AND RESILIENCE

PRIORITY V. GLOBAL AND ONE HEALTH

WASHINGTON STATE DEPARTMENT OF HEALTH

FOUNDATIONAL TRANSFORMATIONS

OUTWARD MINDSET

We build an organizational culture in which we see others as people who matter and focus on achieving agency objectives in ways that help our employees, partners, and customers achieve theirs.

ALIGNED RESOURCES

We use our agency priorities to drive how we develop, manage and invest our funding for maximum effectiveness.

INNOVATIVE ORGANIZATION

We ensure our strategic decisions and work environment support the exploration and adoption of new approaches to address both existing challenges and emerging health needs.

EQUITY CENTERED WORKFORCE

We commit to creating a diverse and inclusive workplace, while centering communities adversely impacted by systemic and cultural oppression in decision-making and ensuring equitable access to services, opportunities, and information.

2022 – Working together for a brighter tomorrow

Washington State Department of Health

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Visit www.doh.wa.gov

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WASHINGTON STATE DEPARTMENT OF HEALTH

TRANSFORMATIONAL PLAN

A VISION FOR HEALTH IN WASHINGTON STATE

CORNERSTONE VALUES: EQUITY • INNOVATION • ENGAGEMENT

VISION: EQUITY AND OPTIMAL HEALTH FOR ALL

The Washington State Department of Health's ***Transformational Plan*** reenergizes our commitment to health for all — creating policies and conditions so everyone can live their healthiest lives. We cannot embark on this journey alone. We must collaborate with communities, community-based organizations, local public health entities, governmental partners, health care providers and systems, the private sector, Tribal Nations, and many, many more. Infusing our agency's values into how we transform our services, go about our activities, and strengthen our core work, is critical to the bright and robust future ahead.

We know our cornerstone values of **Equity**, **Innovation**, and **Engagement** (**EIE**) are key drivers in shaping our future. Our vision for each strategic priority is the "what" we are striving for and key examples of the "how" we will do our work are reflected in our transformations in action. While this is not an exhaustive list of everything we currently do or plan to do, it does provide our roadmap for how and where we prioritize our efforts. Additionally, it boldly positions our agency for the ever-changing future already upon us!

OUR PRIORITIES AND VISION FOR TRANSFORMATIONAL HEALTH

I. HEALTH AND WELLNESS

All Washingtonians have the opportunity to attain their full potential of physical, mental, and social health and well-being.

II. HEALTH SYSTEMS AND WORKFORCE TRANSFORMATION

All Washingtonians are well served by a health ecosystem that is robust and responsive, while promoting transparency, equity, and trust.

III. ENVIRONMENTAL HEALTH

All Washingtonians will thrive in a broad range of healthy environments — natural, built, and social.

IV. EMERGENCY RESPONSE AND RESILIENCE

All Washington communities have the information and resources they need to build resilience in the face of myriad public health threats and are well-positioned to prepare for, respond to, and recover from emergencies and natural disasters.

V. GLOBAL AND ONE HEALTH

All Washingtonians live in ever-connected environments that recognize and leverage the intersection of both global and domestic health as well as the connections of humans, animals, and the environment.

TRANSFORMATIONS IN ACTION

INNOVATION AND TECHNOLOGY

COMMUNITY CENTERED

VISIBILITY AND VALUE

EQUITY DRIVEN

COLLABORATIVE ENGAGEMENT

On behalf of the Washington State Department of Health (DOH), I am pleased to present our agency's ***Transformational Plan: A Vision for Health in Washington State***.

In this document, you will find five Priorities for our agency followed by six Strategies each (30 in total) intended to provide our "north star" for our agency's transformative work over the course of the next few years.

While much of this work has been ongoing already, this document provides our agency an opportunity to align our work with the vision of Governor Jay Inslee's aspirational words during his inauguration speech in 2021 when he asked all of us to "reimagine public health."

We know it is difficult to reimagine health when we have so many challenges about us. Yet, we have a responsibility to respond, and not only respond, but to step up and remind each one of us that we are in this together. In the process, we must also advance the "3Vs" of public health.

What you will see in this document is the culmination of numerous discussions — whether internally or with partners, whether informally or formally, whether within our state or beyond — that provided our team with the insights into a path for advancing "health" in our state moving forward.

We know this document will not be everything to everyone, nor is it intended to be as such. Instead, it gives our agency the direction in how we prioritize our work leveraging our cornerstone values of **Equity**, **Innovation**, and **Engagement** (**EIE**) that have centered our work.

In some cases, this will allow us an opportunity to take a closer look at what we are currently doing and consider the value proposition of continuing that work. In other cases, it will undoubtedly validate our work and inspire us to reach even further than we have ever before. That is what "reimagining health" is all about.

Let me close by saying thank you to the countless partners and colleagues who helped us with this plan and the amazingly dedicated team at DOH that allowed us to move this work forward while simultaneously fighting a pandemic. And, a special shout-out to our HHS subcabinet and other state agencies that will be instrumental in helping advance this work ahead.

Now the hard work begins — making words on paper a reality in action. Yet together, we are confident we can and will do just that!

Sincerely,

Umair A. Shah, MD, MPH
Secretary of Health
The Great State of Washington

Release date: August 1, 2022

This ***Transformational Plan*** is charting the course for our collective future. Serving the health needs of nearly 8 million Washingtonians spread over 71,000 square miles of incredibly beautiful and diverse land, will never be easy. This is exactly why we do not plan to do it alone.

We commit to working alongside communities and partners alike. We will be advocates for the "**health ecosystem**" which is a dynamic landscape of partners and influencers of health at the local, state, and national levels: public health, health care, governmental and private partners, Tribal Nations, and a multitude of other partners whose work and actions impact and influence health. Most importantly, our partners are everyday Washingtonians.

Despite an unprecedented and challenging time in serving the health needs of Washingtonians due to COVID-19, as a state we rose to the occasion, saved lives, leveraged innovations, and built partnerships that will serve to **strengthen communities** and transform how we approach the notion of health to meet the needs of the future.

As we look beyond COVID-19, we aim to approach our work with the same sense of urgency, nimbleness, and innovation that was critical in fighting this pandemic. We will tell our story because our story is the **story of Washington's people** and its communities. In the process, we will demonstrate our field's impact so that others recognize and embrace the vital role of public health in our everyday lives. We will embrace the notion of the "**3Vs**" and increase public health's **Visibility**, which in turn engenders **Value**, and thereby builds trust and **Validation** of our work and its impact.

We will continue to forge and foster partnerships with those we have worked with in the past and newer ones we have only begun engaging so that the health ecosystem is harnessing the strength of our collective effort to improve health. We will convene and lead relationships that reflect the important intersection of countless partners. Our shared **commitment to health and well-being** is the foundation for future collaboration. Given the myriad of challenges in store for all of us — from reproductive health to climate to opioids and addressing social determinants of health — we must astutely pivot to meet these head on. The upcoming work is simply too important to do it alone.

This plan creates **our roadmap** for building healthy communities full of resilient people. We do this by preventing disease and injury, modernizing an array of systems, serving health needs, and helping coordinate the related social needs of all Washingtonians. Through already launched milestone efforts like Governor Inslee's **Pro-Equity Anti-Racism (PEAR) initiative** or the Legislature's investment in **Foundational Public Health Services**, we will demonstrate our commitment to transforming the health of communities while also addressing health inequities that this pandemic has laid bare. By ensuring equity, fairness, and justice principles are embedded in our activities, we will seek impactful and measurable solutions to often complex and historically rooted issues that are preventing equitable access to health and health care alike.

continues on page 2

Our vision for a **modernized public health system** is one that will serve communities through capabilities and tools that further their ability to thrive and are equally supported by a robust, well-trained and capable workforce that is supported and trusted. We will bring novel approaches to improving health through new models of innovation, key engagement and communications pathways, promotion of whole person health, and the detection, prevention and response to a variety of diseases and conditions. We will pursue and support new models of care and innovative technologies that support access to necessary mental, emotional, and physical health.

Since the work of public health is never done, we will remain committed and prepared for future public health threats — from natural to human-caused disasters, infectious disease emergencies, and environmental and climate-related impacts. We will **protect our communities** against the threat from vector-borne and other communicable diseases, as well as the impact of human (and animal) migration patterns across the globe.

More than ever, the connections between **global health** and domestic health as well as principles of **One Health** remind us of why human, animal, and environmental intersections are more important to understand than ever. In the process, we will respectfully learn from others whether across our state, our nation, or across the globe.

We recognize we are emerging from arguably the most difficult and critical time in the history of our nation. We have seen our nation divided far too long. The gravity of this moment has not been lost on any of us and its impact is long-term. Our hope is that together we will not just move forward, but we will thrive and **transform our system of health in Washington** and be a model for others — where together we create the reality that everyone across Washington has the opportunity to live the healthiest of lives. The work has only just begun but this moment marks the beginning of this road.

Thank you for partnering with us on this journey — together we can and will make a difference.

PRIORITY I. HEALTH AND WELLNESS

VISION

All Washingtonians have the opportunity to attain their full potential of physical, mental, and social health and well-being.

GROWING
THRIVING COMMUNITIES

COMMITMENT

We will lead initiatives that support and promote upstream prevention efforts to advance optimal physical health, mental and behavioral health, spiritual health, resilience, and overall well-being where individuals, families, and communities can thrive. Our actions recognize that social, structural, and economic determinants of health must be addressed to achieve true health equity and optimal health for all.

KEY STRATEGIES

1. **Promote** a broad range of initiatives that support pro-health and wellness behaviors and actions related to physical activity, nutritional health, mental and behavioral health, emotional and spiritual health, and comprehensive holistic health to advance both individual and community health across all of Washington.
2. **Support** community rooted and informed initiatives that address conditions early, including for adverse childhood experiences, and throughout the life course, to improve health and well-being longer term.
3. **Advance** a continuum of prevention and harm reduction strategies that address common risk and protective factors associated with injuries as well as use of alcohol, tobacco, marijuana, opioids, and other substances and related behaviors.
4. **Engage** partners and people with lived experience and embrace multisector strategies to address upstream factors that contribute to the impact on key health concerns such as chronic disease, addiction, injuries, and the like.
5. **Utilize** morbidity and mortality data and strategies to inform action-oriented prevention programs and policy recommendations that address disproportionality in health outcomes.
6. **Deploy** proactive communication and health promotion strategies that promote mental and physical health wellness while countering stigma in seeking care.

PRIORITY II. HEALTH SYSTEMS AND WORKFORCE TRANSFORMATION

VISION

All Washingtonians are well served by a health ecosystem that is robust and responsive, while promoting transparency, equity, and trust.

MODERNIZING
DATA ACCESS

COMMITMENT

We will align skills, resources, and partnerships to ensure our health systems and infrastructure capabilities are scalable, responsive, and modernized to promote data driven and innovative approaches to improving health. We will build and transform our systems to be accessible and responsive to Washingtonians regardless of who they are or where they live.

KEY STRATEGIES

1. **Invest in** and **support** secure and innovative health information technologies and infrastructure supports that will enable partners to access and exchange information that addresses whole person health in a culturally and linguistically respectful way.
2. **Ensure** our public health, health care, and community-based partners and their workforce have the data, technology, and system supports they need to build and utilize connections among health, social, and community initiatives.
3. **Champion** the recruitment, development, and retention of a strong, capable, and diverse and inclusive state, local, and Tribal public health workforce and further policies and efforts that support, invest in, and diversify our health system workforce.
4. **Strengthen** the collection, analysis, linkage, and dissemination of timely, accessible, and actionable health data, guided by community priorities, to inform better community level interventions and initiatives that improve both individual and population health.
5. **Co-create** robust data sharing capabilities and systems with local health jurisdictions, with Tribes honoring Tribal data sovereignty, and other stakeholders to support better detection, understanding, and addressing of the burden of disease and health inequities.
6. **Invest in** and **leverage** previously developed tools, technologies, and strategies, including newer ones utilized during the COVID-19 pandemic such as interactive dashboards, communications pathways, and geospatial mapping to assist individuals, communities, health systems, and policy makers, to make data-informed decisions to promote health.

PRIORITY III. ENVIRONMENTAL HEALTH

VISION

All Washingtonians will thrive in a broad range of healthy environments — natural, built, and social.

ENSURING
ENVIRONMENTAL JUSTICE

COMMITMENT

We will lead broad efforts that address external factors impacting health, safety, and well-being, recognize the intersection of people, animals, and environment, and incorporate principles of environmental justice and shared responsibility for community health.

KEY STRATEGIES

1. **Support** systems and policies that promote optimal individual and community health by investing in proactive efforts to advance a broad range of healthy environments and interactions where people live, learn, work, worship, and play.
2. **Ensure** our policies, planning, and programming incorporate environmental justice principles with the goal of reducing health inequities and promoting community well-being.
3. **Incorporate** data-driven approaches and community engagement strategies, assets and strengths, into public health and response planning efforts aimed at building resilience against the health and social impacts of climate change and other environmental challenges.
4. **Ensure** communities likely to bear the worst climate-related and environmental health impacts have resources and support to foster resilient communities that promote true health and well-being.
5. **Support** initiatives that promote safe and active living, commuting and recreation, reduce greenhouse gas emissions, and increase community cohesion.
6. **Communicate** and **promote** the health benefits of behavior change and interventions that protect our environment, while ensuring equitable access to health opportunities through robust data systems and information sharing.

PRIORITY IV. EMERGENCY RESPONSE AND RESILIENCE

VISION

All Washington communities have the information and resources they need to build resilience in the face of myriad public health threats and are well-positioned to prepare for, respond to, and recover from emergencies and natural disasters.

BUILDING
RESILIENCY

COMMITMENT

We will lead our response to health threats and emergencies in a proactive, effective, and equitable way that assures strength of response, supports health systems, leverages community solutions, promotes cross-sector collaboration, and advances health security. Our efforts will learn from previous emergencies and response activities within Washington and beyond to build resilient communities.

KEY STRATEGIES

1. **Respond** with strength and decisiveness on behalf of Washingtonians and the communities in which they live to minimize impact on people and lives, sustain necessary response capabilities, and advance protections in advance of, during, and in the aftermath of a broad range of public health threats and emergencies.
2. **Collaborate** with a myriad of community-rooted organizations, disaster response and recovery partners, and interagency partners to develop, share, and act upon key information in culturally and linguistically appropriate ways related to hazards and emergencies.
3. **Recruit**, **develop**, **train**, and **retain** a robust and capable workforce prepared to respond in an emergency and institute planning initiatives to support response personnel in disaster response and recovery efforts integrating models of excellence and infrastructure advancements from a broad range of emergencies including the COVID-19 pandemic.
4. **Seek** flexible and sustainable funding opportunities to invest in activities that support robust response activities, workforce, tools, and the communities we serve and that allow for scarce resources to be equitably allocated.
5. **Support** and **prioritize** community-led solutions to mitigate barriers to optimal outcomes, survival, and resilience for all communities especially those most at-risk through a broad range of community engagement and response initiatives.
6. **Ensure** resilience and behavioral health promotion planning and implementation efforts are key components of current and future response activities serving community members, partners, and responders alike.

PRIORITY V. GLOBAL AND ONE HEALTH

VISION

All Washingtonians live in ever-connected environments that recognize and leverage the intersection of both global and domestic health as well as the connections of humans, animals, and the environment.

COMMITMENT

We will lead the development and implementation of creative solutions to improve the health and well-being of Washingtonians emphasizing the connectedness of a strong bidirectional global-domestic health ecosystem. It will simultaneously underscore the importance of One Health recognizing the relationships of human health as they intertwine with that of animals and the environment.

LEVERAGING
GLOBAL EXPERTISE

KEY STRATEGIES

1. **Incorporate** best practices from beyond borders to advance the health and well-being of Washingtonians and the communities in which they live through strong bidirectional pathways for advancing partnerships, key planning strategies, and communications efforts.
2. **Leverage** the collective strength and wisdom of existing and emerging global health and One Health stakeholders and institutions within (and beyond) Washington state to participate in and support robust and connected networks of information sharing, strategy development, and engagement.
3. **Seek** resources and funding as well as partnership opportunities to enhance capabilities across health systems to ensure a globally connected community of partners with particular emphasis on mentorship and training opportunities, system and technology enhancements, and engagement pathways to address domestic issues through global health learnings.
4. **Advance** timely, culturally, and linguistically respectful health information and initiatives, in partnership with health system providers and communities, to support the health and well-being of refugee, immigrant, and migrant communities across Washington.
5. **Emphasize** the complex connections of human, animal, and environmental health in our health promotion activities and expand our capacity to prevent, detect, and respond to global public health threats with domestic health impact whether infectious disease or otherwise.
6. **Further** and **support** our important role in binational relations and connectedness with health partners and other key entities in Canada and beyond to advance information sharing, health systems knowledge, and strategy development.

WASHINGTON STATE DEPARTMENT OF HEALTH

FOUNDATIONAL TRANSFORMATIONS

OUTWARD MINDSET

We build an organizational culture in which we see others as people who matter and focus on achieving agency objectives in ways that help our employees, partners, and customers achieve theirs.

ALIGNED RESOURCES

We use our agency priorities to drive how we develop, manage and invest our funding for maximum effectiveness.

INNOVATIVE ORGANIZATION

We ensure our strategic decisions and work environment support the exploration and adoption of new approaches to address both existing challenges and emerging health needs.

EQUITY CENTERED WORKFORCE

We commit to creating a diverse and inclusive workplace, while centering communities adversely impacted by systemic and cultural oppression in decision-making and ensuring equitable access to services, opportunities, and information.

CULTURE

FUNDING

INNOVATION

EQUITY

CONTACT: **Kristin Peterson, JD** | Chief of Policy
kristin.peterson@doh.wa.gov | 360-507-4367

Washington State Department of Health

DOH 824-002 August 2022

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

From: DOH Information
Sent: 8/1/2022 10:38:55 AM
To: DOH WSBOH
Cc:
Subject: FW: Question/Comment from the public

attachments\00D2AB5206A94216_image001.png

Hello,

Below is public comment on one of your meetings.

Thank you,

Customer Service Specialist 2

Center for Public Affairs (C4PA)

Washington State Department of Health

DOH.Information@DOH.WA.GOV <mailto:DOH.Information@DOH.WA.GOV>

1-800-525-0127| www.doh.wa.gov
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.doh.wa.gov%2F&data=05%7

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FNewsroom%

From: DOH Feedback <doh.information@doh.wa.gov>
Sent: Saturday, July 30, 2022 9:03 AM
To: DOH Information <DOH.Information@DOH.WA.GOV>
Subject: Question/Comment from the public

The following survey response is submitted:

1.

Please select one:

Other

2.

Please enter your comments or questions in the space provided below:

July 30, 2022, for Aug 10 meeting, Public Comment To Whom it May Concern, It concerns me greatly that the Board of Health may continue to insist that childhood vaccination is imperative to gain and retain health in our community. There is plenty of evidence to the contrary, and I urge you to look into the following scientific claims (and not label them "misinformation," which is the constant in today's discussions about pandemics & vaccinations). The citations listed are just a sampling of what is available online. Vaccinated children have spread the "virus" more than those who have not been jabbed: https://rumble.com/vkcljx-july-26-2021.html <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frumble.com%2Fvkcljx-july-26-2021.html&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7C
The vaccine insert states that it CANNOT stop the spread of the "virus.": https://www.naturalnews.com/2021-12-03-covid-vaccine-induced-diseases-public-health-threat.html <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.naturalnews.com%2F2021-12-03-covid-vaccine-induced-diseases-public-health-threat.html&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7
The injection forces recipients to MAKE a virus, and not just a spike protein: https://www.bitchute.com/video/43olH6iAvT3f/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bitchute.com%2Fvideo%2F4
Proper nutrition, vitamins C and D, and zinc are important tools in our personal medical cabinet: https://informedchoicewa.org/news/covid-19-key-insight-this-week/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2Fnews%2Fcovid-19-key-insight-this-week%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7C
Dr. Fauci added HIV to the Covid virus from 2003 to 2019, the US patent office confirms: https://forbiddenknowledgetv.net/there-is-no-variant-not-novel-no-pandemic-dr-david-martin-with-reiner-fuellmich/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fforbiddenknowledgetv.net%2Fthere-is-no-variant-not-novel-no-pandemic-dr-david-martin-with-reiner-fuellmich%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%
Natural Immunity IS real, IS important, and can save lives: https://informedchoicewa.org/covid-19/ican-vs-cdc-on-superior-natural-immunity/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2Fcovid-19%2Fican-vs-cdc-on-superior-natural-immunity%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%
The fertility of our children and young adults is at risk due to these injections: https://www.lewrockwell.com/2022/07/joseph-mercola/covid-jabs-impact-both-male-

and-female-fertility/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.lewrockwell.com%2F2022%
mercola%2Fcovid-jabs-impact-both-male-and-female-
fertility%2F&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc%7
The CDC used flawed data when it claimed our children were at extreme risk from Covid:
https://childrenshealthdefense.org/defender/cdc-flawed-data-covid-shots-infants-
children/?utm_source=salsa&eType=EmailBlastContent&eId=a2d4ef24-7d8f-40e0-87aa-
10ac62a79d07
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fchildrenshealthdefense.org%2Fde
flawed-data-covid-shots-infants-
children%2F%3Futm_source%3Dsalsa%26eType%3DEmailBlastContent%26eId%3Da2d4ef24-
7d8f-40e0-87aa-
10ac62a79d07&data=05%7C01%7CWSBOH%40SBOH.WA.GOV%7C74195a73f7174e4ec9c008da73e4b1dc
Be Strong, Be Smart! Stop believing the narrative that has been constructed to control
and manipulate the public. Today's mainstream propaganda has nothing to do with
“health and safety,” only absolute power over The People in perpetuity. Coercion is NOT
Consent, and the Constitution protects our Right to Choose. The rest of the World is
dropping the masks and the “vaccines.” Let's be on the right side of History for once. In
the name of Truth, Sue Coffman 714-337-4331 ICWA Team Leader Legislative District
#24 https://informedchoicewa.org/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Finformedchoicewa.org%2F&data=

3.

If you are sending feedback on one of our Web pages, please paste the URL here:
(no answer)

4.

Would you like a response?

Tell us how to get in touch with you.

Name:
Sue Coffman
Email:
doulasue@yahoo.com <mailto:doulasue@yahoo.com>
Telephone:
7143374331

5.

To receive a confirmation of your submission, please enter your email address again in the space provided below.

_____

doulasue@yahoo.com <mailto:doulasue@yahoo.com>

From: DOH Information
Sent: 7/26/2022 9:04:41 AM
To: DOH WSBOH
Cc:
Subject: Vaccine feedback

attachments\92F50B1EAEDC4390_image002.png

Hello,

This feedback is intended for the Board.

Thank you

Alexandra Moore

Customer Service Specialist

Center for Public Affairs

Washington State Department of Health

DOH.Information@doh.wa.gov

800-525-0127 | www.doh.wa.gov

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FNewsroom%

From: DOH Feedback <doh.information@doh.wa.gov>
Sent: Monday, July 25, 2022 3:47 PM
To: DOH Information <DOH.Information@DOH.WA.GOV>
Subject: Question/Comment from the public

The following survey response is submitted:

1.

Please select one:

Other

2.

Please enter your comments or questions in the space provided below:

_____

For months now, I've wanted to congratulate the WA Board of Health for NOT requiring the COVID vaccine for schools this fall. Thank you for making, in my professional and personal opinion, the right choice for the sake of our children!

3.

If you are sending feedback on one of our Web pages, please paste the URL here:
(no answer)

4.

Would you like a response?

Tell us how to get in touch with you.

Name:
Dr. Carol Volk

Email:
garycarols@hotmail.com <mailto:garycarols@hotmail.com>
Telephone:
(no answer)

5.

To receive a confirmation of your submission, please enter your email address again in the space provided below.

_____

garycarols@hotmail.com <mailto:garycarols@hotmail.com>

_____
From: Petra Hoy
Sent: 8/3/2022 10:29:53 AM
To: DOH WSBOH
Subject: WA Health District - School Safety - Secure Gun Storage

 *attachments\89C5A192DAD14D36_Model Secure Storage Notification_PRDTOOL_NAMETOOLONG.docx*

External Email

Good morning Washington Board of Health members,

I hope you are all enjoying this beautiful sunshine we've had lately. As the School District plans for the upcoming school year, I want to make sure that all School Board members are prioritizing the safety and security of students and staff.

Is this something the Washington Health District can help us with? This is such an important public safety issue.

Our Seattle School Safety Team has developed a relationship with the King County Lock it Up program through King Co Public Health, and now Lock It Up's webpage includes a link to Be SMART as a resource for families (https://kingcounty.gov/depts/health/violence-injury-prevention/violence-prevention/gun-violence/LOCK-IT-UP/parents-community.aspx <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fkingcounty.gov%2Fdepts%2Fheal injury-prevention%2Fviolence-prevention%2Fgun-violence%2FLOCK-IT-UP%2Fparents-community.aspx&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C45540504e49a4fbd39e808da7575b332%). We have a great partner with other government agencies and would love to work with you.

As a volunteer for WA Moms Demand Action and a parent, I know that families and communities expect schools to keep their children safe from threats (human-caused emergencies such as school shootings) and hazards (natural disasters, disease outbreaks like COVID, and accidents). It is always important to be prepared for potential emergencies and to review safety plans regularly. You can refer to the Guide for Developing High-Quality School Emergency Operations Plans <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Frems.ed.gov%2Fdocs%2FSchool_ , the "Keeping Our Schools Safe <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Feverytownresearch.org%2Freport gun-violence-in-american-schools%2F&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C45540504e49a4fbd39e808da7575b332%7C1 " report by Everytown for Gun Safety, as well as reference SchoolSafety.gov <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.schoolsafety.gov%2F&data= , for valuable resources to create safe and supportive learning environments.

In the wake of the horrific Uvalde school shooting, families are feeling increasingly concerned about the risk of gun violence on school grounds. In 2022, there were at least 95 incidents of gunfire on school grounds <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Feverytownresearch.org%2Fmaps%
on-school-
grounds%2F&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C45540504e49a4fbd39e808da7575b332%7C
, resulting in 40 deaths and 76 injuries nationally. Here are some topline facts about youth gun violence in America:

* Approximately 4.6 million children live in a household with at least one gun that is stored, loaded and unlocked. In Washington State, there remains a high prevalence of unlocked household firearms, even in households with children (1).

* In cases of gun violence on school grounds, nearly 80% of all shooters under the age of 18 obtained the firearm from the home of a friend or family member (2). Safe gun storage is a vital practice to protect our entire school community.

* In incidents of averted school violence, nearly two-thirds of would-be perpetrators had access to firearms (3).

* Unintentional shooting deaths by children increased by over 30% in March - May 2020, as compared to the March-May average of the previous three years (4).

* Suicide is the second leading cause of death for youth 10-24 years old in Washington, with firearms being the leading method. 75% of adolescent firearm suicides are carried out with a gun from home, or the home of a friend or relative (5,6).

* Secure gun storage practices are associated with reduced rates of child firearm suicide, and can prevent unintentional shootings. One study showed that households that locked both firearms and ammunition had a 78 percent lower risk of self-inflicted firearm injuries among children and teenagers (7).

All of these statistics point to the urgency for school districts to educate parents and the community on safe firearm storage. More than 2 million students <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.everytown.org%2Fpress%2F
milestone-more-than-two-million-students-nationwide-now-attend-schools-with-secure-
firearm-storage-awareness-
policies%2F%3F_gl%3D1*dd5vn3*_ga*MTMzMTk4OTU1Ni4xNjU4NDIxMTEx*_ga_LT0FWV3EK3*MTY1ODc1
nationwide live in a school district that has already committed to sharing this lifesaving information with families. I urge our school districts to join the more than 45 school

districts across 11 states in signing and/or adopting a School Board Secure Storage Notification Resolution for 2022-23 (template attached), as well as sharing the BeSmartForKids.org <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbesmartforkids.org%2F&data=05% website with all parents. Protecting our kids from gun violence starts in the home, and is a community effort.

Finally, it is important to understand that most school attacks are preventable. The National Threat Assessment Center's recent report, USSS Averting Targeted School Violence <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.secretservice.gov%2Fsites%2 03%2FUSSS%2520Averting%2520Targeted%2520School%2520Violence.2021.03.pdf&data=05%7C01%7C , found that "individuals contemplating violence often exhibit observable behaviors, and when community members report these behaviors, the next tragedy is averted." In fact, 94% of shooters communicate their intentions on social media and to others beforehand. This is why it is important that students know the best way to report these types of concerns, as well as concerns with bullying and harassment. Please be sure that any reporting tool available is communicated to all students, parents, and staff prior to the beginning of the school year. Also make sure that this information is quick and easy to find on our school district website and printed on student ID badges.

In summary, I ask that in preparation for the 2022/2023 school year, School Districts:

1) Review safety plans and procedures

2) Sign a Safe Storage Resolution and share educational information <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fbesmartforkids.org%2F&data=05% about the importance of safe firearm storage with parents

3) Remind students how they can report threats or concerns

I am happy to answer any questions you may have, and can provide further examples of how this information is being communicated with families across our Nation.

Thank you for your time, and for all you do for our children.

Sincerely,

Petra Hoy

Central Valley School District Parent

Volunteer, WA Moms Demand Action

Judy Bacon, Volunteer, WA Moms Demand Action

Connie Pittman, Volunteer, WA Moms Demand Action

Pastor Genavieve Heywood, CVSD Parent

Jerry Leclaire, Retired Physician

Anya Turner, Parent, Substitute Teacher and former Spokane Moms Demand Action lead

Jennifer Calvert, Educator

Patty Grandos, Volunteer WA Moms Demand Action, Educator, former Spokane Moms Demand Action lead

Maria Bachman, CVSD Parent

Chelsie Chatman, RN, Parent, Spokane Moms Demand Action Lead

Dr. Doug Danner, Physician, The Native Project; CVSD Parent

Heather Tanner, CVSD Parent

Bob West, CVSD Grandparent

Alison Ashlock, CVSD Parent, Educator

Stan Chalich, Active Retired CVSD Educator

Grace Wahlman, Students Demand Action, Volunteer

1. Firearm storage practices in households with children: A survey of community-based firearm safety event participants <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.sciencedirect.com%2Fscienc ; King, A., Simonetti, J., Bennett, E., Simeona, C., Stanek,L., Roxby, A., Rowhani-Rahbar, A.; University of Washington, Preventative Medicine, ScienceDirect.com <https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsciencedirect.com%2F&data=05%7

2. National Threat Assessment Center, "Protecting America's Schools."

3. National Threat Assessment Center. (2021). Averting Targeted School Violence: A U.S Secret Service Analysis of Plots Against Schools. U.S. Secret Service, Department of Homeland Security.

4. Everytown for Gun Safety Support Fund, "#NotAnAccident Index," 2020, https://everytownresearch.org/notanaccident <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Feverytownresearch.org%2Fnotana .

5. Washington State Department of Health, "Youth Suicide," 2020

6. University of Washington, "Pacific Northwest Suicide Prevention Resource," 2020, https://hiprc.org/outreach/suicide/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fhiprc.org%2Foutreach%2Fsuicide

7. Grossman DC, Mueller BA, Riedy C, et al. Gun storage practices and risk of youth suicide and unintentional injuries. JAMA. 2005; 293(6): 707-714. Study found households that locked both firearms and ammunition had an 85 percent lower risk of

unintentional firearm deaths than those that locked neither.

https://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/SuicidePrevention/YouthSuicide/

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.doh.wa.gov%2FYouandYour

_____

From: Nancy the Soul Dancer
Sent: 6/23/2022 1:35:47 PM
To: DOH WSBOH
Cc:
Subject: episode 273 clarifies results of VRBPAC June 14, 2022

External Email

Hello. Members of WSBOH/DOH,

Please find below the link to some clarifying information about the recent decision by the CDC to authorized COVID 19 shots to babies and children 6 mos. to 5 yrs.

It is a long video, however, it is archives and can be watched in short intervals. At the end is an interview with pathologist Dr, Claire Craig, FSCPATH who sums up the Pfizer trials for this age group.

https://thehighwire.com/watch/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fthehighwire.com%2Fwatch%2F&d

I encourage everyone to watch this!

Thank you for your time and attention to this important issue and study!

From: j
Sent: 7/25/2022 11:56:21 PM
To: j
Cc:
Subject: VERY IMPORTANT!! from Mary Hath Spokane, Peace Prophet

External Email

Dear Ones,

This is the VERY BEST short and concise explanation of the 'shedding' aspect of the vaccines I have seen.

Please watch and KNOW THE TRUTH about the agenda of the World Economic. Forum/ Cabal to eliminate YOU and ME and 2/3rds of the world's population with these vaccines/bioweapons and 5G frequency.

We The People of the World MUST UNITE and STOP THIS EVIL AGENDA NOW.
1) Ask your county sheriff to ACT NOW!! 2) Vote in Republicans endorsed by Trump. 3) Support those bringing lawsuits against these evil people NOW!! 4) PRAY for personal strength to ACT NOW!! 5)FOCUS/VISUALIZE the END OF THIS EVIL CABAL. Love to all,
Mary www.maryhathspokane.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.maryhathspokane.com%2F&c

Dr. Abdul Alim - Avoid Vaccinated People!!! They will make you sick! I can attest to this! (bitchute.com)
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.bitchute.com%2Fvideo%2FG

From: Lisa Templeton
Sent: 8/5/2022 10:40:14 AM
To: DOH WSBOH
Cc:
Subject: Comments for BOH meeting on August 10

External Email

Dear Board members,

Since Covid began, the FDA and CDC have taught us that we should proceed with caution when it comes to their proclamations on public health. For example, a little over a year ago, they told us that the J&J Covid shot met the FDA's so-called "rigorous standards for safety, effectiveness, and manufacturing quality." Now the FDA essentially no longer approves of the use of J&J due to its adverse effects.

Have you listened to the recent VRBPAC and ACIP proceedings during which Covid shots were authorized then recommended for babies and toddlers? If you employed discernment, you know that the risks of the infection for children were exaggerated, the effectiveness of these consumer products was inflated, and the injuries from the shots were practically ignored.

Three members of Congress recently asked VRBPAC the following questions, which deserve answers before this mass human experiment is further unleashed on millions more Americans—our children.

* Why did the FDA lower its efficacy bar for Covid injections for the youngest children?
* How many lives does the FDA estimate will be saved in this age group?
* How will the FDA evaluate the injuries and deaths reported to VAERS compared to serious Covid outcomes?
* Why has the FDA been so slow to release the hundreds of thousands of pages of data from manufacturer studies and post-approval adverse events?

These are just four of many questions that bona fide science requires be answered before rolling ahead. It is evident that the risks of these experimental, liability-free shots outweigh the purported benefits, and our government barely seem to care. The public is taking note, however. I respectfully plead with each member of this Board to become informed of the many dangers of these for-profit products and stand for protecting the public from them.

Thank you,

Lisa Templeton

Covington

_____
From: John Anderson
Sent: 7/13/2022 7:44:17 AM
To: DOH WSBOH
Subject: Re: Comments on Public School MASK Policy

attachments\BA6AE21CFA03471A_CDC-Response-Letter-February-22-2_PRDTOOL_NAMETOOLONG.pdf

External Email

Greetings Working Group -

Also attached, as a convenience, is a document that is in the public record. This is the letter to the CDC containing the perspective and citations offered by Stephen Petty on the topic of whether masks are safe and effective.

Strength and Honor

John Anderson
President
GDP Group Ltd SPC
MOBILE: (253) 459-3447

On Wed, Jul 13, 2022 at 7:21 AM John Anderson <j2j.anderson@gmail.com <mailto:j2j.anderson@gmail.com> > wrote:

Greetings Working Group -

I wish to provide, for your consideration, the attached testimony (with numerous studies cited in bibliographical links) of Stephen Petty. a recognized expert on the protection offered by Masks, including N95 for both general population and for children.

in his testimony he specifically cites recent cases where his science prevailed against the flawed studies on N95 masking conducted by the CDC to promote masking of school children.

Your committee would be hard pressed to find a better compendium of information, and should you ignore this resource it could be at your peril. Note his citation of the regulatory and legal risks of advocating N95 masks without specific physician evaluation of patients over the warnings issued by the manufacturer.

Please keep our children safe!

(321) Ep. 141 The Ultimate PPE Expert with Incredible Insights into Mask Science! - YouTube <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv

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Strength and Honor

John Anderson
President
GDP Group Ltd SPC
MOBILE: (253) 459-3447

On Wed, Dec 29, 2021 at 1:11 PM John Anderson <j2j.anderson@gmail.com <mailto:j2j.anderson@gmail.com> > wrote:

Greetings Working Group

Personal Background

I am a vaccinated (2x), healthy 68 year old male. I have lived in Washington since 1993. My education includes science (BS Physics, Pre-med, Nuclear Engineering graduate school, and IT professional coursework) and business (MBA Marketing, graduate studies in Marketing and Strategy) from 7 universities. I have written US Patents on behalf of inventors who developed anti-viral, anti-bacterial, and other immunological effects. Currently, I lead the materials science Product Development efforts of a WA state clean energy venture. I review on a daily basis the many observational studies and Randomized Control Trials from select nations concerning COVID.

These reviews have included:

* Evidence comparing Vaccine immunity vs Natural Immunity.
* Breakthrough infection rates by immunity class (No Vaxx, Vaxx only, Natual Immunity Only, Vaxx after recovery from infection).
* Symptom and infection severity by Variant
* Viral load and transmissivity by immunity class.
* Infection rates and clinical outcomes by age group.
* Vaccine Adverse Effects (UK Yellow Card System, US VAERS, etc.)
* Infection and severity of symptoms serum nutrient content {Vit A, Vit D, Vit C, Vit K, Zinc, Iron}

DISCLAIMER

I am not a physician nor an academically-certified virologist nor nutritionist. My comments are not intended to make claims nor to provide advice.

COMMENTS FOR YOUR CONSIDERATION

Prudent policy decisions are always a risk-reward (or cost-benefit) trade-off. There literally is no free lunch. I suggest strongly that your deliberation consider the following facts:

* Herd immunity occurs when nearly all community members have immunity.
* Omicron is now outcompeting other variants. People get infected with OMICRON rather than Delta, Alpha, Beta etc.
* Omicron will likely infect everyone.
* Young people, unvaccinated, are most likely to be asymptomatic,

and acquire natural immunity superior to vaccine immunity.

* Young people, regardless of immunity class, will infect teachers and parents with OMICRON regardless of their immunity class.
* Unless the policy for IM injection returns to the international best practice of aspirating the syringe after insertion, young people will be placed at a statistical rick of adverse side effects (from injection into the vascular system) that is greater than the risk of severe infection from COVID.

ADVICE:

* Let the Omicron variant run its course, and monitor new variants for infection and severity.
* Do NOT mandate COVID vaccines as a condition of participation in classrooms.
* The risk TO unvaccinated and BY unvaccinated students is acceptable. The reward of vaccination is outweighed by the adverse affects, discrimination against children, and the further invasion of patient rights by government.

I am available for discussion should follow-up be desired.

Strength and Honor

John Anderson
MOBILE: (253) 459-3447

February 22, 2022

Rochelle P. Walensky, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30329

Anthony S. Fauci, MD
Director, National Institute of Allergy and Infectious Diseases
National Institutes of Health
31 Center Dr # 7A03
Bethesda, MD 20892

Honorable Senator Ronald H. Johnson
328 Hart Senate Office Building
Washington DC 20510

Douglas L. Parker,
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210

Mr. Jeffrey Zients
Coordinator and Counselor to the President
COVID-19 Pandemic Response
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Sent via US Mail Certified Return Receipt and e-mail

Re: Request for Immediate Corrections to the CDC Guidance on Masks and Respirators

Dear Dr. Walensky, Dr. Fauci, Senator Johnson, Mr. Parker, and Mr. Zients:

We the undersigned, professional experts in the field of industrial hygiene, with combined experience of nearly 150 years, are highly concerned with the inaccurate and misleading guidance being promoted by the CDC on its website regarding efficacy of masking to prevent COVID-19 and now similar guidance regarding respirators and request for immediate correction to said guidance. The guidance is overly broad, inaccurate, and especially inappropriate for children and the general public.

For reference, the field of industrial hygiene is defined as:

> *"That science and art devoted to the anticipation, recognition, evaluation, and control of those environmental factors or stressors arising in or from the workplace, which may cause sickness, impaired health and well-being, or significant discomfort among workers or among of the citizens of the community" (https://www.aiha.org/about-ih/Pages/default.aspx).*

The AIHA defines an Industrial Hygienist (https://www.aiha.org/ih-careers/discover-industrial-hygiene) as:

> *"Scientists and engineers committed to protecting the health and safety of people in the workplace and the community."*

Thus, our profession is dedicated, in part, to providing controls to exposures and rely upon what is known as the hierarchy of controls. The hierarchy of controls was first developed by the National Safety Council (NSC) in 1950. This guides us as to the most effective to least effective exposure controls (see Figure 1):

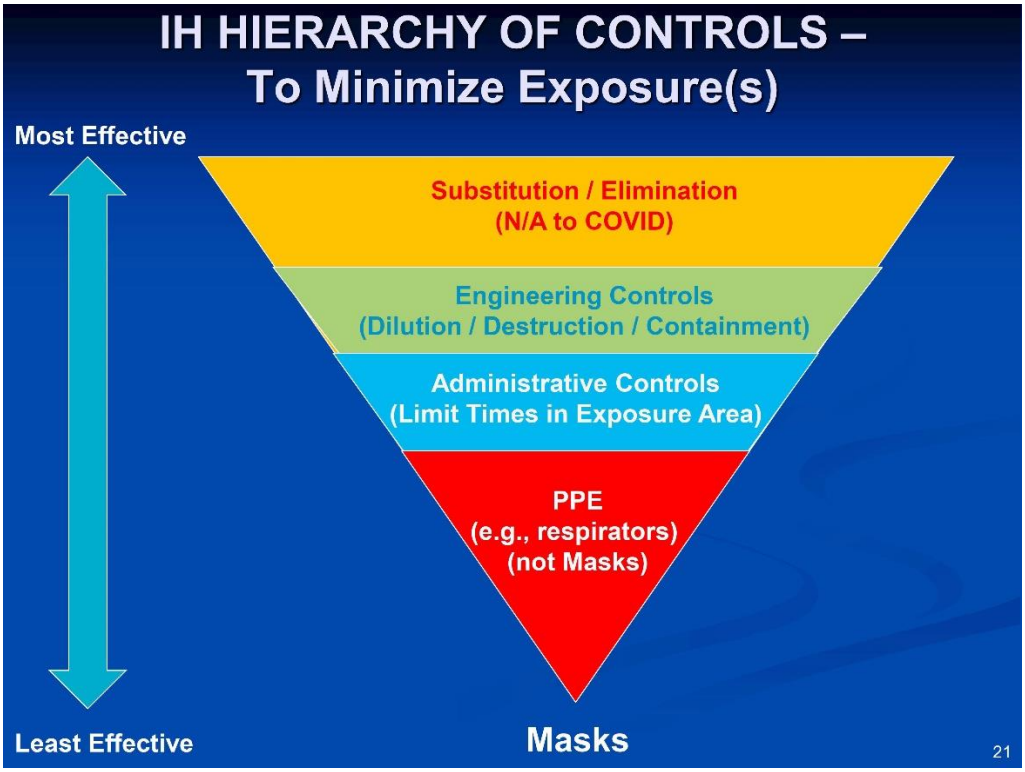
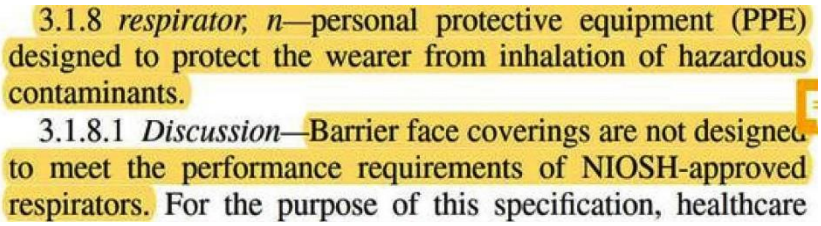


Figure 1: Hierarchy of Controls

Note that masks do not fit into the hierarchy of controls simply because they are not even personal protective equipment. This is recognized in the recent ASTM Face Covering (mask) Standard [ASTM F3502-21 – Standard Specification for Barrier Face Coverings (BFCs)] illustrated in Figure 2:



3.1.8 *respirator, n*—personal protective equipment (PPE) designed to protect the wearer from inhalation of hazardous contaminants.

3.1.8.1 *Discussion*—Barrier face coverings are not designed to meet the performance requirements of NIOSH-approved respirators. For the purpose of this specification, healthcare

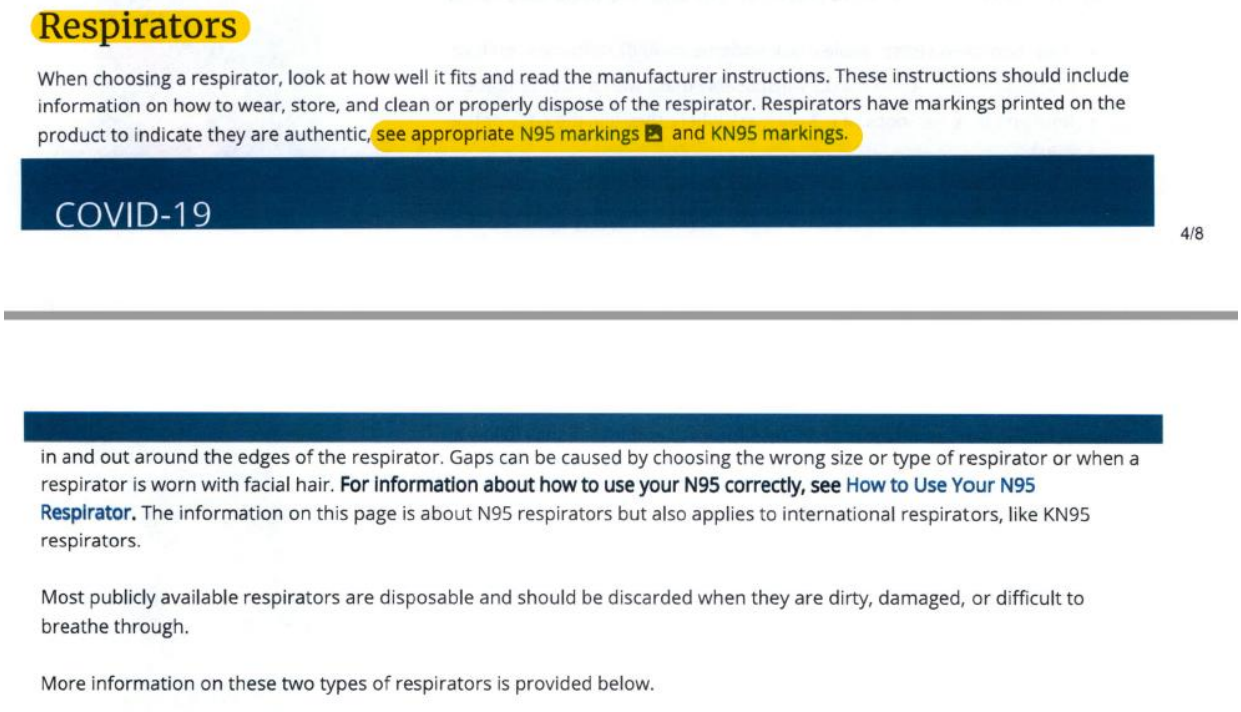
Figure 2: ASTM 2021 BFC Standard – Masks Not PPE (Respirators)

The best industrial hygiene solution has for decades been engineering controls of dilution with fresh air, filtration, and/or destruction – all of which are readily available technologies.

Given this background, we the undersigned have been increasingly concerned about the mis-information provided by the CDC to the public; often reflected by inappropriately conclusive language that *omits technical limitations and documented negative effects associated with masks and face coverings*. Examples of our concerns follow:

Issue #1: Recommending N-95 type masks is inappropriate for the general population and children:

The CDC's January 14, 2022 and January 28, 2022 webpage language have instructed people to move away from masks and toward N95-type respirators (see for example https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html), including KN95 respirators (Figure 3):



Respirators

When choosing a respirator, look at how well it fits and read the manufacturer instructions. These instructions should include information on how to wear, store, and clean or properly dispose of the respirator. Respirators have markings printed on the product to indicate they are authentic, see appropriate N95 markings and KN95 markings.

COVID-19

4/8

in and out around the edges of the respirator. Gaps can be caused by choosing the wrong size or type of respirator or when a respirator is worn with facial hair. **For information about how to use your N95 correctly, see** How to Use Your N95 Respirator. The information on this page is about N95 respirators but also applies to international respirators, like KN95 respirators.

Most publicly available respirators are disposable and should be discarded when they are dirty, damaged, or difficult to breathe through.

More information on these two types of respirators is provided below.

Figure 3: CDC January 14 & January 28, 2022 Guidance on Respirators – pgs. 4-5

Under the topic of respirators, the CDC lists both N95 and KN95 respirators.

Moreover, as the CDC knows, persons or entities providing respirators in the workplace (unlike masks) must follow OSHA's Personal Protective Equipment Standard (OSHA 29 CFR 1910.132) to establish the nature of the hazard (Hazards Assessment) and the Respiratory Protection Standard (RPS) requirements (29 CFR 1910.134). Non-employees must also follow the RPS under the manufacturers' instructions (as we shall show later). These RPS requirements are substantial and include factors such as:

- Written RPS Plan
- Medical Clearance
- Initial Fit Test
- Annual Fit Test
- Training by a professional such as an IH on fit testing, cleaning, storage, and changeout.

As the CDC knows, or should know, movement from masks to respirators comes with significant requirements or as the manufacturers such as 3M state on their instructions, improper usage "may result in sickness or death".

In this context, we have recently been provided by the following request, and rejection by OSHA, to investigate improper usage of KN respirators by an employer (Figure 4):

U.S. Department of Labor

Occupational Safety and Health Administration
Toledo Area Office
420 Madison Ave, Suite 600
Toledo, OH 43604

February 9, 2022

[redacted]

RE: OSHA Complaint No. 1864651

Dear [redacted]

The Occupational Safety and Health Administration (OSHA) has received your notice of alleged workplace hazard(s) against notified Gun Lake Casino. After careful review we have decided not to conduct an inspection because:

On the basis of the information provided to our office during our phone conversation the employer has provided and is requiring employees to wear KN95 masks which are not NIOSH certified respirators and would not be covered by OSHA's respiratory protection standard.

If you do not agree with this decision, you may contact me for a clarification of the matter at (419) 259-7542.

Section 11(c) of the OSH Act provides protection for employees against discrimination because of their involvement in protected safety and health related activity. If you believe you are being treated differently or action is being taken against you because of your safety or health activity, you may file a complaint with OSHA. You should file this complaint as soon as possible, since OSHA normally can accept only those complaints filed within 30 days of the alleged discriminatory action.

Thank you for your concern for a safe and healthful workplace.

Respectfully,

For

Todd Jensen
Area Director

Figure 4: OSHA February 9, 2022 Response Letter to Gun Lake Casino Complaint

OSHA rejected the employee complaint on a technicality that the employer was not following the OSHA RPS because the respirator was a KN95 rather than an N95. And, as shown in Figure 5, NIOSH does not approve KN95's:

CDC Centers for Disease Control and Prevention

Promoting productive workplaces through safety and health research NIOSH

NIOSH-approved N95 Particulate Filtering Facepiece Respirators

This list is reviewed and updated weekly.

Manufacturers Listed from A to Z – L

The N95 respirator is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles but is not resistant to oil-based particles.

This web page provides a table of NIOSH-approved N95 respirators listed by manufacturer from A-Z. You can find a specific manufacturer by clicking on the first letter of their name on the index below. Web links in the table go to the NIOSH Approval Holder's website. See the Notes section for information about private labels.

NIOSH entered a Memorandum of Understanding (MOU) in 2018 with the Food and Drug Administration (FDA). This MOU granted NIOSH the authority to approve surgical N95 filtering facepiece respirators. Prior to this MOU, both NIOSH and FDA approved and cleared surgical N95s. The **Model Number/Product Line in bold text followed by (FDA)** indicates these surgical N95 respirators in the table below. NIOSH also provides a table of the surgical N95 respirators approved prior to the MOU. Surgical N95 respirators approved under the MOU do not require FDA's 510(k) clearance. These NIOSH-approved surgical N95 respirators are only on the Certified Equipment List (CEL).

A respirator labeled as a KN95 respirator is expected to conform to China's GB2626 standard. NIOSH does not approve KN95 products or any other respiratory protective devices certified to international standards. For more information, view Factors to Consider When Planning to Purchase Respirators from Another Country.

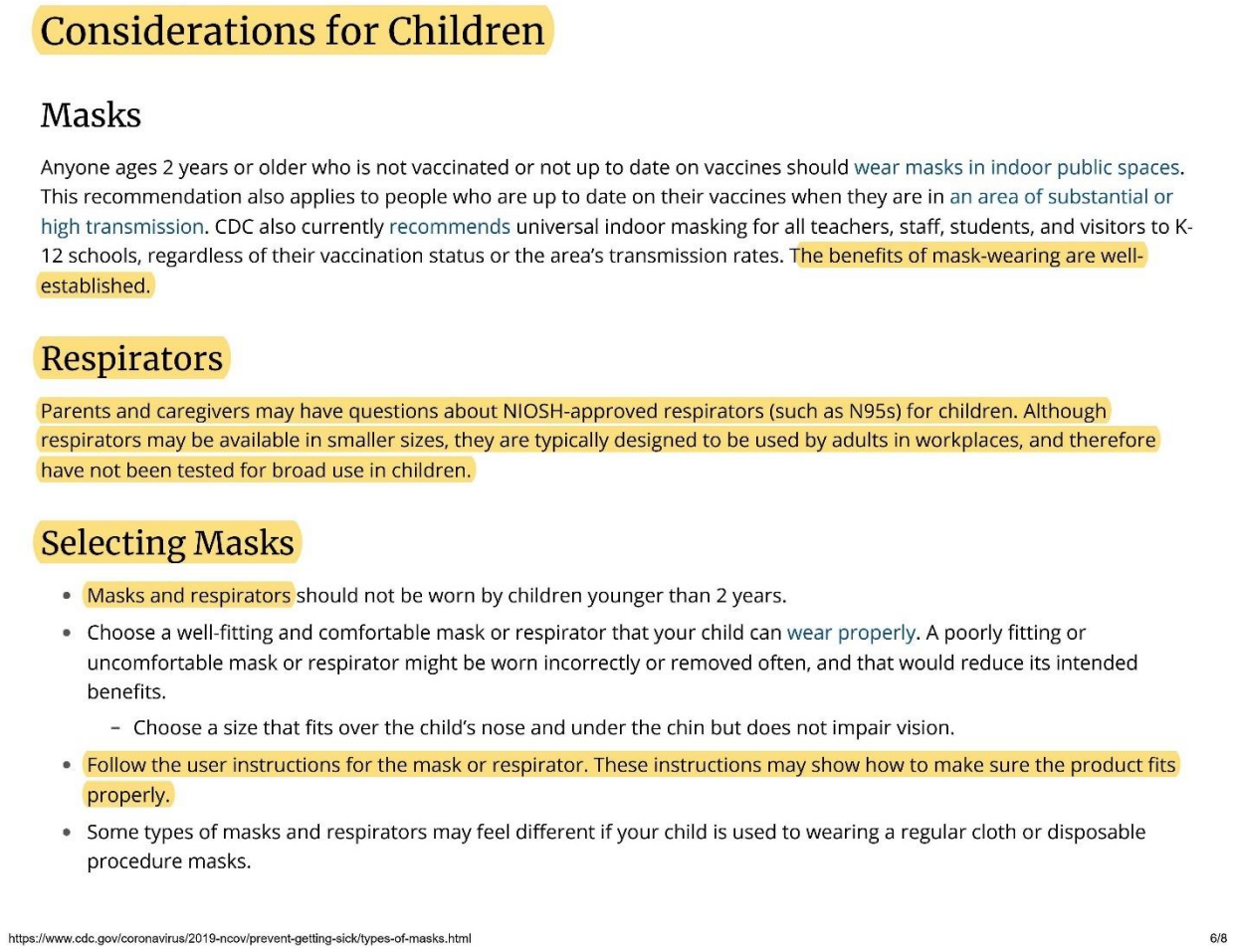
Figure 5: NIOSH Language Regarding Approval of KN95 Respirators

So, in an obvious case of deception, the CDC recommends the usage of N95 and KN95 respirators (see Figure 3) yet must know they are not approved by NIOSH and that OSHA will not enforce the RPS. The irony here is that NIOSH is part of the CDC (see Figure 5 letterhead), so the CDC clearly knows this. Note that it is known that KN95 respirators from China are known to be less expensive than those made with the N95 designation and find widespread usage; this too was known, or should have been known, by the CDC.

Thus, the CDC pushes KN95 respirators as part of the move toward respirators, knowing they are not approved by their sub-agency NIOSH, which allows employers to make employees wear respirators without the protections of OSHA's Respiratory Protection Standard (RPS). This is an unconscionable breach of the public health function and should be corrected immediately.

Issue #2: CDC has issued harmful guidance for masking children that contradicts manufacturers' recommendations, world-wide standard practice and CDC's own guidance, and without appropriate risk-benefit analysis:

The CDC's January 28, 2022 webpage language misleadingly implies respirators are acceptable for children yet knows that this is not the case simply based on manufacturer instructions, they link the reader to https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html – see Figure 6:



Considerations for Children

Masks

Anyone ages 2 years or older who is not vaccinated or not up to date on vaccines should wear masks in indoor public spaces. This recommendation also applies to people who are up to date on their vaccines when they are in an area of substantial or high transmission. CDC also currently recommends universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of their vaccination status or the area's transmission rates. The benefits of mask-wearing are well-established.

Respirators

Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. Although respirators may be available in smaller sizes, they are typically designed to be used by adults in workplaces, and therefore have not been tested for broad use in children.

Selecting Masks

- Masks and respirators should not be worn by children younger than 2 years.
- Choose a well-fitting and comfortable mask or respirator that your child can wear properly. A poorly fitting or uncomfortable mask or respirator might be worn incorrectly or removed often, and that would reduce its intended benefits.
  - Choose a size that fits over the child's nose and under the chin but does not impair vision.
- Follow the user instructions for the mask or respirator. These instructions may show how to make sure the product fits properly.
- Some types of masks and respirators may feel different if your child is used to wearing a regular cloth or disposable procedure masks.

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html 6/8

Figure 6: Misleading CDC Language Regarding Children Wearing Masks and Respirators

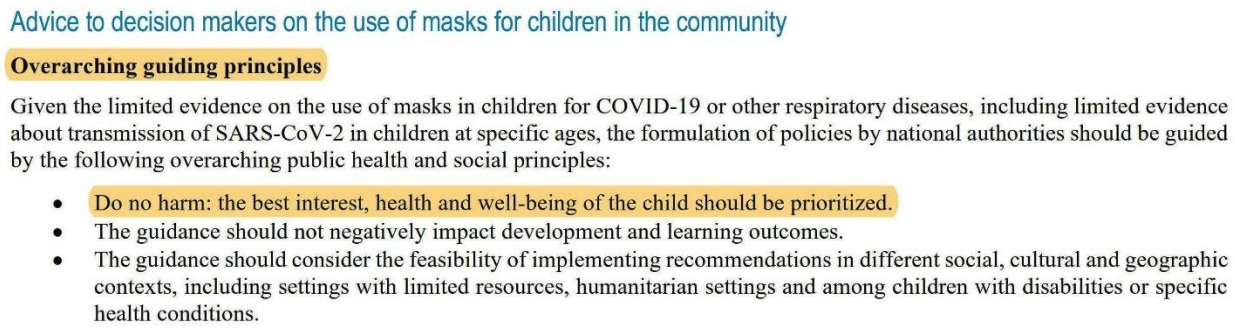
As illustrated in detail below, the CDC provided language in its January 28, 2022 guidance for children that is particularly misleading by obfuscating and omitting information readily known, or likely to have been known by the CDC.

<u>"The benefits of mask-wearing are well-established:"</u>

First, the benefits of children, or anyone for that matter, of wearing masks being well

established is simply false. A Brownstone paper by Paul Elias Alexander published December 21, 2021 (https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/) shows both the effectiveness of masks and their harms, citing 150 studies. One of these author's testified in the Western District Court of Michigan on September 28, 2021, in a half-dozen interviews (e.g., Jeff Hayes Films: https://rumble.com/vrfoox-covid-revealed-episode-8b-bonus-video-stephen-petty.html), in his own podcasts (https://rumble.com/c/PettyPodcasts) and in the Liberty Dispatch in Canada (https://podcasts.apple.com/us/podcast/episode-99-masks-dont-work-an-interview-with-ppe/id1559570986?i=1000550149187). During this testimony it was shown that the nearly 50 studies cited by the CDC purportedly showing masks are effective did not support statements made by the CDC and most suffered from a lack of a control group (group similar to the mask study group not wearing masks) or cofounding factors (multiple factors such as changes in HVAC systems, distancing, quarantining, and masks) wherein one cannot determine the specific contribution by masking.

But the most egregious part of this statement is that it only addresses supposed benefits, not liabilities. Even the WHO - UNICEF (https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Children-2020.1) understands that risk-rewards analysis should be done before recommending unproven, unscientifically-supported policies before masking them. Remember – do no harm – is the overarching principle (Figures 7 & 8):



Advice to decision makers on the use of masks for children in the community

Overarching guiding principles

Given the limited evidence on the use of masks in children for COVID-19 or other respiratory diseases, including limited evidence about transmission of SARS-CoV-2 in children at specific ages, the formulation of policies by national authorities should be guided by the following overarching public health and social principles:

- Do no harm: the best interest, health and well-being of the child should be prioritized.
- The guidance should not negatively impact development and learning outcomes.
- The guidance should consider the feasibility of implementing recommendations in different social, cultural and geographic contexts, including settings with limited resources, humanitarian settings and among children with disabilities or specific health conditions.

Figure 7: WHO UNICEF Recommendations for Children and Masks

From Figure 7, the overarching guiding principle is to do no harm.

Advice on the use of masks in children

WHO and UNICEF advise decision makers to apply the following criteria for use of masks in children when developing national policies, in countries or areas where there is known or suspected community transmission[a] of SARS-CoV-2 and in settings where physical distancing cannot be achieved.

1. Based on the expert opinion gathered through online meetings and consultative processes, children aged up to five years should not wear masks for source control. This advice is motivated by a "do no harm" approach and considers:
    - childhood developmental milestones[b] [41]
    - compliance challenges and
    - autonomy required to use a mask properly.

The experts (following the methods described above) recognized that the evidence supporting the choice of the age cut-off is limited (see above, section related to transmission of COVID-19 in children), and they reached this decision mainly by consensus. The rationale included consideration of the fact that by the age of five years, children usually achieve significant developmental milestones, including the manual dexterity and fine motor coordination movements needed to appropriately use a mask with minimal assistance.

In some countries, guidance and policies recommend a different and lower age cut-off for mask use[42-45]. It is recognized that children may reach developmental milestones at different ages and children five years of age and under may have the dexterity needed to manage a mask. Based on the do no harm approach, if the lower age cut-off of two or three years of age is to be used for recommending mask use for children, appropriate and consistent supervision, including direct line of sight supervision by a competent adult and compliance need to be ensured, especially if mask wearing is expected for an extended period of time. This is both to ensure correct use of the mask and to prevent any potential harm associated with mask wearing to the child.

Children with severe cognitive or respiratory impairments who have difficulties tolerating a mask should, under no circumstances, be required to wear masks.

Other IPC, public health and social measures should be prioritized to minimize the risk of SARS-CoV-2 transmission for children five years of age and under; specifically maintaining physical distance of at least 1 meter where feasible, educating children to perform frequent hand hygiene and limiting the size of school classes. It is also noted that there may be other specific considerations, such as the presence of vulnerable persons or other local medical and public health advice that should be considered when determining if children five years of age and under need to wear a mask.

2. For children between six and 11 years of age, a risk-based approach should be applied to the decision to use of a mask. This approach should take into consideration:
    - intensity of transmission in the area where the child is and updated data/available evidence on the risk of infection and transmission in this age group;
    - social and cultural environment such as beliefs, customs, behaviour or social norms that influence the community and population's social interactions, especially with and among children;
    - the child's capacity to comply with the appropriate use of masks and availability of appropriate adult supervision;
    - potential impact of mask wearing on learning and psychosocial development; and
    - additional specific considerations and adaptions for specific settings such as households with elderly relatives, schools, during sport activities or for children with disabilities or with underlying diseases.

3. Advice on mask use in children and adolescents 12 years or older should follow the WHO guidance for mask use in adults[1] and/or the national mask guidelines for adults.

    Even where national guidelines apply, additional specific considerations (see below) and adaptions for special settings such as schools, during sport, or for children with disabilities or with underlying diseases will need to be specified.

Figure 8: WHO UNICEF Recommendations for Children and Masks by Age

Note that from Figure 8, WHO recommends against masking below age 6 and that children ages 6 to 11 may be masked upon completion of a risk assessment. England has similar guidance. But the CDC requires masks for children down to age 2 against WHO guidance and based on extensive reviews, has yet to perform any risk assessment on the net benefits of children wearing masks.

Specifically, it is well established that significant harms (i.e., reduced learning and development and physical, emotional, and social harms) have been reported in the literature (Figures 9-18):

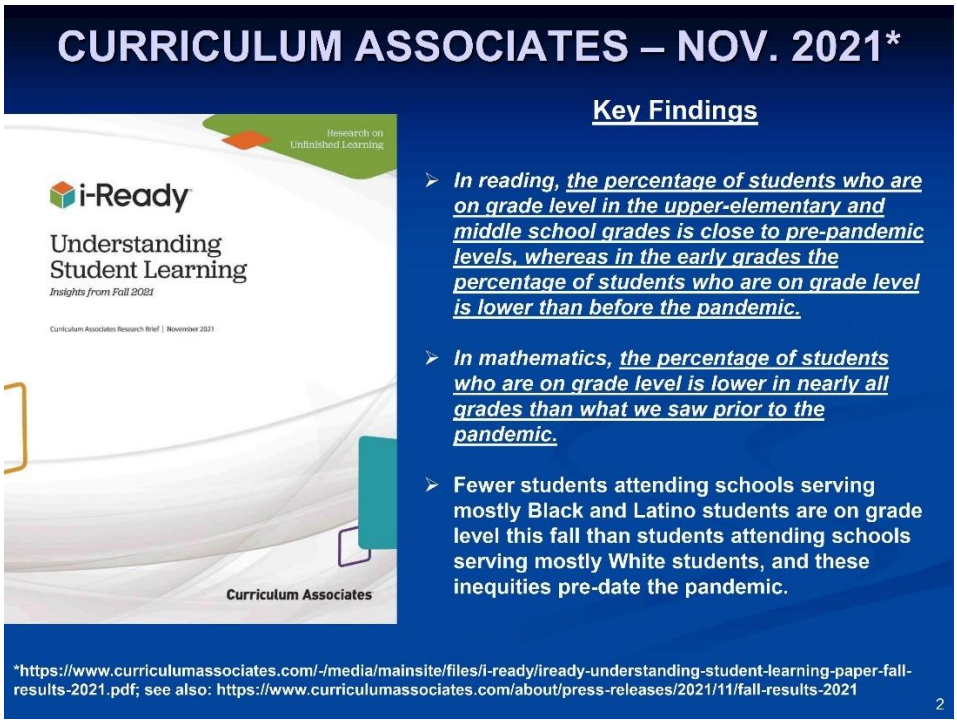


Figure 9: Curriculum Associates – Nov. 2021 – Title Page

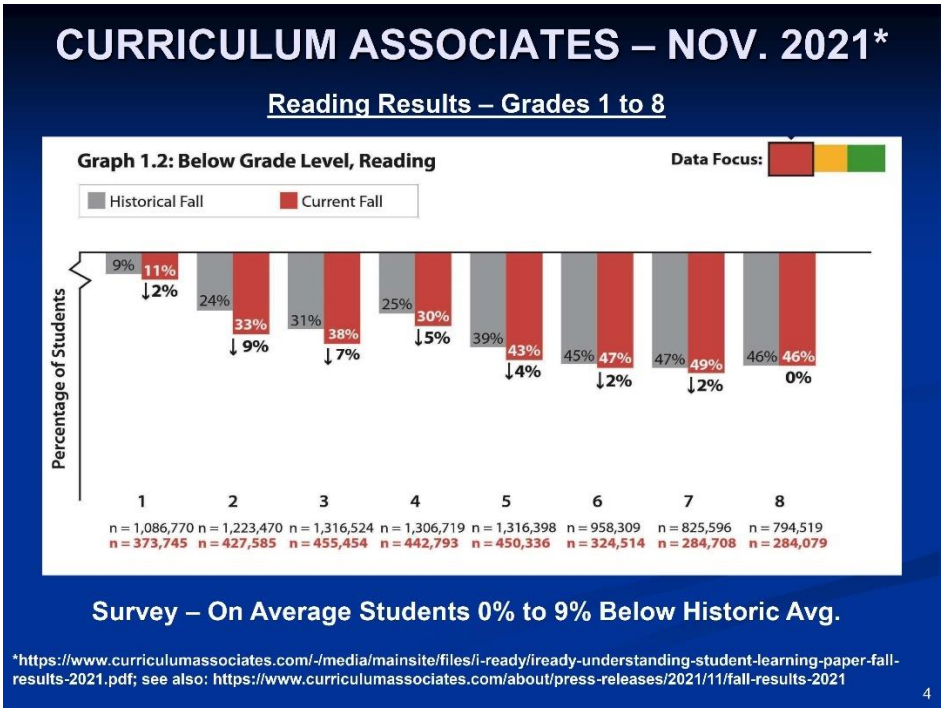


Figure 10: Curriculum Associates – Reading Deficits in 2021 vs. Prior Years

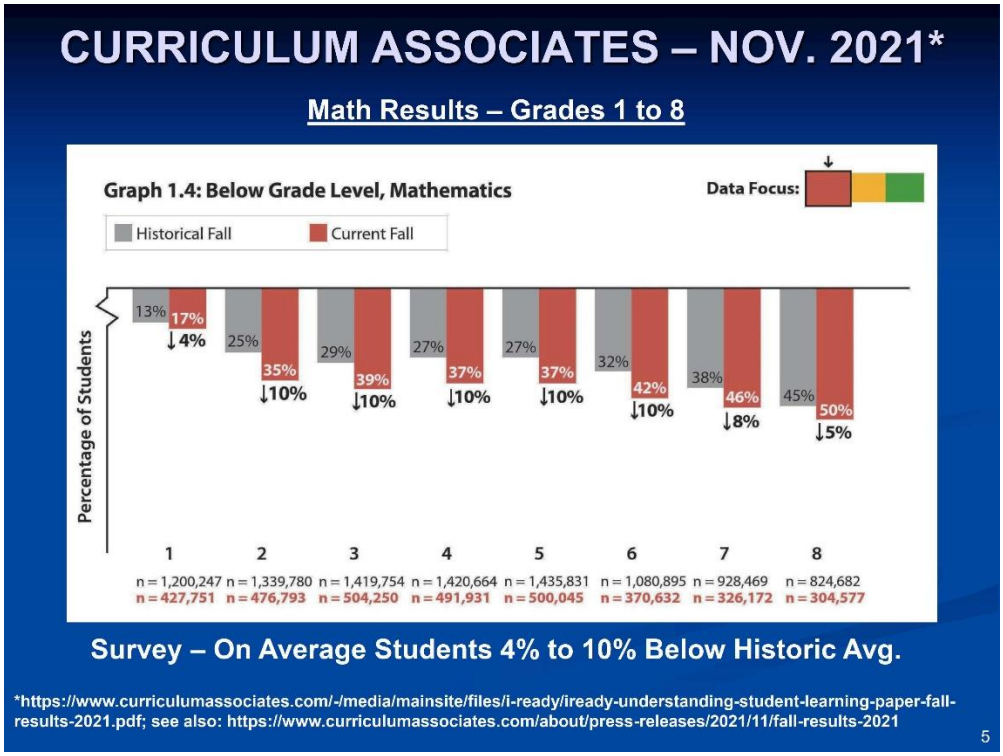


Figure 11: Curriculum Associates – Math Deficits in 2021 vs. Prior Years

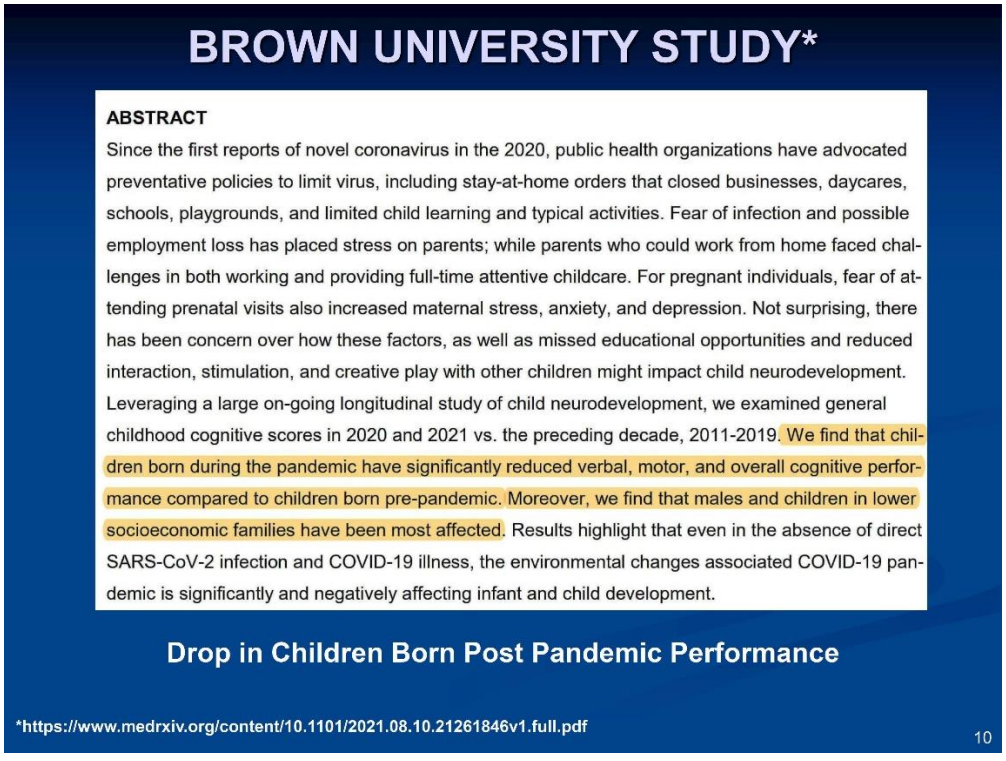


Figure 12: Brown University – Cognitive Deficits

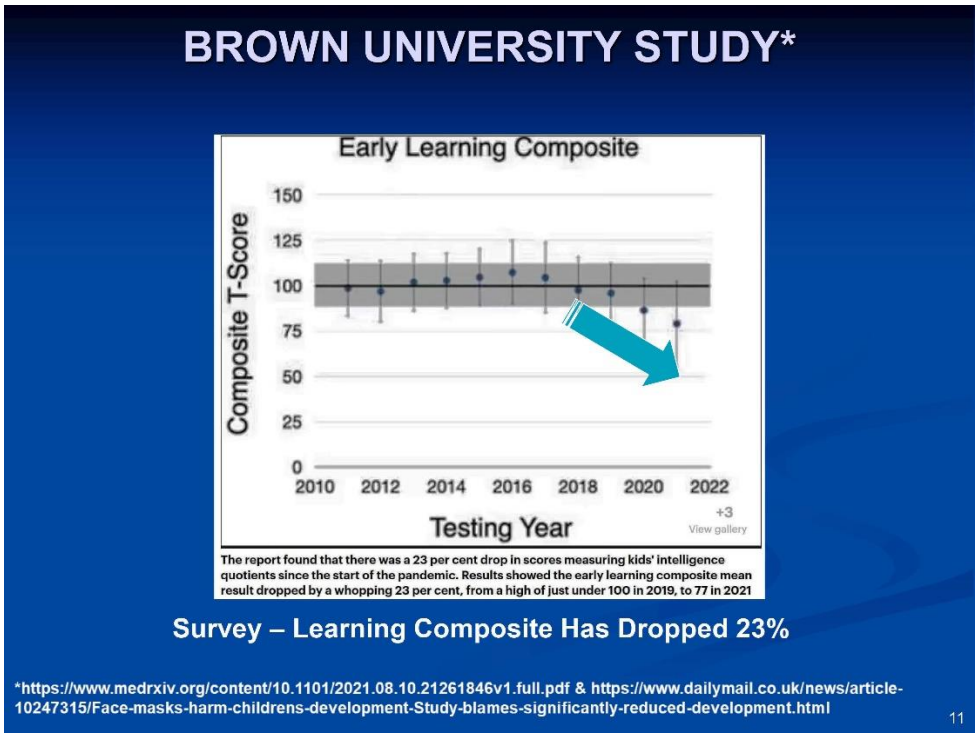


Figure 13: Brown University Study – Learning Loss of 23% for Children Born Since Pandemic

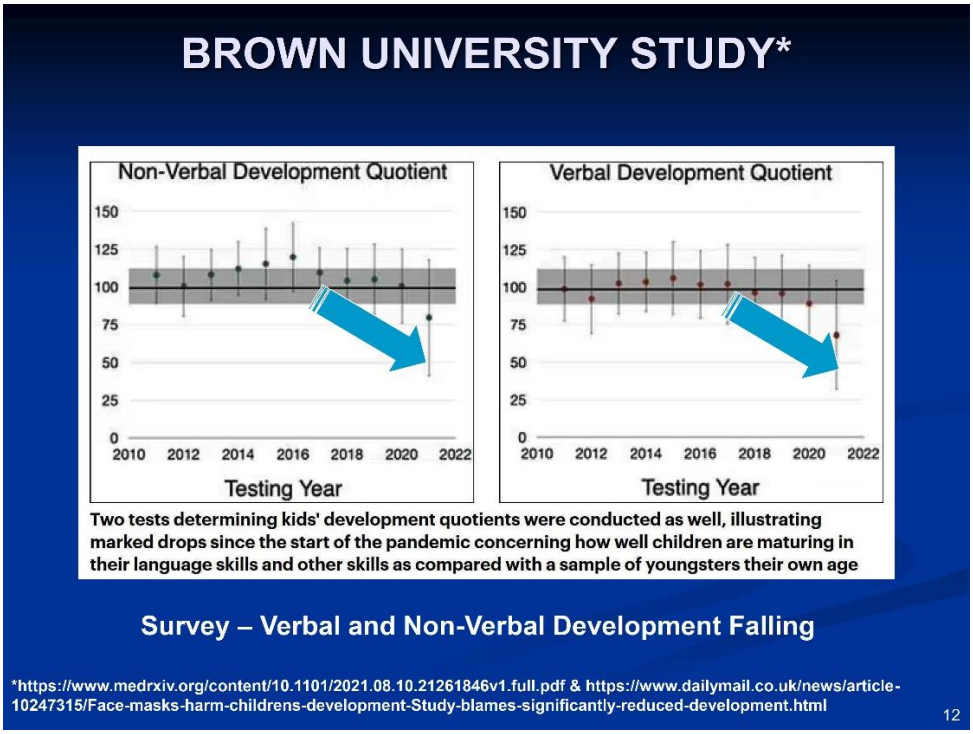


Figure 14: Brown University Study – Non-Verbal and Verbal Development Losses

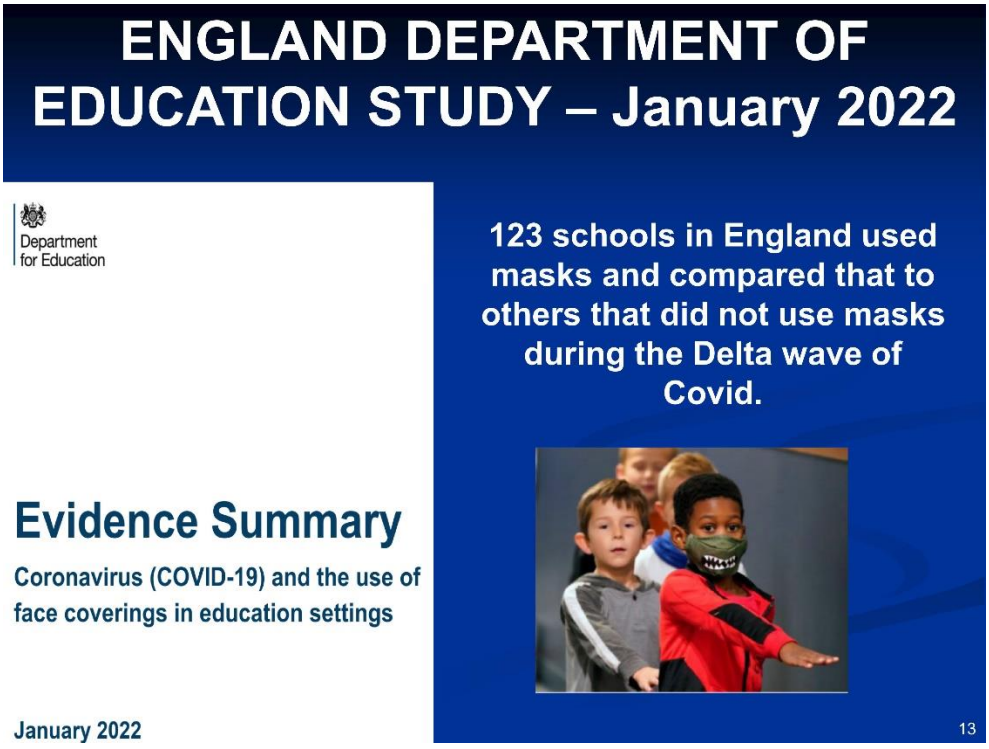


Figure 15: England Department of Education

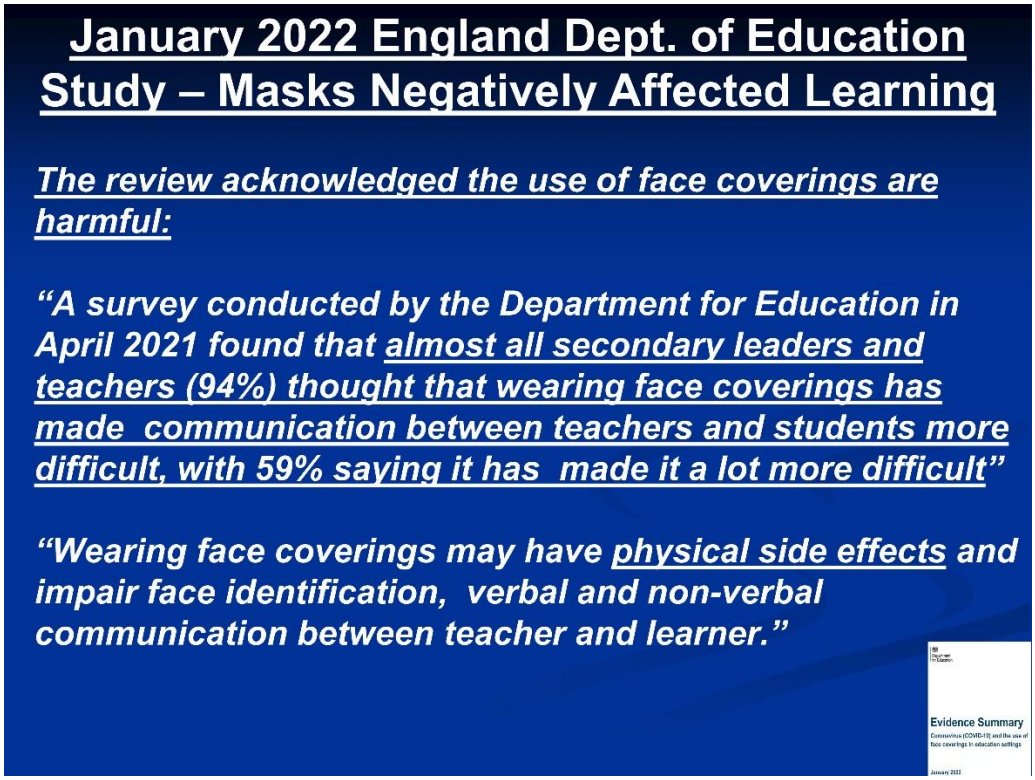


Figure 16: England Department of Education – Loss of Communication and Physical Effects

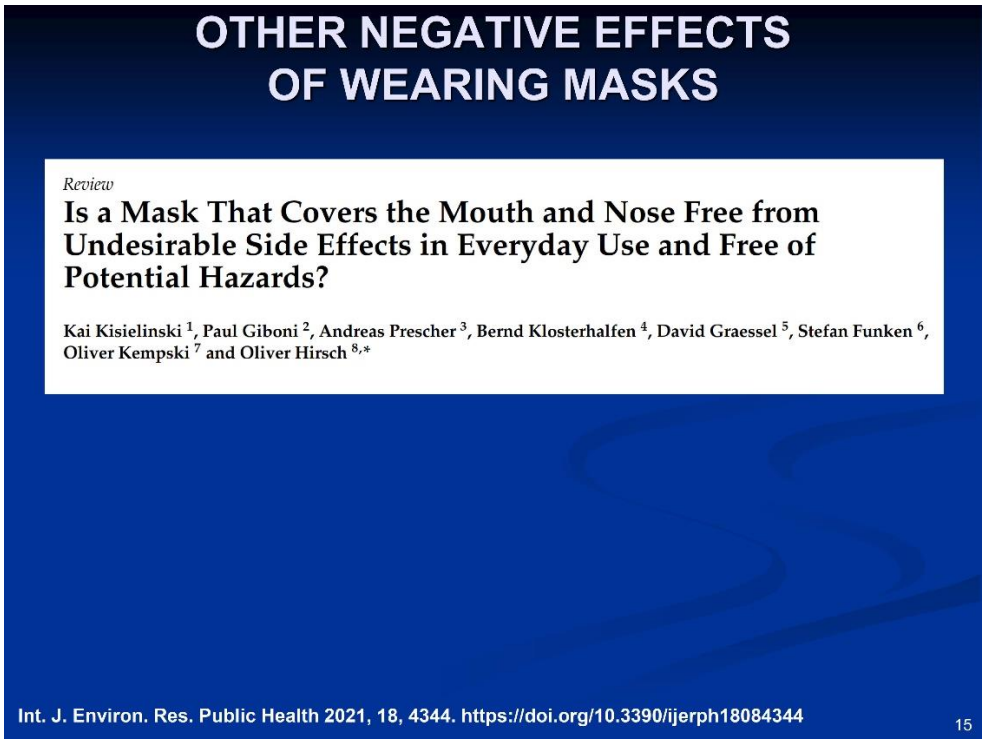


Figure 17: Kisielinski et al. – Mask Meta Study – Reviewed 1,226 Studies

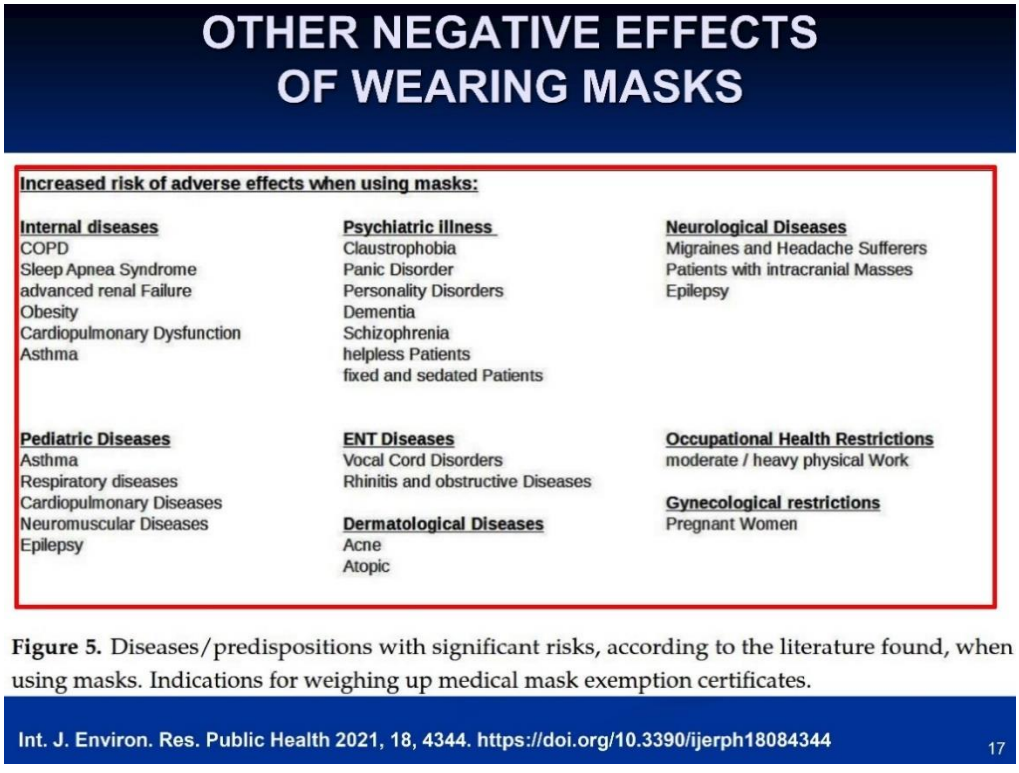


Figure 18: Kisielinski et al., – Areas of Quantitated Adverse Effects on Children and Adults

Clearly, the CDC has not conducted a net risk assessment and should have, and must do so to avoid continuing harms to children.

Even more disturbing, in their innocent looking, new Guidance for Children (Learn the Signs, Act Early) the CDC has in part, extended the timeframes for children to achieve learning outcomes (https://www.cdc.gov/ncbddd/actearly/milestones/index.html). Regarding these changes – Figure 19, CDC refers the reader to an American Academy of Pediatrics (AAP) webpage (https://publications.aap.org/pediatrics/article-abstract/doi/10.1542/peds.2021-052138/184748/Evidence-Informed-Milestones-for-Developmental?redirectedFrom=fulltext):

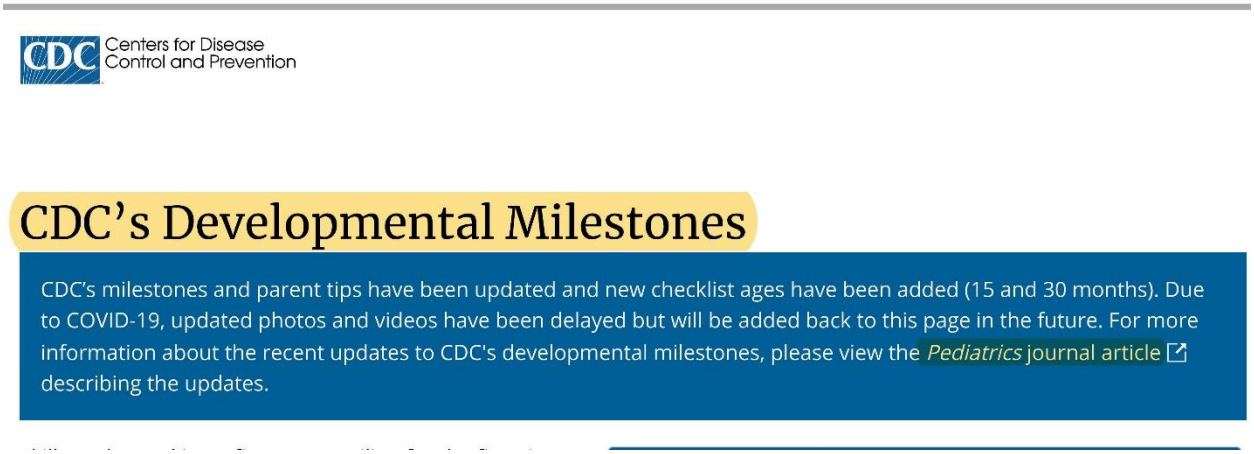


Figure 19: CDC Learn the Signs, Act Early New Webpage – Reference to AAP

The headlines for the reference paper are reproduced as Figure 20:

Figure 20: CDC Referenced AAP Paper by Zubler (CDC) et al. Dated February 8, 2022

Zubler et al., write in part:

"*The Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. program, funded the American Academy of Pediatrics (AAP) to convene an expert working group to revise its developmental surveillance checklists*. The goals of the group were to identify evidence-informed milestones to include in CDC checklists, clarify when most children can be expected to reach a milestone (to discourage a wait-and-see approach), and support clinical judgment regarding screening between recommended ages. Subject matter experts identified by the AAP established 11 criteria for CDC milestone checklists, including using milestones most children (≥75%) would be expected to achieve by specific health supervision visit ages and those that are easily observed in natural settings. A database of normative data for individual milestones, common screening and evaluation tools, and published clinical opinion was created to inform revisions. ***Application of the criteria established by the AAP working group and adding milestones for the 15- and 30-month health supervision visits resulted in a 26.4% reduction and 40.9% replacement of previous CDC milestones***. ***One third of the retained milestones were transferred to different ages; 67.7% of those transferred were moved to older ages.*** *Approximately 80% of the final milestones had normative data from ≥1 sources*. Social-emotional and cognitive milestones had the least normative data. These criteria and revised checklists can be used to support developmental surveillance, clinical judgment regarding additional developmental screening, and research in developmental surveillance processes. Gaps in developmental data were identified particularly for social-emotional and cognitive milestones.

Thus, at least 22.3% [67.7% of 33%] of the CDC child developmental milestones in place for ~18 years, were moved from a younger age to an older age in February 2022.

One must conclude the CDC, rather than acknowledging the harms being done to children's development by their COVID policies, including masking, is simply moving the goalposts for what constitutes normal child development rather than admitting and moving away from failed policies.

Statements under "Respirators" and "Selecting Masks":

- Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. *Although respirators may be available in smaller sizes,* ***they are typically designed to be used by adults in workplaces****, and therefore have not been tested for broad use in children*.
- ***Masks and respirators should not be worn by children younger than 2 years.***
- Choose a size that fits over the child's nose and under the chin but does not impair vision. ***Follow the user instructions for the mask or respirator.*** *These instructions may show how to make sure the product fits properly.*

This language may be the most misleading and egregious given that the links CDC provides to manufacturers' instruction state that their N95s are not for use with children – the CDC has to know this.

The links to manufacturers' instructions from the January 28, 2022 mask and January 25, 2022 How to Use Your N95 Respirator are shown in Figures 21 and 22 respectively:

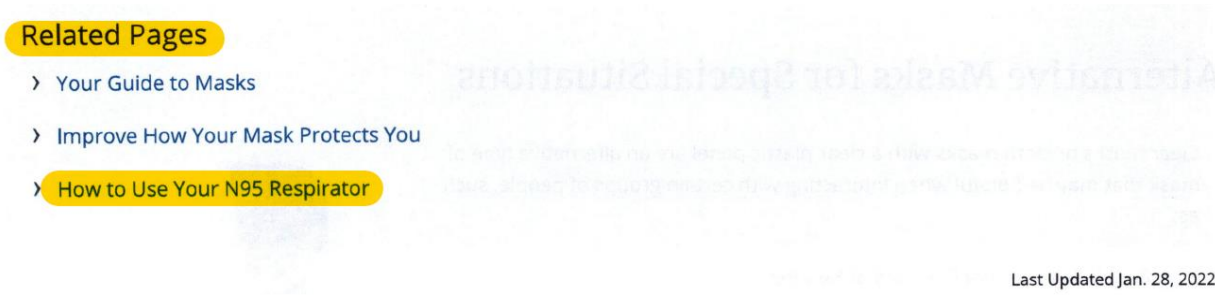


Figure 21: CDC January 28, 2022 Link – Bottom of Page and CDC January 25, 2022 Link to Manufacturers' Guidance and Warnings

The "How to Use Your N95 Respirator" is at the bottom of the CDC January 28, 2022 webpage.

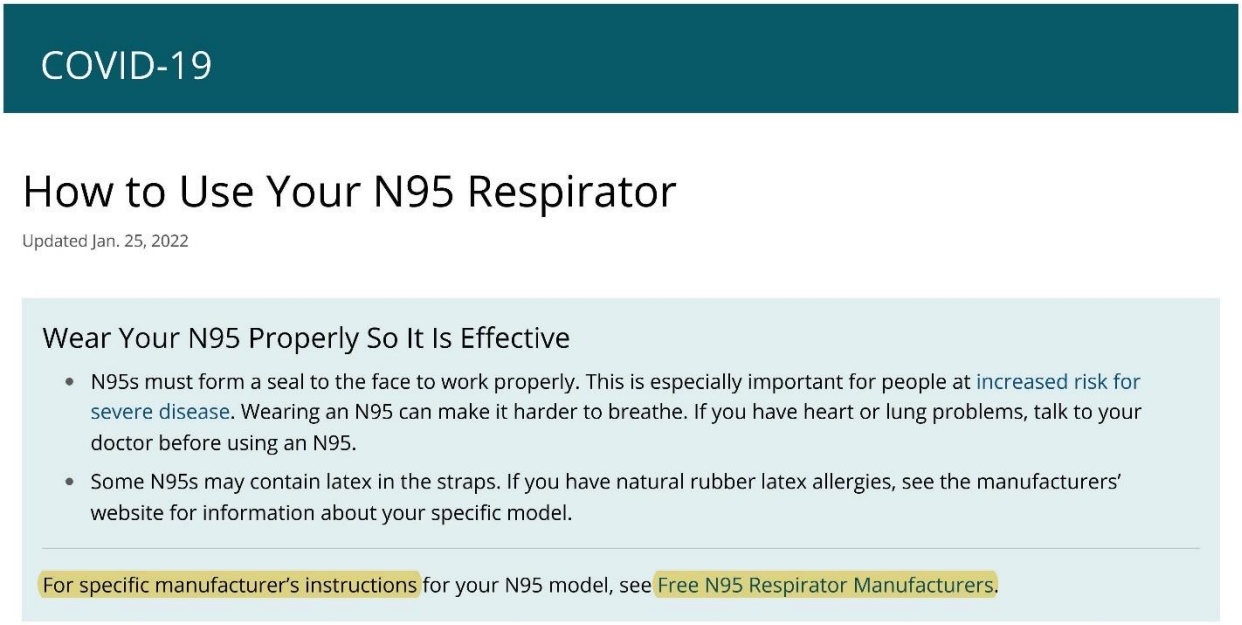


Figure 22: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers

The link in turn takes one to the following page (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/free-n95-manufacturers.html) (Figure 23):

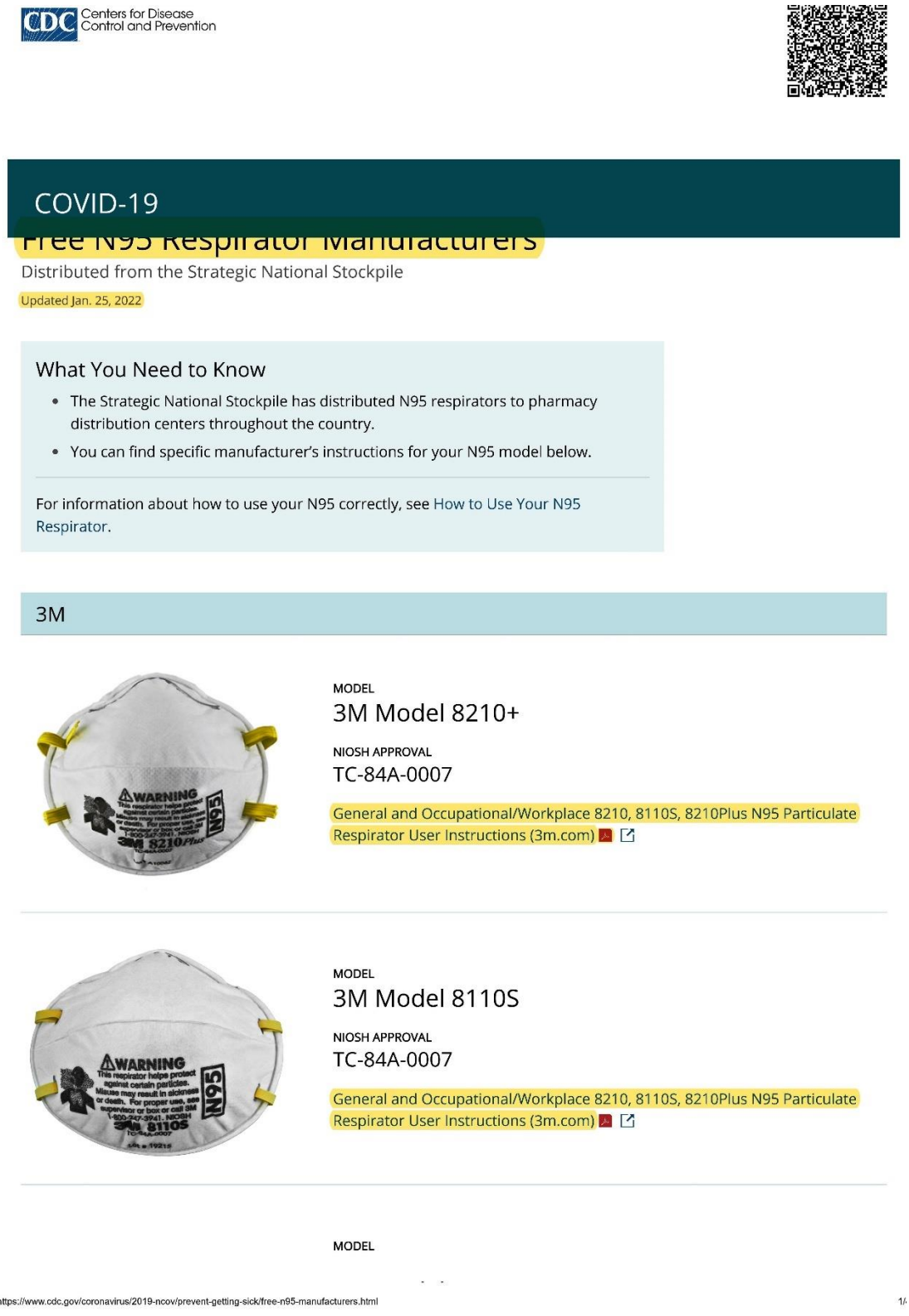


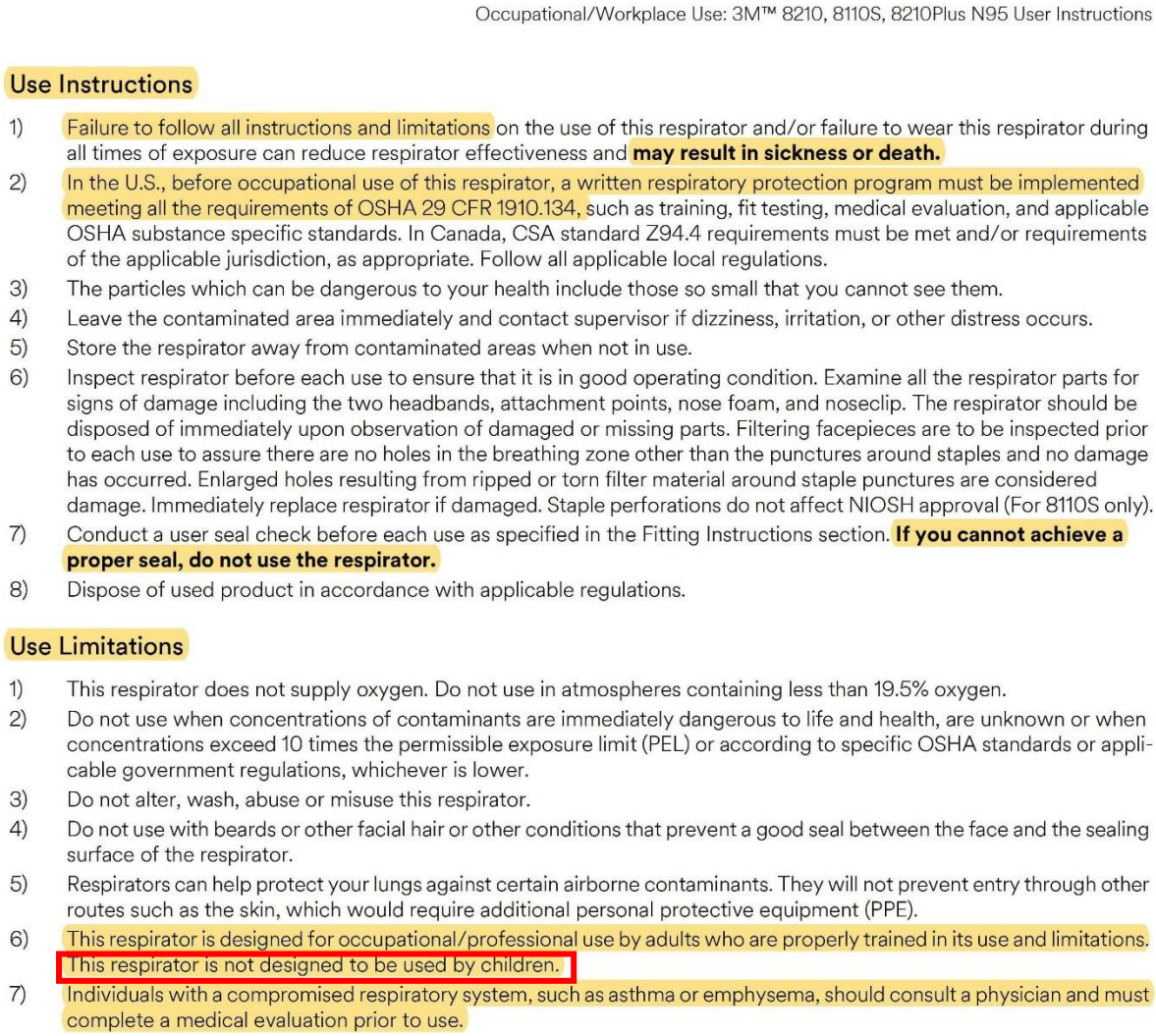
Figure 23: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers – pg. 1

From this webpage, four manufacturers are listed representing 12 respirators:

- 3M (6 models)
- Drager (1 model)
- Honeywell (2 models)
- Moldex (3 models).

For each model, the link can be clicked to get directly to the manufacturers' instructions for each respirator. For 3M and Moldex, major suppliers, only one set of instructions is used for each of their individually listed respirators. In other words, the same instructions were provided for each of the manufacturers' listed products.

Both 3M and Moldex explicitly state that their masks are not to be use by children (Figure 24).



Occupational/Workplace Use: 3M™ 8210, 8110S, 8210Plus N95 User Instructions

Use Instructions

1) Failure to follow all instructions and limitations on the use of this respirator and/or failure to wear this respirator during all times of exposure can reduce respirator effectiveness and **may result in sickness or death.**
2) In the U.S., before occupational use of this respirator, a written respiratory protection program must be implemented meeting all the requirements of OSHA 29 CFR 1910.134, such as training, fit testing, medical evaluation, and applicable OSHA substance specific standards. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Follow all applicable local regulations.
3) The particles which can be dangerous to your health include those so small that you cannot see them.
4) Leave the contaminated area immediately and contact supervisor if dizziness, irritation, or other distress occurs.
5) Store the respirator away from contaminated areas when not in use.
6) Inspect respirator before each use to ensure that it is in good operating condition. Examine all the respirator parts for signs of damage including the two headbands, attachment points, nose foam, and noseclip. The respirator should be disposed of immediately upon observation of damaged or missing parts. Filtering facepieces are to be inspected prior to each use to assure there are no holes in the breathing zone other than the punctures around staples and no damage has occurred. Enlarged holes resulting from ripped or torn filter material around staple punctures are considered damage. Immediately replace respirator if damaged. Staple perforations do not affect NIOSH approval (For 8110S only).
7) Conduct a user seal check before each use as specified in the Fitting Instructions section. **If you cannot achieve a proper seal, do not use the respirator.**
8) Dispose of used product in accordance with applicable regulations.

Use Limitations

1) This respirator does not supply oxygen. Do not use in atmospheres containing less than 19.5% oxygen.
2) Do not use when concentrations of contaminants are immediately dangerous to life and health, are unknown or when concentrations exceed 10 times the permissible exposure limit (PEL) or according to specific OSHA standards or applicable government regulations, whichever is lower.
3) Do not alter, wash, abuse or misuse this respirator.
4) Do not use with beards or other facial hair or other conditions that prevent a good seal between the face and the sealing surface of the respirator.
5) Respirators can help protect your lungs against certain airborne contaminants. They will not prevent entry through other routes such as the skin, which would require additional personal protective equipment (PPE).
6) This respirator is designed for occupational/professional use by adults who are properly trained in its use and limitations. This respirator is not designed to be used by children.
7) Individuals with a compromised respiratory system, such as asthma or emphysema, should consult a physician and must complete a medical evaluation prior to use.

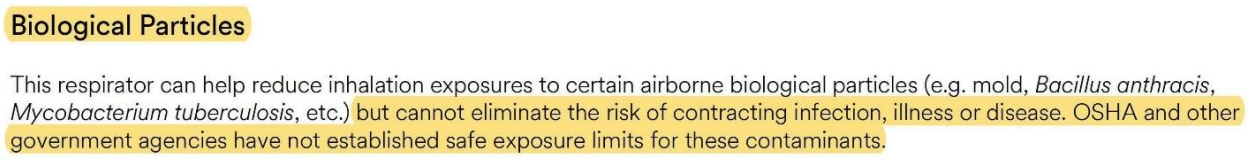
Figure 24: 3M Instructions for CDC Listed 3M N95 Respirators – Not Designed to be Used by Children

Note the following observations from Figure 24:

- ***This respirator is not designed to be used by children***!
- The respirator is only intended to be used for occupational or professional adults properly trained (e.g., under the RPS).
- Failure to follow instructions may result in sickness or death.
- A written respiratory protection plan, under the requirements of 29 CFR 1910.134 (RPS) must be in place prior to use of this respirator.

The Moldex instructions are essentially the same.

Moreover, 3M warns it is not protective against infectious diseases (Figure 25):



Biological Particles

This respirator can help reduce inhalation exposures to certain airborne biological particles (e.g. mold, *Bacillus anthracis*, *Mycobacterium tuberculosis*, etc.) but cannot eliminate the risk of contracting infection, illness or disease. OSHA and other government agencies have not established safe exposure limits for these contaminants.

5

Figure 25: 3M Instructions for CDC Listed 3M N95 Respirators – Not Protective Against Infection, Illness, or Disease

Note that anthrax and TB are much larger particles than virus particles like the COVID-19 virus.

In light of this discussion, the CDC should immediately correct their webpage stating explicitly that respirators, according to manufacturers' instructions, "Are not designed to be used by Children" and that anyone using a respirator must be doing so under a written respiratory protection plan that follows the OSHA RPS.

Issue #3: The CDC continues to ignore the fact that COVID-19 is primarily spread by aerosols (not droplets) making mask use mostly ineffective:

The CDC continues to make the misleading argument that masks stop COVID droplets. This is misleading because while masks do stop some droplets (> 50 to 10 micron), the vast majority of COVID particles are smaller aerosols (≤ 5 microns) – see Figure 26:

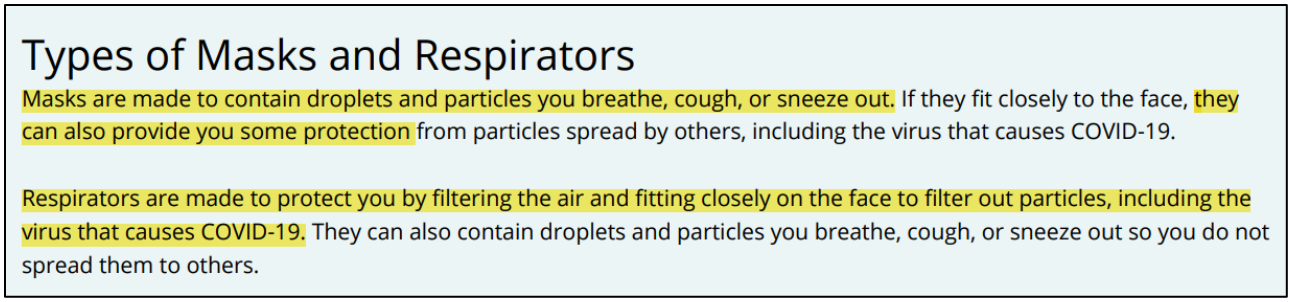


Figure 26: CDC – Misleading Guidance on Masks and Droplets

We are not the only ones who have written you regarding this issue. On February 15, 2021, the following scientists wrote a lengthy memo to you regarding your misleading language in this area and asked you to correct it:

- Rick Bright, PhD, Former Director of BARDA, Dept of Health and Human Services
- Lisa M. Brosseau, ScD, CIH, University of Minnesota CIDRAP
- Lynn R. Goldman, MD, MS, MPH, George Washington University
- Céline Gounder, MD, ScM, NYU Grossman School of Medicine & Bellevue Hospital Center
- Jose Jimenez, PhD, University of Colorado at Boulder
- Yoshihiro Kawaoka, DVM, PhD, University of Wisconsin-Madison and University of Tokyo
- Linsey Marr, PhD, Virginia Tech
- David Michaels, PhD, MPH, George Washington University
- Donald K. Milton, MD, DrPH, University of Maryland
- Michael Osterholm, PhD, MPH, University of Minnesota CIDRAP
- Kimberly Prather, PhD, University of California San Diego
- Robert T. Schooley, MD, University of California San Diego
- Peg Seminario, MS, AFL-CIO (retired)

They wrote in part:

> "To address and limit transmission via inhalation exposure and prevent COVID infections and deaths, we urge the Biden administration to take the following immediate actions:
>
> - Update and strengthen CDC guidelines to fully address transmission via inhalation exposure to *small inhalable particles* from infectious sources at close, mid and longer range. Updated guidelines should be informed by a risk assessment model that focuses on source and pathway (ventilation) controls first, followed by respiratory protection…

- *Issue an OSHA emergency standard on COVID-19 that recognizes the importance of aerosol inhalation, includes requirements to assess risks of exposure, and requires implementation of control measures following a hierarchy of controls*…

Edwards et al. (https://www.pnas.org/content/118/8/e2021830118) demonstrated that that the vast majority of COVID particles emitted during illness are aerosols not droplets (see Figure 27):

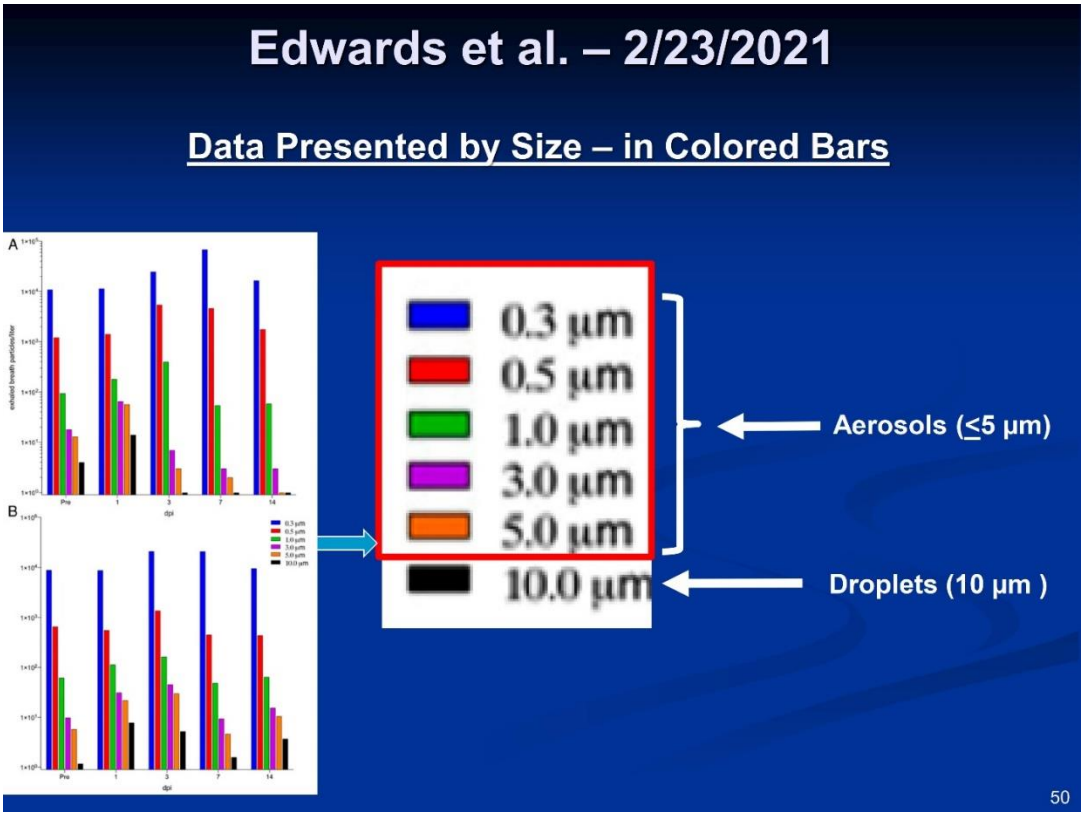


Figure 27: Edwards et al., 2021 – Particle Size Emissions by Size and Time

Edwards et al. concluded their paper with the following statements:

- Our finding that *the proportion of small respiratory droplets (i.e., aerosols) were the majority of particles exhaled in all subjects*.
- There may be an elevated risk of the airborne transmission of SARS CoV 2 by way of the very small droplets (aerosols) that transmit through conventional masks and *traverse distances far exceeding the conventional social distance of 2 m (~7').*
- Exhaled aerosol numbers appear to be not only an indicator of disease progression, *but a marker of disease risk in non-infected individuals.*

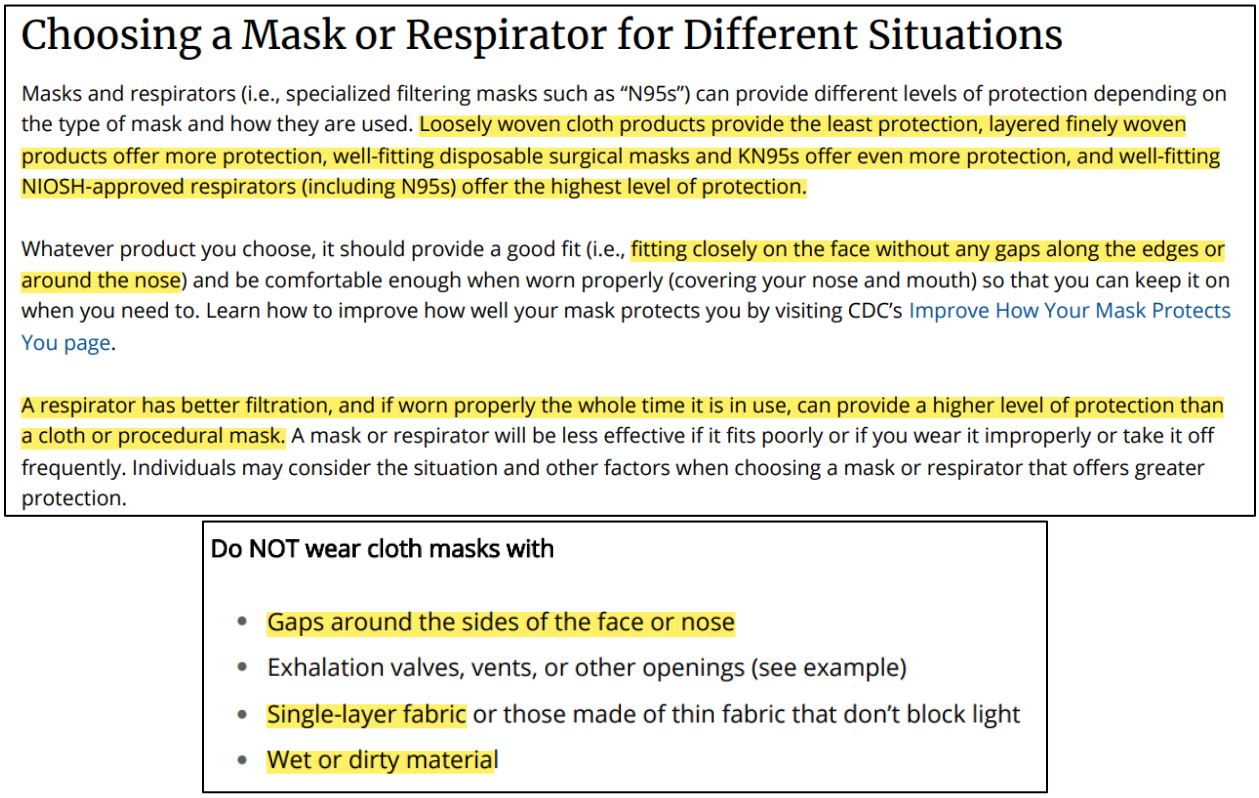
While the mask may contain droplets, they only do so for a period. As the masks are exposed to heat and moisture they suffer from degradation within a few hours.

We ask that the CDC immediately suspend misleading statements in all their public information that masks stop droplets when the vast majority of particles are smaller aerosols that stay suspended for days to weeks (vs. minutes for droplets), readily pass through gaps around the masks, and can reach deep into the lungs (see for example Fennelly, Kevin, P., 2020, Particle sizes of infectious aerosols: implications for infection control, Lancet Respir Med 2020; 8: 914–24).

Issue #4: CDC's position for masks used by the general public lacks proper scientific justification and creates potential harm based on a false sense of security:

Statements that a mask can provide protection are false and mislead the public into a false sense of security. Industrial Hygiene solutions seek a more than 90% relative risk reduction, and this publication continues to focus on the lowest form of non-protection that does not meet the least desirable mode of protection (PPE) in the Hierarchy of Controls with PPE. The September 9, 2020 guidance from AIHA illustrated this concept of the need for a super reduction in relative risk, not a minor one (https://aiha-assets.sfo2.digitaloceanspaces.com/AIHA/resources/Guidance-Documents/Reducing-the-Risk-of-COVID-19-using-Engineering-Controls-Guidance-Document.pdf - pg. 4).

Moreover, the CDC continues to provide guidance that gaps in masks can be eliminated; in the real world that never happens (Figure 28):



Choosing a Mask or Respirator for Different Situations

Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection depending on the type of mask and how they are used. Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection.

Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to. Learn how to improve how well your mask protects you by visiting CDC's Improve How Your Mask Protects You page.

A respirator has better filtration, and if worn properly the whole time it is in use, can provide a higher level of protection than a cloth or procedural mask. A mask or respirator will be less effective if it fits poorly or if you wear it improperly or take it off frequently. Individuals may consider the situation and other factors when choosing a mask or respirator that offers greater protection.

Figure 28: CDC Guidance Suggesting Gaps in Masks Can be Eliminated

The CDC statement that masks should not be worn if gaps cannot be eliminated is meaningless because this cannot occur; only properly selected and fitted respirators can accomplish this.

Masks cannot ever obtain a perfect fit to the face and efficiencies of masks when worn in real world scenarios (day-long usage). When the mask has more than a 3% gap, it offers effectively zero protection (Figure 29):

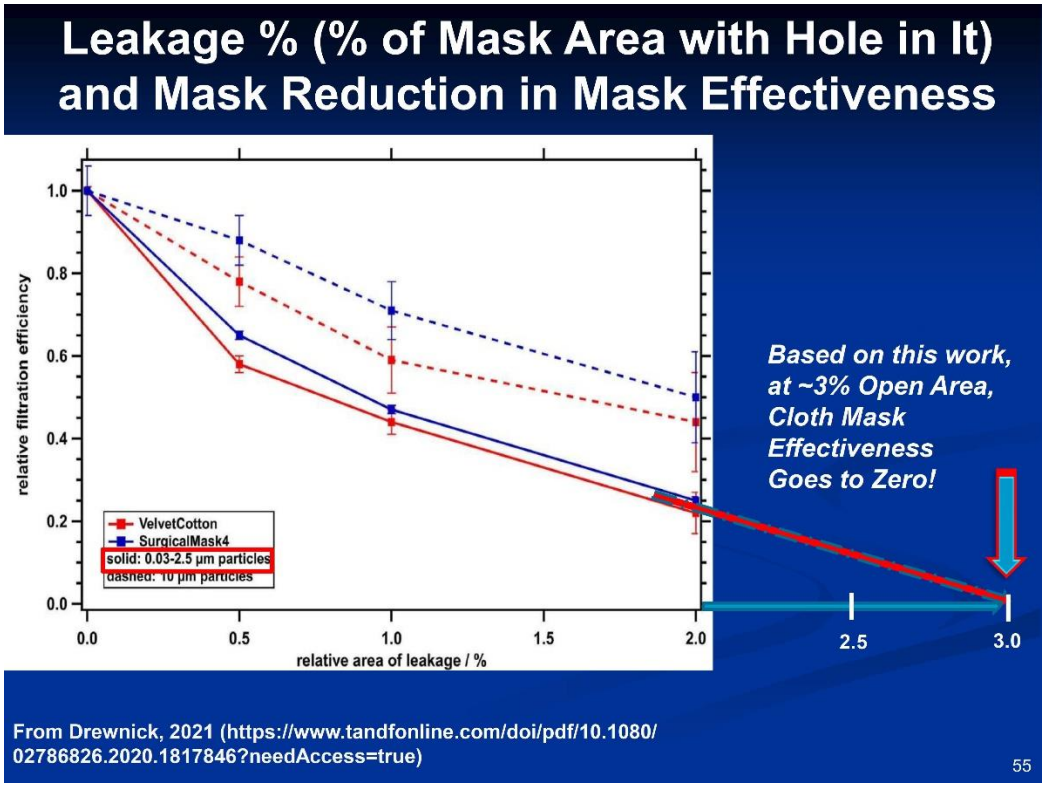


Figure 29: Loss of Mask Effectiveness in the Real World

Thus, the core issue with masks, and even respirators, is the seal – small gap areas effectively render these devices ineffective.

The American Society for Testing and Materials (ASTM) Standard Specification for Barrier Face Coverings F3502-21 Note 2 states, “There are currently no established methods for measuring outward leakage from a barrier face covering, medical mask, or respirator. Nothing in this standard addressed or implied a quantitative assessment of outward leakage and no claims can be made about the degree to which a barrier face covering reduces emission of human-generated particles.”

As well as, importantly, Note 5, “There are currently no specific accepted techniques that are available to measure outward leakage from a barrier face covering or other products. Thus, no claims may be made with respect to the degree of source control offered by the barrier face covering based on the leakage assessment.”

Every breath increases atmospheric viral load, or the amount of viral matter held aloft in an enclosed space. In instances when it does not take very much of an airborne pathogen for vulnerable individuals to get sick, a contagious individual should not wear a mask or respirator that creates a concentrated plume of aerosols, thinking they are protecting others from their respiratory emissions.

Explosive force-generating events, such as coughs and sneezes, increase the pressure behind exhaled matter. Masks can exacerbate the spread of airborne pathogens by creating focused plumes of fine particulates, in turn increasing emission trajectory, with the added concern of aerosolization of droplets through the mask membrane.

Finally, what is now most concerning, is that public entities are taking CDC guidance and making respirators available for free (Figure 30):

Figure 30: "Free" Open Contaminated N95s Being Given Away to the Public at Grocery Stores

These entities, based on CDC guidance, likely and/or unknowingly, do not address the requirements of the Respiratory Protection Standard and causing additional harm to the public by such a lack of understanding. Inevitably, this practice will result in harm and liability to their employees and customers for improper distribution and storage of respirators under the RPS.

Conclusion:

The CDC has built a series of recommendations for masking that are inconsistent with the technical and medical literature. The policy and procedural recommendations exaggerate the benefits, while ignoring the limitations and harms, especially for children and the general population. In addition, the CDC has taken a policy position of "it might work" and "it can't hurt" and use selective and weak observational data in the place of actual controlled scientific study to justify inappropriate recommendations for masks and face coverings.

Recently, the CDC has deployed a respiratory protection policy (i.e., masks to N95s) that dismisses the key principles in any Safety and Health program regarding the use of respirators – namely the Respiratory Protection Program. There is no mention of potential risks if the respirator is not properly used or fitted correctly. Moreover, it is clear that respirators are not intended for use with children. In our profession, if PPE and respiratory protection guidance was to ever be delivered without risk identification, fit testing, and training, we would be liable for putting personnel in a high-risk scenario, which is what the CDC is doing with their policy.

We would ask the CDC to accept these basic industrial hygiene facts that we have presented, update their public guidance accordingly regarding the issue of droplets vs. aerosols, stop confusing the public regarding the effectiveness of masks, and stop implying respirators are acceptable for children, and to be given generally to the public. In addition, it is clear the CDC knows, or should know, that gaps between the face and mask are a major problem for real mask effectiveness and could never have met our industry's requirement of 90% relative risk reduction.

The CDC is doing enormous damage to science and scientists by allowing politics to dictate public health policy rather than actual science. Increasingly, and for good reason as we have illustrated, the public does not trust the CDC and its science; this must change.

We recognize that it is easy to judge from afar and know that you and your team are under tremendous stress during this period. Our desire is to see the CDC and our country succeed in these efforts. As such, instead of just being critical, we want to offer our time to your organization to find solutions together. We would be willing to collaborate in the creation of a competent plan that will be based on the Hierarchy of Controls and will be tailored to various work and living environments. We will also help develop data points we can use to monitor and measure this program to enable proper adjustments as needed.

We look forward to your responses to our concerns as we continue to work to protect the public.

Sincerely:

Stephen E. Petty, P.E., C.I.H., C.S.P.*
EES Group, Inc.
Pompano Beach, FL 33030
(spetty@eesgroup.us)

James R. Casciano, MS, CIH
Certified Industrial Hygienist
Lafayette, Colorado
(jamescasciano@gmail.com)

Tammy Clark
Occupational and Environmental Health and Safety Professional
(tammy@standupmichigan.com)

Tyson Gabriel, IH, OEHS Pro
Premier Risk Management
4501 N 22nd St, Unit 190
Phoenix, AZ 85016
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Dave Howard, Founder
Premier Risk Management
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Nathaniel Kelly, MPH, M.S. OSH, GSP
Health and Safety Manager
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Megan K. Mansell
Risk Assessment, Compliance, and Accommodations for Special Populations
Tallahassee, FL 32303
(MeganKristenMansell@gmail.com)

Kristen Meghan Kelly, M.S. OSH
Senior Industrial Hygienist
(kristenmeghan@gmail.com)

* Corresponding Author

From: Bill Osmunson
Sent: 8/4/2022 11:15:49 AM
To: DOH WSBOH
Cc:
Subject: My Public Comments

External Email

Washington State Board of Health For August 10, 2022 Meeting

I am a dentist in Bellevue, Washington, graduated in 1977 and have a Masters Degree in Public Health. For about 25 years I promoted community water fluoridation. However, after careful consideration of the scientific empirical evidence I no long support fluoridation.

It is my understanding, the Washington State Department of Health has determined the Board of Health has Jurisdiction over Community Water Fluoridation in Washington State. Your action to protect the public is urgently needed.

70% of children and adolescents have dental fluorosis. Two studies funded by the EPA for the EPA by Collins, University of Texas Health Science Center, San Antonio, reported more costs to treat functional damage from dental fluorosis than cosmetic damage. https://nepis.epa.gov/Exe/ZyPDF.cgi/2000TTWA.PDF?Dockey=2000TTWA.PDF <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fnepis.epa.gov%2FExe%2FZyPDF.

I treat dental fluorosis damage and have mixed feelings. On the one hand I should thank the Board for sending me business in the form of dental fluorosis harm, chipped, broken, warn, fractured teeth. On the other hand, I ach inside knowing the Board would not intentionally harm our children and youth.

Feels so good to "do good" and applaud our good intentions. And too easy to ignored the harm being caused by flawed policies.

Please respond to the questions previously sent to you.

Below are a few professionals in Washington State who have said they are opposed to community water fluoridation.

Sincerely,
Bill Osmunson DDS MPH
1418 – 112th Ave NE
Bellevue, WA 98004Public Comment for August 10, 2022

Washington Public Health and Scientific Professionals

Calling for an End to Artificial Water Fluoridation

* Helen Abay, RDH, BS, Lynnwood, WA
* Sheila Adkins, RN, Prosser, WA
* Rebecca Allen, RN, Shoreline, WA
* Jodie Anderson, MAT, Seattle, WA
Mary Lou Andersen, MS (biology), LPN, CHT, Nurse, Nutritionist, Bellingham, WA
* Julie Anderson, ARNP, Seattle, WA

* Linda L Andersson, EdD thereapist in private practice, Medina, WA
* Maryann Andonian, RDH, BA, Battle Ground, WA
* Denel Andreas, ND, Seattle, WA
* Nathan Banks, DC, Redmond, WA
* James Bentz, DC, Anacortes, WA
* Teresa Berry, RN, Tacoma, WA
* Toni Best, DC, ReDmond, WA
* Jeffrey T. Bland, PhD, (the father of functional medicine) Seattle, WA
* Mark Blessley, DC, NTS, BS, Vancouver, WA
* John Blye, DC, (Developer, Encephalitis /Resistance Model of Disease Instructor, Blye Cranial Technique) Lynnwood, WA
* Colleen Bolander, RN, Woodinville, WA
Russ Borneman, DDS, Anacortes, WA
* Michael Breneman, DC, Arlington, WA
* Jon Burke, PhD (Clinical Psychologist), Union, WA
* Valerie Burke, RN, MSN, Union, WA
Blair B. Burroughs, JD, Burroughs & Baker P.C., Seattle, WA
* Mikayla Byers, DC, Auburn, WA
* Paul Byers, DC, Auburn, WA
* Janell Chandler, DC, Vancouver, WA
* Wenliang Chen, PhD, Vancouver, WA
* Beverly Clark, RN, BSN, Seattle, WA
Lawrence A. Clayman, BS, DC, Roxbury Spine and Wellness Clinic, Seattle, WA
* Ann Clifton, RN, Olympia, WA
* Kevin Conroy, ND, Port Angeles, WA
* Louis Cook, DC, DesMoines, WA
* Deborah Cummings, OT (Occupational Therapist), LMP, Snohomish, WA
* James Robert Deal, JD, Lynnwood, WA
Armand V. DeFelice, DDS, Spokane, WA
* Resa Delany, PA-C (Physician Assistant-Certified), Shelton, WA
* Beth DiDomenico, ND, Family Practice, Federal Way, WA
* Debra DiPietro, RN, CGRN, Federal Way, WA
* Kenneth Dunning, MS, Mount Vernon, WA
* Richard Edlich, MD, PhD, Brush Prairie, WA
Roger Eichman, DDS (retired), Nordland, WA
* Karla Eilers, RN, Aberdeen, WA
* Dwight Erickson, DC, Diplomate American Board of Disability Analysts, Colville, WA
* Sylvia Ericson, MS, Certified Nutritionist Washington state, Mountlake Terrace, WA
* Daniel Eschbach, DC, Bellingham, WA
Diana L. Estberg, PhD, Chemistry (retired), Port Angeles, WA
Gerald N. Estberg, PhD, Professor Emeritus in Physics, University of San Diego, CA, resident Port Angeles, WA
* Gayle Eversole, PhD, DHom, MH, NP, ND, Spokane, WA
* Shannon Fisher, RD, Tacoma, WA
Paul Framson, PhD, Seattle, WA
* Sharon Frederick, RN, Tacoma, WA
* Robert Gabriel, PhD, Olympia, WA
* Erwin Gemmer, DC, Silverdale, WA
* Jill Goetsch, RN, MSN, Kirkland, WA
* Brandy Gove, RD, CD, CNSD, Shoreline, WA
* Sharon Greene, BSN, RN, MS, Pateros, WA
C. Jess Groesbeck, MD, Preventive Medicine, Mount Vernon, WA
James A. Gruber, former water superintendent, Lakeview Park Water Association (retired after 24 years service), near Soap Lake, WA
* Lois Gruber, RN (retired), Seattle, WA
* Jose Gude, MD, Seattle, WA
* John B. Hallawell, DC, Harbor, WA
* Michael Hanson, PhD, Shoreline, WA

* Loraine Harkin, ND, Yakima, WA
* Ruth Hawkinson, RN, Colbert, WA
* Joan Hill, ND, RN, Seattle, WA
* Holly Hochstadt, DC, Seattle, WA
* Cynthia Hodges, JD, LL.M, MA, Edmonds, WA
Debra Hopkins, DDS, Tacoma, WA
* Marlie Hostetter, RN, Redmond, WA
* Becki Hoyt, RN, Lynnwood, WA
* Charles W. Huffine, MA (Sociology), Pullman, WA
Shirley Jacobson, MSc (Nursing), USPHS Nurse Corps (retired), Bellingham, WA
* David John, MD, Mercer Island, WA
* Duane Jones, DDS, Federal Way, WA
* Lynn Jonsson, PhD, Tacoma, WA
Eloise Kailin, MD, Sequim, WA
* Dora Keating, ND (naturopathic physician), Seattle, WA
* Elton Kerr, MD, FACOG, FRSM, Pasco, WA
* Marga Kerr, RN, BS, Pasco, WA
Dietrich Klinghardt, MD, Seattle, WA
* Vernita C. Kontz, RN, BS, College Place, WA
* Brice Kovarik, DC, BS, Lynnwood, WA
* Michael Kucher, PhD, University of Washington (Tacoma), Seattle, WA
* Grace Lasker, PhD, MS, Kirkland, WA
* Alli Larkin, President, Board of Commissioners, King County Water District 54, Des Moines, WA
Todd Lawson, DMD, Aesthetic Dentistry of Bellevue, WA
* Richard Levine, DC, Bellevue, WA
* Susan D. Liddel-Jones, RN, BS, Nurse-Educator, Renton, WA
* Joanne Loudin, PhD (Psychotherapist), Fox Island, WA
* Cheryl Malcham, RD (Nutritionist), Mercer Island, WA
Avery N. Martin, BS, DC, Mt. Vernon, WA
* Elizabeth Martin, DC, Seattle, WA
* Matt McCann, DC, Marysville, WA
* Ben McCay, DC, Lynnwood, WA
* Carol McDowell, EFDA (Expanded Function Dental Auxiliary), DuPont, WA
* John McLean, Water System Manager (#5829) in the state of Washington, Camano Island, WA
* Mary Meier, RN, Seattle, WA
* Donald Miller, MD, Professor of Surgery, University of Washington School of Medicine; author Fluoride Follies, Seattle, WA
* Matthew Miller, DC, Vancouver, WA
* Joshua Minks, BSN, Bothell, WA
* John Mishko, DC, Fircrest, WA
* Bill Misner, PhD, Author: What Should I Eat? A Food-Endowed Prescription For Well Being, Spokane, WA
Jeffrey Morris, PhD (Economics), Sound Resource Management, Olympia, WA
* Richard Morrison, PhD, Bellingham, WA
* Jon R. Mundall, MD, Dipl. ABCMT, CNS, Connell, WA
* Michelle Murphy, Sr. Electrical Engineer, Mental Health Advocate for Washington State, Richland, WA
* Cheryl Murray, RN, Newcastle, WA
* Fred Neil, DC, Bellingham, WA
Helene R. (Vaughn) Newbaker, RN, DC (retired), Sedro Woolley, WA
* Judith Night, BA, BFA, MA, Ocean Park, WA
* Sheryl Nixon, RN, Toledo, WA
* Chris Nubbe, MA (Environmental Engineering), BS (Civil Engineering), Olympia, WA
* Lalania Olsby, RN, Seattle, WA
* Ann Olsen, LM, CPM (Licensed Midwife and Certified Professional Midwife), Enumclaw, WA

* Mike Pagan, CMPT, CCCE, PT (Physical Therapist), Seattle, WA
* Lisa Paulk, RN, Arlington, WA
* Margaret Piela, RN, Nutritional Counselor, Certified Herbalist, Sammamish, WA
* Wendy Phillips Piret, BS USNA 93', Pediatric Craniosacral Therapist, Licensed Brain Gym Practioner, Mercer Island, WA
* Terry K. Poth, DC, Bellingham, WA
Jody Prusi, RDH, dental hygienist, Seattle, WA
* Karen Ranheim, RN, Lake Stevens, WA
* Phillip Ranheim, MD, Lake Stevens, WA
* Danielle Reilly, BSN, RN, Bellevue, WA
* Jennifer Ricker, DC, BA, Edmonds, WA
* Patrick A. Robinson, DDS, Bellevue, WA
* Elizabeth Rosendahl, RN, Tacoma, WA
Darryl W. Roundy, DC, Gig Harbor, WA
* Judith Royse, BSRDH, Spanaway, WA
Paul G. Rubin, DDS, Seattle, WA
* Jessica P. Saepoff, DDS, Issaquah, WA
* David Schorno, Waste Water treatment Operator group II, Sedro-Woolley, WA
* Ruth W. Shearer, PhD, Lacey, WA
* John Sheridan, MAT (Education), Issaquah, WA
* John Sherman, ND, Renton, WA
* Barara Simons, PA-C (Primary Care Physician Assistant), Freeland, WA
* Lucy Smith, ND, Shoreline, WA
* Samantha South, MS (criminal justice), Renton, WA
Mark Stahl, DDS, Seattle, WA
* Katie Stamwitz, DC, Hoquiam, WA
* Gerald Steel, MS, PE, Esq., Olympia, WA
* Robert Stephan, DDS, BS, FAPD, Nine Mile Falls, WA
* Crystal Tack, ND, LAc, Sequim, WA
* Carol Taylor, PhD (Computer Science), Spokane, WA
J. Miranda R. Taylor, LAc, MTCM, Licensed Acupuncturist, Master of TCM, Gesundheit Acupuncture and Herbs PLLC, Seattle, WA
* Ruth Tudor, RN, Olympia, WA
* Joseph Ulrich, RRT, NPS, Respiratory Therapist for 34 years, Vancouver, WA
* Christine Walker, RD (Registered Dietitian), MS (Nutrition and Dietetics), CD (Certified Dietitian in the state of Washington), Bonney Lake, WA
* Stephen Walsh, MS (Mathematical Statistics), Research Scientist, Richland, WA
* Lee Whitmer, OD, Chattaroy, WA
Richard S. Wilkinson, MD, Yakima, WA
* Shirley Williams, RN, Ferndale, WA
* Carla Witham, RDH, Bellingham, WA
* Keith Wollen, PhD, Port Angeles, WA
* Julie Woodbury, RN, Pascoe, WA
* Linda Zachariah, JD, Bellevue, WA
* Marina Zherebnenko, LMP, Vancouver, WA

Link to the Fluoride Action Network's Professional's Statement to End Water Fluoridation:
http://fluoridealert.org/researchers/professionals-statement
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Ffluoridealert.org%2Fresearchers%2
statement&data=05%7C01%7Cwsboh%40sboh.wa.gov%7C0eff1b31e8bc4fd4c30c08da76455354%7C11d0
/

From: Garry Blankenship
Sent: 7/12/2022 8:26:17 AM
To: hcinfo.infosc@canada.ca,DOH
WSBOH,OADS@cdc.gov,sheriff@co.clallam.wa.us,ombuds@oc.fda.gov,mozias@co.clallam.wa.us,rjohnson@

Cc:
Subject: The mRNA Jabs Do not Work

attachments\F61279EA886C415C_Martin Kulldorf on mRNA Efficacy.docx

attachments\09E215F5D1EB4A35_Why The Jabs Do Not Work.docx

External Email

Multiple health professionals and publications have accurately reported that the Coronavirus is not a viable vaccine candidate because of it's mutation natural proneness. This cycle of rewarding pharma for drugs ineffective against current viruses must end. It is not possible to vaccinate out of a pandemic. Healthy living, (diet & exercise), optimum vitamin D levels, natural immunity, effective repurposed drugs, etc. are discounted by our health care system, while experimental drugs with unknown efficacy and side effects are solely promoted. This is irrational by any standard. While the harmful adverse events from these experimental drugs appear statistically small, repeated injections will ultimately render the harm inevitable, (if you have not been harmed yet, you will be). All associated mandates, (masks, proof of vaccination and isolation), are now known to be ineffective or health net negatives. No question isolation is in order for symptomatic individuals. Please consider the benefit of proof of vaccination when the vaccinated undisputedly become infected with, spreaders of and die from COVID. The "vaccine hesitation" the CDC hoped to lessen by censoring resultant mRNA data, has only served to solidify same. Please stop this madness and collectively study a rational approach to threatening viruses.

I / we want to believe in our health care professionals. Please restore that confidence by publicly acknowledging the shortcomings of the current COVID policy/s.

Please review supportive attachments,

Sincerely,

Garry Blankenship

_____
From: Jodi Dotson
Sent: 7/21/2022 10:30:59 AM
To: DOH WSBOH
Cc:
Subject: Dori: Local health stats show unvaxxed kids less likely to have COVID than vaccinated youth

External Email

<https://static.particlenews.com/logo/brand_logo_white.png> NewsBreak
Used by over 45 million people
Open APP
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fnewsbreakapp.onelink.me%2F211

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.newsbreakapp.com%2Fn%2

Dori: Local health stats show unvaxxed kids less likely to have COVID than vaccinated youth

MyNorthwest.com
I found this on NewsBreak: Dori: Local health stats show unvaxxed kids less likely to have COVID than vaccinated youth
<https://img.particlenews.com/img/id/3reTYF_0glccReD00?type=_180x000>
Click to read the full story
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.newsbreakapp.com%2Fn%2

Sent from my iPhone

_____

From: Enrique Leon (he/el)
Sent: 6/23/2022 1:01:19 PM
To: DOH WSBOH
Cc:
Subject: Communicating With Board Members - lack of Infectious disease consultation in Tacoma

External Email

Dear Health board,

Can your health board make recommendations to Multicare about finding an urgent safe long term solution for the lack of infectious disease doctors in hospital and outside of hospital for follow up. This has been a significant problem for 2 years but critical the last 6 months. We had only 2 ID doctors past 6 months with 2-4 month long out patient follow up appointment wait time. One doctor quit 2 months ago. The last one is quitting 7/16 th. There are no replacements identified yet.

There have been delayed and misdiagnosis throughout our system because of this problem. Many patient complications. Likely deaths, though none of my patients.

See the attached e mail from our chief medical officer.

Don't use my name as there may be retribution against me if you do. Thanks

From: Paula Loveless <Paula.Loveless@multicare.org <mailto:Paula.Loveless@multicare.org> > On Behalf Of Ralph Costanzo
Sent: Wednesday, June 22, 2022 3:22 PM
Subject: ALERT! No on-site Infectious Disease coverage at TGAH June 27 - July 10
Importance: High

Dear Colleagues,

Once again, I want to apologize because due to an ongoing staffing shortage, Tacoma General-Allenmore Hospitals will not have available on-site Infectious Disease consultation services next week from June 27 – July 10, including the absence of our wonderful ID Pharmacist, Julianna Van Enk, who is on much deserved PTO. Dr. Courtney Beuning's last week with us will be July 17. Please join me in wishing her all the best as she transitions from MultiCare. We have truly appreciated her engagement and dedicated work within our infectious disease program.

We also anticipate a lack of coverage the weeks of July 18 through August 7 although this could change depending upon locums provider availability.

I apologize for the interruption in this important care line and as previously communicated, we are actively working with MMA leadership on a plan to effectively rebuild our infectious disease program. We have several additional locums providers undergoing privileging along with offers to new full time physicians and APPs. Last, we are close to consummating a contract with a Tele-ID vendor, ID Connect, staffed by physicians at the University of Pittsburgh Medical Center. We believe that if all of these initiatives achieve fruition, we will have a much more stable program with expanded bench strength by Q3 of this year. In the meantime, we continue to ask for your understanding and collaboration as we navigate the gaps in coverage during the next few months.

At present, similar shortages at Good Samaritan Hospital will prevent them from acting as a resource for us. When possible, we ask that you work with our onsite pharmacy teams in making decisions about antibiotic treatment for your patients. Julianna Van Enk is also a very knowledgeable resource and would be available for advice on the days she is working at the facility.

Last, if you are caring for a patient that you believe requires an urgent/emergent in-person consult, please work with MC2 (transfer center) to affect a patient transfer to the most appropriate facility.

As always, I appreciate your collaboration and understanding. If you do have specific questions or concerns about the process, please feel free to reach out to me directly.

Best,

Ralph

Ralph M. Costanzo, MD, MHA

Chief Medical Officer | MultiCare Health System-Tacoma General/Allenmore Hospitals

Cell: 406.591.7839 | Work: 253.403.4925
Address: MS: 315-C3-AD 315 Martin Luther King Jr Way, Tacoma, WA 98405

_____
From: Jotform
Sent: 7/26/2022 10:25:40 AM
To: DOH WSBOH
Cc:
Subject: Re: Stop The Child Vaccine Mandate Petition - Kimberley Phillips

External Email

<https://cdn.jotfor.ms/assets/img/logo2021/jotform-logo.png>

Stop The Child Vaccine Mandate Petition

Name

Kimberley Phillips

Email

phillipskimberley1974@gmail.com

Zip

, , , , 98901

You can edit this submission
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.jotform.com%2Fedit%2F534
and view all your submissions
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.jotform.com%2Ftables%2F2
easily.

From: Joshua Allen
Sent: 7/15/2022 1:45:03 AM
To: DOH WSBOH
Cc:
Subject: Re: Now Available: June 8 Proposed Final Agenda for State Board of Health Public Meeting

attachments\81B58BCAC7E84918_image002.png

External Email

https://thinkcivics.com/scientists-say-government-main-source-of-covid-misinformation/

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fthinkcivics.com%2Fscientists-say-government-main-source-of-covid-misinformation%2F&data=05%7C01%7Cwsboh%40sboh.wa.gov%7Cd36a83f340484514994308da663e1f8
Sent from my iPhone

On Jun 1, 2022, at 5:15 PM, DOH WSBOH <WSBOH@sboh.wa.gov> wrote:

☐

The proposed final agenda <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsboh.wa.gov%2Fsites%2Fdefault%06%2FTab01a-ProposedFinalAgenda-Jun2022.pdf&data=05%7C01%7Cwsboh%40sboh.wa.gov%7Cd36a83f340484514994308da663e1f8e%7C1 is now available for the State Board of Health's public meeting on Wednesday, June 8. We will meet from 9:30 a.m. – 4:30 p.m. Meeting materials are available on the meeting webpage.

Please read the proposed final agenda for more information about the meeting, including how to give public comments and when to give testimony on the Keeping of Animals rules hearing. We encourage you to submit written public comments to the Board in advance of the meeting. You may access the meeting in the following ways:

1. Online and register: https://us02web.zoom.us/webinar/register/WN_6vqdRyUmTamyb61z3wCSBA <https://us02web.zoom.us/webinar/register/WN_6vqdRyUmTamyb61z3wCSBA>

2. Call-in and participate using your phone:

0. Webinar Call in: +1 (253) 215-8782
1. Webinar ID: 847-8253-4990
2. Webinar Passcode: 887573

About Public Comment:

* We encourage you to submit written public comments to the Board in advance of the meeting. To help ensure Board members have an opportunity to read and consider your comments before the meeting, please email us your comments <mailto:wsboh@sboh.wa.gov?subject=My%20Public%20Comments> by Friday, June 3 by 12:00 Noon. Written comments received after 12:00 Noon on Friday will be shared with Board members; however, Board members may not have the capacity to read or consider your comments over the weekend before the meeting or during the meeting. You may give verbal comments at the meeting during the public comment or rules hearing segments.

Other Meeting Information:

* This meeting will be held online through the Zoom Webinar application.
* Board members, presenters, and staff will participate remotely.

Phone: (360) 236-4110

Mailing Address: P.O. Box 47990, Olympia, WA 98504-7990

Location
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.google.com%2Fmaps%2Fpla
122.9083621%2C17z%2Fdata%3D!3m1!4b1!4m5!3m4!1s0x549173f074205aa3%3A0x552ddc5f79ee44b6!
122.9061681%3Fhl%3Den&data=05%7C01%7Cwsboh%40sboh.wa.gov%7Cd36a83f340484514994308da6
· Website
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fsboh.wa.gov%2F&data=05%7C01%
· Email <mailto:wsboh@sboh.wa.gov> · Facebook
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.facebook.com%2FWashington
· Twitter
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ftwitter.com%2FWASBOH&data=0
· Subscribe
<mailto:wsboh@sboh.wa.gov?subject=Please%20Add%20My%20Name%20to%20the%20WSBOH%20Ema

Please send us an email with the subject "unsubscribe" if you no longer wish to receive communications from us

_____

From: Jodi Dotson
Sent: 7/13/2022 3:30:56 PM
To: DOH WSBOH
Cc:
Subject: Covid shots for children

External Email

Dear Board,

I am begging you people to stop this horendous act against humanity. The citizens of Washington State are at your mercy in the fact that they rely on your expert opinion. Most people have faith in your decisions to do NO HARM to the public. This whole agenda to force a deadly shot on children who have next to zero threat of death from the covid virus. I cannot fathom your reasoning to push for any human being to have this deadly shot.
The more I learn the more disheartening this whole situation has become. There are thousands of people who have been injured or dead from this shot and the numbers continue to rise. I am not sure if you people are not recieiving the studies and research on this stuff or you are receiving monetary gains to look the other way.

You know back in 1986 I was in school for healthcare and I had always wondered why you actually need an army. Why couldn't a person or persons just put a deadly virus in the air , water or a shot instead of the WARS. Well, low and behold 32 years later it was accomplished. The sad thing is it was man made and not something that occured naturally.

The very people who took oaths to protect the human race are trying to depopulize the world. I cannot fathom how anyone with a conscience could go along with this diabolical plan. It is bad enough that we loose children from other diseases but to knowingly put something in them to kill them is just so sick.

I beg you to do further research and not to just rely on the information provided to you from lord knows where. Does it really make sense to give children a shot that the mortality rate is 99.8%. Does it make sense to give them a shot that killed all the animals that were tested with it, so they decided to give it to the world. Why are children of all having heart problems and dropping dead? Why is anyone that recieved this shot getting mamed or killed? When does it stop? You people have the power to stop this crime against humanity here in Washington State. My heart is broken to know you would harm people and you are THE BOARD OF HEALTH.

I would like a response to this letter. I have written to you folks and have heard nothing back. I would like for the Board to do their own research in to the ingredients of all the manufacturers of this deadly liquid.

Sincerely,

Jodi Dotson

_____
From: John Anderson
Sent: 7/13/2022 7:21:59 AM
To: DOH WSBOH
Subject: Comments on Public School MASK Policy

External Email

Greetings Working Group -

I wish to provide, for your consideration, the attached testimony (with numerous studies cited in bibliographical links) of Stephen Petty. a recognized expert on the protection offered by Masks, including N95 for both general population and for children.

in his testimony he specifically cites recent cases where his science prevailed against the flawed studies on N95 masking conducted by the CDC to promote masking of school children.

Your committee would be hard pressed to find a better compendium of information, and should you ignore this resource it could be at your peril. Note his citation of the regulatory and legal risks of advocating N95 masks without specific physician evaluation of patients over the warnings issued by the manufacturer.

Please keep our children safe!

(321) Ep. 141 The Ultimate PPE Expert with Incredible Insights into Mask Science! - YouTube
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.youtube.com%2Fwatch%3Fv

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Strength and Honor

John Anderson
President
GDP Group Ltd SPC
MOBILE: (253) 459-3447

On Wed, Dec 29, 2021 at 1:11 PM John Anderson <j2j.anderson@gmail.com <mailto:j2j.anderson@gmail.com> > wrote:

Greetings Working Group

Personal Background

I am a vaccinated (2x), healthy 68 year old male. I have lived in Washington since 1993. My education includes science (BS Physics, Pre-med, Nuclear Engineering graduate school, and IT professional coursework) and business (MBA Marketing, graduate studies in Marketing and Strategy) from 7 universities. I have written US Patents on behalf of inventors who developed anti-viral, anti-bacterial, and other immunological effects. Currently, I lead the materials science Product Development efforts of a WA state clean energy venture. I review on a daily basis the many observational studies and Randomized Control Trials from select nations concerning COVID.

These reviews have included:

* Evidence comparing Vaccine immunity vs Natural Immunity.
* Breakthrough infection rates by immunity class (No Vaxx, Vaxx only, Natual Immunity Only, Vaxx after recovery from infection).
* Symptom and infection severity by Variant
* Viral load and transmissivity by immunity class.
* Infection rates and clinical outcomes by age group.
* Vaccine Adverse Effects (UK Yellow Card System, US VAERS, etc.)
* Infection and severity of symptoms serum nutrient content {Vit A, Vit D, Vit C, Vit K, Zinc, Iron}

DISCLAIMER

I am not a physician nor an academically-certified virologist nor nutritionist. My comments are not intended to make claims nor to provide advice.

COMMENTS FOR YOUR CONSIDERATION

Prudent policy decisions are always a risk-reward (or cost-benefit) trade-off. There literally is no free lunch. I suggest strongly that your deliberation consider the following facts:

* Herd immunity occurs when nearly all community members have immunity.
* Omicron is now outcompeting other variants. People get infected with OMICRON rather than Delta, Alpha, Beta etc.
* Omicron will likely infect everyone.
* Young people, unvaccinated, are most likely to be asymptomatic, and acquire natural immunity superior to vaccine immunity.
* Young people, regardless of immunity class, will infect teachers and parents with OMICRON regardless of their immunity class.
* Unless the policy for IM injection returns to the international best practice of aspirating the syringe after insertion, young people will be placed at a statistical rick of adverse side effects (from injection into the vascular system) that is greater than the risk of severe infection from COVID.

ADVICE:

* Let the Omicron variant run its course, and monitor new variants for infection and severity.
* Do NOT mandate COVID vaccines as a condition of participation in classrooms.
* The risk TO unvaccinated and BY unvaccinated students is acceptable. The reward of vaccination is outweighed by the adverse affects, discrimination against children, and the further invasion of patient rights by government.

I am available for discussion should follow-up be desired.

Strength and Honor

John Anderson
MOBILE: (253) 459-3447

From: Jessie Nearing
Sent: 7/6/2022 10:10:49 PM
To: DOH WSBOH,Davis, Michelle (SBOH),Hisaw, Melanie (SBOH),Hoff, Christy Curwick (DOH),Glasoe, Stuart D (SBOH),Pskowski, Samantha L (SBOH),Donahoe, Kaitlyn N (SBOH),Lang, Caitlin M (SBOH),lindsey.erendeen@sboh.wa.gov,Schreiber, Tracy N (SBOH),Haag, Hannah R (SBOH),Kahler, Kelie (SBOH),Thai, Nathaniel J (SBOH)
Cc:
Subject: Children Mandate Opposition for discussion 1/12/22.

attachments\1FD9D56CAD0F4737_Children Mandate Opposition.pdf

External Email

To the BOH or whomever this may concern:

I am writing this email to voice my strong stance **against** the COVID vaccines for our children of Washington state or anywhere for that matter. COVID vaccines should absolutely NOT be required for our children. Children are at extreme low risk for Covid and the vaccines are still ONLY EUA (emergency use authorization).

Here is Rep Jim Walsh's statement regarding this agenda item from his Facebook page:

"[Agenda]Item 9 is troubling–but not news. We've discussed it on this page and in Q&As many times. It's the section of WAC that allows local Health Dept's to set up isolation and quarantine facilities. And, in certain situations, send people to those facilities involuntarily. Against their will.
Again, this isn't new. That bad WAC has been in place for a while–even before COVID. It has never been used in WA. ***And it runs against various sections of the WA State Constitution. It's unconstitutional! The Board of Health's possible action is to extend this WAC. It should NOT do that. To extend the rule would just be bureaucratic rubber-stamping of the current Governor's unconstitutional excesses."***

I would also hope with such a bold, risk of our babies lives, unethical, and extremely quiet approach to your agenda that The Unity Project backed by globally esteemed experts in health care and science would hinder your approach to potentially hurt or kill our children.

Dr. Peter McCullough

The Unity Project – Strategic Advisory Council Member

MD, MPH, FACC, FAHA, FASN, FNKF, FNLA, FCRSA, internist, cardiologist, epidemiologist, Chief Medical Officer, Truth for health Foundation, most highly published cardiac and kidney specialist in history, globally

Dr. Robert Malone

Chief Medical & Regulatory Officer

MD, MS, Northwestern School of Medicine, Harvard Medical School fellow - Global Clinical Research Scholar (2016), original Inventor of the mRNA Vaccine Platform used in the Pfizer and Moderna COVID-19 vaccines

Dr. Paul Alexander

Chief Scientific Officer

MA, PhD, Oxford University, McMaster University, Former WHO Consultant and Senior Advisor to US Dept of HHS in 2020 for the COVID-19 response

Dr. Aaron Kheriaty

Chief of Medical Ethics

MD, Georgetown University, Notre Dame, Professor at University of California Irvine, Chairman, UCI Hospital's medical ethics committees and at the California Department of State Hospitals

I don't believe that the science behind these experts and the adverse effects that are proven towards children and the facts that continue daily to present themselves are unseen by caring humans with families like yourselves?

With this, I DO NOT APPROVE OF THIS AGENDA OF MANDATING CHILDREN. WAC 246-105. I APPOSE ALL THAT IS SPOKE OF IN THIS AGENDA. I DISAGREE WITH WAC 246-100-070. I DISAGREE WITH WAC 246-100-045. I DISAGREE WITH WAC 246-100-040.

Respectfully and devoted to our children's safety,

Jessie Nearing

Washington state resident of Grays Harbor County

From: karen raper
Sent: 6/26/2022 12:45:51 PM
To: DOH WSBOH
Cc:
Subject: Allergy Medication

External Email

I know people that need allergy medication with the decongestant this time of the year.

Having to spend over $10 or more just to run into town every week or so just to get over the counter medication can cause people to go without it.

Please consider allowing these people to get enough medication to last at least one month.

Sincerely
Karen

From: Garry Blankenship
Sent: 7/15/2022 10:40:35 AM
To: hcinfo.infosc@canada.ca,DOH
WSBOH,OADS@cdc.gov,sheriff@co.clallam.wa.us,mozias@co.clallam.wa.us,rjohnson@co.clallam.wa.us,sha

Cc:
Subject: Fauci; COVID Drugs Do Not Protect, (overly well)

attachments\A0E73EF0CE8C4DFB_Fauci Drugs Don't Work.docx

External Email

Attached is an article on the efficacy of COVID "vaccines". The world's number one promoter of our mRNA drug campaign now concedes they do not work well. Though this has long been known, government health management lock stepped with mass media have been resistant to admit same. Finally the pinnacle of world health management admits these drugs are not working. Adverse reactions aside, there is a huge takeaway from this. Recommending these drugs is now at best questionable. Mandating them or requiring proof of having taken them is a combination of incompetence and malpractice and should be punishable. Any requirement to take mRNA COVID "vaccines" is counter to now known science, data and studies. As people responsible for health management, please see that the proliferation of these dangerous chemical concoctions is halted. Please also investigate why effective and safe repurposed drugs have been blocked and why natural immunity is not acknowledged as being infinitely superior to vaccinated immunity. You cannot exclusively rely upon recommendations from the CDC, FDA or NIH. Please do your own homework, as your life is also at stake.

Sincerely,

Garry Blankenship

From: Gerald Braude
Sent: 8/5/2022 11:27:53 AM
To: DOH WSBOH
Cc:
Subject: COVID-19 shot mandates

External Email

I wanted to thank you for not putting COVID-19 shot mandates for Washington schools on the agenda for this meeting. I shall stay tuned to your meeting to make sure that you're still not interested on putting this on the school vaccine schedule. Although I am well past the parenting stage of my life, I still strongly believe parents have the right to decide whether their kids should take these experimental gene therapy shots. I would like to remind you that these shots do not prevent transmission, so requiring these shots to protect others in the classroom is an oxymoron.

Gerald Braude
Port Townwend

_____

From: Lisa Templeton
Sent: 8/5/2022 8:23:22 AM
To: DOH WSBOH
Cc:
Subject: Comments for BOH meeting on August 10

External Email

Dear Board members,

Since Covid began, the FDA and CDC have taught us that we should proceed with caution when it comes to their proclamations on public health. For example, a little over a year ago, they told us that the J&J Covid shot met the FDA's so-called "rigorous standards for safety, effectiveness, and manufacturing quality." Now the FDA essentially no longer approves of the use of J&J due to its adverse effects.

Have you listened to the recent VRBPAC and ACIP proceedings during which Covid shots were authorized then recommended for babies and toddlers? If you employed discernment, you know that the risks of the infection for children were exaggerated, the effectiveness of these consumer products was inflated, and the injuries from the shots were practically ignored.

Three members of Congress recently asked VRBPAC the following questions, which deserve answers before this mass human experiment is further unleashed on millions more Americans—our children.

* Why did the FDA lower its efficacy bar for Covid injections for the youngest children?
* How many lives does the FDA estimate will be saved in this age group?
* How will the FDA evaluate the injuries and deaths reported to VAERS compared to serious Covid outcomes?
* Why has the FDA been so slow to release the hundreds of thousands of pages of data from manufacturer studies and post-approval adverse events?

These are just four of many questions that bona fide science requires be answered before rolling ahead. It is evident that the risks of these experimental, liability-free shots outweigh the purported benefits, and our government barely seem to care. The public is taking note, however. I respectfully plead with each member of this Board to become informed of the many dangers of these for-profit products and stand for protecting the public from them.

Thank you,

Lisa Templeton

Covington

To the BOH or whomever this may concern:

I am writing this email to voice my strong stance **against** the COVID vaccines for our children of Washington state or anywhere for that matter. COVID vaccines should absolutely NOT be required for our children. Children are at extreme low risk for Covid and the vaccines are still ONLY EUA (emergency use authorization).

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I would also hope with such a bold, risk of our babies lives, unethical, and extremely quiet approach to your agenda that The Unity Project backed by globally esteemed experts in health care and science would hinder your approach to potentially hurt or kill our children.

Dr. Peter McCullough

The Unity Project – Strategic Advisory Council Member

MD, MPH, FACC, FAHA, FASN, FNKF, FNLA, FCRSA, internist, cardiologist, epidemiologist, Chief Medical Officer, Truth for health Foundation, most highly published cardiac and kidney specialist in history, globally

Dr. Robert Malone

Chief Medical & Regulatory Officer

MD, MS, Northwestern School of Medicine, Harvard Medical School fellow - Global Clinical Research Scholar (2016), original Inventor of the mRNA Vaccine Platform used in the Pfizer and Moderna COVID-19 vaccines

Dr. Paul Alexander

Chief Scientific Officer

MA, PhD, Oxford University, McMaster University, Former WHO Consultant and Senior Advisor to US Dept of HHS in 2020 for the COVID-19 response

Dr. Aaron Kheriaty

Chief of Medical Ethics

MD, Georgetown University, Notre Dame, Professor at University of California Irvine, Chairman, UCI Hospital's medical ethics committees and at the California Department of State Hospitals

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Respectfully and devoted to our children's safety,

Jessie Nearing

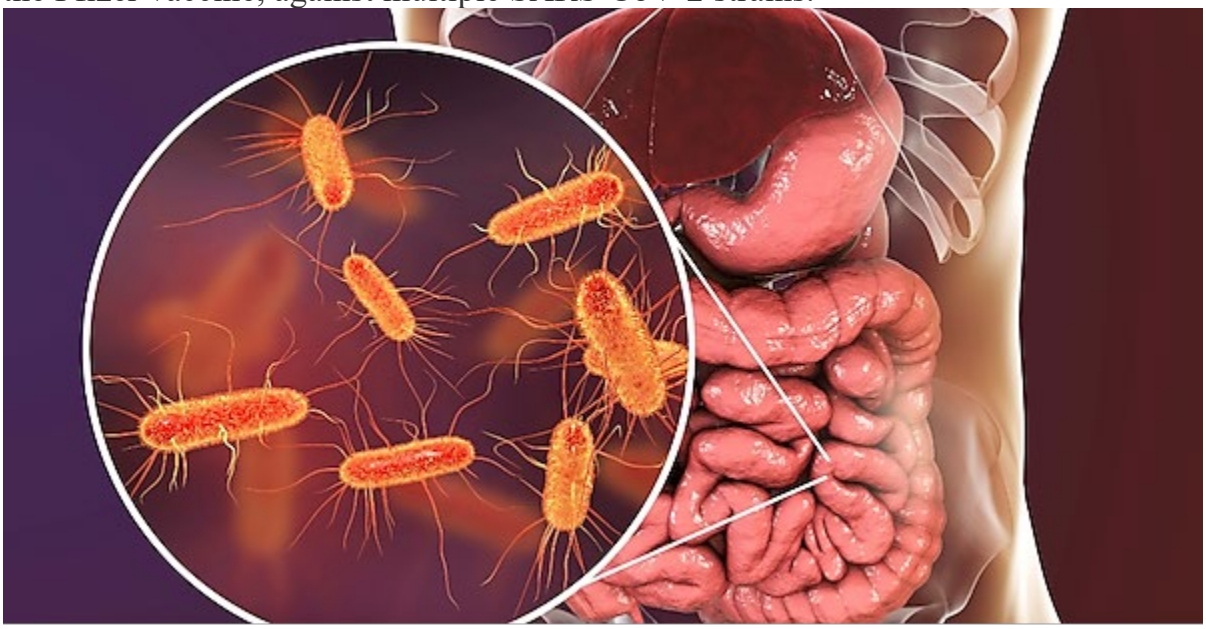
Washington state resident of Grays Harbor County

COVID-19 Jab Does Not Work. Here's Why

BY JOE WANG AND JENNIFER MARGULIS TIMEJULY 11, 2022 PRINT

A team of Harvard research scientists, publishing in the New England Journal of Medicine, have found that SARS-CoV-2 virus has mutated so much that the Pfizer mRNA vaccines developed against the original Wuhan strain now have little to no effect.

The study, "Neutralization Escape by SARS-CoV-2 Omicron Subvariants BA.2.12.1, BA.4, and BA.5," evaluated neutralizing antibody titers of participants vaccinated with the Pfizer vaccine, against multiple SARS-CoV-2 strains.



The scientists found that the titers dropped from 5,783 (against the WA1/2020 isolate, Wuhan strain) to 275 (against the BA.4 or BA.5 subvariant, omicron variants), by a factor of 21.

In other words, they found the mRNA vaccine to be essentially ineffective against Omicron variants currently in circulation.

SARS-CoV-2 Mutations

SARS-CoV-2 has been a quickly evolving virus since late 2019. Like all RNA viruses, it has a strand of RNA that is packaged in a delivery vehicle that allows it to attach

itself to host cells and inject its RNA into the cells and hijack the cells to make more copies of its RNA.

A virus must interact with living cells in order to reproduce. Without this interaction, the virus itself is inert. It has no metabolism. It cannot move. It doesn't eat. It cannot reproduce with other viruses. What this means is that a virus has none of the characteristics of living organisms. Because of this, some scientists want to classify viruses as part of life while others point out that viruses are not alive. At least not without hosts.

Life or not, all viruses must have genetic material RNA (ribonucleic acid) or DNA (deoxyribonucleic acid). RNA or DNA make copies using templates of complementary strands of RNA or DNA. There is always a chance for errors to happen during this process. We call these "errors" mutations.

Often these errors make the DNA or RNA too imperfect to carry on functioning, so the mutation goes nowhere. But if the mutated version is viable, the result is a new, slightly changed version of the DNA or RNA.

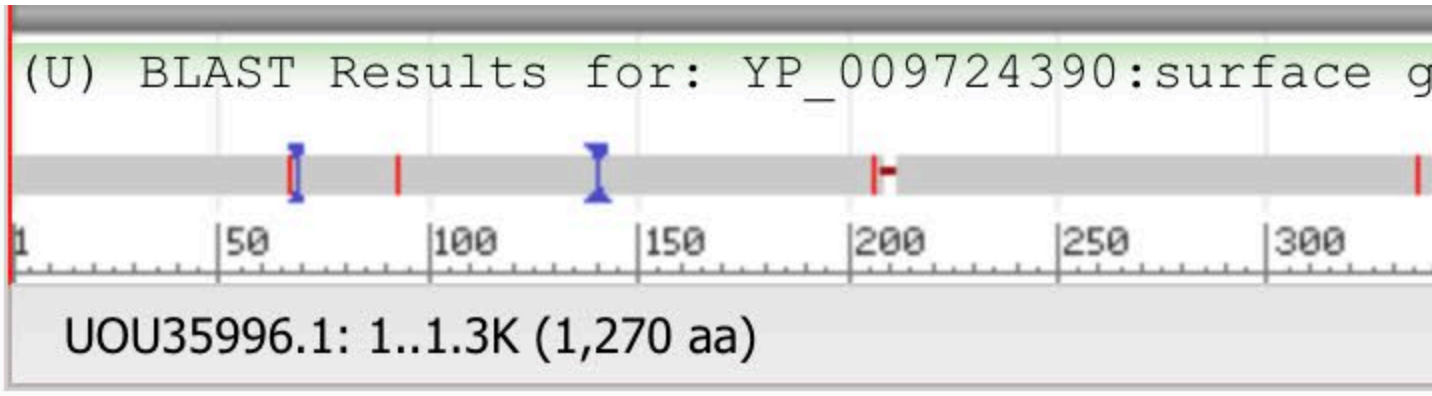
A virus that does not kill its host but is able to keep using the host to replicate itself is able to continue replicating. There is an advantage to a virus developing a way to become chronic or endemic, rather than being rabidly lethal to the host.

By every indication, that is what is happening with SARS-CoV-2, the novel virus that likely originated in Wuhan, China, and quickly spread around the globe, using humans and other animals as its host.

Anti-Spike Antibodies

Many of the mutations to the SARS-CoV-2 RNA do not change any of the proteins the virus needs to survive and proliferate. These are called silent or synonymous mutations. Others, known to scientists as non-synonymous mutations, do change the amino acid composition of the proteins.

The amino acid sequence differences (about 3 percent) observed between SARS-CoV-2 spike proteins from the original Wuhan strain (GenBank # YP_009724390) and an Omicron isolate from Norway on January 3rd, 2022 (GenBank # UOU35996.1) are the results of two years of evolution of the virus on its spike protein.



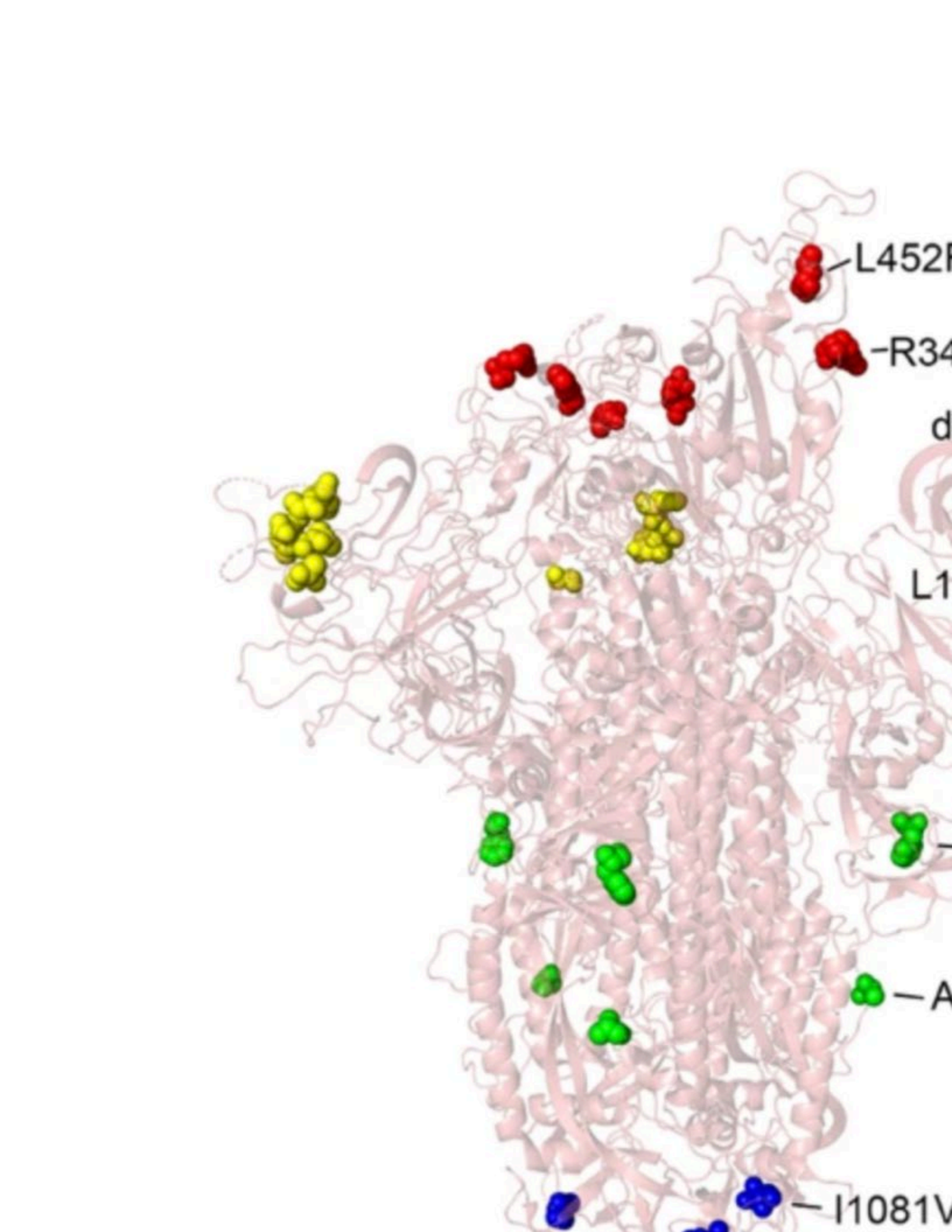
(National Library of Medicine's online Blast service)

Using the National Library of Medicine's online Blast service, the authors compared the spike protein sequences from the Wuhan strain and an Omicron variant. The red lines highlight the mismatches.

Compared to other parts of the virus genome, the gene that codes for the spike protein evolve faster, as the spike protein is on the surface of the virus and is under much more selection pressure.

This poses a problem for the current vaccines and any future vaccines based on the spike protein. The fast-changing spike protein would likely make the existing vaccines and any new vaccines less effective. In other words, the virus has moved on, but the vaccines have not.

Existing vaccines based on the spike protein generate multiclonal antibodies against different epitopes of the spike protein. If an antibody reacts to an epitope that is not affected by the mutations that Omicron has, then this antibody would be effective against Omicron. Otherwise, it will not be effective.


L452
R34
d
L1
A
I1081V

Structure of SARS-CoV-2 Omicron spike protein mapped with the novel mutations.
(Source: Tracking SARS-CoV-2 Omicron diverse spike gene mutations identifies multiple inter-variant recombination events)

When most, if not all antibodies that the COVID-19 mRNA vaccines developed based on the original Wuhan strain fails to react to the current SARS-CoV-2 variant, the vaccine becomes ineffective.

Vaccinated Have Negligible Antibodies Against Current Strain

In the new Harvard study, the scientists tested 27 participants who had been vaccinated with Pfizer's messenger RNA vaccine (BNT162b2) and 27 participants who had been infected naturally with the original Wuhan strain.

Most of those who had had COVID already had also been vaccinated, so most, but not all, had hybrid immunity.

Those who had recovered from COVID had a strong immune response to the original virus, which is no longer circulating in the world.

But those who had been vaccinated just six months prior to the test had only 1 percent as many antibodies as those who had recovered from having the virus.

Participants who had been boosted just two weeks before the test and were at the peak of their immunity did have a strong response, though it was still half as strong as those with natural immunity. Evidently their vaccine-acquired immune response was not long lasting, either.

And these results were only for the original, outdated virus, which is no longer a danger.

Against the strain currently dominant in the United States, those who had been vaccinated, even at the peak of their protection two weeks after the booster, had a very scant antibody response to the current virus, about 7 percent as strong as their antibody response to the original 2020 virus.

Those who were vaccinated six months before, but not boosted, had negligible antibodies against the current virus.

Natural Immunity Provides Substantial Immune Response

Those with natural immunity after recovering from COVID had a substantial immune response to the current virus.

Though it was only 10 percent as strong as their response to the original 2020 virus, their immune systems still responded with three times as many antibodies as the boosted group's peak response.

More importantly, compared to immunity acquired through the spike-protein-based vaccines, natural immunity from SARS-CoV-2 infections covers the whole spectrum of immunity, giving the body short-term antibody protection as well as memory B and T cells for long-term protection. In addition, the short-term antibodies cover not only the fast-changing spike protein (S), but also other viral proteins, such as nucleocapsid protein (N) and envelope protein (E), making natural immunity less vulnerable for immune escape.

The takeaway is that even for the brief period right after a booster, vaccination was not as effective as natural immunity. Six months later, it was essentially useless.

The good news is that almost everyone in the U.K. has SARS-CoV-2 antibodies. This suggests that almost everyone there has had a SARS-CoV-2 infection at some point, and so has some level of natural immunity.

This does not mean that COVID-19 is over. It does mean that nature has provided people in the U.K. with protection better than the current spike-protein-based vaccines. We believe that the same is true in the United States and Canada.

Take the jab, if you want, and get the boosters. But don't be fooled. They will not give you any more protection than what you already have.

DRAFT: School Boards Secure Storage Notification Resolution for States with Safe Storage or Child Access Prevention Laws

Whereas, Evidence strongly suggests that secure firearm storage is an essential component to any effective strategy to keep schools and students safe;

Whereas, An estimated 4.6 million American children live in households with at least one loaded, unlocked firearm;

Whereas, Every year, roughly 350 children under the age of 18 unintentionally shoot themselves or someone else. That's roughly one unintentional shooting per day, and 70 percent of these incidents take place inside a home;

Whereas, Another 1,200 children and teens die by gun suicide each year, most often using guns belonging to a family member;

Whereas, In incidents of gun violence on school grounds, 75 percent of active shooters are current students or recent graduates, and up to 80 percent of shooters under the age of 18 obtained their guns from their own home, a relative's home, or from friends;

Whereas, Research shows that secure firearm storage practices are associated with up to an 85 percent reduction in the risk of unintentional firearm injuries among children and teens;

Whereas, The U.S. Secret Service National Threat Assessment Center recommends the importance of appropriate storage of weapons because many school attackers used firearms acquired from their homes;

Whereas, Across the country, lawmakers, community members, and local leaders are working together to implement public awareness campaigns, such as the Be SMART program, which is endorsed by the National PTA and which encourages secure gun storage practices and highlights the public safety risks of unsecured guns;

Whereas, School districts across the country have begun to proactively send materials home to parents and guardians informing them of applicable firearm storage laws and firearm secure storage best practices;

Whereas, Keeping students, teachers and staff safe from the threat of gun violence should be the responsibility of all adult stakeholders at each of our school sites;

Whereas, State law imposes penalties on adults when a child gains unsupervised access to

unsecurely stored firearms;

Whereas, In order to continue with preventative measures to increase student and school safety we must act now; now therefore, be it

Resolved, That the Board directs the Superintendent and staff to update the Student Handbook to include information about parents' legal obligations regarding the secure storage of firearms;

Resolved further, That the Board directs the Superintendent to create an appropriate letter, in English and Spanish, to parents and guardians that explains the importance of secure gun storage and the legal obligations to protect minors from accessing irresponsibly stored guns, to be included in annual registration materials at each school site, and requiring a signature acknowledging awareness of secure gun storage responsibilities; and, be it finally;

Resolved, That the Board and the Superintendent will continue to work with local law enforcement agencies, health agencies and non-profits to collaborate and increase efforts to inform District parents of their obligations regarding secure storage of firearms in their homes.

VACCINES & SAFETY

Fauci Makes Surprising Concession Regarding COVID-19 Vaccines

By Jack Phillips

July 13, 2022 Updated: July 14, 2022

Print
0:002:58

1

White House COVID-19 adviser Anthony Fauci conceded Wednesday morning that COVID-19 vaccines don't protect "overly well" against the virus.

Speaking during a Fox News interview, Fauci told host Neil Cavuto that "one of the things that's clear from the data [is] that ... vaccines—because of the high degree of transmissibility of this virus—don't protect overly well, as it were, against infection."

But Fauci said later that the vaccines "protect quite well against severe disease leading to hospitalization and death" before he made note of his recent COVID-19 diagnosis.

"At my age, being vaccinated and boosted, even though it didn't protect me against infection, I feel confident that it made a major role in protecting me from progressing to severe disease," said Fauci, who is 81 and has worked in various capacities in the federal government since the late 1960s. He's also headed the National Institute of Allergy and Infectious Diseases since the Reagan administration.

Fauci then said it's because of the vaccination that it is "very likely why I had a relatively mild course."

Natural Immunity

The official's comments come just days after a bombshell study revealed that natural immunity, or the immunity conferred via a previous COVID-19 infection, provides superior protection against the virus when compared with vaccines.

Researchers in Qatar said that individuals who survived a COVID-19 infection and weren't vaccinated had very high protection against severe or fatal disease.

"Effectiveness of primary infection against severe, critical, or fatal COVID-19 reinfection was 97.3 percent … irrespective of the variant of primary infection or reinfection, and with no evidence for waning. Similar results were found in sub-group analyses for those ≥50 years of age," Dr. Laith Abu-Raddad of Weill Cornell Medicine–Qatar wrote.

But the researchers noted that both natural and artificial immunity conferred via vaccines waned over time. People who were previously infected with COVID-19 and were not vaccinated had half the risks of reinfection as compared to those that were vaccinated with two doses but not infected.

During an interview with the Washington Post this week, Fauci suggested that Americans aged 5 to 50 should be allowed to get a second booster shot.

The federal government, he argued, "need[s] to allow people who are under 50 to get their second booster shot, since it may have been months since many of them got their first booster."

"If I got my third shot [in 2021], it is very likely the immunity is waning," Fauci proclaimed.

Marina Zhang contributed to this report.

Jack Phillips

BREAKING NEWS REPORTER

February 22, 2022

Rochelle P. Walensky, MD, MPH
Director, Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30329

Anthony S. Fauci, MD
Director, National Institute of Allergy and Infectious Diseases
National Institutes of Health
31 Center Dr # 7A03
Bethesda, MD 20892

Honorable Senator Ronald H. Johnson
328 Hart Senate Office Building
Washington DC 20510

Douglas L. Parker,
Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210

Mr. Jeffrey Zients
Coordinator and Counselor to the President
COVID-19 Pandemic Response
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Sent via US Mail Certified Return Receipt and e-mail

Re: Request for Immediate Corrections to the CDC Guidance on Masks and Respirators

Dear Dr. Walensky, Dr. Fauci, Senator Johnson, Mr. Parker, and Mr. Zients:

We the undersigned, professional experts in the field of industrial hygiene, with combined experience of nearly 150 years, are highly concerned with the inaccurate and misleading guidance being promoted by the CDC on its website regarding efficacy of masking to prevent COVID-19 and now similar guidance regarding respirators and request for immediate correction to said guidance. The guidance is overly broad, inaccurate, and especially inappropriate for children and the general public.

For reference, the field of industrial hygiene is defined as:

> *"That science and art devoted to the anticipation, recognition, evaluation, and control of those environmental factors or stressors arising in or from the workplace, which may cause sickness, impaired health and well-being, or significant discomfort among workers or among of the citizens of the community" (https://www.aiha.org/about-ih/Pages/default.aspx).*

The AIHA defines an Industrial Hygienist (https://www.aiha.org/ih-careers/discover-industrial-hygiene) as:

> *"Scientists and engineers committed to protecting the health and safety of people in the workplace and the community."*

Thus, our profession is dedicated, in part, to providing controls to exposures and rely upon what is known as the hierarchy of controls. The hierarchy of controls was first developed by the National Safety Council (NSC) in 1950. This guides us as to the most effective to least effective exposure controls (see Figure 1):

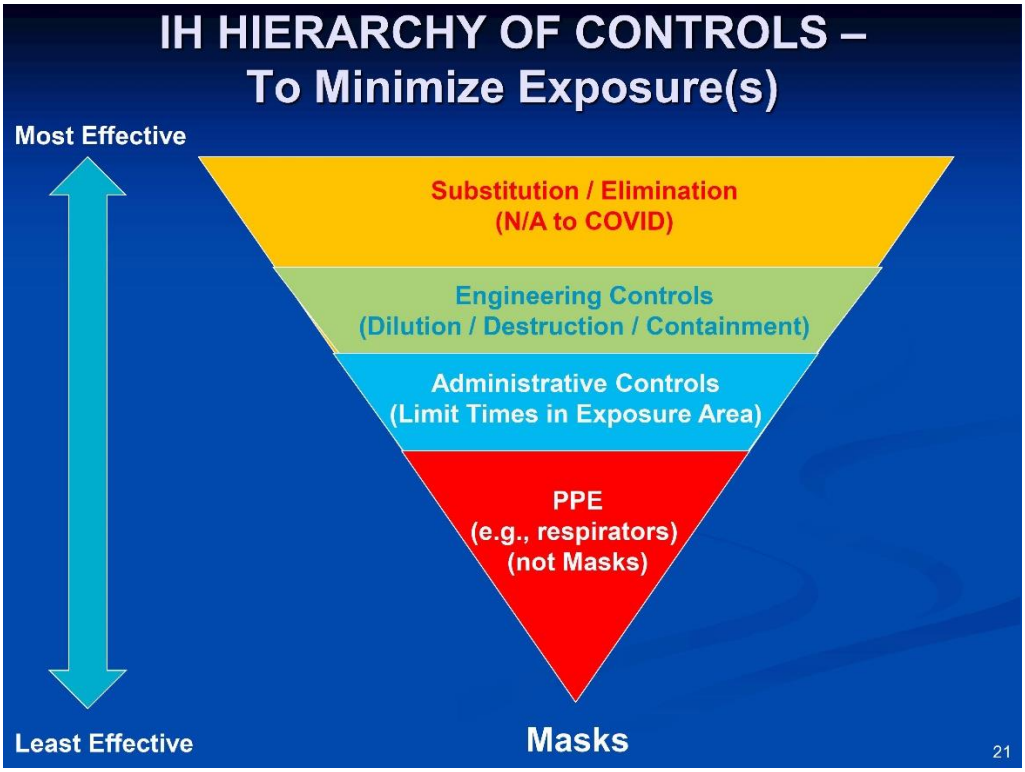
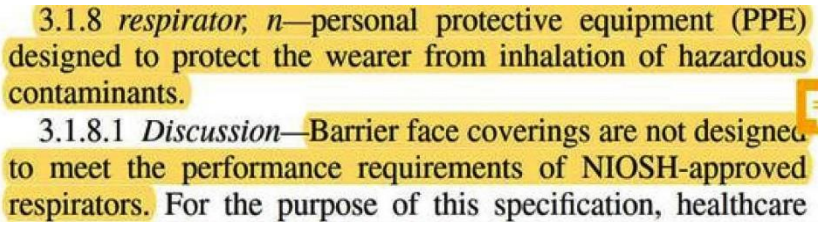


Figure 1: Hierarchy of Controls

Note that masks do not fit into the hierarchy of controls simply because they are not even personal protective equipment. This is recognized in the recent ASTM Face Covering (mask) Standard [ASTM F3502-21 – Standard Specification for Barrier Face Coverings (BFCs)] illustrated in Figure 2:



3.1.8 *respirator, n*—personal protective equipment (PPE) designed to protect the wearer from inhalation of hazardous contaminants.

3.1.8.1 *Discussion*—Barrier face coverings are not designed to meet the performance requirements of NIOSH-approved respirators. For the purpose of this specification, healthcare

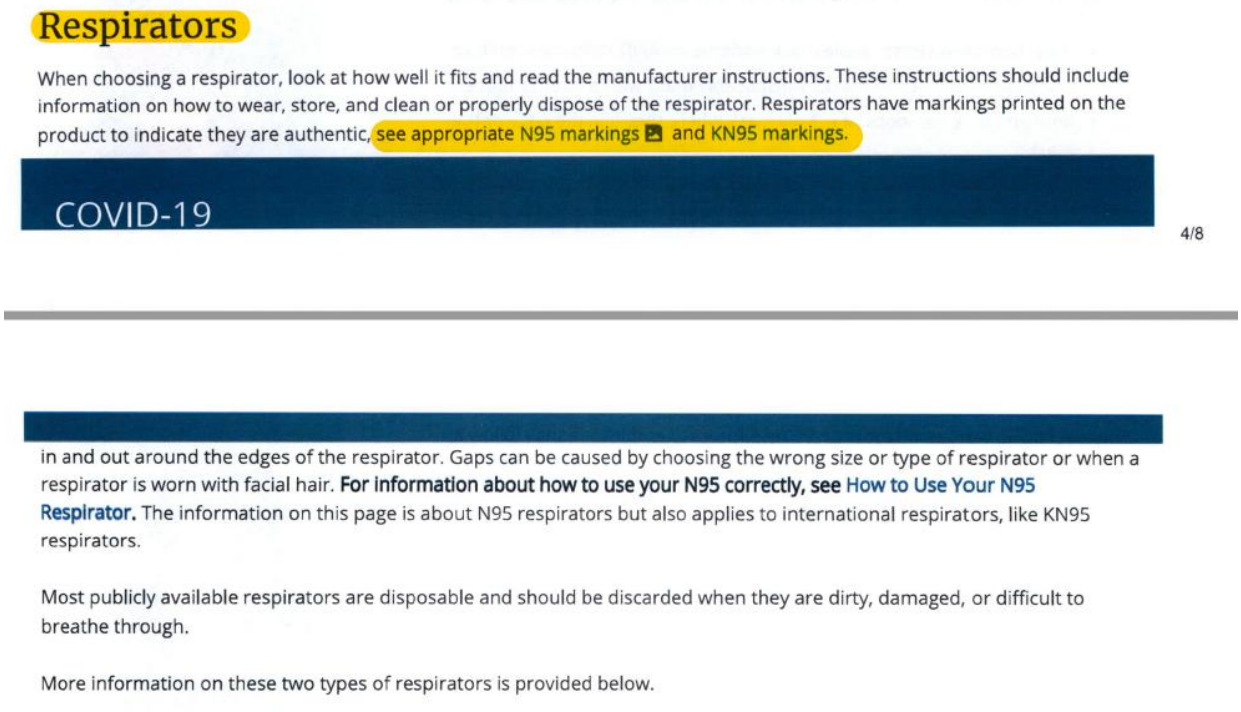
Figure 2: ASTM 2021 BFC Standard – Masks Not PPE (Respirators)

The best industrial hygiene solution has for decades been engineering controls of dilution with fresh air, filtration, and/or destruction – all of which are readily available technologies.

Given this background, we the undersigned have been increasingly concerned about the mis-information provided by the CDC to the public; often reflected by inappropriately conclusive language that *omits technical limitations and documented negative effects associated with masks and face coverings*. Examples of our concerns follow:

Issue #1: Recommending N-95 type masks is inappropriate for the general population and children:

The CDC's January 14, 2022 and January 28, 2022 webpage language have instructed people to move away from masks and toward N95-type respirators (see for example https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html), including KN95 respirators (Figure 3):



Respirators

When choosing a respirator, look at how well it fits and read the manufacturer instructions. These instructions should include information on how to wear, store, and clean or properly dispose of the respirator. Respirators have markings printed on the product to indicate they are authentic, see appropriate N95 markings and KN95 markings.

COVID-19

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in and out around the edges of the respirator. Gaps can be caused by choosing the wrong size or type of respirator or when a respirator is worn with facial hair. **For information about how to use your N95 correctly, see** How to Use Your N95 Respirator. The information on this page is about N95 respirators but also applies to international respirators, like KN95 respirators.

Most publicly available respirators are disposable and should be discarded when they are dirty, damaged, or difficult to breathe through.

More information on these two types of respirators is provided below.

Figure 3: CDC January 14 & January 28, 2022 Guidance on Respirators – pgs. 4-5

Under the topic of respirators, the CDC lists both N95 and KN95 respirators.

Moreover, as the CDC knows, persons or entities providing respirators in the workplace (unlike masks) must follow OSHA's Personal Protective Equipment Standard (OSHA 29 CFR 1910.132) to establish the nature of the hazard (Hazards Assessment) and the Respiratory Protection Standard (RPS) requirements (29 CFR 1910.134). Non-employees must also follow the RPS under the manufacturers' instructions (as we shall show later). These RPS requirements are substantial and include factors such as:

- Written RPS Plan
- Medical Clearance
- Initial Fit Test
- Annual Fit Test
- Training by a professional such as an IH on fit testing, cleaning, storage, and changeout.

As the CDC knows, or should know, movement from masks to respirators comes with significant requirements or as the manufacturers such as 3M state on their instructions, improper usage "may result in sickness or death".

In this context, we have recently been provided by the following request, and rejection by OSHA, to investigate improper usage of KN respirators by an employer (Figure 4):

U.S. Department of Labor

Occupational Safety and Health Administration
Toledo Area Office
420 Madison Ave, Suite 600
Toledo, OH 43604

February 9, 2022

[redacted]

RE: OSHA Complaint No. 1864651

Dear [redacted]

The Occupational Safety and Health Administration (OSHA) has received your notice of alleged workplace hazard(s) against notified Gun Lake Casino. After careful review we have decided not to conduct an inspection because:

On the basis of the information provided to our office during our phone conversation the employer has provided and is requiring employees to wear KN95 masks which are not NIOSH certified respirators and would not be covered by OSHA's respiratory protection standard.

If you do not agree with this decision, you may contact me for a clarification of the matter at (419) 259-7542.

Section 11(c) of the OSH Act provides protection for employees against discrimination because of their involvement in protected safety and health related activity. If you believe you are being treated differently or action is being taken against you because of your safety or health activity, you may file a complaint with OSHA. You should file this complaint as soon as possible, since OSHA normally can accept only those complaints filed within 30 days of the alleged discriminatory action.

Thank you for your concern for a safe and healthful workplace.

Respectfully,

For

Todd Jensen
Area Director

Figure 4: OSHA February 9, 2022 Response Letter to Gun Lake Casino Complaint

OSHA rejected the employee complaint on a technicality that the employer was not following the OSHA RPS because the respirator was a KN95 rather than an N95. And, as shown in Figure 5, NIOSH does not approve KN95's:

CDC Centers for Disease Control and Prevention

Promoting productive workplaces through safety and health research NIOSH

NIOSH-approved N95 Particulate Filtering Facepiece Respirators

This list is reviewed and updated weekly.

Manufacturers Listed from A to Z – L

The N95 respirator is the most common of the seven types of particulate filtering facepiece respirators. This product filters at least 95% of airborne particles but is not resistant to oil-based particles.

This web page provides a table of NIOSH-approved N95 respirators listed by manufacturer from A-Z. You can find a specific manufacturer by clicking on the first letter of their name on the index below. Web links in the table go to the NIOSH Approval Holder's website. See the Notes section for information about private labels.

NIOSH entered a Memorandum of Understanding (MOU) in 2018 with the Food and Drug Administration (FDA). This MOU granted NIOSH the authority to approve surgical N95 filtering facepiece respirators. Prior to this MOU, both NIOSH and FDA approved and cleared surgical N95s. The **Model Number/Product Line in bold text followed by (FDA)** indicates these surgical N95 respirators in the table below. NIOSH also provides a table of the surgical N95 respirators approved prior to the MOU. Surgical N95 respirators approved under the MOU do not require FDA's 510(k) clearance. These NIOSH-approved surgical N95 respirators are only on the Certified Equipment List (CEL).

A respirator labeled as a KN95 respirator is expected to conform to China's GB2626 standard. NIOSH does not approve KN95 products or any other respiratory protective devices certified to international standards. For more information, view Factors to Consider When Planning to Purchase Respirators from Another Country.

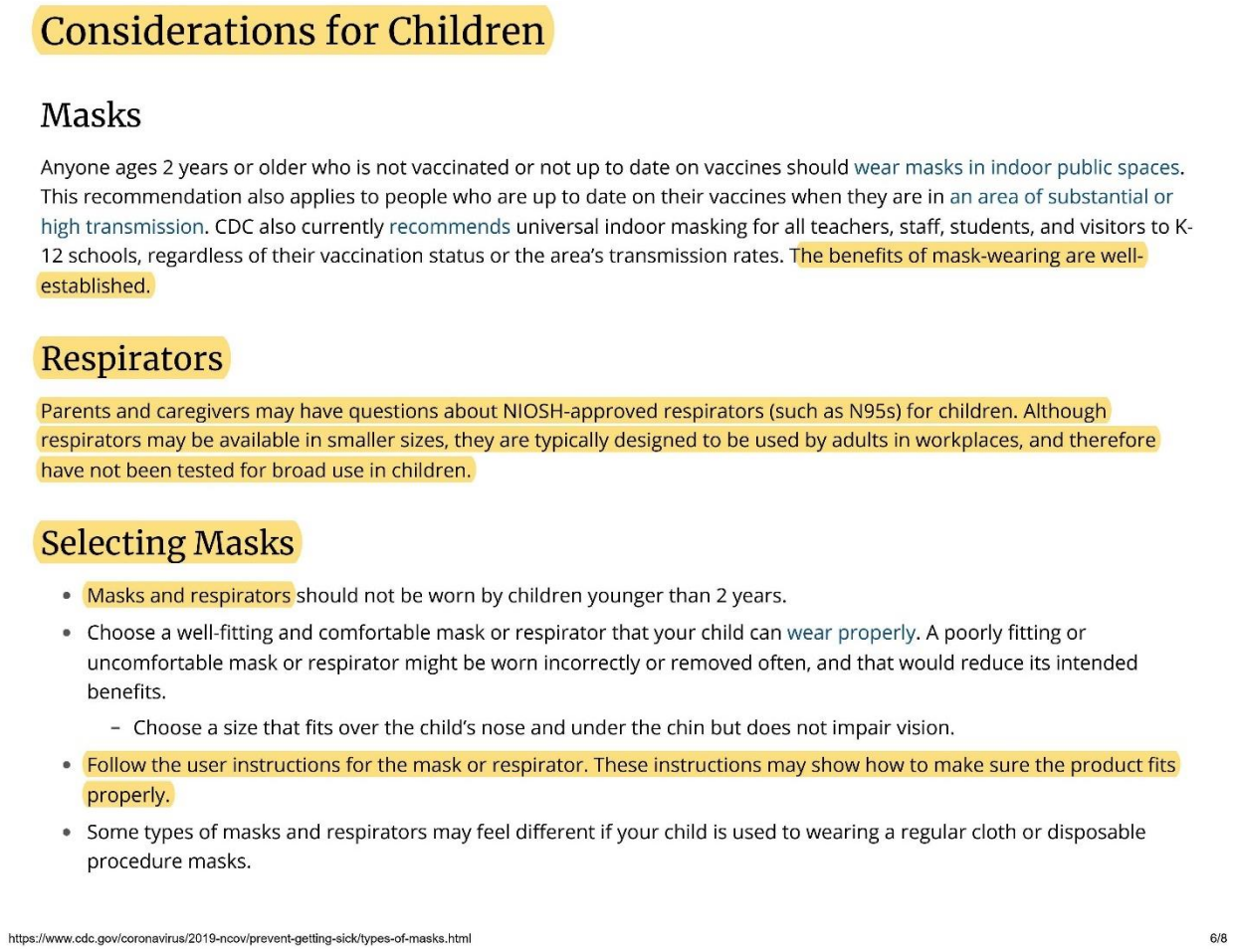
Figure 5: NIOSH Language Regarding Approval of KN95 Respirators

So, in an obvious case of deception, the CDC recommends the usage of N95 and KN95 respirators (see Figure 3) yet must know they are not approved by NIOSH and that OSHA will not enforce the RPS. The irony here is that NIOSH is part of the CDC (see Figure 5 letterhead), so the CDC clearly knows this. Note that it is known that KN95 respirators from China are known to be less expensive than those made with the N95 designation and find widespread usage; this too was known, or should have been known, by the CDC.

Thus, the CDC pushes KN95 respirators as part of the move toward respirators, knowing they are not approved by their sub-agency NIOSH, which allows employers to make employees wear respirators without the protections of OSHA's Respiratory Protection Standard (RPS). This is an unconscionable breach of the public health function and should be corrected immediately.

Issue #2: CDC has issued harmful guidance for masking children that contradicts manufacturers' recommendations, world-wide standard practice and CDC's own guidance, and without appropriate risk-benefit analysis:

The CDC's January 28, 2022 webpage language misleadingly implies respirators are acceptable for children yet knows that this is not the case simply based on manufacturer instructions, they link the reader to https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html – see Figure 6:



Considerations for Children

Masks

Anyone ages 2 years or older who is not vaccinated or not up to date on vaccines should wear masks in indoor public spaces. This recommendation also applies to people who are up to date on their vaccines when they are in an area of substantial or high transmission. CDC also currently recommends universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of their vaccination status or the area's transmission rates. The benefits of mask-wearing are well-established.

Respirators

Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. Although respirators may be available in smaller sizes, they are typically designed to be used by adults in workplaces, and therefore have not been tested for broad use in children.

Selecting Masks

- Masks and respirators should not be worn by children younger than 2 years.
- Choose a well-fitting and comfortable mask or respirator that your child can wear properly. A poorly fitting or uncomfortable mask or respirator might be worn incorrectly or removed often, and that would reduce its intended benefits.
  - Choose a size that fits over the child's nose and under the chin but does not impair vision.
- Follow the user instructions for the mask or respirator. These instructions may show how to make sure the product fits properly.
- Some types of masks and respirators may feel different if your child is used to wearing a regular cloth or disposable procedure masks.

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html 6/8

Figure 6: Misleading CDC Language Regarding Children Wearing Masks and Respirators

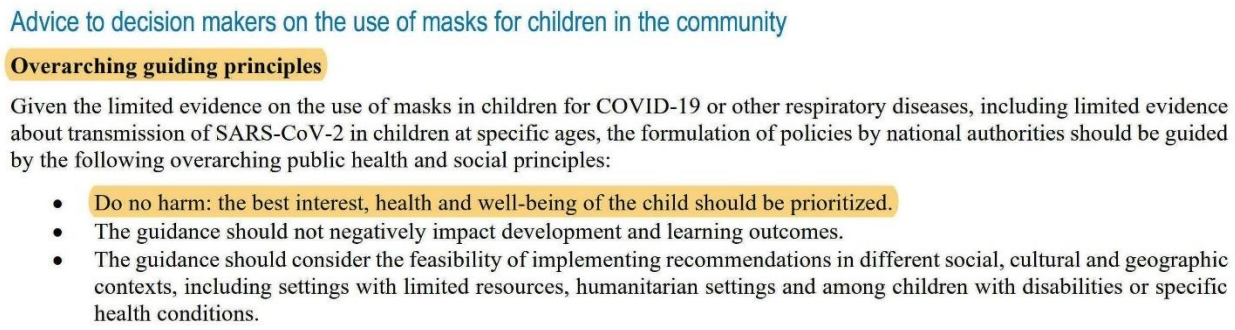
As illustrated in detail below, the CDC provided language in its January 28, 2022 guidance for children that is particularly misleading by obfuscating and omitting information readily known, or likely to have been known by the CDC.

<u>"The benefits of mask-wearing are well-established:"</u>

First, the benefits of children, or anyone for that matter, of wearing masks being well

established is simply false. A Brownstone paper by Paul Elias Alexander published December 21, 2021 (https://brownstone.org/articles/more-than-150-comparative-studies-and-articles-on-mask-ineffectiveness-and-harms/) shows both the effectiveness of masks and their harms, citing 150 studies. One of these author's testified in the Western District Court of Michigan on September 28, 2021, in a half-dozen interviews (e.g., Jeff Hayes Films: https://rumble.com/vrfoox-covid-revealed-episode-8b-bonus-video-stephen-petty.html), in his own podcasts (https://rumble.com/c/PettyPodcasts) and in the Liberty Dispatch in Canada (https://podcasts.apple.com/us/podcast/episode-99-masks-dont-work-an-interview-with-ppe/id1559570986?i=1000550149187). During this testimony it was shown that the nearly 50 studies cited by the CDC purportedly showing masks are effective did not support statements made by the CDC and most suffered from a lack of a control group (group similar to the mask study group not wearing masks) or cofounding factors (multiple factors such as changes in HVAC systems, distancing, quarantining, and masks) wherein one cannot determine the specific contribution by masking.

But the most egregious part of this statement is that it only addresses supposed benefits, not liabilities. Even the WHO - UNICEF (https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC_Masks-Children-2020.1) understands that risk-rewards analysis should be done before recommending unproven, unscientifically-supported policies before masking them. Remember – do no harm – is the overarching principle (Figures 7 & 8):



Advice to decision makers on the use of masks for children in the community

Overarching guiding principles

Given the limited evidence on the use of masks in children for COVID-19 or other respiratory diseases, including limited evidence about transmission of SARS-CoV-2 in children at specific ages, the formulation of policies by national authorities should be guided by the following overarching public health and social principles:

- Do no harm: the best interest, health and well-being of the child should be prioritized.
- The guidance should not negatively impact development and learning outcomes.
- The guidance should consider the feasibility of implementing recommendations in different social, cultural and geographic contexts, including settings with limited resources, humanitarian settings and among children with disabilities or specific health conditions.

Figure 7: WHO UNICEF Recommendations for Children and Masks

From Figure 7, the overarching guiding principle is to do no harm.

Advice on the use of masks in children

WHO and UNICEF advise decision makers to apply the following criteria for use of masks in children when developing national policies, in countries or areas where there is known or suspected community transmission[a] of SARS-CoV-2 and in settings where physical distancing cannot be achieved.

1. Based on the expert opinion gathered through online meetings and consultative processes, children aged up to five years should not wear masks for source control. This advice is motivated by a "do no harm" approach and considers:
    - childhood developmental milestones[b] [41]
    - compliance challenges and
    - autonomy required to use a mask properly.

The experts (following the methods described above) recognized that the evidence supporting the choice of the age cut-off is limited (see above, section related to transmission of COVID-19 in children), and they reached this decision mainly by consensus. The rationale included consideration of the fact that by the age of five years, children usually achieve significant developmental milestones, including the manual dexterity and fine motor coordination movements needed to appropriately use a mask with minimal assistance.

In some countries, guidance and policies recommend a different and lower age cut-off for mask use[42-45]. It is recognized that children may reach developmental milestones at different ages and children five years of age and under may have the dexterity needed to manage a mask. Based on the do no harm approach, if the lower age cut-off of two or three years of age is to be used for recommending mask use for children, appropriate and consistent supervision, including direct line of sight supervision by a competent adult and compliance need to be ensured, especially if mask wearing is expected for an extended period of time. This is both to ensure correct use of the mask and to prevent any potential harm associated with mask wearing to the child.

Children with severe cognitive or respiratory impairments who have difficulties tolerating a mask should, under no circumstances, be required to wear masks.

Other IPC, public health and social measures should be prioritized to minimize the risk of SARS-CoV-2 transmission for children five years of age and under; specifically maintaining physical distance of at least 1 meter where feasible, educating children to perform frequent hand hygiene and limiting the size of school classes. It is also noted that there may be other specific considerations, such as the presence of vulnerable persons or other local medical and public health advice that should be considered when determining if children five years of age and under need to wear a mask.

2. For children between six and 11 years of age, a risk-based approach should be applied to the decision to use of a mask. This approach should take into consideration:
    - intensity of transmission in the area where the child is and updated data/available evidence on the risk of infection and transmission in this age group;
    - social and cultural environment such as beliefs, customs, behaviour or social norms that influence the community and population's social interactions, especially with and among children;
    - the child's capacity to comply with the appropriate use of masks and availability of appropriate adult supervision;
    - potential impact of mask wearing on learning and psychosocial development; and
    - additional specific considerations and adaptions for specific settings such as households with elderly relatives, schools, during sport activities or for children with disabilities or with underlying diseases.

3. Advice on mask use in children and adolescents 12 years or older should follow the WHO guidance for mask use in adults[1] and/or the national mask guidelines for adults.

    Even where national guidelines apply, additional specific considerations (see below) and adaptions for special settings such as schools, during sport, or for children with disabilities or with underlying diseases will need to be specified.

Figure 8: WHO UNICEF Recommendations for Children and Masks by Age

Note that from Figure 8, WHO recommends against masking below age 6 and that children ages 6 to 11 may be masked upon completion of a risk assessment. England has similar guidance. But the CDC requires masks for children down to age 2 against WHO guidance and based on extensive reviews, has yet to perform any risk assessment on the net benefits of children wearing masks.

Specifically, it is well established that significant harms (i.e., reduced learning and development and physical, emotional, and social harms) have been reported in the literature (Figures 9-18):

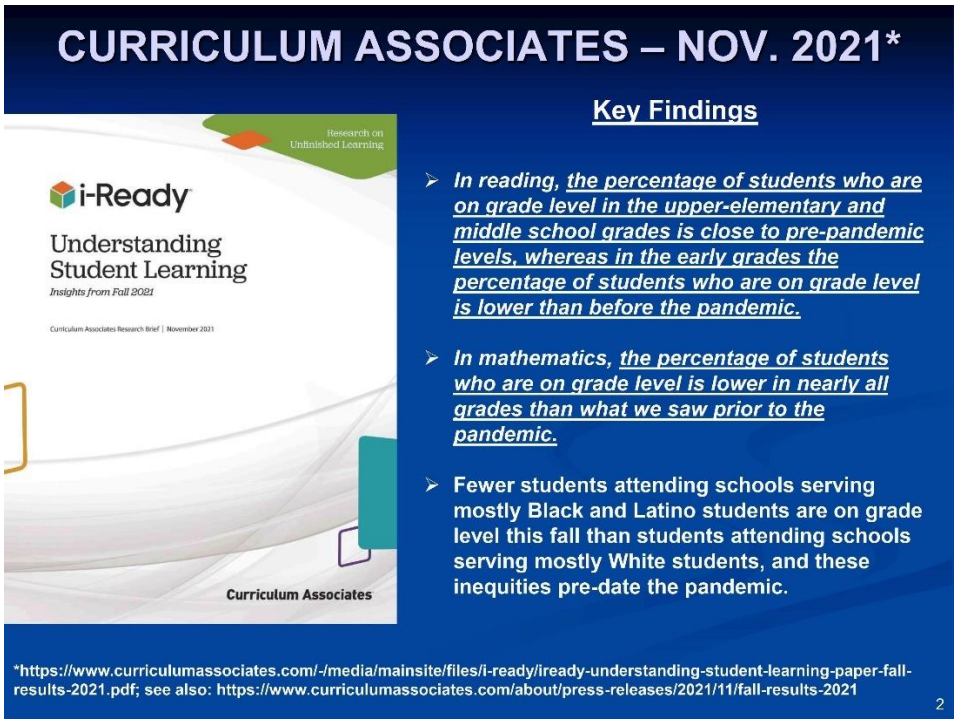


Figure 9: Curriculum Associates – Nov. 2021 – Title Page

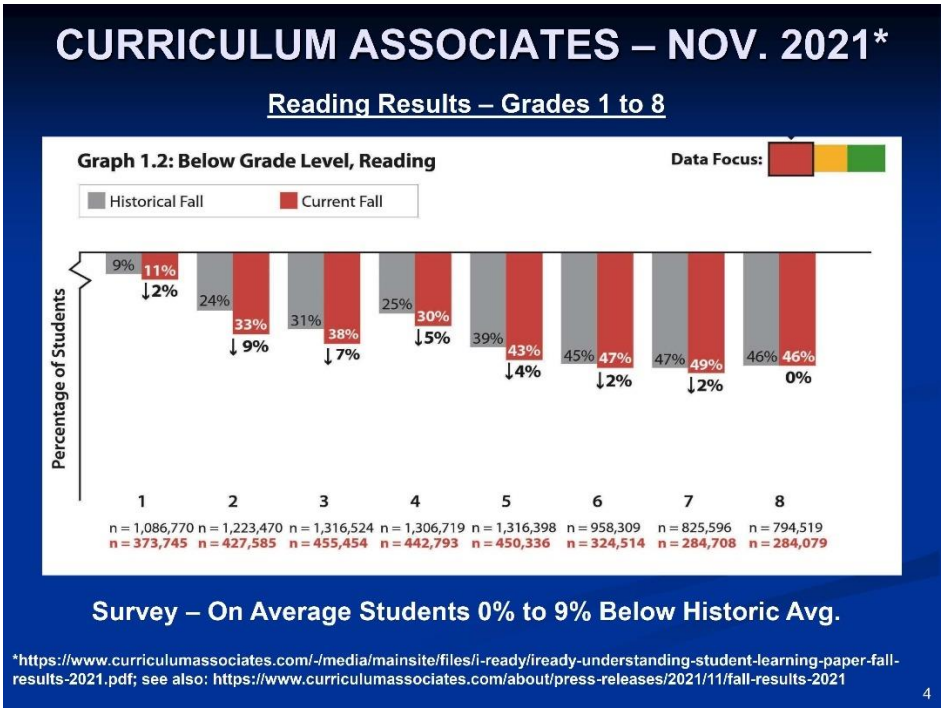


Figure 10: Curriculum Associates – Reading Deficits in 2021 vs. Prior Years

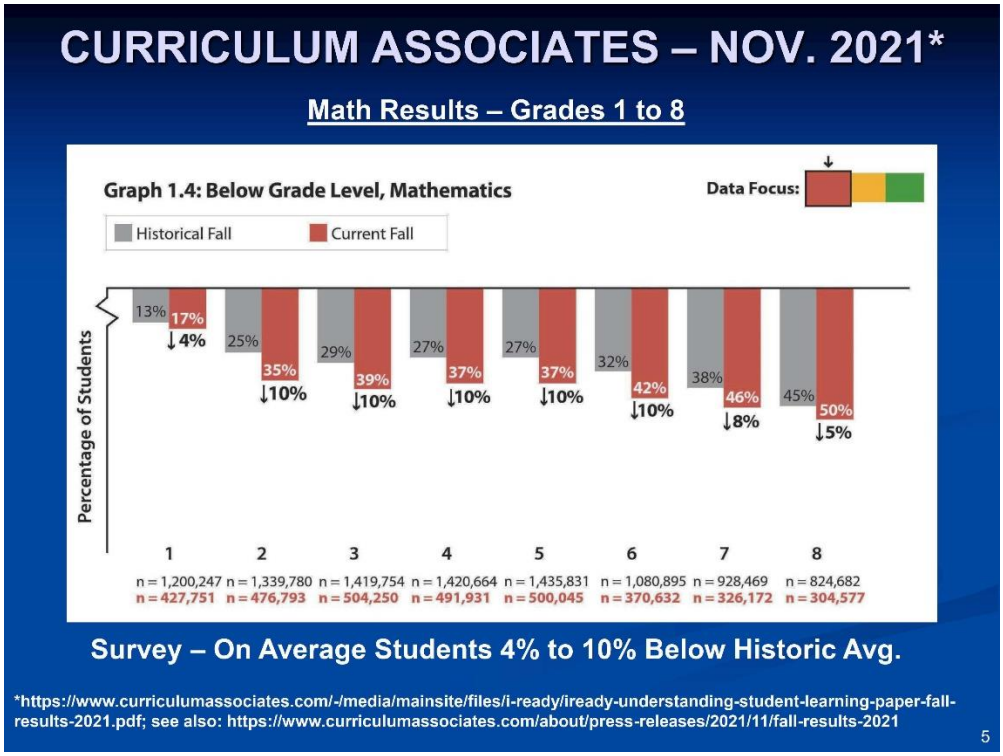


Figure 11: Curriculum Associates – Math Deficits in 2021 vs. Prior Years

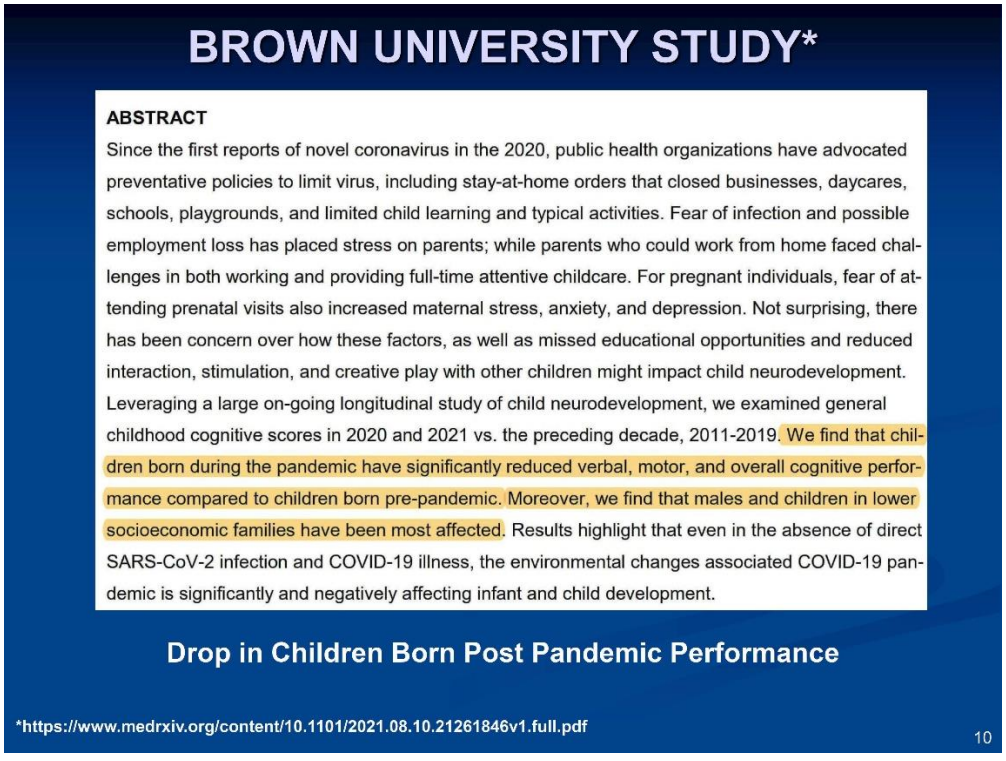


Figure 12: Brown University – Cognitive Deficits

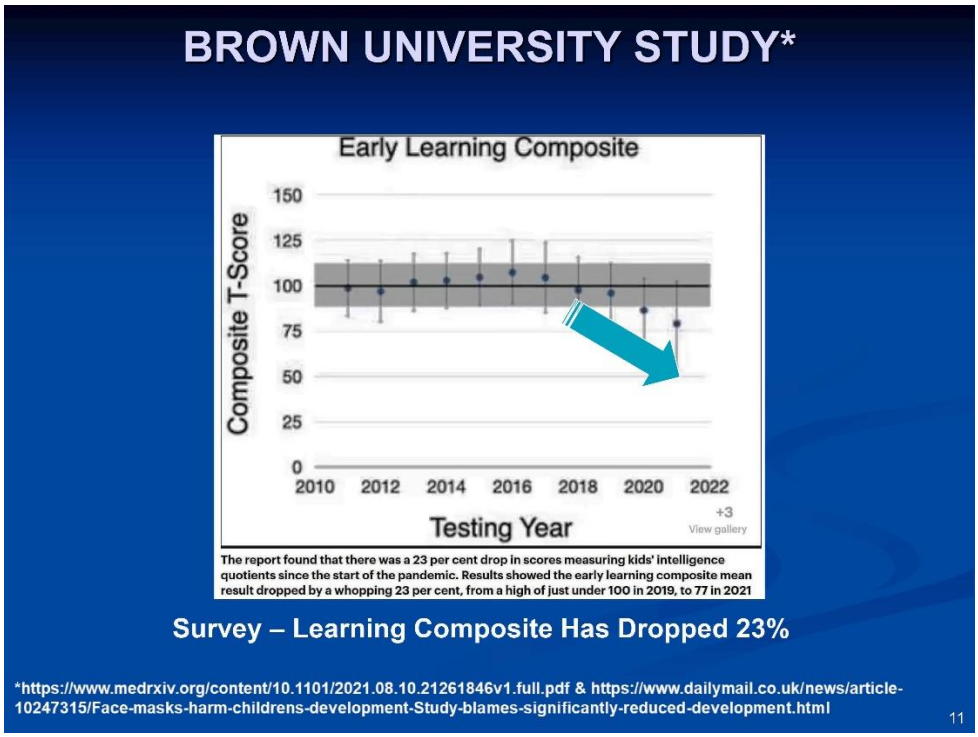


Figure 13: Brown University Study – Learning Loss of 23% for Children Born Since Pandemic

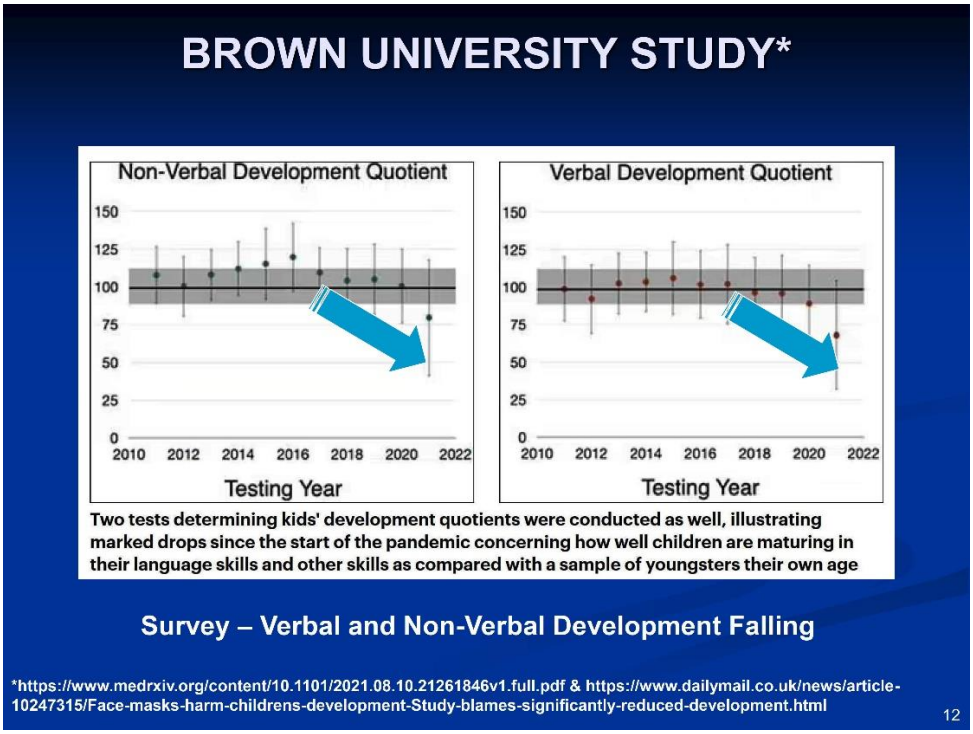


Figure 14: Brown University Study – Non-Verbal and Verbal Development Losses

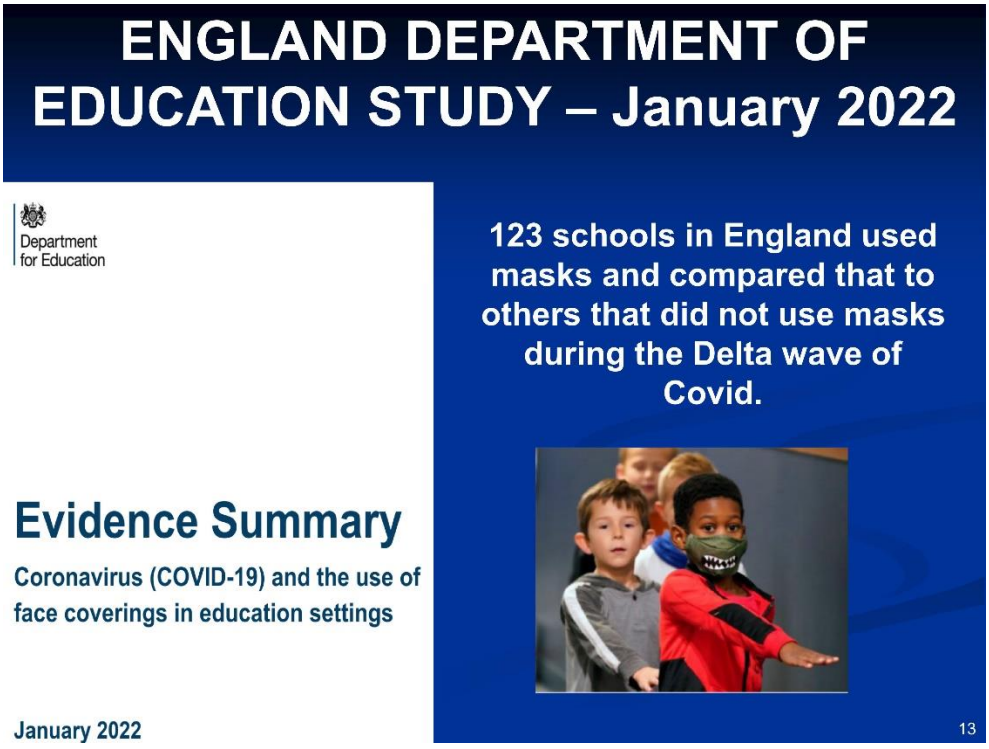


Figure 15: England Department of Education

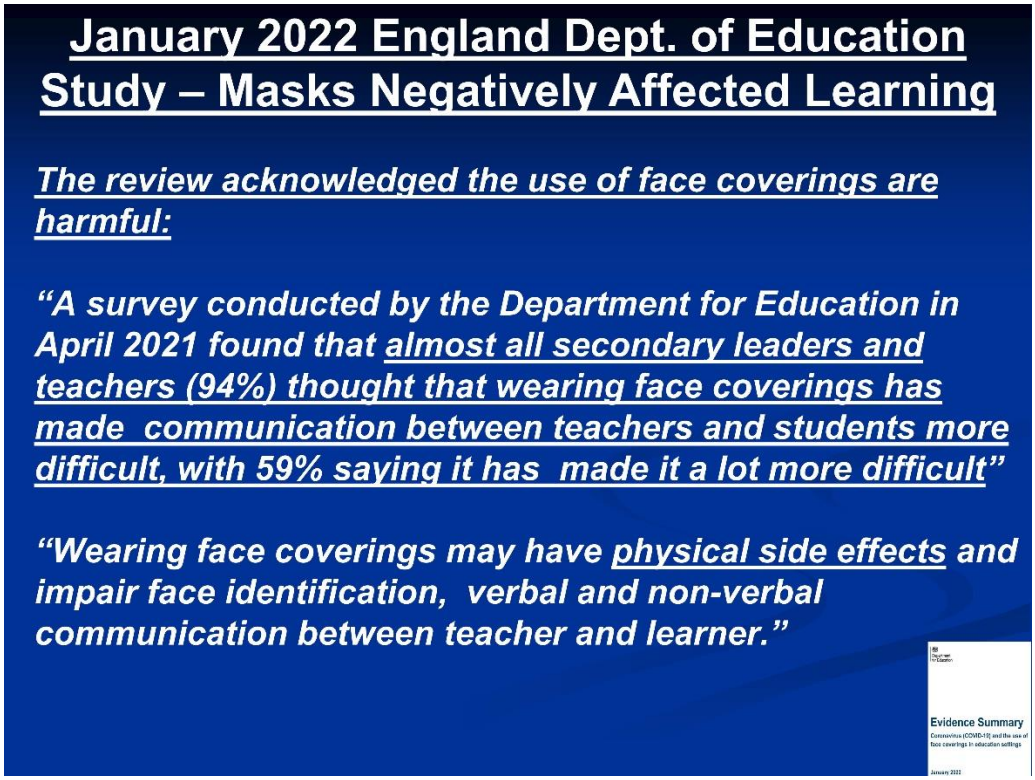


Figure 16: England Department of Education – Loss of Communication and Physical Effects

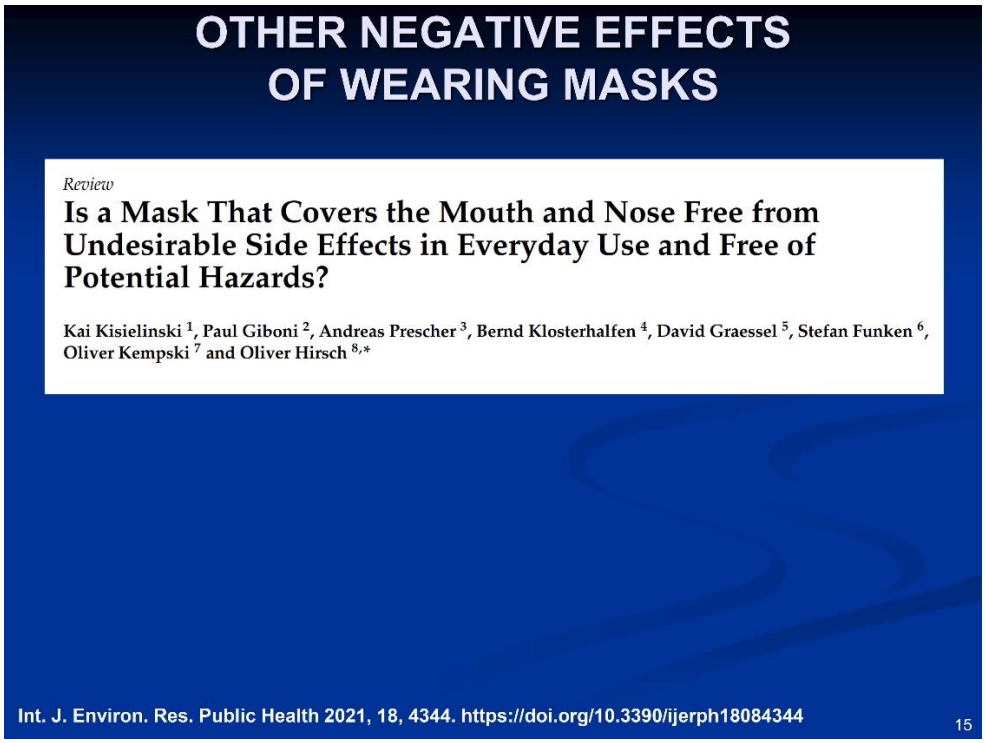


Figure 17: Kisielinski et al. – Mask Meta Study – Reviewed 1,226 Studies

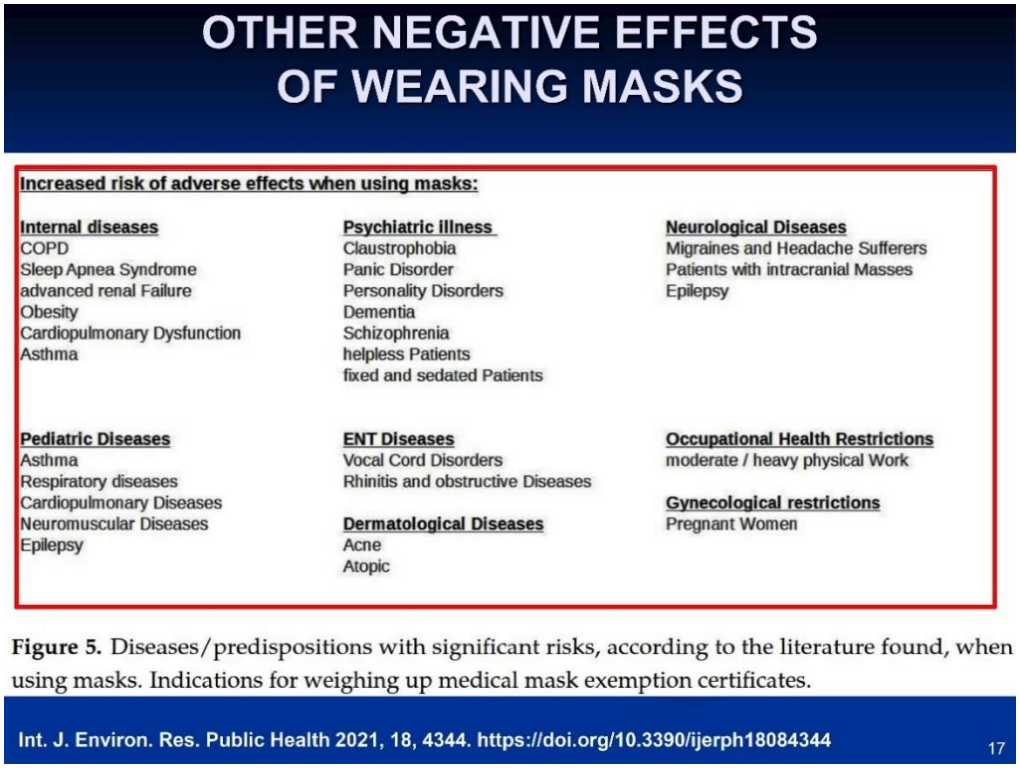


Figure 18: Kisielinski et al., – Areas of Quantitated Adverse Effects on Children and Adults

Clearly, the CDC has not conducted a net risk assessment and should have, and must do so to avoid continuing harms to children.

Even more disturbing, in their innocent looking, new Guidance for Children (Learn the Signs, Act Early) the CDC has in part, extended the timeframes for children to achieve learning outcomes (https://www.cdc.gov/ncbddd/actearly/milestones/index.html). Regarding these changes – Figure 19, CDC refers the reader to an American Academy of Pediatrics (AAP) webpage (https://publications.aap.org/pediatrics/article-abstract/doi/10.1542/peds.2021-052138/184748/Evidence-Informed-Milestones-for-Developmental?redirectedFrom=fulltext):

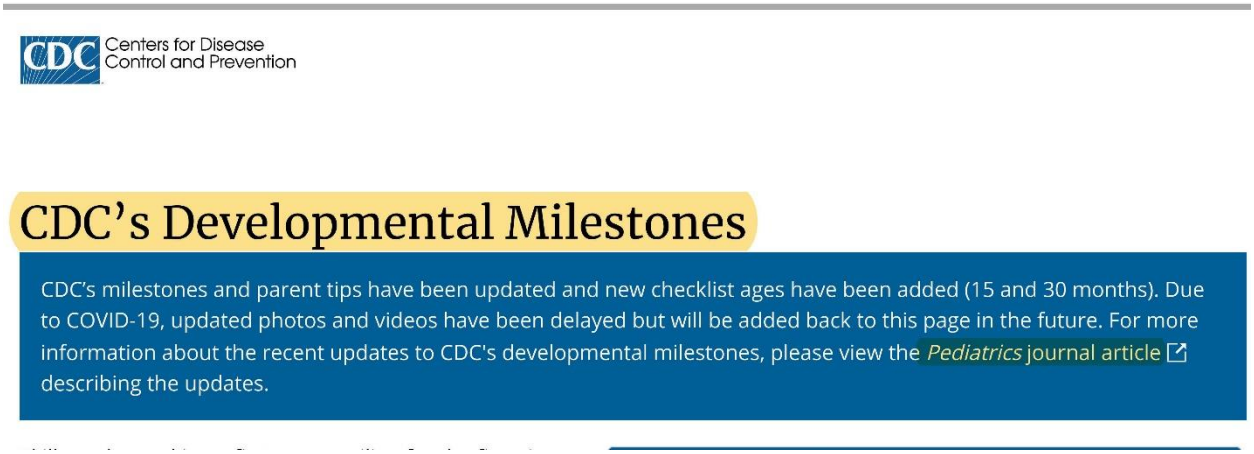


Figure 19: CDC Learn the Signs, Act Early New Webpage – Reference to AAP

The headlines for the reference paper are reproduced as Figure 20:

Figure 20: CDC Referenced AAP Paper by Zubler (CDC) et al. Dated February 8, 2022

Zubler et al., write in part:

"*The Centers for Disease Control and Prevention's (CDC) Learn the Signs. Act Early. program, funded the American Academy of Pediatrics (AAP) to convene an expert working group to revise its developmental surveillance checklists*. The goals of the group were to identify evidence-informed milestones to include in CDC checklists, clarify when most children can be expected to reach a milestone (to discourage a wait-and-see approach), and support clinical judgment regarding screening between recommended ages. Subject matter experts identified by the AAP established 11 criteria for CDC milestone checklists, including using milestones most children (≥75%) would be expected to achieve by specific health supervision visit ages and those that are easily observed in natural settings. A database of normative data for individual milestones, common screening and evaluation tools, and published clinical opinion was created to inform revisions. ***Application of the criteria established by the AAP working group and adding milestones for the 15- and 30-month health supervision visits resulted in a 26.4% reduction and 40.9% replacement of previous CDC milestones***. ***One third of the retained milestones were transferred to different ages; 67.7% of those transferred were moved to older ages.*** *Approximately 80% of the final milestones had normative data from ≥1 sources*. Social-emotional and cognitive milestones had the least normative data. These criteria and revised checklists can be used to support developmental surveillance, clinical judgment regarding additional developmental screening, and research in developmental surveillance processes. Gaps in developmental data were identified particularly for social-emotional and cognitive milestones.

Thus, at least 22.3% [67.7% of 33%] of the CDC child developmental milestones in place for ~18 years, were moved from a younger age to an older age in February 2022.

One must conclude the CDC, rather than acknowledging the harms being done to children's development by their COVID policies, including masking, is simply moving the goalposts for what constitutes normal child development rather than admitting and moving away from failed policies.

Statements under "Respirators" and "Selecting Masks":

- Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. *Although respirators may be available in smaller sizes,* ***they are typically designed to be used by adults in workplaces****, and therefore have not been tested for broad use in children*.
- ***Masks and respirators should not be worn by children younger than 2 years.***
- Choose a size that fits over the child's nose and under the chin but does not impair vision. ***Follow the user instructions for the mask or respirator.*** *These instructions may show how to make sure the product fits properly.*

This language may be the most misleading and egregious given that the links CDC provides to manufacturers' instruction state that their N95s are not for use with children – the CDC has to know this.

The links to manufacturers' instructions from the January 28, 2022 mask and January 25, 2022 How to Use Your N95 Respirator are shown in Figures 21 and 22 respectively:

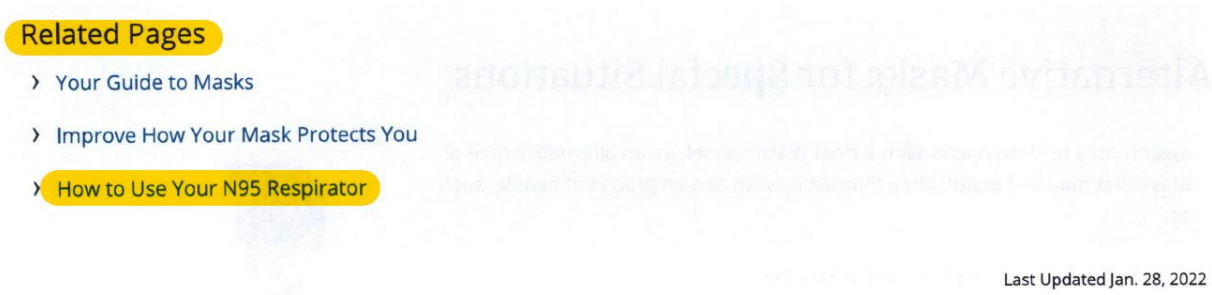


Figure 21: CDC January 28, 2022 Link – Bottom of Page and CDC January 25, 2022 Link to Manufacturers' Guidance and Warnings

The "How to Use Your N95 Respirator" is at the bottom of the CDC January 28, 2022 webpage.

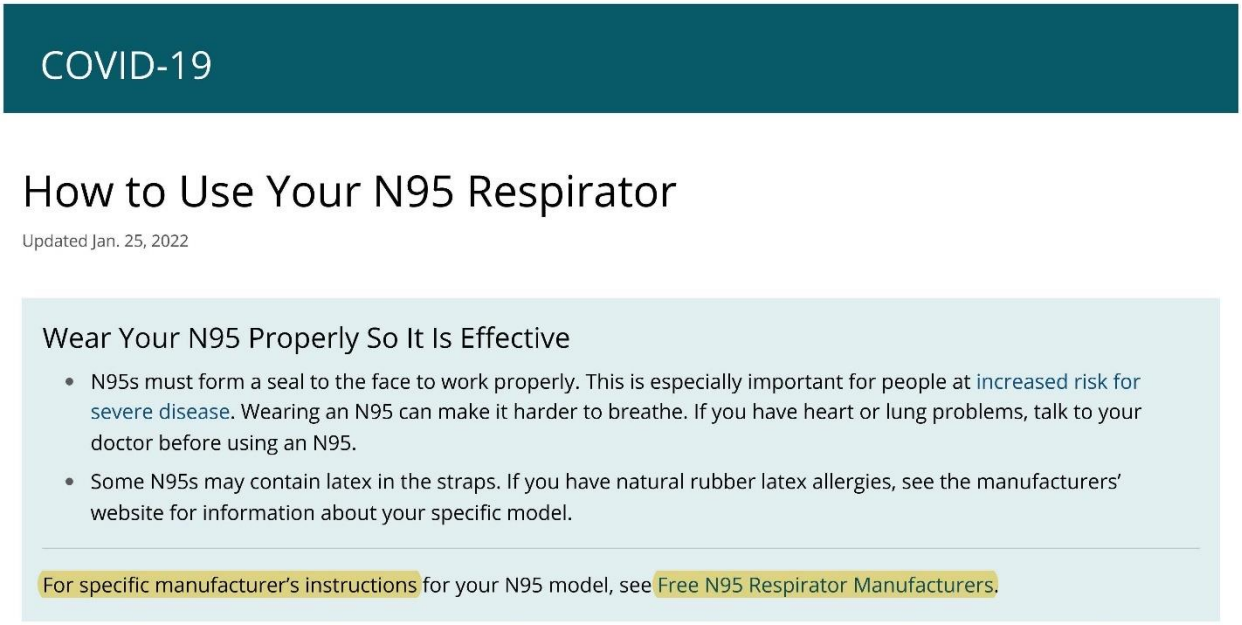


Figure 22: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers

The link in turn takes one to the following page (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/free-n95-manufacturers.html) (Figure 23):

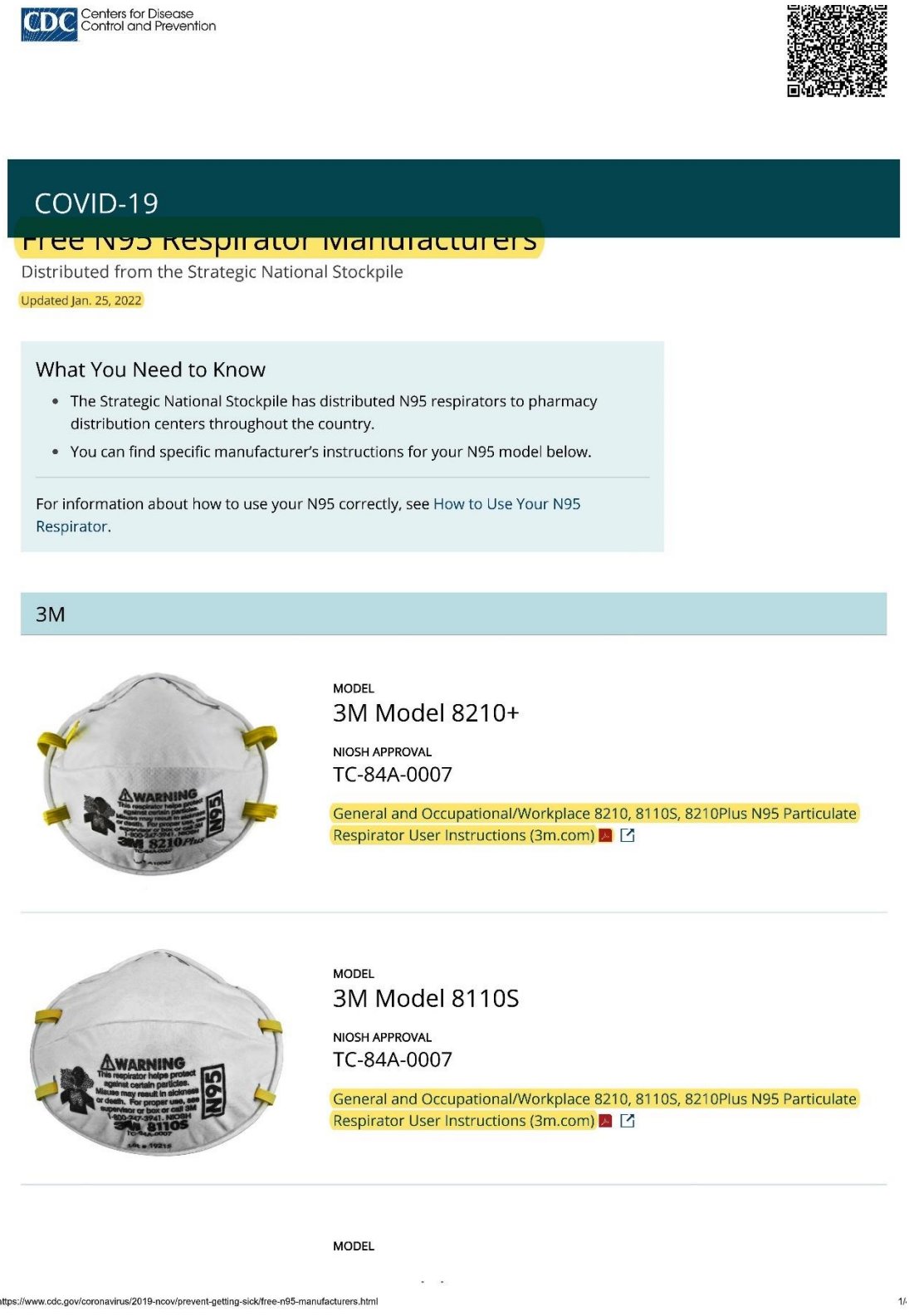


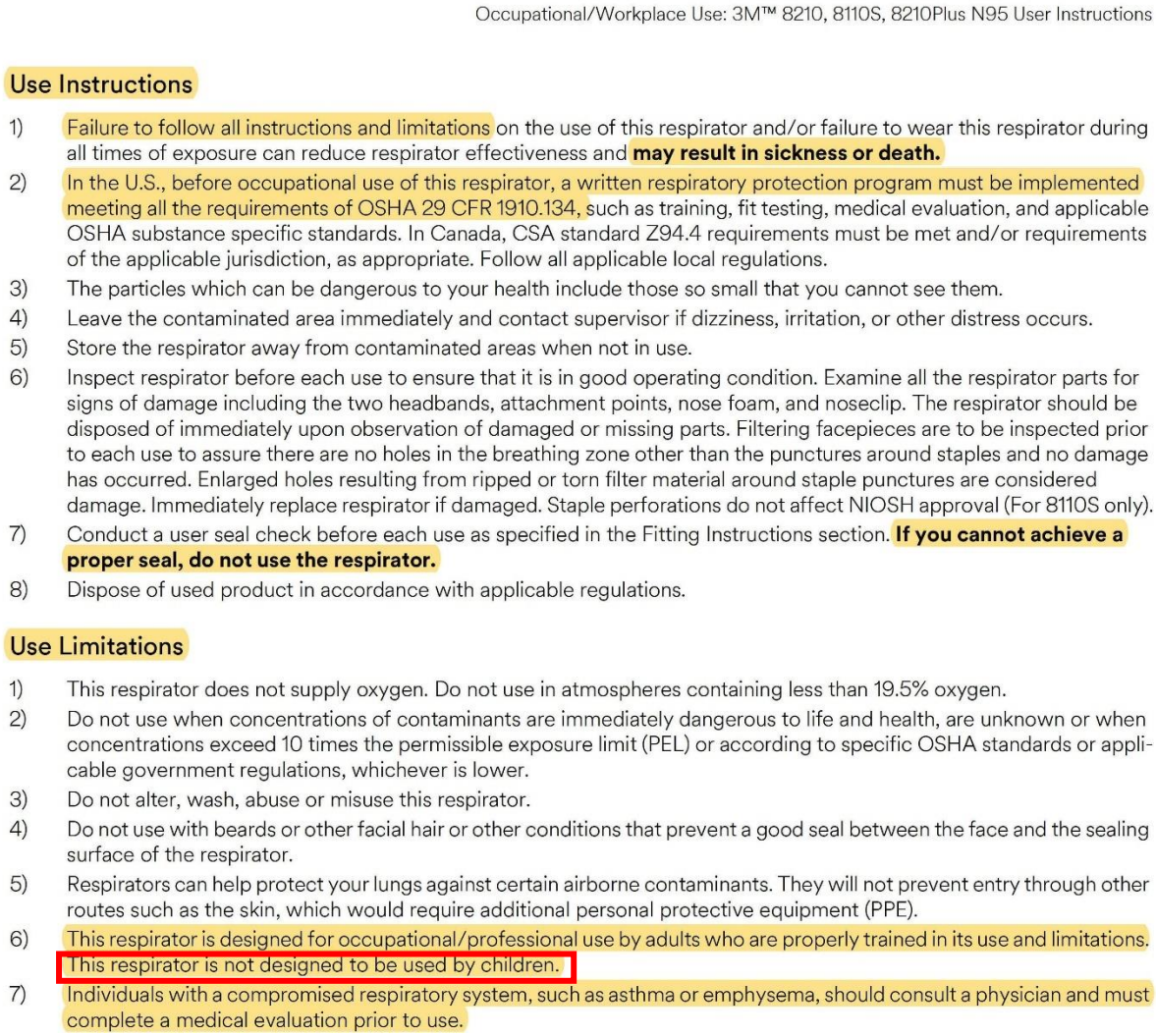
Figure 23: CDC January 15, 2022 Link to How to Use Your N-95 Respirator – Link to Manufacturers – pg. 1

From this webpage, four manufacturers are listed representing 12 respirators:

- 3M (6 models)
- Drager (1 model)
- Honeywell (2 models)
- Moldex (3 models).

For each model, the link can be clicked to get directly to the manufacturers' instructions for each respirator. For 3M and Moldex, major suppliers, only one set of instructions is used for each of their individually listed respirators. In other words, the same instructions were provided for each of the manufacturers' listed products.

Both 3M and Moldex explicitly state that their masks are not to be use by children (Figure 24).



Occupational/Workplace Use: 3M™ 8210, 8110S, 8210Plus N95 User Instructions

Use Instructions

1) Failure to follow all instructions and limitations on the use of this respirator and/or failure to wear this respirator during all times of exposure can reduce respirator effectiveness and **may result in sickness or death.**
2) In the U.S., before occupational use of this respirator, a written respiratory protection program must be implemented meeting all the requirements of OSHA 29 CFR 1910.134, such as training, fit testing, medical evaluation, and applicable OSHA substance specific standards. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Follow all applicable local regulations.
3) The particles which can be dangerous to your health include those so small that you cannot see them.
4) Leave the contaminated area immediately and contact supervisor if dizziness, irritation, or other distress occurs.
5) Store the respirator away from contaminated areas when not in use.
6) Inspect respirator before each use to ensure that it is in good operating condition. Examine all the respirator parts for signs of damage including the two headbands, attachment points, nose foam, and noseclip. The respirator should be disposed of immediately upon observation of damaged or missing parts. Filtering facepieces are to be inspected prior to each use to assure there are no holes in the breathing zone other than the punctures around staples and no damage has occurred. Enlarged holes resulting from ripped or torn filter material around staple punctures are considered damage. Immediately replace respirator if damaged. Staple perforations do not affect NIOSH approval (For 8110S only).
7) Conduct a user seal check before each use as specified in the Fitting Instructions section. **If you cannot achieve a proper seal, do not use the respirator.**
8) Dispose of used product in accordance with applicable regulations.

Use Limitations

1) This respirator does not supply oxygen. Do not use in atmospheres containing less than 19.5% oxygen.
2) Do not use when concentrations of contaminants are immediately dangerous to life and health, are unknown or when concentrations exceed 10 times the permissible exposure limit (PEL) or according to specific OSHA standards or applicable government regulations, whichever is lower.
3) Do not alter, wash, abuse or misuse this respirator.
4) Do not use with beards or other facial hair or other conditions that prevent a good seal between the face and the sealing surface of the respirator.
5) Respirators can help protect your lungs against certain airborne contaminants. They will not prevent entry through other routes such as the skin, which would require additional personal protective equipment (PPE).
6) This respirator is designed for occupational/professional use by adults who are properly trained in its use and limitations. This respirator is not designed to be used by children.
7) Individuals with a compromised respiratory system, such as asthma or emphysema, should consult a physician and must complete a medical evaluation prior to use.

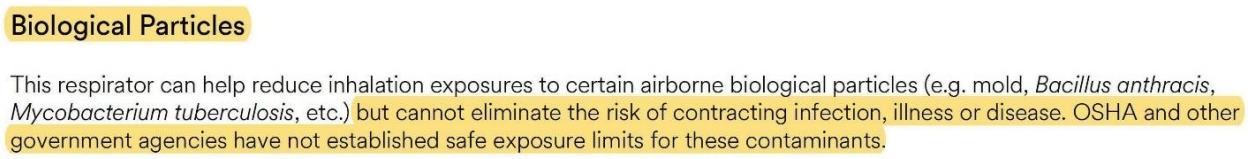
Figure 24: 3M Instructions for CDC Listed 3M N95 Respirators – Not Designed to be Used by Children

Note the following observations from Figure 24:

- ***This respirator is not designed to be used by children***!
- The respirator is only intended to be used for occupational or professional adults properly trained (e.g., under the RPS).
- Failure to follow instructions may result in sickness or death.
- A written respiratory protection plan, under the requirements of 29 CFR 1910.134 (RPS) must be in place prior to use of this respirator.

The Moldex instructions are essentially the same.

Moreover, 3M warns it is not protective against infectious diseases (Figure 25):



Biological Particles

This respirator can help reduce inhalation exposures to certain airborne biological particles (e.g. mold, *Bacillus anthracis*, *Mycobacterium tuberculosis*, etc.) but cannot eliminate the risk of contracting infection, illness or disease. OSHA and other government agencies have not established safe exposure limits for these contaminants.

5

Figure 25: 3M Instructions for CDC Listed 3M N95 Respirators – Not Protective Against Infection, Illness, or Disease

Note that anthrax and TB are much larger particles than virus particles like the COVID-19 virus.

In light of this discussion, the CDC should immediately correct their webpage stating explicitly that respirators, according to manufacturers' instructions, "Are not designed to be used by Children" and that anyone using a respirator must be doing so under a written respiratory protection plan that follows the OSHA RPS.

Issue #3: The CDC continues to ignore the fact that COVID-19 is primarily spread by aerosols (not droplets) making mask use mostly ineffective:

The CDC continues to make the misleading argument that masks stop COVID droplets. This is misleading because while masks do stop some droplets (> 50 to 10 micron), the vast majority of COVID particles are smaller aerosols (≤ 5 microns) – see Figure 26:

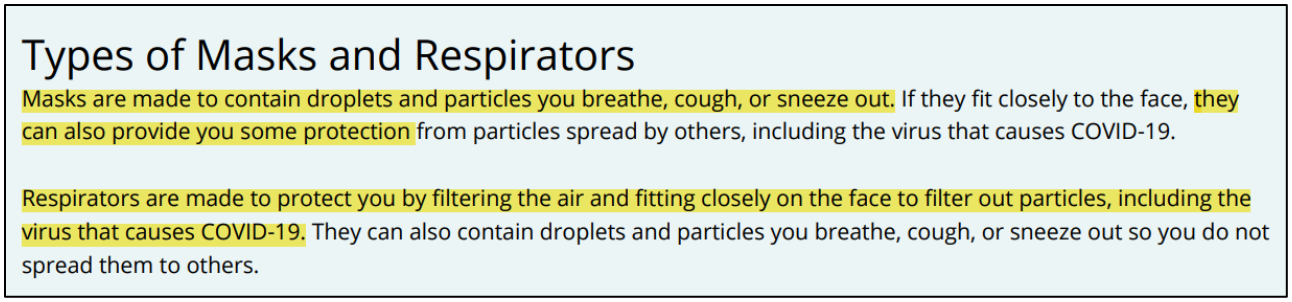


Figure 26: CDC – Misleading Guidance on Masks and Droplets

We are not the only ones who have written you regarding this issue. On February 15, 2021, the following scientists wrote a lengthy memo to you regarding your misleading language in this area and asked you to correct it:

- Rick Bright, PhD, Former Director of BARDA, Dept of Health and Human Services
- Lisa M. Brosseau, ScD, CIH, University of Minnesota CIDRAP
- Lynn R. Goldman, MD, MS, MPH, George Washington University
- Céline Gounder, MD, ScM, NYU Grossman School of Medicine & Bellevue Hospital Center
- Jose Jimenez, PhD, University of Colorado at Boulder
- Yoshihiro Kawaoka, DVM, PhD, University of Wisconsin-Madison and University of Tokyo
- Linsey Marr, PhD, Virginia Tech
- David Michaels, PhD, MPH, George Washington University
- Donald K. Milton, MD, DrPH, University of Maryland
- Michael Osterholm, PhD, MPH, University of Minnesota CIDRAP
- Kimberly Prather, PhD, University of California San Diego
- Robert T. Schooley, MD, University of California San Diego
- Peg Seminario, MS, AFL-CIO (retired)

They wrote in part:

> "To address and limit transmission via inhalation exposure and prevent COVID infections and deaths, we urge the Biden administration to take the following immediate actions:
>
> - Update and strengthen CDC guidelines to fully address transmission via inhalation exposure to *small inhalable particles* from infectious sources at close, mid and longer range. Updated guidelines should be informed by a risk assessment model that focuses on source and pathway (ventilation) controls first, followed by respiratory protection…

- *Issue an OSHA emergency standard on COVID-19 that recognizes the importance of aerosol inhalation, includes requirements to assess risks of exposure, and requires implementation of control measures following a hierarchy of controls*…

Edwards et al. (https://www.pnas.org/content/118/8/e2021830118) demonstrated that that the vast majority of COVID particles emitted during illness are aerosols not droplets (see Figure 27):

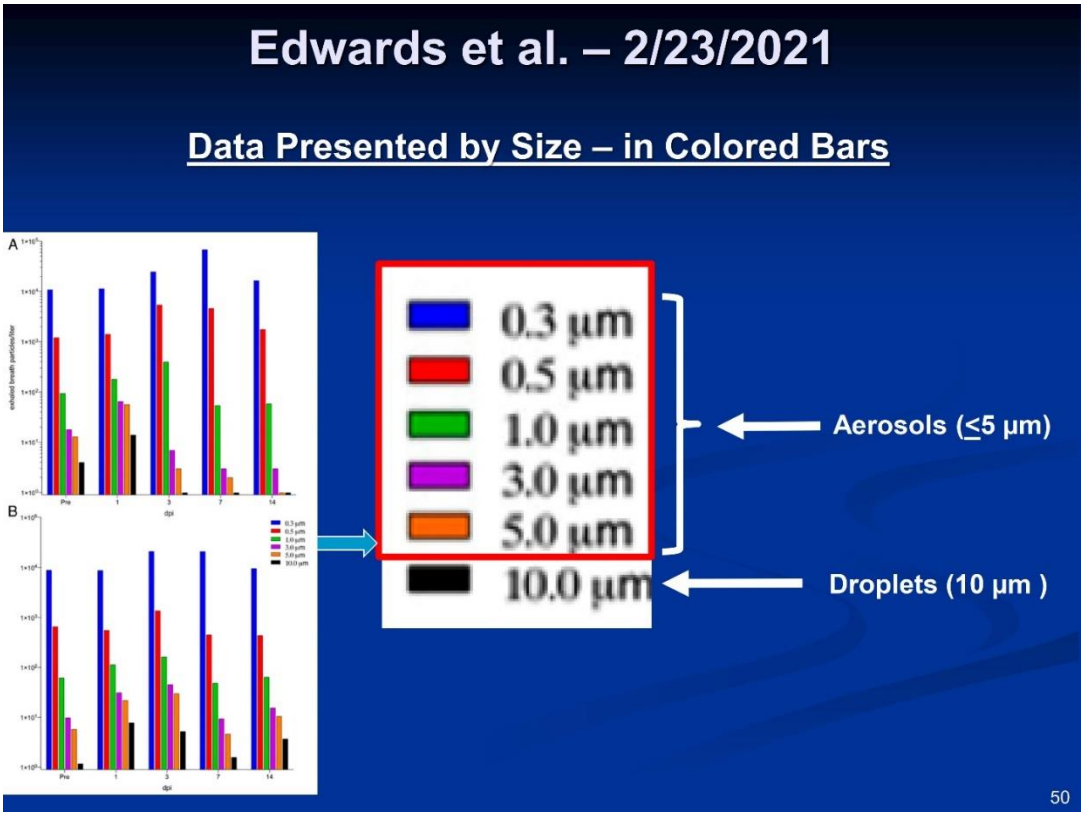


Figure 27: Edwards et al., 2021 – Particle Size Emissions by Size and Time

Edwards et al. concluded their paper with the following statements:

- Our finding that *the proportion of small respiratory droplets (i.e., aerosols) were the majority of particles exhaled in all subjects*.
- There may be an elevated risk of the airborne transmission of SARS CoV 2 by way of the very small droplets (aerosols) that transmit through conventional masks and *traverse distances far exceeding the conventional social distance of 2 m (~7').*
- Exhaled aerosol numbers appear to be not only an indicator of disease progression, *but a marker of disease risk in non-infected individuals.*

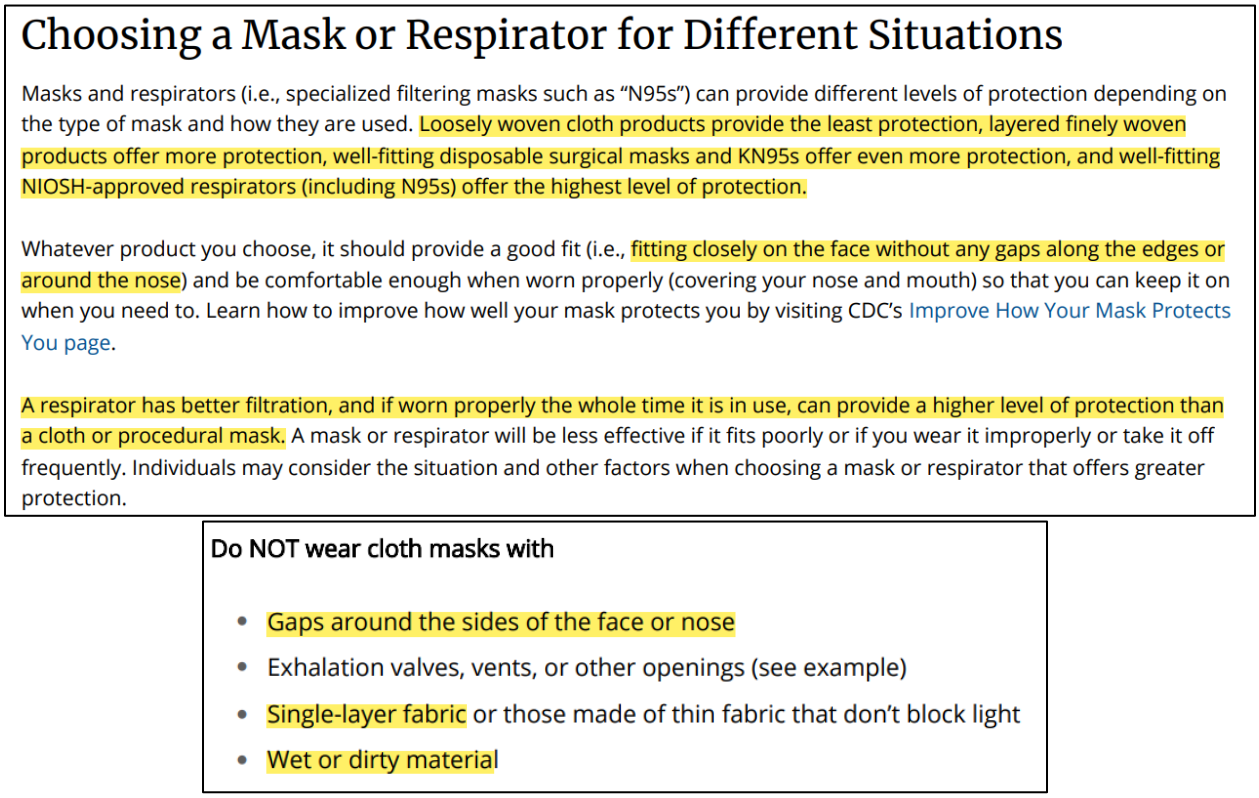
While the mask may contain droplets, they only do so for a period. As the masks are exposed to heat and moisture they suffer from degradation within a few hours.

We ask that the CDC immediately suspend misleading statements in all their public information that masks stop droplets when the vast majority of particles are smaller aerosols that stay suspended for days to weeks (vs. minutes for droplets), readily pass through gaps around the masks, and can reach deep into the lungs (see for example Fennelly, Kevin, P., 2020, Particle sizes of infectious aerosols: implications for infection control, Lancet Respir Med 2020; 8: 914–24).

Issue #4: CDC's position for masks used by the general public lacks proper scientific justification and creates potential harm based on a false sense of security:

Statements that a mask can provide protection are false and mislead the public into a false sense of security. Industrial Hygiene solutions seek a more than 90% relative risk reduction, and this publication continues to focus on the lowest form of non-protection that does not meet the least desirable mode of protection (PPE) in the Hierarchy of Controls with PPE. The September 9, 2020 guidance from AIHA illustrated this concept of the need for a super reduction in relative risk, not a minor one (https://aiha-assets.sfo2.digitaloceanspaces.com/AIHA/resources/Guidance-Documents/Reducing-the-Risk-of-COVID-19-using-Engineering-Controls-Guidance-Document.pdf - pg. 4).

Moreover, the CDC continues to provide guidance that gaps in masks can be eliminated; in the real world that never happens (Figure 28):



Choosing a Mask or Respirator for Different Situations

Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection depending on the type of mask and how they are used. Loosely woven cloth products provide the least protection, layered finely woven products offer more protection, well-fitting disposable surgical masks and KN95s offer even more protection, and well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection.

Whatever product you choose, it should provide a good fit (i.e., fitting closely on the face without any gaps along the edges or around the nose) and be comfortable enough when worn properly (covering your nose and mouth) so that you can keep it on when you need to. Learn how to improve how well your mask protects you by visiting CDC's Improve How Your Mask Protects You page.

A respirator has better filtration, and if worn properly the whole time it is in use, can provide a higher level of protection than a cloth or procedural mask. A mask or respirator will be less effective if it fits poorly or if you wear it improperly or take it off frequently. Individuals may consider the situation and other factors when choosing a mask or respirator that offers greater protection.

Figure 28: CDC Guidance Suggesting Gaps in Masks Can be Eliminated

The CDC statement that masks should not be worn if gaps cannot be eliminated is meaningless because this cannot occur; only properly selected and fitted respirators can accomplish this.

Masks cannot ever obtain a perfect fit to the face and efficiencies of masks when worn in real world scenarios (day-long usage). When the mask has more than a 3% gap, it offers effectively zero protection (Figure 29):

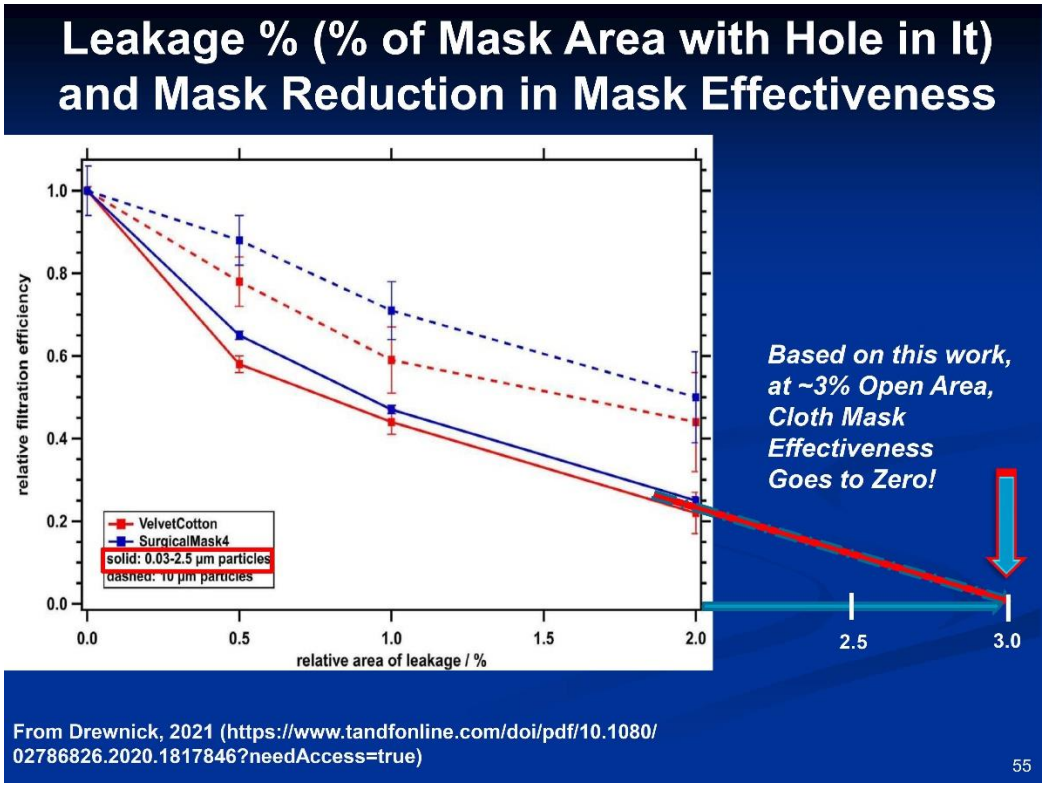


Figure 29: Loss of Mask Effectiveness in the Real World

Thus, the core issue with masks, and even respirators, is the seal – small gap areas effectively render these devices ineffective.

The American Society for Testing and Materials (ASTM) Standard Specification for Barrier Face Coverings F3502-21 Note 2 states, “There are currently no established methods for measuring outward leakage from a barrier face covering, medical mask, or respirator. Nothing in this standard addressed or implied a quantitative assessment of outward leakage and no claims can be made about the degree to which a barrier face covering reduces emission of human-generated particles.”

As well as, importantly, Note 5, “There are currently no specific accepted techniques that are available to measure outward leakage from a barrier face covering or other products. Thus, no claims may be made with respect to the degree of source control offered by the barrier face covering based on the leakage assessment.”

Every breath increases atmospheric viral load, or the amount of viral matter held aloft in an enclosed space. In instances when it does not take very much of an airborne pathogen for vulnerable individuals to get sick, a contagious individual should not wear a mask or respirator that creates a concentrated plume of aerosols, thinking they are protecting others from their respiratory emissions.

Explosive force-generating events, such as coughs and sneezes, increase the pressure behind exhaled matter. Masks can exacerbate the spread of airborne pathogens by creating focused plumes of fine particulates, in turn increasing emission trajectory, with the added concern of aerosolization of droplets through the mask membrane.

Finally, what is now most concerning, is that public entities are taking CDC guidance and making respirators available for free (Figure 30):

Figure 30: "Free" Open Contaminated N95s Being Given Away to the Public at Grocery Stores

These entities, based on CDC guidance, likely and/or unknowingly, do not address the requirements of the Respiratory Protection Standard and causing additional harm to the public by such a lack of understanding. Inevitably, this practice will result in harm and liability to their employees and customers for improper distribution and storage of respirators under the RPS.

Conclusion:

The CDC has built a series of recommendations for masking that are inconsistent with the technical and medical literature. The policy and procedural recommendations exaggerate the benefits, while ignoring the limitations and harms, especially for children and the general population. In addition, the CDC has taken a policy position of "it might work" and "it can't hurt" and use selective and weak observational data in the place of actual controlled scientific study to justify inappropriate recommendations for masks and face coverings.

Recently, the CDC has deployed a respiratory protection policy (i.e., masks to N95s) that dismisses the key principles in any Safety and Health program regarding the use of respirators – namely the Respiratory Protection Program. There is no mention of potential risks if the respirator is not properly used or fitted correctly. Moreover, it is clear that respirators are not intended for use with children. In our profession, if PPE and respiratory protection guidance was to ever be delivered without risk identification, fit testing, and training, we would be liable for putting personnel in a high-risk scenario, which is what the CDC is doing with their policy.

We would ask the CDC to accept these basic industrial hygiene facts that we have presented, update their public guidance accordingly regarding the issue of droplets vs. aerosols, stop confusing the public regarding the effectiveness of masks, and stop implying respirators are acceptable for children, and to be given generally to the public. In addition, it is clear the CDC knows, or should know, that gaps between the face and mask are a major problem for real mask effectiveness and could never have met our industry's requirement of 90% relative risk reduction.

The CDC is doing enormous damage to science and scientists by allowing politics to dictate public health policy rather than actual science. Increasingly, and for good reason as we have illustrated, the public does not trust the CDC and its science; this must change.

We recognize that it is easy to judge from afar and know that you and your team are under tremendous stress during this period. Our desire is to see the CDC and our country succeed in these efforts. As such, instead of just being critical, we want to offer our time to your organization to find solutions together. We would be willing to collaborate in the creation of a competent plan that will be based on the Hierarchy of Controls and will be tailored to various work and living environments. We will also help develop data points we can use to monitor and measure this program to enable proper adjustments as needed.

We look forward to your responses to our concerns as we continue to work to protect the public.

Sincerely:

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new scientific study entitled *"Serious adverse events of special interest following mRNA vaccination in randomized trials"* provides the best evidence yet concerning the safety of the mRNA Covid vaccines. For most vaccines in common use, benefits far outweigh risks, but that may not be the case for the mRNA covid vaccines, according to this study by Joseph Fraiman and his colleagues. It depends on your age and medical history.

The randomized controlled clinical trial is the gold standard of scientific evidence. When regulators approved the Pfizer and Moderna mRNA vaccines for emergency use in December 2020, two randomized trials showed that the vaccines reduced symptomatic covid infection by over 90% during the first few months after the second dose.

Pfizer and Moderna did not design the trials to evaluate long-term efficacy or the more important outcomes of preventing hospitalization, death, or transmission.

The randomized trials did collect adverse event data, including the presence of mild symptoms (such as fever) and more serious events requiring hospitalization or leading to death. Most vaccines generate some mild adverse reactions in some people, and there were considerably more adverse such reactions after the mRNA vaccines compared to the placebo.

That is annoying but not a major issue. We care about severe health outcomes. The key question is whether the vaccine's efficacy outweighs the risks of severe adverse reactions.

The Fraiman study uses data from the same Pfizer and Moderna-sponsored randomized trials presented to the FDA for vaccine approval, but with two innovations that provide additional information.

First, the study pools data from both mRNA vaccines to increase the sample size, which decreases the confidence intervals' size and the uncertainty about the estimated harms.

Second, the study focuses only on the severe adverse events plausibly due to the vaccines. Serious adverse events such as gunshot wounds, suicide, animal bites, foot fractures, and back injury are unlikely to be due to a vaccine, and cancer is unlikely to be due to a vaccine within a few months after vaccination. By removing such random noise, the ability (statistical power) to detect genuine problems increases. If there is no excess risk, shorter confidence intervals bolster confidence in the safety of the vaccines.

Classifying adverse events into the two groups is not a trivial task, but Fraiman et al. do an excellent job to avoid bias. They rely on the pre-defined Brighton Collaboration definitions of adverse events of special interest (AESI). Founded in 2000, the Brighton Collaboration has two decades of experience using rigorous science to define clinical outcomes for vaccine safety studies.

Moreover, Fraiman and colleagues blinded the process where they classified the clinical events as AESIs. Adjudicators did not know whether the individual had received the vaccine or the placebo. Hence, any criticism of so-called p-hacking is unwarranted.

So, what are the results? There were 139 AESIs among the 33,986 people vaccinated, one for every 244 people. That may sound bad, but those numbers mean nothing without comparison against a control group. There were 97 AESIs among the 33,951 people who received a placebo. Combining these numbers implies 12.5 vaccine-induced AESIs for every 10,000 people vaccinated, with a 95% confidence interval of 2.1 to 22.9 per 10,000 people. To phrase it differently, there is one additional AESI for every 800 people vaccinated (95% CI: 437-4762).

That is very high for a vaccine. No other vaccine on the market comes close.

The numbers for the Pfizer and Moderna vaccines are 10 and 15 additional events per 10,000 people, respectively, so both vaccines contributed to the finding. The numbers are similar enough that we cannot confidently say that one is safer than the other. Most excess AESIs were coagulation disorders. For the Pfizer vaccine, there was also an excess of cardiovascular AESIs.

While these safety results are concerning, we must not forget the other side of the equation. Unfortunately, the study does not calculate composite estimates that also included the reduction in serious covid infections, but we have such estimates for mortality.

Dr. Christine Benn and her colleagues calculated a combined estimate of the effect of vaccination on all-cause mortality using the same randomized trial data as Fraiman et al. They did not find a mortality reduction for the mRNA vaccines (relative risk 1.03, 95% CI: 0.63-1.71).

One important limitation of both Fraiman's and Benn's studies is that they do not distinguish the adverse reactions by age, comorbidities, or medical history. That is not their fault. Pfizer and Moderna have not released that information, so outside researchers do not have access.

We know that the vaccine benefits are not equally distributed among people since covid mortality is more than a thousand times higher among the old. Thus, risk-benefit calculations must be done separately for different groups: with and without prior covid infection, by age, and for the first two doses versus boosters.

1. Covid-recovered people have natural immunity that is stronger than vaccine-induced immunity. So, the benefit of vaccination is – at best – minimal. If the risk of adverse reactions is the same as in the randomized trials, there is a negative risk-benefit difference. Why are we mandating people in this group to be vaccinated? It is both unethical and damaging to public health.
2. While everyone can get infected, children have a minuscule risk of covid mortality. There is very limited safety data from the trials on children. If the risk of adverse reactions is the same as for adults, the harms outweigh the risks. Children should not receive these vaccines.
3. Older people above 70 have a much higher risk of covid mortality than the population in the Fraiman study. If their risk of adverse reaction is the same, then the benefits outweigh the harms. Hence, older people who have never had covid and are not yet vaccinated may benefit from these vaccines. However, we do not know if they are better than the Johnson & Johnson and Astra-Zeneca vaccines.

4. It is unclear from the clinical trial data whether the benefits outweigh the risks for working-age adults who have not been vaccinated and who have not already had covid. This is true both historically, for the original covid variants, and currently for the newer ones.
5. The Fraiman study analyzes data after the first and second doses. Both risks and benefits may differ for booster shots, but no randomized trial has properly evaluated the trade-off.

These results concern only the Pfizer and Moderna mRNA vaccines. Fraiman et al. did not analyze data on the adenovirus-vector vaccines marketed by Johnson & Johnson and Astra-Zeneca. Benn et al. found that they reduced all-cause mortality (RR=0.37, 95% CI:0.19-0.70), but nobody has used trial data to analyze AESIs for these vaccines.

Critically, the Fraiman and Benn studies had a follow-up of only a few months after the second dose because Pfizer and Moderna, unfortunately, terminated their randomized trials a few months after receiving emergency use authorization. Of course, a longer-term benefit can provide a basis to tolerate negative or neutral short-term risk-benefit differences. However, that is unlikely since we know from observational studies that mRNA vaccine efficacy deteriorates a few months after the second dose.

There may also be long-term adverse reactions to the vaccine regarding which we do not yet know. Since the randomized trials ended early, we must look at observational data to answer that question. The publicly available data from the Vaccine Adverse Event Reporting System is of low quality, with both under- and over-reporting. The best observational data is from CDCs Vaccine Safety Datalink (VSD) and FDA's Biologics and Effectiveness Safety System (BEST), but there have only been limited reports from these systems.

Fraiman and colleagues have produced the best evidence yet regarding the overall safety of the mRNA vaccines. The results are concerning. It is the responsibility of the manufacturers and FDA to ensure that benefits outweigh harms. They have failed to do so.

Author

Martin Kulldorff

Martin Kulldorff, Senior Scholar at Brownstone Institute, is a Professor of Medicine at Harvard University (on leave). He is the developer of Free SaTScan, TreeScan, and RSequential software. Most recently, he was professor at the Harvard Medical School for ten years. Co-Author of the Great Barrington Declaration. kulldorff@brownstone.org

WASHINGTON STATE BOARD OF HEALTH

Date: August 10, 2022

To: Washington State Board of Health Members

From: Michelle Davis, Executive Director

Subject: 2017-2022 Strategic Plan

Background and Summary:

In 2016 the Board the Washington State Board of Health (Board) adopted its 2017-2022 Strategic Plan. The Plan is aligned with the Board's vision and mission to provide statewide leadership in developing and promoting policies that prevent disease and improve and protect the public's health for all people in Washington.

The goals contained in the Strategic Plan focus on strengthening the public health system, promoting prevention to improve health and wellness, promoting health equity, and promoting healthy and safe environments. These goals support the Board's core mission of providing statewide leadership in developing and promoting policies that prevent disease and improve and protect the public's health, for all people living in our state. Each goal has associated objectives and activities. The 2017-2022 Strategic Plan includes 49 total activities, of which 33 have been completed, 10 are currently underway, and 6 have not been started to date.

I have invited Kaitlyn Donahoe, Board Staff, to provide the status of the Board's Strategic Plan, describe outcomes of the Plan, and provide a recommendation regarding next steps for the Board's strategic planning activities.

Recommended Board Actions:

The Board may wish to consider and amend, if necessary, the following motion:

The Board extends its Strategic Plan to 2023 to address activities considered "underway" or "not started." The Board directs staff to draft a proposal and timeline for strategic planning, including a community engagement plan, in close consultation with the Chair for consideration by the Board at a future meeting.

To request this document in an alternate format or a different language, please contact Kelie Kahler, Washington State Board of Health Communication Manager, at 360-236-4102 or by email at kelie.kahler@sboh.wa.gov. TTY users can dial 711.

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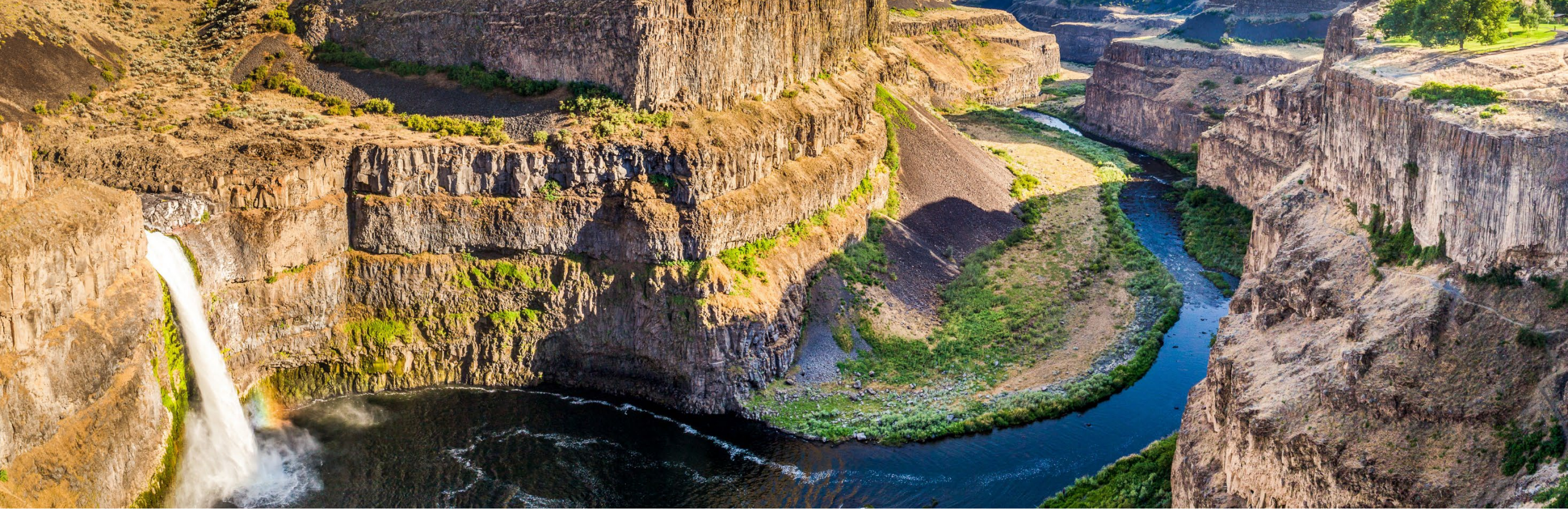


Washington State Board of Health

2017-2022 Strategic Plan

August 10, 2022

Kaitlyn Donahoe, MPA

Policy Advisor, State Board of Health

Background

In 2016, the Board adopted its 2017-2022 Strategic Plan aligned with the Board's mission and vision

The 2017-2022 Strategic Plan contains four goals, each with specific objectives and activities. Goals focus on:

- Strengthening the public health system
- Promoting prevention to improve health and wellness
- Promoting health equity
- Promoting healthy and safe environments

Overview: All Strategic Plan Activities

Goal 1: Strengthening the Public Health System

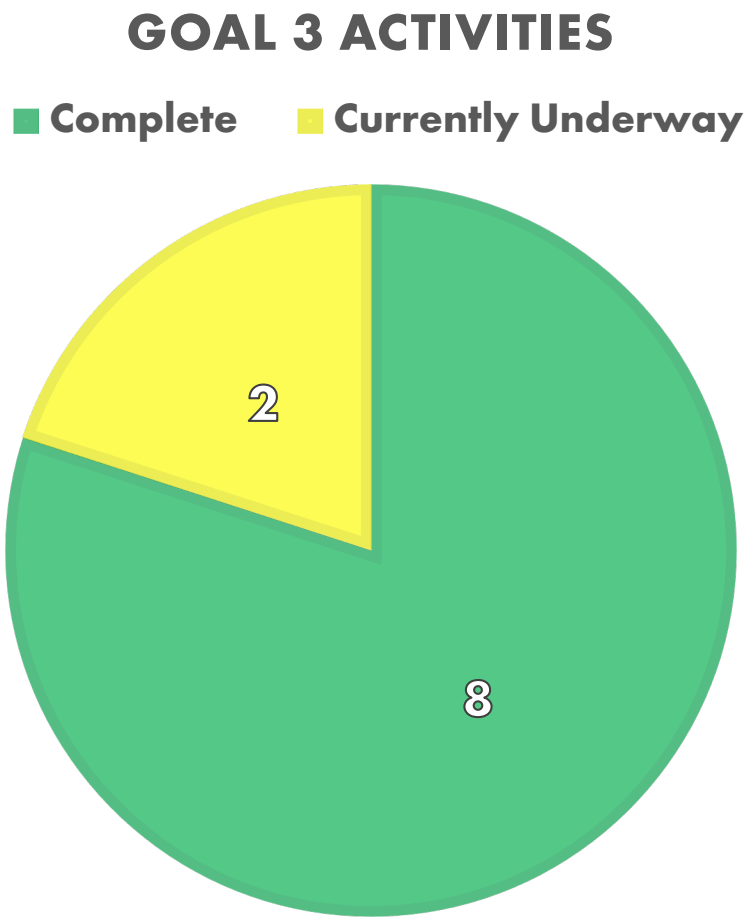
- Objective 1: Contribute to Public Health's Capacity to Control Disease and Respond to Public Health Emergencies
  - 4 activities
- Objective 2: Maintain and Strengthen the Organizational Capacity of the Public Health Network
  - 8 activities

Goal 2: Promote Prevention to Improve Health & Wellness

- Objective 1: Increase the Availability, Accessibility, and Utilization of Preventative Health Services2017-2022 Strategic Plan Status Report
    - 6 activities
- Objective 2: Promote a Preventative Approach to Improve Behavioral Health and Wellness
    - 2 activities
- Objective 3: Encourage Healthy Behaviors
    - 7 activities

Goal 3: Promote Health Equity

- Objective 1: Support Statewide Initiatives to Reduce Health Disparities2017-2022 Strategic Plan Status Report
  - 4 activities
- Objective 2: Integrate Health Equity Awareness into Board Activities
  - 6 activities



Goal 4: Promote Healthy and Safe Environments

- Objective 1: Promote Environmental Health in Urban, Suburban, Rural, and Recreational Settings
  - 5 activities
- Objective 2: Promote School Environments that Protect Health
  - 5 activities
- Objective 3: Monitor the Health Effects of Climate Change
  - 2 activities

Factors Impacting Activity Completion

- Routine Rulemaking Projects
- Legislative Directives
- Pandemic Response
- Petitions & Complaints
- Staff Turnover/Staff Expansion

Where do we go from here?

Proposal: Extend current plan to 2023

Future Strategic Priorities

- Board staff recommend developing and implementing a community engagement plan to inform strategic priorities
- Engagement should involve community groups representing the social service sector, local medical providers, local foundations, policy and advocacy groups, and local public health
- Engaging community on the Board's strategic plan is a key opportunity to build bridges across various sectors of the governmental public health system

DISCUSSION

THANK YOU

WASHINGTON STATE BOARD OF HEALTH

To request this document in an alternate format, please contact Kelie Kahler, Washington State Board of Health Communication Manager, at 360-236-4102, or by email at kelie.kahler@sboh.wa.gov
TTY users can dial 711

SBOH 2017-2022 Strategic Plan: Status Report

Goal 1: Strengthening the Public Health System

Objective 1: Contribute to Public Health's Capacity to Control Disease and Respond to Public Health Emergencies

Activities	*Outcomes and Examples of Work*
Hold a briefing following emergency event exercises to identify potential gaps in public health response.	**Not started**. The Board has not had a formal briefing on this topic. However, the Department of Health may include in information about emergency event response in regular updates to the Board.
Assure Notifiable Conditions rules are up to date.	**Complete**. Notifiable Conditions rules related to communicable disease were adopted by the Board in March 2021. These rules will go into effect January 1, 2023. Rulemaking regarding non-communicable disease is forthcoming, as early as 2023.
Monitor the impact of multi-drug resistant infections to understand the state's response capacity.	**Not started**. The Board has not had a formal briefing or monitored multi-drug resistant infections. The Board may want to consider a future briefing on the regulatory authority of the Board, Department of Health, and Department of Social and Health Services to prevent and control tuberculosis.
Develop a protocol for emergency rulemaking to prevent and control the spread of infectious disease during emerging outbreaks and epidemics.	**Underway**. The Board will incorporate lessons learned from COVID-19 and on-site sewage emergency rulemaking into future protocols.

Objective 2: Maintain and Strengthen the Organizational Capacity of the Public Health Network

Activities	*Outcomes and Examples of Work*
Work in partnership with local health to advance public health and promote stronger state/local coordination by participating in WSALPHO membership meetings.	***Complete**. Board staff participated in WSALPHO membership meetings including weekly legislative priorities meetings throughout legislative session, monthly Environmental Health Director meetings (and weekly COVID-19 response meetings during the height of the pandemic), ad hoc participation in joint WSALPHO/WSAC meetings to discuss specific rulemaking projects, annual statewide conferences organized by WSALPHO.
Provide a public forum to promote local health successes and identify challenges and opportunities within the public health system (e.g., oral health strategy, local health's drinking water/on-site efforts, CAFOs). This activity will include:	
• Inviting local health officials and local Boards of Health to join Board of Health Meetings.	**Complete**. The Board routinely invited local health officials and local boards of health to participate in regular Board meetings. When meetings were held in person in various jurisdictions, the Board included agenda items to showcase the work and key issues of the host LHJ (e.g., wildfire smoke response when meeting in Ellensburg).
• Holding Board of Health meetings in locations outside of Thurston County.	**Complete**. The Board routinely held meetings in locations across the state from 2017-2020. This practice was put on hold during the COVID-19 pandemic.
• Maintaining a website that provides information about local Boards of Health.	***Complete**. The Board maintains information on local boards of health on its website and is updated annually.
Endorse strategies to implement and fully fund Foundational Public Health Services (FPHS). This activity will include:	
• Participating in FPHS workgroups.	***Complete**. Board staff participate in FPHS Steering Committee meetings as well as FPHS subject matter expert workgroups.
• Monitoring FPHS efforts through regular updates to the Board.	***Complete**. Executive Director provides regular FPHS updates to the Board at regularly scheduled Board meetings and via email as necessary.
• Participate in active communications such as webinars and social media to promote awareness of FPHS to engage local communities.	**Underway**. Executive Director participated in a FPHS panel during one of WSPHA's annual conferences. The Board is also collaborating with WSALPHO on a new member training for local boards of health funded through FPHS dollars.
Increase awareness of the Board's role and authority and communicate information regarding how to engage the Board to other agencies, organizations, and community groups.	***Complete.** The Board increased its efforts to engage community partners in its work through additional Community Engagement staffing. Board staff have conducted outreach meetings with community groups representing the social service sector, local medical providers, local foundations, policy and advocacy groups, and local public health, and have set goals for ongoing outreach to build bridges across various sectors of the governmental public health system. The Board also hired a Communication Consultant to support additional communication activities to increase awareness of the Board's work and role within the public health system. The communications office has developed and implemented a strategic social media campaign to connect with core community groups and public health organizations. Board staff have also employed the use of community listening sessions to solicit feedback on rulemaking and policy decisions.

*Indicates activities have been completed during the 2017-2022 timeframe; however, work is ongoing.

SBOH 2017-2022 Strategic Plan Status Report

Goal 2: Promote Prevention to Improve Health & Wellness

Objective 1: Increase the Availability, Accessibility, and Utilization of Preventative Health Services

Activities	*Outcomes and Examples of Work*
Work with the Department of Health to engage stakeholders to identify possible inconsistencies in the immunizations rules, and strategies to reduce the administrative burden to schools while decreasing the number of children who are out of compliance with school immunization requirements.	**Complete**. Immunizations rulemaking completed in 2019 and went into effect August 2020.
Convene an advisory committee to review the Board's 2006 immunization criteria and make recommendations to the Board on potential revisions.	**Complete**. Immunization criteria updated in 2017 following a technical advisory group process.
Engage in conversations with partners (e.g., DOH, LHJs) to identify ways to improve the public health system's response to disease outbreaks.	**Underway**. Conversations were initiated during emergency rulemaking for COVID-19 and Notifiable Conditions. Collection of disaggregated data is needed for enhanced response.
Work with partners to promote fluoridation of drinking water and its oral health benefits.	**Complete**. During the 2022 legislative session the Board advocated for the passage of HB 1684 concerning community water fluoridation.
Hold briefings on, and endorse when appropriate, partner activities supporting the Oral Health Initiative.	**Complete**. The Board received a briefing regarding strategies to promote equity in oral health, as well as results from the 2015-2016 Smile Survey, in 2017.
Assure child health rules are current (Newborn Screening, Vision Screening, Immunization rules, etc.)	**Complete**. The Board revised its Vision Screening rules in 2017, Immunization rules in 2019, and Newborn Screening rules in 2017, 2019, and 2021. The Board completed a review of its Auditory Screening rules in 2020. In 2020 the Board provided updated guidance for auditory and vision screenings during the COVID-19 pandemic.

Objective 2: Promote a Preventative Approach to Improve Behavioral Health and Wellness

Activities	*Outcomes and Examples of Work*
Support and promote statewide efforts and partnerships (such as the State Prevention Advisory Group) that work to improve behavioral health and wellness and expand capacity to address behavioral health infrastructure.	**Complete**. Board staff regularly participated in Strategic Prevention Enhancement (SPE) Policy Consortium meetings.
Hold briefings on pertinent behavioral health and wellness topics (e.g., Adverse Childhood Experiences, mitigation of toxic stresses, Accountable Communities of Health activities, Healthier WA initiative, etc.) and identify how the Board's work or authority intersects with each topic.	**Complete**. The Board received briefings on the Washington State Suicide Prevention Plan in 2018.

Objective 3: Encourage Healthy Behaviors

Activities	*Outcomes and Examples of Work*
Improve nutrition and increase physical activity/access to nutritious foods by participating in Washington's Food Insecurity Nutrition Incentives Project to improve the nutrition status of low income households participating in the Supplemental Nutrition Assistance Program.	**Complete**. The Board participated in the Food Insecurity Nutrition Incentives Advisory Network from 2015-2019.
Support efforts to reduce youth access to tobacco and vaping by encouraging the state to increase the age for purchasing tobacco from 18 to 21.	**Complete**. The Board identified this topic as a legislative priority in its 2017-2018 and 2019 Legislative Statements. During the 2019 legislative session, the Board advocated for the passage of HB 1074 which increased the purchase age of tobacco and vapor products from 18 to 21 (effective January 1, 2020).
Identify and pursue opportunities to highlight the adverse health impacts of vaping.	***Complete**. The Board adopted emergency and permanent rules to prohibit the use of Vitamin E Acetate in vapor products, and continues to highlight the adverse health impacts of vaping through legislative advocacy, Health Impact Reviews, and in publications such as State Health Reports and Legislative Statements.
Monitor the use of vaping products among youth and the emerging evidence regarding health impacts.	***Complete**. The Board adopted emergency and permanent rules to prohibit the use of Vitamin E Acetate in vapor products, and continues to highlight the adverse health impacts of vaping through legislative advocacy, Health Impact Reviews, and in publications such as State Health Reports and Legislative Statements.
Hold a briefing on opioid abuse and unintentional overdose deaths in Washington, and statewide efforts to address this issue.	**Complete**. The Board received an update on the State Opioid Plan in 2018.

Hold a briefing on youth marijuana use.	**Complete**. The Board received a briefing on marijuana use prevention in 2019 with a focus on youth prevention. The Board also discussed the use of marijuana vaping products at a briefing regarding the Governor's Executive Order 19-03 addressing the vaping use public health crisis in 2019.
Explore authorities related to and feasibility of rulemaking to increase the utilization of immunization registries.	**Not started.**

*Indicates activities have been completed during the 2017-2022 timeframe; however, work is ongoing.

SBOH 2017-2022 Strategic Plan Status Report

Goal 3: Promote Health Equity

Objective 1: Support Statewide Initiatives to Reduce Health Disparities

Activities	*Outcomes and Examples of Work*
Support the Governor's Interagency Council on Health Disparities. This activity will include:	
• Annual updates to the Board regarding Council recommendations.	***Complete**. Executive Director provided regular updates to the Board regarding the Council's work, including the work of its task forces (e.g., Social Equity in Cannabis Task Force, Office of Equity Task Force, Environmental Justice Task Force), and provided the Council's recommendations to Board members as they were updated.
• Incorporate Council recommendations in the Board's State Health Report.	***Complete**. The Board regularly incorporated Council recommendations in the State Health Report.
Complete Health Impact Reviews for the Governor and Legislature.	***Complete**. From July 1, 2016 through June 30, 2022, staff completed 87 Health Impact Reviews
Support partners work to promote health equity through activities such as writing letters, resolutions, sharing communications, etc.	***Complete**. In 2020, the Board adopted a resolution declaring racism as a public health crisis. In 2022, the Board signed onto the Office of Equity's comment letter regarding Council on Environmental Quality's beta Climate and Economic Justice Screening Tool, and its failure to include race or ethnicity as indicators to identify "disadvantaged communities," and limiting language to English.

Objective 2: Integrate Health Equity Awareness into Board Activities

Activities	*Outcomes and Examples of Work*
Include disparities data and other equity considerations in Board briefings and reports.	***Complete**. The Board regularly includes data on health inequities and equity considerations in Board publications such as the biennial State Health Report, annual Legislative Statement, and more.
Require cultural humility training for Board staff (and members when resources allow).	***Complete**. Prior to the COVID-19 pandemic, Board staff participated in quarterly cultural humility trainings. Since then, these trainings have been on an ad hoc basis on relevant and timely topics. Board staff participated spaces for learning and unlearning, examining systemic racism, through the Department of Health's Equity & Social Justice Collaborative in 2020.
Assure government to government (tribal relations) training for Board staff (and members when resources allow).	***Complete**. Board staff routinely participate in opportunities to learn more about tribal engagement. Most recently, staff participated in tribal relations training with DOH Tribal Relations Director Tamara Fife in 2022. Select staff have also received training through the Governor's Office if Indian Affairs.
Establish and integrate processes for applying an equity lens to Board policy development.	**Underway**. Board staff are currently working to incorporate community engagement and equity best practices into rulemaking processes, as well as closely following and collaborating with the Environmental Justice Council's Interagency Work Group on activities related to the HEAL Act.
Develop a plan to implement the National Standards for Culturally and Linguistically Appropriate Services (CLAS).	**Underway**. In alignment with the National CLAS Standards Blueprint, the Board and Health Disparities Council supported CLAS implementation in a variety of venues: The Board and Council supported efforts at the Department of Health to initiate curated CLAS trainings for program staff. The Council and Department conducted a points-of-contact language access assessment with community groups. Council staff supported COVID-19 response through developing a comprehensive language access plan.
Explore opportunities to use an equity lens in Board communications.	***Complete**. The Board implemented an Equity in Communications framework in 2017 as guidance for external communication. In 2018, the Board conducted a website audit to ensure readability, accessibility, and ADA requirements were met. In 2019, the Board updated materials to meet ADA and accessibility compliance and offered training to staff on ADA and accessibility related matters. Board and Council staff ensure that Health Impact Reviews contain terminology that respects and honors the individuals to whom the research is concerned. In 2022, Board staff participated in a cultural humility training that highlighted the use of preferred terms.

*Indicates activities have been completed during the 2017-2022 timeframe; however, work is ongoing.

SBOH 2017-2022 Strategic Plan Status Report

Goal 4: Promote Healthy and Safe Environments

Objective 1: Promote Environmental Health in Urban, Suburban, Rural, and Recreational Settings

Activities	*Outcomes and Examples of Work*
Monitor on-site sewage systems operations and improvements. This activity will include:	
• Review and update rule as needed.	**Underway**. The Board completed a review of the On-site Sewage rules in 2018; efforts to revise the rule have been ongoing since. COVID-19 response, staffing changes, and other factors have delayed rulemaking progress.
• Support efforts to fully fund local implementation of local on-site sewage systems plan.	**Underway**. FPHS includes funding support for local on-site sewage programs and other related areas such as data management, and regional on-site sewage loan programs for system repair and replacement has been expanded statewide.
Hold a briefing on zoonotic diseases in Washington, including emerging diseases.	**Complete**. In 2018, the Board received a briefing on zoonotic disease regarding the state's surveillance of vector-borne disease, focusing on ticks, mosquitos, and the soil fungus Coccidioides, as well as the impacts of the changing climate. The Board also discussed its statutory authority related to zoonotic disease in 2021 after receiving a petition for rulemaking related to canines in the workplace.
Promote safe and reliable drinking water systems.	**Complete**. The Board supported strategies to address lead remediation in the built environment since the Governor's Directive 16-06 in 2016, including addressing lead in school and childcare facility drinking water, improved blood lead monitoring, and identifying drinking water service lines at risk of producing lead exposure. In 2021, the Board adopted amendments to Group A water systems to establish drinking water standards for five PFAS as State Action Levels (SALs); requirements for monitoring, recordkeeping, reporting, and other follow-up actions; criteria and procedures for adopting SALs and state maximum contaminant levels (MCLs); and laboratory analytical and reporting requirements.
Convene state agencies and partners to support efforts to reduce exposure to environmental toxics and toxins and address environmental health.	**Not started**. The Department of Ecology and Department of Health Washington identify and take action against chemicals that pose the highest risks to human health and the environment through chemical action plans. The Board will support these efforts as appropriate.

Objective 2: Promote School Environments that Protect Health

Activities	*Outcomes and Examples of Work*
Work with state and local partners to increase the understanding and identification of potential public health risks and hazards in schools and appropriate techniques and procedures for addressing these risks.	**Underway**. Board staff meet regularly with Department of Health partners on school environmental health and safety topics.
Assess and improve school environmental health and safety rules.	**Complete**. In 2016 the Board and Department of Health completed a review of the school rules as part of the Governor's Directive 16-06 on lead and provided numerous recommendations for improvement. Since then, the Board has periodically assessed the rules and opportunities for improvement through. The rules cannot be formally revised and implemented due to the budget proviso.
Help create a coalition of support for safe and healthy schools.	**Underway**. Board staff meet regularly with DOH partners on school environmental health and safety topics. The Board has also had preliminary conversations with public health partners regarding the Board's school environmental health and safety rules, including prioritizing FPHS funds for inspections.
Support DOH in engaging local health jurisdictions, OSPI, and school districts and partners to cooperatively strengthen efforts to improve Environmental Health and safety in schools.	**Underway**. The Board has worked closely with DOH, OSPI, OFM, and the Governor's Office regarding possible removal of the budget proviso restricting rule implementation. Board staff meet regularly with DOH partners on school environmental health and safety topics. School environmental health and safety, including school inspection programs, has also been identified as a priority for FPHS funding.
Support and advance efforts to improve school safety (e.g., emergency preparedness and response).	**Complete**. The Board has supported legislative proposals to mitigate lead in drinking water.

Objective 3: Monitor the Health Effects of Climate Change

Activities	*Outcomes*
Adjust rules for effects on water systems, sewage systems, food supply, air quality, and zoonotic effects.	**Not started**.
Monitor health effects (need for cooling, stress, health disparities) associated with climate change.	**Not started**.

*Indicates activities have been completed during the 2017-2022 timeframe; however, work is ongoing.

WASHINGTON STATE BOARD OF HEALTH

Date: August 10, 2022

To: Washington State Board of Health Members

From: Keith Grellner, Chair

Subject: Update—Per- and Polyfluoroalkyl Substances (PFAS) Rule Implementation and Related Issues, Group A Public Water Supplies, Chapter 246-290 WAC

Background and Summary:

Per- and polyfluoroalkyl substances (PFAS) are a group of chemicals used or found in many industrial processes and consumer products ranging from carpets and clothing to cookware and fire-fighting foam. Among other qualities, PFAS are stain resistant, water repellant, and heat stable.

Unfortunately, some PFAS also have known health effects and are considered PBTs—persistent in the environment, bio-accumulative in organisms, and toxic at relatively low levels. The synthetic chemicals are now found globally in the environment often associated with releases from manufacturing sources or use of fire-fighting foam at military installations, airports, and fire-training stations. PFAS are increasingly detected in drinking water sources across the country and have been detected in drinking water in Washington state. These include drinking water sources near several military installations in Washington.

In 2021, the State Board of Health (Board) working closely with the Washington Department of Health (Department), adopted revisions to Board rules on Group A Drinking Water Supplies, chapter 246-290 WAC, and companion rules on Drinking Water Laboratory Certification and Data Reporting, chapter 246-390 WAC. The rulemaking reset procedures and requirements for developing and adopting State Action Levels (SALs) and state Maximum Contaminant Levels (MCLs) for drinking water. The rulemaking also established SALs for five PFAS. There currently are no federal drinking water MCLs for PFAS, but work on such standards is underway. In the absence of federal PFAS MCLs, many states have taken action to regulate PFAS in drinking water.

Today, Mike Means of the Department's Office of Drinking Water will update the Board on early efforts implementing the new state drinking water rules for PFAS and possible future action by the Board. The update will include results of voluntary PFAS drinking water monitoring that is currently underway in Washington that precedes the rule's initial required monitoring in 2023-2025. Staff will update the status of work at the federal level on revised PFAS health advisory levels (HALs) and PFAS drinking water MCLs. Staff will also cover other related work in Washington, including recent PFAS drinking water

(continued on the next page)

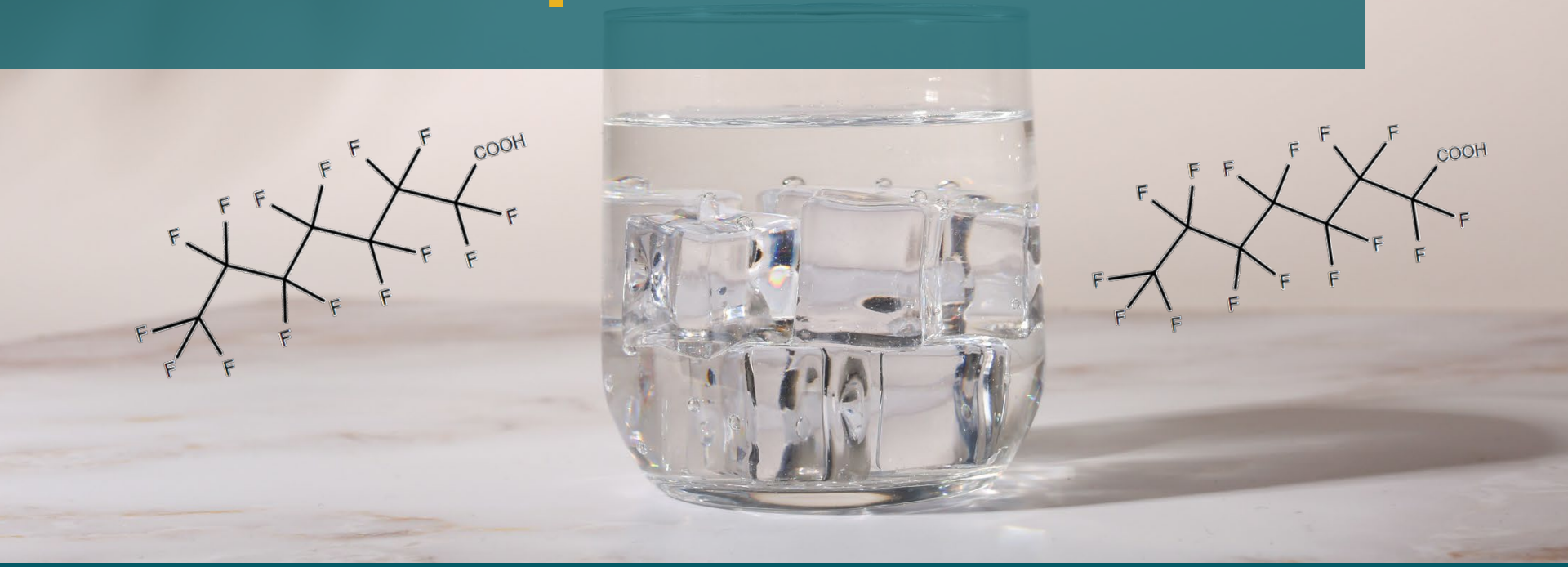
detections near the Yakima Training Center involving work with the local community, Department of Defense, and other partners.

Today's update is informational only. There is no formal Board action. Meeting material includes a fact sheet from the Department on the 2021 state PFAS rulemaking; an FAQ from the Department on the U.S. Environmental Protection Agency's 2022 PFAS HALs; and a fact sheet from the Washington Department of Ecology on recommended PFAS soil and groundwater cleanup levels for Washington state.

Staff
Stuart Glasoe

To request this document in an alternate format or a different language, please contact Kelie Kahler, Washington State Board of Health Communication Manager, at 360-236-4102 or by email at kelie.kahler@sboh.wa.gov. TTY users can dial 711.

Department of Health Updates



Washington State Department of Health

Update: PFAS in Drinking Water

August 10, 2022

@WaDeptHealth
@WaHealthSec

Speakers

Capacity Development and Policy Manager

Mike Means

Office of Drinking Water
Department of Health

Toxicologist

Barbara Morrissey

Office of Environmental Public Health Sciences
Department of Health

Overview

Review 2021 Drinking Water Rule for PFAS
DOH Rule Implementation
New EPA health guidance
Next steps for SBOH

Briefings

- Yakima Training Center
- New ECY Cleanup Values for PFAS
- Planning for a state PFAS forum

Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS)

Nonstick, Stain and Water Resistant, Heat Stable

Some PFAS are PBTs

Persistent in the environment

Bioaccumulate in humans

Toxic at relatively low (ppt) levels

Health Concerns

In **Laboratory Animals**

- Liver toxicity
- Developmental toxicity
- Reproductive toxicity
- Immune toxicity
- Endocrine disruption
- Tumors in liver, pancreas, testes

In Humans

- Increased cholesterol levels
- Altered liver enzyme levels
- Reduced immune response to vaccines
- Lower birth weight
- Blood pressure problems during pregnancy
- Increase risk of thyroid disease
- Increased risk of cancer (kidney and testicular)- PFOA

Citizen Petition 2017

Requested state drinking water standards for PFAS based on:

- Serious public health threat
- Known occurrence in state drinking water supplies
- Need to address more than two compounds
- Need for more comprehensive water testing

Timeline of PFAS Drinking Water Rule

2021 State Action Levels (SALs)

WASHINGTON STATE BOARD OF HEALTH

Features

- Sets action levels for 5 PFAS.
- Requires PFAS testing by most Group A water systems.
- Requires notification of customers.
- Requires follow-up monitoring
- Effective date: Jan 1, 2022.
- Mitigation of water is not required but systems are encouraged to follow public health advice and funding support is available.

Drinking water Contaminant	SAL (parts per trillion)
PFOA	10
PFOS	15
PFNA	9
PFHxS	65
PFBS	345

Monitoring Requirements

If PFAS results from last year are:

Low

Monitoring = 1 time every 3 years

Medium

Monitoring = Annually

High

Monitoring = Quarterly

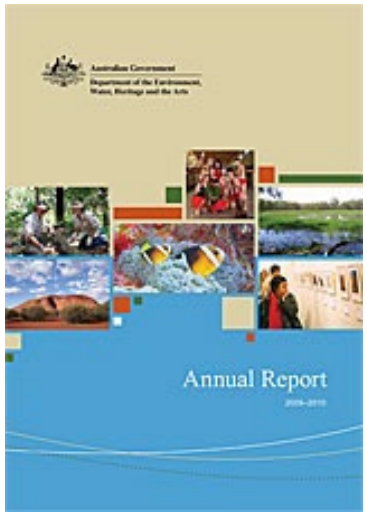
Public Notice Requirements

Water Systems that exceed a SAL

- Inform customers about the health effects of the contaminant
- What, if anything, are they doing to address the issue
- What consumers can do to reduce their exposure

Community water systems with a detection

- Include any PFAS detections in their annual consumer confidence report



A SAL is a Bridge to an MCL

- SALs **require** testing and public notification and **guide** public health action.
- Testing will help define scope of problem and necessary funding and resources.
- Testing data is needed to develop state cost-benefit analyses for Maximum Contaminant Levels (MCL).

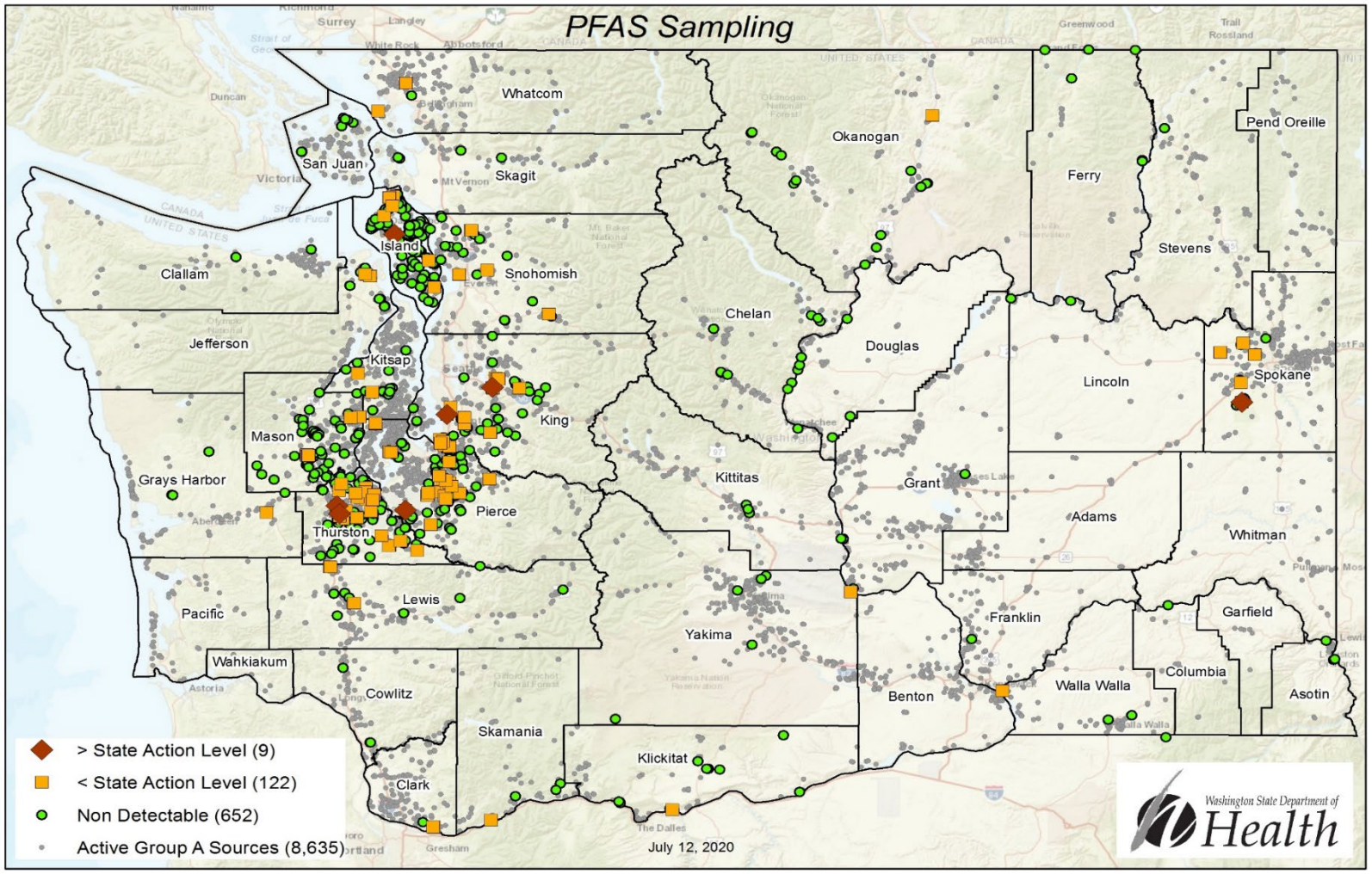
Implementation of the Rule

- Funding for water testing and water treatment
- Voluntary free testing program
- Early water testing results

2022—Voluntary Water Testing Program

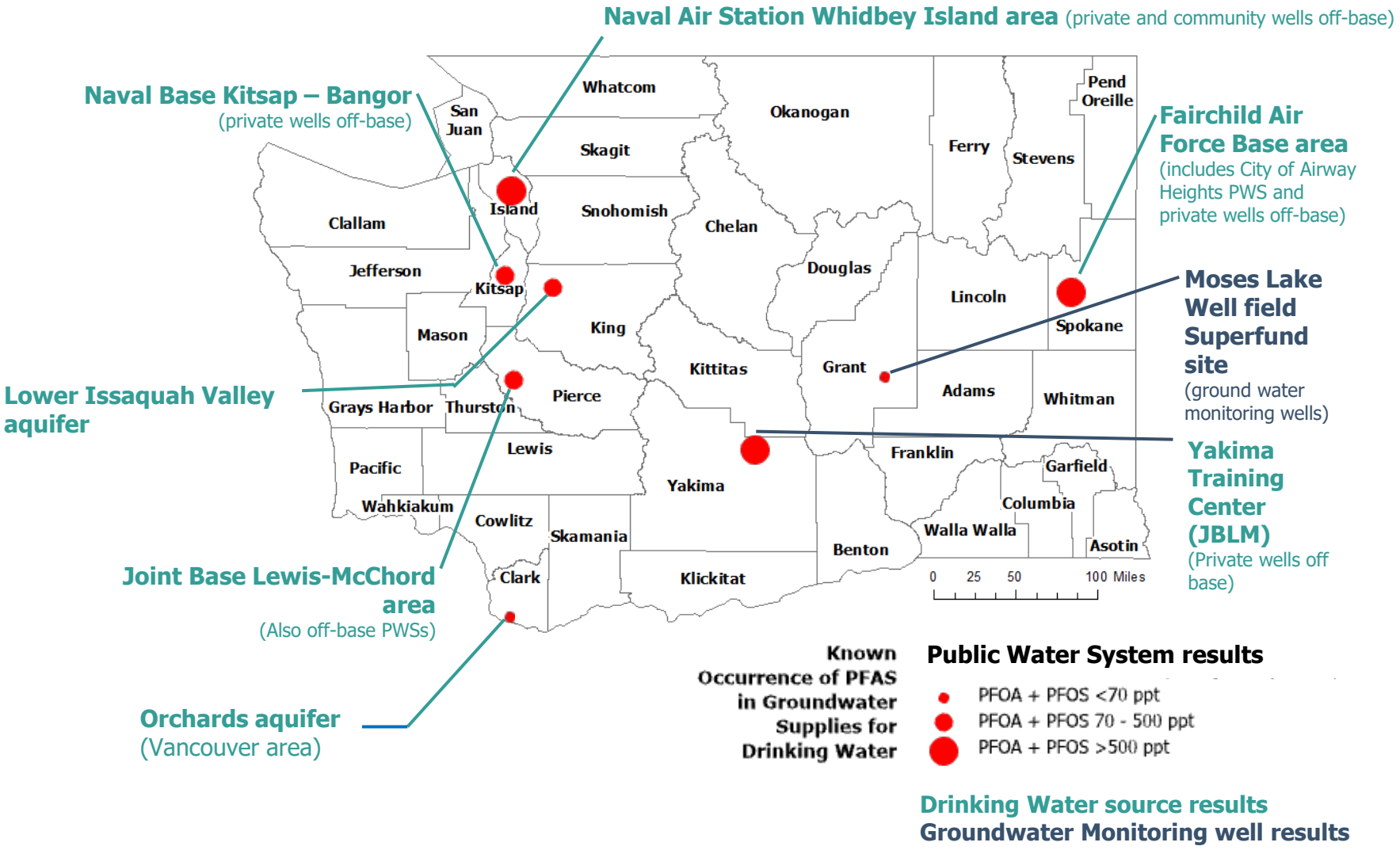
- Offered in advance of required testing (2023-2025)
- Summary (as of July 15, 2022)
  - 427 water systems have tested (659 sources tested)
  - 7 systems (9 sources) had a SAL exceedance
  - 131 sources had PFAS detections
  - 80 percent of sources tested were < detection limits (~2 ppt)

PFAS in Drinking Water and Ground Water



Source of data: PFAS Detections reported to Sentry Database—primarily voluntary testing.

PFAS in Drinking Water and Ground Water



Source of data: voluntary testing by military bases and public water systems.

How Water Systems are Responding to Detections

- **Community Water System responses**
  - Notifying public of SAL exceedance (required)
  - Annual notification for PFAS detections (required)
  - Removing sources from service
  - Exploring treatment alternatives
- **DOD response**
  - Interim actions to provide alternate water for drinking and cooking when PFOS +PFOA >70 ppt
  - Understanding impacts of changing science
    - Messaging to communities
    - Extent of investigation for long term solutions

New Health Guidance From EPA

EPA United States Environmental Protection Agency

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EPA Announces New Drinking Water Health Advisories for PFAS Chemicals, $1 Billion in Bipartisan Infrastructure Law Funding to Strengthen Health Protections

Agency establishes new health advisories for GenX and PFBS and lowers health advisories for PFOA and PFOS

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NATIONAL

EPA warns that even tiny amounts of chemicals found in drinking water pose risks

June 15, 2022 · 11:47 AM ET

THE ASSOCIATED PRESS

USA TODAY

NEWS

EPA finds no safe level for two toxic 'forever chemicals,' found in many U.S. water systems

Studies have linked the these 'forever chemicals' to different types of cancer, low birthweights and other health ailments. 'This will set off alarm bells,' one expert said.

Chemours challenges US EPA drinking water advisory for PFAS

Company raises argument from a recent Supreme Court ruling

by Cheryl Hogue

July 14, 2022

HAL vs. SAL vs. MCL

HAL

Set at the Public Health Goal

Equivalent to MCLG

SAL

Set as close to Public Health Goal as feasible

Considering: Technical feasibility

MCL

Set as close to Public Health Goal as feasible

Considering:

Technical feasibility

Cost-benefit

HAL = Health Advisory Level
SAL = State Action Level
MCLG = Maximum Contaminant Level Goal
MCL = Maximum Contaminant Level

Evolving Health Guidance Values (ng/L)

Changes over time largely reflect expanding and strengthening scientific understanding of adverse impacts of PFAS.

PFAS	EPA HALs 2016	WA SALs 2021	EPA HALs 2022
PFOA	70	10	***0.004***
PFOS	70	15	***0.020***
PFHxS	-	65	-
PFNA	-	9	
PFBS	-	345	**2,000**
GenX	-	-	**10**

Italics indicate an interim value

SAL - State Action Level; HAL – Health Advisory Level

SALs are set to be Health Protective

A level in water expected to be without appreciable health effects over a lifetime of exposure, this includes sensitive groups.

Impacts to Risk Communication

- New interim PFOA and PFOS HALs
  - Any detections in drinking water are above what EPA recommends for a lifetime of exposure in residential drinking water.
- EPA recommends that people with detectable PFOA and PFOS be informed and told how to reduce their exposure.
- Impacts a narrow range of results (between WA SALs and detection limit of 2 ppt in drinking water).

DOH Recommends

- Update public messaging to relay new EPA advice
- Continue to regulate with SALs for now
  - Prefer WA SAL for PFBS
  - Interim HALs for PFOA, PFOS are still undergoing expert review and may change
- Follow the expert review, evaluate final EPA assessment
- When EPA finalizes PFOA and PFOS numbers and proposes the MCL (in late 2022):
  - Review EPA's analyses of technical feasibility, costs-benefits
  - Update the SBOH and present options for SAL adjustment

State Activities — PFAS in Drinking Water

2022	2023	2024	2025
SAL rule effective Identifying funding for mitigation DOH-Voluntary Sampling with federal funding	Utilities to begin required PFAS sampling	SBOH begins Rule Making process to adopt federal MCLs and add or update other PFAS in state rule	Complete initial testing of water systems Adopt federal standard

EPA developing standard for PFAS in drinking water (DW)

Propose PFAS Standard for DW by Dec 2022	Adopt PFAS Standard for DW by Dec 2023

State Activities — PFAS in Drinking Water

2022	2023	2024	2025
SAL rule effective Identifying funding for mitigation DOH-Voluntary Sampling with federal funding **Respond to HALs**	Utilities to begin required PFAS sampling **Rule revision in response to new EPA health values?**	SBOH begins Rule Making process to adopt federal MCLs and add or update other PFAS in state rule	Complete initial testing of water systems Adopt federal standard

EPA developing standard for PFAS in drinking water (DW)

Issued 4 new HALs Propose PFAS Standard for DW by Dec 2022	Adopt PFAS Standard for DW by Dec 2023

Next Steps for SBOH Consideration

- Provide input on DOH's current response
- Possible action in January 2023 to revise rule based on new health information
  - Consider options for rule revision
  - Consider rule-making to adopt revision

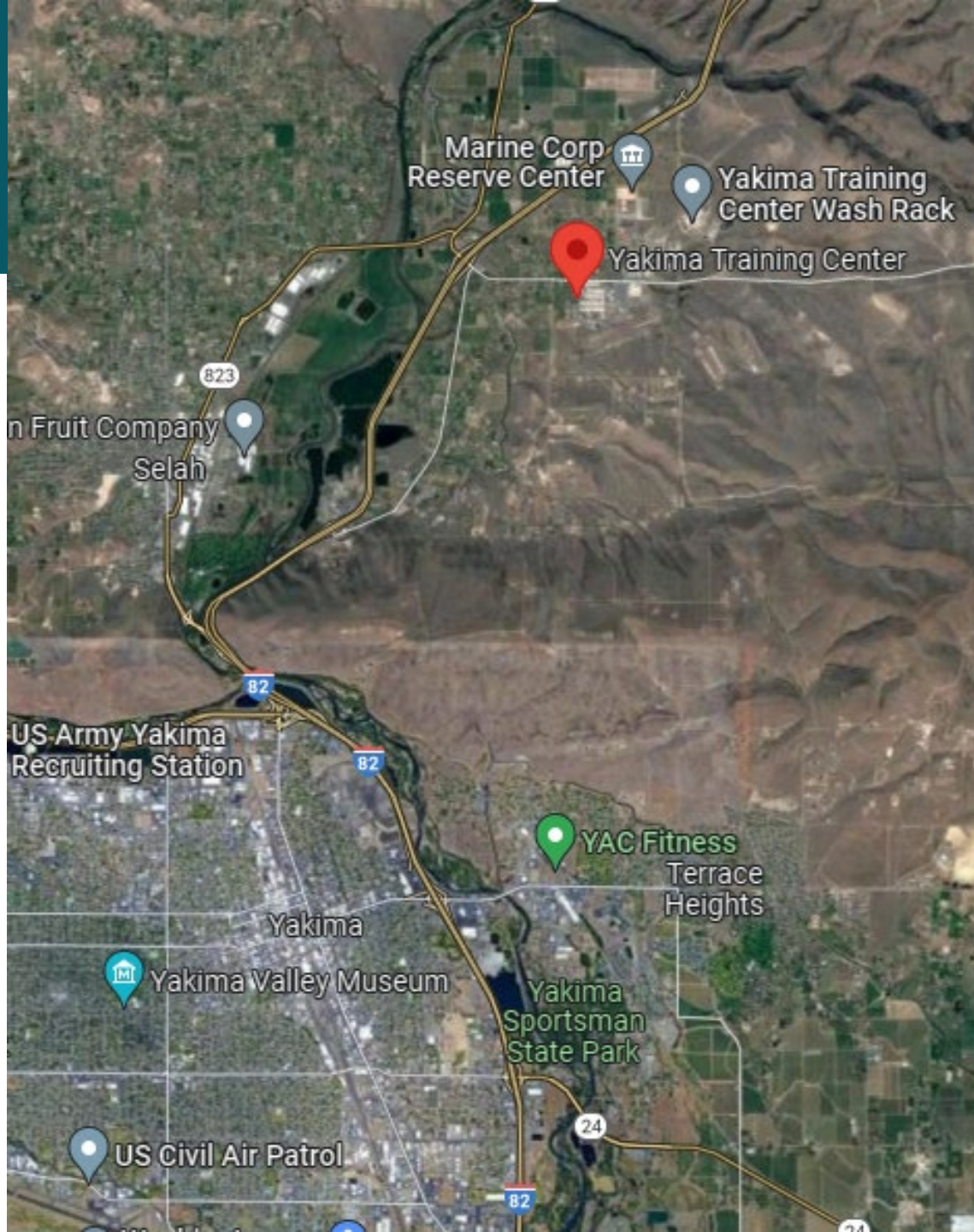
Briefing

Three PFAS activities in WA

Yakima Training Center

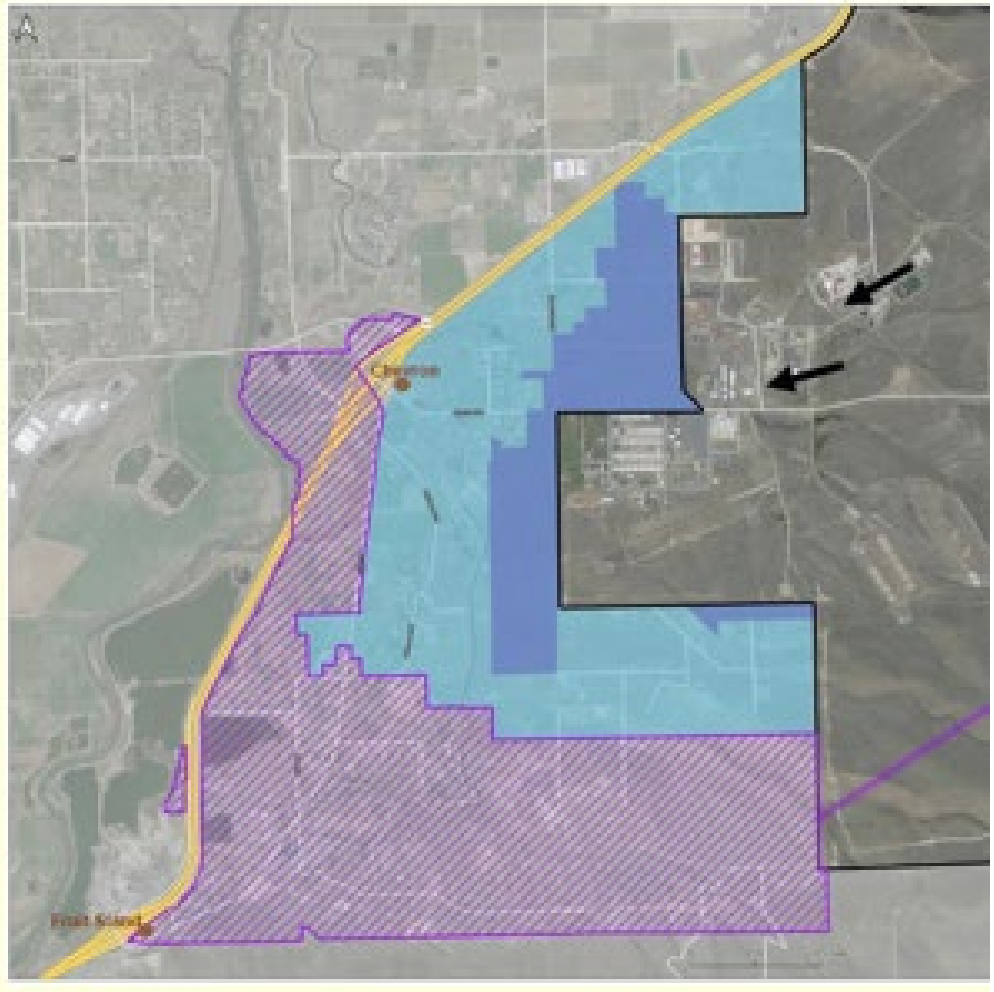
PFAS in drinking water

Rural community west of base—private wells



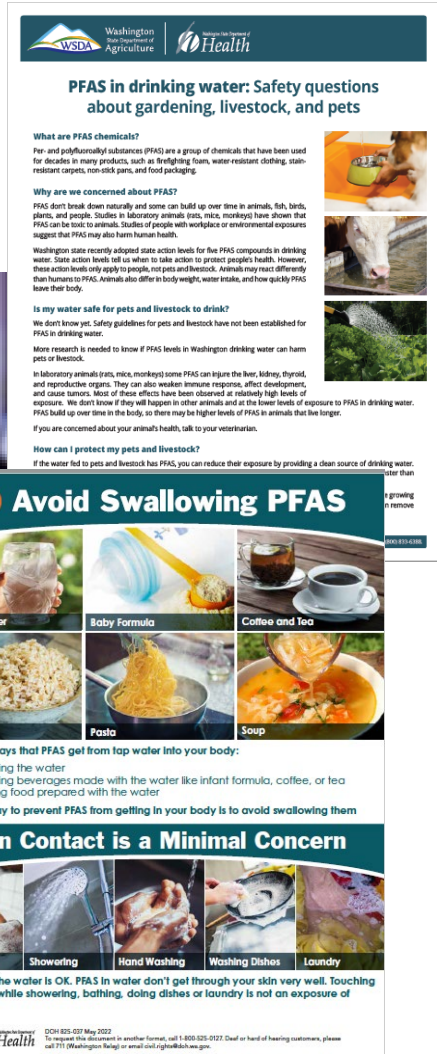
Yakima Training Center — PFAS investigation

- 2020 on-base groundwater testing: highest detection PFOA + PFOS ~50,000 ppt
- 2021-22 **Phase 1** & **2** off-base testing of drinking water
- 38 private wells serving 56 households > 2016 EPA HAL.
- 21 additional wells exceeded a WA SAL
- Highest detection PFOS +PFOS: ~1600 ppt
- 2022 **Phase 3** testing



State Response to Yakima Training center

Addressing community's health questions



Washington State Department of Agriculture | Washington State Department of Health

PFAS in drinking water: Safety questions about gardening, livestock, and pets

What are PFAS chemicals?

Per- and polyfluoroalkyl substances (PFAS) are a group of chemicals that have been used for decades in many products, such as firefighting foam, water-resistant clothing, stain-resistant carpets, non-stick pans, and food packaging.

Why are we concerned about PFAS?

PFAS don't break down naturally and some can build up over time in animals, fish, birds, plants, and people. Studies in laboratory animals (rats, mice, monkeys) have shown that PFAS can be toxic to animals. Studies of people with workplace or environmental exposures suggest that PFAS may also harm human health.

Washington state recently adopted state action levels for five PFAS compounds in drinking water. State action levels tell us when to take action to protect people's health. However, these action levels only apply to people, not pets and livestock. Animals may react differently than humans to PFAS. Animals also differ in body weight, water intake, and how quickly PFAS leave their body.

Is my water safe for pets and livestock to drink?

We don't know yet. Safety guidelines for pets and livestock have not been established for PFAS in drinking water.

More research is needed to know if PFAS levels in Washington drinking water can harm pets or livestock.

In laboratory animals (rats, mice, monkeys) some PFAS can injure the liver, kidney, thyroid, and reproductive organs. They can also weaken immune response, affect development, and cause tumors. Most of these effects have been observed at relatively high levels of exposure. We don't know if they will happen in other animals and at the lower levels of exposure to PFAS in drinking water. PFAS build up over time in the body, so there may be higher levels of PFAS in animals that live longer.

If you are concerned about your animal's health, talk to your veterinarian.

How can I protect my pets and livestock?

If the water fed to pets and livestock has PFAS, you can reduce their exposure by providing a clean source of drinking water.

Avoid Swallowing PFAS

Drinking Water | Baby Formula | Coffee and Tea | Rice | Pasta | Soup

The main ways that PFAS get from tap water into your body:

- drinking the water
- drinking beverages made with the water like infant formula, coffee, or tea
- eating food prepared with the water

The best way to prevent PFAS from getting in your body is to avoid swallowing them

Skin Contact is a Minimal Concern

Bathing | Showering | Hand Washing | Washing Dishes | Laundry

Touching the water is OK. PFAS in water don't get through your skin very well. Touching the water while showering, bathing, doing dishes or laundry is not an exposure of concern.

Washington State Department of Health

DOH 825-037 May 2022

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Coordination with

- Army
- ECY, WSDA
- Yakima Health District
- ASTDR
- UW Medicine
- Funding gap for private wells, burdens the community and hinders health equity

State PFAS Stakeholder forum

Topics

- Forum to discuss solutions to PFAS in surface and drinking water
- **Intended audience**
  - Drinking water purveyors and private wells owners
  - Others who investigate, mitigate, or clean up PFAS
  - State and local governments
  - Any interested parties (communities)

WA Department of Ecology — Clean Up Values

Purpose and background

This focus sheet provides the Washington State Department of Ecology's (Ecology's) recommended soil and groundwater cleanup levels for part of a group of harmful compounds known as per- and polyfluoroalkyl substances, or PFAS. These compounds include:

1. PFOA, or perfluorooctanonic acid,
2. PFOS, or perfluorooctane sulfonic acid,
3. PFNSA, or perfluorononanoic acid,
4. PFHxS, or perfluorohexane sulfonic acid,
5. PFBS, or perfluorobutane sulfonic acid, and
6. HFPO-DA (GenX), or hexafluoropropylene oxide dimer acid.

The Washington State Department of Health (DOH) issued a final rule that included groundwater State Action Levels (SALs) for the first five PFAS compounds listed above, which became effective on January 1, 2022. The Department of Health calculated the SALs using peer-reviewed non-cancer reference doses (RfDs) that represent the best available science. They used RfDs to establish the SALs because there are limited data available to support a quantitative assessment of cancer risk for PFAS compounds.

At a future date, we will release our recommended cleanup levels for terrestrial ecological, surface water, sediments, and air quality.

Recommended groundwater cleanup levels

For PFAS with SALs, Ecology recommends using the SALs as the appropriate groundwater cleanup levels. For chemicals without SALs, Ecology recommends using RfDs developed by EPA to calculate the appropriate cleanup level. The recommended groundwater cleanup levels for the first five compounds in Table 1 are the DOH SALs.

We calculated the recommended groundwater cleanup level for HFPO-DA using Model Toxics Control Act (MTCA) Equation 720-1[1] and EPA reference doses (RfDs).

For comparison purposes, we've also included the Environmental Protection Agency's (EPA) Health Advisory Levels for PFOA, PFOS, PFBS, and HFPO-DA. EPA is still evaluating the RfDs they used to develop the interim Health Advisory Levels for PFOA and PFOS, and it's possible these levels could be revised in the future. EPA is also developing RfDs for several other PFAS compounds, which may lead to additional groundwater health advisories.

Table 1: Recommended groundwater cleanup levels

PFAS Compound	Recommended Groundwater Cleanup Level	EPA Health Advisory Level
PFOA	10 ng/L	0.004 ng/L
PFOS	15 ng/L	0.02 ng/L
PFNA	9 ng/L	None
PFHxS	65 ng/L	None
PFBS	345 ng/L	2,000 ng/L
HFPO-DA (GenX)	24 ng/L	10 ng/L

Note: On June 15, 2022, EPA issued "interim" Health Advisories for PFOS and PFOA, and final Health Advisories for PFBS and HFPO-DA. Ecology is not using the EPA Health Advisory Levels as recommended cleanup levels because: 1) the levels for PFOA and PFOS are interim and subject to change, 2) the PFBS level exceeds the DOH SAL, and 3) the approach used to determine the level for HFPO-DA is not consistent with the process set out in MTCA.

- In 2021, ECY announced that PFAS are Hazardous Substances under MTCA
- In 2022 - ECY established recommended clean-up values for 6 PFAS in groundwater and soil
- https://ecology.wa.gov/Spills-Cleanup/Contamination-cleanup

2022 – Working together for brighter tomorrow

Washington State Department of Health

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Visit www.doh.wa.gov

@WaDeptHealth
@WaHealthSec

Group A Public Water Supplies • Chapter 246-290 WAC
PFAS, Drinking Water, & State Action Levels Overview

Updated November 2021

Rulemaking to Address Unregulated Contaminants

The Washington State Board of Health (board) has adopted changes to chapter 246-290 WAC Group A public water supplies and chapter 246-390 WAC Drinking water laboratory certification and data reporting to address per- and polyfluoroalkyl substances (PFAS).

Background

PFAS are a family of chemicals used since the 1950s to manufacture coatings and materials that repel water and oil and are resistant to heat and chemical reactions. PFAS are also used as surfactants. PFAS are widely used in common consumer products such as food packaging, outdoor clothing, carpets, leather goods, and nonstick cookware. Certain types of firefighting foam also contained PFAS—historically, these have been used by the U.S. military, local fire departments, and airports.

Manufacturing and extensive use of PFAS has led to wide-spread human exposure in the U.S. and globally. In laboratory animals, some PFAS produce liver and kidney toxicity, altered hormones, suppressed immune response, adverse reproductive and developmental effects, and certain tumors. Evidence from some, but not all, epidemiological studies in people suggest that exposure to some PFAS increases cholesterol levels, alters hormone levels, reduces birth weight, reduces immune antibody response to childhood vaccines, and may increase rates of some types of cancers such as kidney and testicular cancer.

There are many sources of human exposure to PFAS. However, when drinking water is contaminated, it can be a major contributor to our overall exposure. In Washington State, voluntary testing conducted by the Department of Defense (DoD) and public water systems between 2016-2020 has documented PFAS in drinking water supplies above EPA health advisory levels in five areas of the state. These areas are the Lower Issaquah Valley Aquifer and groundwater aquifers at and/or near four military bases (Navy Bases at Whidbey Island and Bangor, Fairchild Airforce Base near Spokane, and Joint Base Lewis–McChord in Pierce County). The Department of Health (department) is working with local health jurisdictions and other agencies to address concerns in these communities. Although testing in Washington has not been comprehensive, all known sites of drinking water PFAS contamination in our state involve ground water contaminated by nearby use or release of PFAS containing fire-fighting foam.

Federal and State Actions

In 2016, EPA established a non-regulatory lifetime health advisory level (HAL) for two PFAS, perfluorooctanoic acid (PFOA) and perfluorooctanesulfonic acid (PFOS), of 70 parts per trillion combined. In 2021, EPA announced it will develop federal drinking water standards for PFOA and PFOS. This EPA rulemaking process may take several years to complete. In the meantime, at least six U.S. states have established state enforceable limits on two or more PFAS in drinking water.

To address concerns that several water systems are contaminated above EPA and other state's health advisory levels, the board filed a CR-101 on December 15, 2017, to begin the rulemaking process to set adrinking water standard for PFAS in our state.

The newly adopted rule includes:

- Criteria for setting state action levels (SAL) for contaminants that do not have an EPA established a maximum contaminant level (MCL).
- State action levels (SAL) for five PFAS found in Washington state drinking water.
- Requirements for monitoring and reporting, follow-up actions, and public notice.

It is important to note that when an MCL is exceeded, the water system is required to treat the water, while exceeding a SAL does not require a water system to treat. SALs are established using the same calculations EPA uses to establish maximum contaminant level goals, which is one of the first steps in determining an MCL.

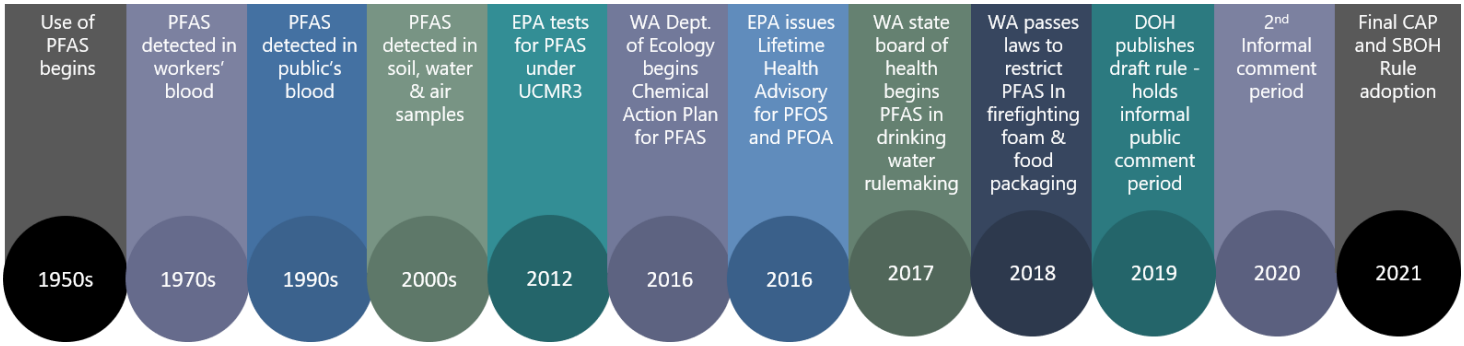
The SALs provide state public health recommendations for the safe, long-term consumption of drinking water, below which there is no known or expected health risk. If a SAL is exceeded, follow-up actions, including monitoring and public notification are required. Since EPA has not adopted MCLs for PFAS, the board determined that acting now is the best course to protect public health. The board held the public comment period in August 2021 and held the public hearing at the October 13, 2021, board meeting. The board voted to adopt the rule at that same meeting. The rule becomes effective January 1, 2022, and monitoring requirements begin in 2023.

Department of Ecology (Ecology) worked with the Department of Health and diverse stakeholders to develop a state PFAS Chemical Action Plan (CAP). The CAP looks broadly at all uses and exposures of PFAS and makes recommendations that will protect human health and the environment.

The newly adopted rules are aligned with several recommendations in the CAP. The rule expands drinking water testing toinclude all Group A community water systems, provides health-protective standards for the most common PFAS found in drinking water, and will expand the number of PFAS that are routinely measured and reported in drinking water testing.

Several other CAP recommendations support the safety of drinking water including:

1. Notification of local governments when PFAS are discovered in a Group A system so that Group B water systems and private wells can be notified.
2. Ecology support to identify the source of contaminated aquifers.
3. Coherence between PFAS SALs and Ecology groundwater cleanup standards.
4. Ecology designation of PFAS as hazardous substances under the Model Toxics Control Act (MTCA) to bring PFAS into the regulatory framework of our state clean-up law.
5. Funding to support PFAS testing and mitigation.



Interested Stakeholders

Stakeholders interested in the rulemaking include, but are not limited to, water systems owners and operators, environmental laboratories that analyze drinking water samples, local health jurisdictions, environmental and human health advocacy groups, military entities, individuals and communities with known PFAS contamination in their drinking water, as well as manufacturers and users of PFAS.

Key Messages

- PFAS have become a serious public health concern across our state and country.
- Almost a dozen Group A public water systems and over 200 private wells in five areas of the state are known to have PFAS contamination in their groundwater supplies above EPA and other state's health advisory levels.
- PFAS do not break down easily and can persist in the environment for long periods of time. Over time, PFAS released from manufacturing sites, landfills, firefighting foam, and other products have contaminated groundwater, rivers, lakes, fish, and wildlife.
- Some PFAS are widely detected in human breastmilk and blood serum.
- Exposure can occur when someone uses certain products that contain PFAS, eats PFAS-contaminated food, or drinks PFAS-contaminated water. When ingested, some PFAS chemicals can build up in the body and, over time, they may increase to a level where health effects could occur.
- Voluntary phase-outs of PFOS and PFOA and some other highly bioaccumulative PFAS occurred between 2000 - 2015 in the U.S.

Contacts

Stuart Glasoe, Policy Advisor, State Board of Health (360) 236-4111 or stuart.glasoe@sboh.wa.gov
Jocelyn Jones, Rulemaking Project Manager, Department of Health (360) 236-3020 or jocelyn.jones@doh.wa.gov

More Information

For more information about PFAS visit the PFAS webpage.

To find out more about the PFAS rulemaking visit the Office of Drinking Water's Rulemaking webpage.

To find out more about the Lab rulemaking visit the Office of Drinking Water's Rulemaking webpage.

EPA revised Health Advisory Levels for PFAS - FAQ

What did EPA announce?

On June 15, 2022, the Environmental Protection Agency (EPA) released drinking water lifetime Health Advisory Levels (HALs) for four per- and polyfluoroalkyl substances (PFAS). These included interim HALs for PFOA and PFOS and final HAL for PFBS and GenX.

What is a lifetime Health Advisory Level (HAL)?

A Health Advisory Level is an amount of a contaminant in drinking water that is almost certain not to cause harmful human health effects if consumed over a lifetime.

The PFOA and PFOA HALs also apply to shorter periods of exposure (months) in sensitive groups (pregnant and lactating persons, children aged birth to 5 years old).

PFAS	EPA HALs (2022)	WA SALs (2021)
PFOA	*0.004* ppt	10 ppt
PFOS	*0.02* ppt	15 ppt
PFNA	-	9 ppt
PFHxS	-	65 ppt
PFBS	2,000 ppt	345 ppt
GenX	10 ppt	-

Italics indicates interim HALs -not yet finalized by EPA
ppt = parts per trillion

Health advisories are set well below the level at which scientists expect to see health impacts. Health advisories are not regulations and are not enforceable.

What should you know about the new assessments?

According to EPA new analyses, people drinking water with any detectable concentrations of PFOA or PFOS can decrease their lifetime health risk by reducing their exposure to PFAS in their drinking water.. Learn more about EPA's advice here: https://www.epa.gov/sdwa/drinking-water-health-advisories-pfoa-and-pfos)

EPA is only part way through a multi-year process of setting a drinking water standard for PFAS in drinking water. In the next step of EPA's effort, the agency will finalize its public health goals for PFOS and PFOA and will propose a standard that is as close to the goal as technically feasible while taking costs and benefits into consideration. Balancing costs against the expected benefits allows the Agency to keep costs in proportion to the health benefits expected. EPA expects to propose a drinking water standard by the end of 2022 and adopt a standard by the end of 2023.

Will Washington change its SAL values based on the new information?

In general, WA SALs are in place until they are replaced by a federal or state maximum contaminant level (MCL). Any change of a SAL requires rule-making by the State Board of Health. EPA's new interim HALs for PFOA and PFOS are still undergoing expert review and may change. After EPA finalizes their values and proposes an MCL for PFOA and PFOA, we will consider whether to recommend adjustment of our SAL values.

How do HALs differ from WA SALs?

A HAL is based on health science alone. It does not consider if that level can be achieved. EPA's interim HALs for PFOA and PFOS are below what we can accurately measure with approved laboratory methods and below what current PFAS treatment technology is certified or demonstrated to achieve. In contrast, a SAL can't be set below what we can measure in drinking water (2 ppt). SALs also must consider

whether available treatment can reliably attain a SAL. EPA says it is working with third party certifiers to certify water filters that can treat to lower levels.

What's behind the different HAL and SAL values?

- **PFOA and PFOS**. EPA derived interim HALs from a human study of immune effects in children. The study measured reduced serum antibodies following childhood vaccines. The WA SALs are based on developmental and immune effects observed in controlled rodent studies.

- **PFBS**. The WA SAL and the EPA HAL were derived the same except that EPA used a drinking water intake rate associated with women of reproductive age and WA selected a higher rate of intake associated with infant consumption. While The EPA's HAL provides adequate protection for adults and fetuses, WA's SAL better protects infants which we deemed a sensitive life stage for PFBS.

New public health goals set by EPA for PFOS and PFOA require a broader approach

We can't reach EPAs new HALs for PFOA and PFOS in drinking water anytime soon. We can't measure those levels in water and aren't sure that PFAS removal technology can treat to those levels in a financially viable manner.

In addition, we'll need a sustained and broader effort to lower exposure from all sources to EPA's recommended exposure limits for PFOA and PFOS. This means reducing PFAS in foods and consumer products, and preventing environmental releases from users of PFAS, waste streams, and disposal sites.

WA has been a leader in this broader approach. In 2018, we were one of the first states to pass restrictions on major sources of PFAS in our food and water (firefighting foam and food packaging). In 2019, our state legislature authorized Ecology to further regulate PFAS in consumer products through the Safer Products for WA Program. Ecology is currently considering restrictions on PFAS in carpets, leather and textile furnishings, and aftermarket stain and waterproofing sprays. Ecology is also investigating occurance and sources of PFAS in surface water, fish, and key waste streams. DOH developed state action levels for PFAS in drinking water, is administering funding to address PFAS in public water systems, and is developing recommendations for PFAS in recreational freshwater fish. In 2021, WA Depts of Ecology and Health issued a statewide action plan for PFAS to guide state work. https://ecology.wa.gov/Waste-Toxics/Reducing-toxic-chemicals/Addressing-priority-toxic-chemicals/PFAS . EPA is also taking action at the federal level https://www.epa.gov/pfas/epa-actions-address-pfas

DEPARTMENT OF ECOLOGY
State of Washington

Focus on: PFAS Cleanup Levels

Photo credit: jplenio on Pixabay

Purpose and background

This focus sheet provides the Washington State Department of Ecology's (Ecology's) recommended soil and groundwater cleanup levels for part of a group of harmful compounds known as per- and polyfluoroalkyl substances, or PFAS. These compounds include:

1. PFOA, or perfluorooctanonic acid,
2. PFOS, or perfluorooctane sulfonic acid,
3. PFNSA, or perfluorononanoic acid,
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6. HFPO-DA (GenX), or hexafluoropropylene oxide dimer acid.

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At a future date, we will release our recommended cleanup levels for terrestrial ecological, surface water, sediments, and air quality.

Recommended groundwater cleanup levels

For PFAS with SALs, Ecology recommends using the SALs as the appropriate groundwater cleanup levels. For chemicals without SALs, Ecology recommends using RfDs developed by EPA to calculate the appropriate cleanup level. The recommended groundwater cleanup levels for the first five compounds in Table 1 are the DOH SALs.

We calculated the recommended groundwater cleanup level for HFPO-DA using Model Toxics Control Act (MTCA) Equation 720-1[1] and EPA reference doses (RfDs).

For comparison purposes, we've also included the Environmental Protection Agency's (EPA) Health Advisory Levels for PFOA, PFOS, PFBS, and HFPO-DA. EPA is still evaluating the RfDs they used to develop the interim Health Advisory Levels for PFOA and PFOS, and it's possible these levels could be revised in the future. EPA is also developing RfDs for several other PFAS compounds, which may lead to additional groundwater health advisories.

Table 1: Recommended groundwater cleanup levels

PFAS Compound	Recommended Groundwater Cleanup Level	EPA Health Advisory Level
PFOA	10 ng/L	0.004 ng/L
PFOS	15 ng/L	0.02 ng/L
PFNA	9 ng/L	None
PFHxS	65 ng/L	None
PFBS	345 ng/L	2,000 ng/L
HFPO-DA (GenX)	24 ng/L	10 ng/L

Note: On June 15, 2022, EPA issued "interim" Health Advisories for PFOS and PFOA, and final Health Advisories for PFBS and HFPO-DA. Ecology is not using the EPA Health Advisory Levels as recommended cleanup levels because: 1) the levels for PFOA and PFOS are interim and subject to change, 2) the PFBS level exceeds the DOH SAL, and 3) the approach used to determine the level for HFPO-DA is not consistent with the process set out in MTCA.

Recommended soil cleanup levels protective of groundwater

Table 2 provides recommended soil concentrations for both the vadose zone and the saturated zone that are protective of groundwater. We calculated these levels using MTCA Equation 747-1,[2] the groundwater cleanup levels in Table 1, and the default soil characteristics listed in the MTCA Cleanup Rule. We used organic carbon-water partitioning coefficients (Koc) and Henry's Law constants (Hcc) from the Oak Ridge National Labs database.[3] We calculated soil water distribution coefficient (Kd) values from Koc values using MTCA Equation 747-2.

Table 2: Recommended soil cleanup levels protective of groundwater

PFAS Compounds	Vadose Zone	Saturated Zone
PFOA	6.3E-05 mg/kg	4.0E-06 mg/kg
PFOS	1.7E-04 mg/kg	9.9E-06 mg/kg
PFNA	8.0E-05 mg/kg	4.8E-06 mg/kg
PFHxS	4.1E-04 mg/kg	2.6E-05 mg/kg
PFBS	1.8E-03 mg/kg	1.2E-04 mg/kg
HFPO-DA (GenX)	1.0E-04 mg/kg	7.2E-06 mg/kg

Soil direct contact cleanup levels

The soil direct contact levels in Table 3 are protective of human health based on exposure through incidental soil ingestion. We calculated recommended cleanup levels using Equation 740-1[4] (Method B—unrestricted use) and Equation 745-1[5] (Method C—sites meeting the definition of an industrial property under the MTCA Cleanup Rule). We used the RfDs that were adopted by the Department of Health for establishing the State Action Levels, along with the associated default exposure assumptions provided in the MTCA Cleanup Rule. For HFPO-DA, we used the RfD developed by EPA.

Table 3: Recommended soil direct contact cleanup levels

PFAS Compounds	Method B	Method C
PFOA	0.24 mg/kg	11 mg/kg
PFOS	0.24 mg/kg	11 mg/kg
PFNA	0.2 mg/kg	8.8 mg/kg
PFHxS	0.78 mg/kg	34 mg/kg
PFBS	24 mg/kg	1,100 mg/kg
HFPO-DA (GenX)	0.24 mg/kg	11 mg/kg

Compliance with state and federal laws

Cleanup levels must comply with applicable local, state, and federal laws, along with requirements Ecology has determined to be relevant and appropriate in the MTCA Cleanup Rule (WAC 173-340-710(4)).[6] Together these requirements are referred to as ARARs. As of June 2022, there are no legally applicable state or federal laws, such as Maximum Contaminant Levels, to apply when developing PFAS cleanup levels. However, each cleanup site can be reviewed to determine if there are relevant and appropriate requirements that, while not legally required, should be applied depending on circumstances at the site. To make this determination, Ecology needs to evaluate criteria in WAC 173-340-710(4) to establish that the recommended levels are relevant and appropriate.

Until Ecology makes a site-specific determination, you can consider the soil and groundwater cleanup levels set forth in this focus sheet to be preliminary cleanup levels. This will provide a common understanding of the potential severity of the PFAS contamination found as part of a site investigation.

Related information

- PFAS and cleanups[7]
- Learn more about PFAS and health[8]
- MTCA Cleanup Rule (Chapter 173-340 WAC)[9]

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360-529-7727

To request an ADA accommodation, contact Ecology by phone at 360-407-7170 or email at first.last@ecy.wa.gov, or visit https://ecology.wa.gov/accessibility.
For Relay Service or TTY call 711 or 877-833-6341.

[1] https://apps.leg.wa.gov/WAC/default.aspx?cite=173-340-720
[2] https://apps.leg.wa.gov/WAC/default.aspx?cite=173-340-747
[3] https://rais.ornl.gov/
[4] https://apps.leg.wa.gov/wac/default.aspx?cite=173-340-740
[5] https://apps.leg.wa.gov/wac/default.aspx?cite=173-340-745
[6] https://app.leg.wa.gov/wac/default.aspx?cite=173-340-710
[7] https://ecology.wa.gov/PFAScleanup
[8] https://ecology.wa.gov/PFAS
[9] https://apps.leg.wa.gov/WAC/default.aspx?cite=173-340

WASHINGTON STATE BOARD OF HEALTH

Date: August 10, 2022

To: Washington State Board of Health Members

From: Umair A. Shah, MD, MPH, Secretary of Health

Subject: WAC 246-101-017, Notification and Reporting Requirements of Novel Coronavirus (SARS-CoV-2)

Background and Summary:

Since the first confirmed case of Novel Coronavirus (SARS-CoV-2), also known as Coronavirus Disease 2019 (COVID-19), was reported in Washington State in January 2020, there have been over 90 million confirmed cases and over one million deaths reported in the United States.[1]

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law on March 27, 2020, includes a requirement for every laboratory that performs or analyzes a test intended to detect or diagnose a possible case of COVID-19 to report the results to the U.S. Department of Health and Human Services (HHS) in a manner prescribed by the HHS Secretary until the end of the public health emergency.

On June 4, 2020, HHS released laboratory data reporting guidance for COVID-19 that specifies standards for reporting laboratory testing data, including test results, relevant demographic details (e.g., patient's age, race, ethnicity, sex), and additional information to improve the public health response to COVID-19. These data must be collected and reported to state or local public health departments using existing reporting channels in accordance with state law or policies.

In September 2020, the Centers for Medicare and Medicaid Services (CMS) published an interim final rule in the Federal Register Volume 85, Number 171 stipulating that all laboratories conducting SARS-CoV-2 testing and reporting patient-specific results, including hospital laboratories, nursing homes, and other facilities conducting testing for COVID-19, who fail to report information required under the CARES Act will be subject to monetary penalties.

HHS has since updated its guidance twice: in January 2021 and March 2022. The most recent update removes requirements to report antibody or self-administered tests and specifies reporting requirements by testing entity and test type. The updated guidance also refines the reportable data components that accompany test results, and no longer suggests reporting answers to ask-on-order entry questions.

[1] Centers for Disease Control and Prevention, COVID Data Tracker, accessed July 26, 2022

(continued on the next page)

The State Board of Health (Board) has the authority under RCW 43.20.050 to adopt rules for the prevention and control of infectious and noninfectious diseases. The purpose of chapter 246-101 WAC, Notifiable Conditions, is to provide critical information to public health authorities to aid them in protecting and improving public health through prevention and control of disease.

The Board previously adopted seven emergency rules under WAC 246-101-017 to designate COVID-19 as a notifiable condition and require reporting of essential COVID-19 testing and patient demographic data aligned with the CARES Act:

- CR-103E filed on July 31, 2020 as WSR 20-16-121
- CR-103E filed on November 25, 2020 as WSR 20-24-081
- CR-103E filed on March 26, 2021 as WSR 21-08-009
- CR-103E filed on July 23, 2021 as WSR 21-16-014
- CR-103E filed on August 23, 2021 as WSR 21-18-034
- CR-103E filed on December 21, 2021 as WSR 22-01-200
- CR-103E filed on April 20, 2022 as WSR 22-09-082

To ensure consistency in reporting between regulated entities under chapter 246-101 WAC, the Board has required COVID-19 reporting by health care providers, health care facilities, laboratories, local health jurisdictions, and the Department of Agriculture. Additionally, the seventh emergency rule went beyond updated HHS guidance to require reporting of negative and inconclusive results from certain antigen testing in order for the Department of Health to calculate percent positivity for surveillance purposes.

Per the requirements of the Administrative Procedures Act, RCW 34.05.350, the Board has taken steps to integrate requirements of the emergency rules into the permanent Notifiable Conditions chapter. The Board filed a CR-101, Preproposal Statement of Inquiry on July 23, 2021. Rulemaking is currently underway.

Until permanent rules are in effect, I recommend the Board adopt an eighth emergency rule to continue to designate COVID-19 as a notifiable condition and require reporting of essential COVID-19 testing and demographic data to allow the governmental public health system to identify appropriate public health interventions. I believe the continuation of these requirements through emergency rule adoption is necessary for the preservation of the public health, safety, and general welfare of the State of Washington.

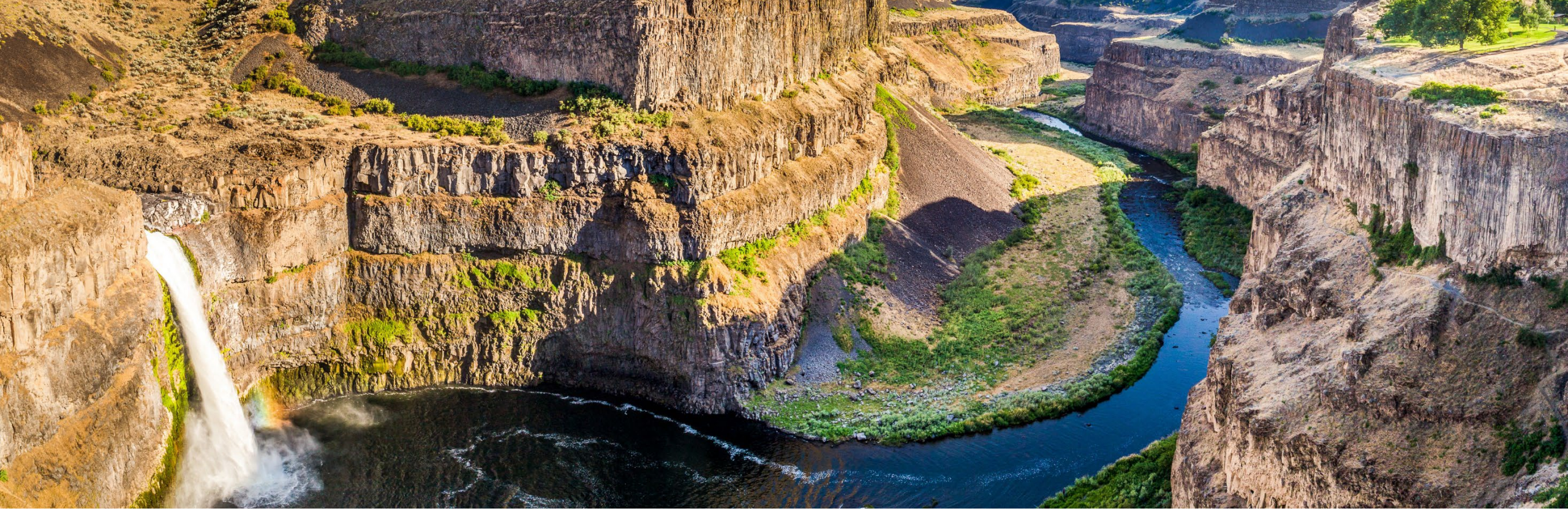
Recommended Board Actions:

The Board may wish to consider and amend, if necessary, the following motion:

The Board adopts an eighth emergency rule to extend the designation of COVID-19 as a notifiable condition and the required reporting of essential testing and demographic data to maintain the necessary public health response to COVID-19. The Board directs staff to file a CR-103E to extend WAC 246-101-017 without lapse, effective August 18, 2022.

Staff
Kaitlyn Donahoe

To request this document in an alternate format or a different language, please contact Kelie Kahler, Washington State Board of Health Communication Manager, at 360-236-4102 or by email at kelie.kahler@sboh.wa.gov. TTY users can dial 711.



Washington State Board of Health

Emergency Rule: WAC 246-101-017, COVID-19 Reporting

August 10, 2022

Kaitlyn Donahoe, MPA

Policy Advisor, State Board of Health

Overview

- Background
- Prior Emergency Rules
- Proposed Eighth Emergency Rule
- Next Steps

Background: CARES Act Requirements, HHS Guidance

- **March 2020:** the Coronavirus Aid, Relief, and Economic Security (CARES) Act requires laboratories to report COVID-19 test results to the Secretary of the U.S. Department of Health and Human Services (HHS) in a manner prescribed by the Secretary
- **June 2020 (updated January 2021, March 2022):** HHS releases COVID-19 laboratory data reporting guidance specifying standards for reporting testing and demographic data
- **September 2020:** Centers for Medicare and Medicaid Services (CMS) publish an interim final rule stipulating all laboratories conducting COVID-19 testing and reporting patient-specific results who fail to report information required under the CARES Act will be subject to monetary penalties

Prior Emergency Rules

1

July 2020

- Required reporters: health care providers & facilities, laboratories, LHJs
- All data components required by HHS
- Additional data reporting (e.g., patient emergency contact, preferred language)
- Disaggregated race and ethnicity

2

November 2020

- Dept. of Agriculture added to the list of required reporters
- More closely aligned with HHS guidance; additional data components not required by HHS removed

3

March 2021

- No changes; rule language identical to November 9, 2020, emergency rule

4

June 2021

- No changes; rule language identical to November and March, emergency rules

5

August 2021

- Adjusted reporting requirements for LHJs to report to the Dept. of Health to better reflect the capacity of the Dept. of Health and LHJs to receive and send these data
- All other requirements unchanged

6

November 2021

- No change; rule language identical to August emergency rule

7

April 2022

- Specifies reporting requirements by testing entity and test type
- Removes reporting for ask-on-order entry questions
- Refines list of reportable data components that accompany test results

Proposed Eighth Emergency Rule

- No proposed changes are recommended today
- Eighth emergency rule is identical to the seventh emergency rule adopted by the Board in April
    - Nucleic Acid Amplification Test (NAAT) testing conducted in a facility certified to perform high- or moderate-complexity tests: positive, negative, and inconclusive results
    - All other testing: positive results
    - No antibody or self-administered tests
- Rule language is provided in today's meeting materials

Permanent Rulemaking

- COVID-19 will be a permanent notifiable condition starting January 1, 2023 per previous rule revision by the Board
- The Board filed a CR-101 on July 20, 2021 to integrate emergency rule requirements and provisions into permanent rule

Next Steps

- Current emergency rule expires August 18, 2022.
- If the Board elects to adopt an eighth emergency rule, staff will file a CR-103E with the code reviser to extend WAC 246-101-017 without lapse.
- The emergency rule will be in effect for 120 days.

THANK YOU

WASHINGTON STATE BOARD OF HEALTH

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TTY users can dial 711

NEW SECTION

WAC 246-101-017 Novel coronavirus (SARS-CoV-2), coronavirus disease 2019 (COVID-19) reporting. (1) Designating coronavirus disease 2019 (COVID-19), and the novel coronavirus (SARS-CoV-2) that causes it, as a notifiable condition, and requiring the reporting of race and ethnicity and other essential data by health care providers, health care facilities, laboratories, and local health departments related to cases of COVID-19 are necessary to ensure that public health agencies receive complete notice of COVID-19 cases and to address racial and ethnic inequities in morbidity and mortality among individuals with the disease. This rule is also necessary to align with the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and the U.S. Department of Health and Human Services laboratory data reporting requirements for COVID-19 testing, which require reporting of COVID-19 data to the appropriate state or local health department and the U.S. Department of Health and Human Services, and further, that any person or entity ordering a diagnostic or serologic test, collecting a specimen, or performing a test should make every reasonable effort to collect complete demographic information and include such data when ordering a laboratory test to enable the entities performing the test to report these data to state, territorial, local, and tribal public health departments. During this global pandemic, immediate adoption of a rule requiring notice of novel coronavirus (SARS-CoV-2) as a notifiable condition and reporting of race, ethnicity, and other essential data is necessary for the preservation of public health, safety, and general welfare.

(2) For the purpose of this section:

(a) "Animal case" means an animal, alive or dead, with a diagnosis of novel coronavirus (SARS-CoV-2) made by a veterinarian licensed under chapter 18.92 RCW, veterinary medical facility licensed under chapter 18.92 RCW, or veterinary laboratory as defined under chapter 16.70 RCW based on clinical criteria, or laboratory criteria, or both.

(b) "Antigen test" means an immunoassay test that detects the presence or absence of SARS-CoV-2 protein to indicate current SARS-CoV-2 infection.

(c) "Business day" means any day that the department is open for business.

(d) "Health care facility" means:

(i) Any assisted living facility licensed under chapter 18.20 RCW; birthing center licensed under chapter 18.46 RCW; nursing home licensed under chapter 18.51 RCW; hospital licensed under chapter 70.41 RCW; adult family home licensed under chapter 70.128 RCW; ambulatory surgical facility licensed under chapter 70.230 RCW; private establishment licensed under chapter 71.12 RCW; or enhanced service facility licensed under chapter 70.97 RCW; and

(ii) Clinics or other settings where one or more health care providers practice.

(e) "Immediately" means without delay, twenty-four hours a day, seven days a week.

(f) "Nucleic acid amplification test" or "NAAT" means a viral diagnostic test including reverse transcription polymerase chain reaction (RT-PCR), transcription mediated amplification (TMA), loop-mediated isothermal amplification (LAMP), strand displacement amplifications (SDA), and other NAATs authorized for emergency use by the U.S. Food and Drug Administration for the detection for SARS-CoV-2.

(g) "Reference laboratory" means a laboratory licensed inside or outside of Washington state that receives a specimen from another licensed laboratory and performs one or more tests on that specimen.

(h) "Secure electronic data transmission" means electronic communication and accounts developed and maintained to prevent unauthorized access, loss, or compromise of sensitive information including, but not limited to, secure file transfer, secure facsimile, a health information exchange authorized under RCW 41.05.039, and the secure electronic disease surveillance system.

(i) "Secure electronic disease surveillance system" means the secure electronic data transmission system maintained by the department and used by local health departments to submit notifications, investigation reports, and outbreak reports under this chapter.

(j) "Waived test" has the same meaning as WAC 246-338-010 (45)(b).

(k) Patient's ethnicity shall be identified by the patient and reported using one of the following categories:

(i) Hispanic or Latino;

(ii) Non-Hispanic or Latino;

(iii) Unknown; or

(iv) Asked, but unknown.

(l) Patient's race shall be identified by the patient and reported using one or more of the following categories:

(i) American Indian or Alaska Native;

(ii) Asian;

(iii) Black or African American;

(iv) Native Hawaiian or Other Pacific Islander;

(v) White;

(vi) Unknown; or

(vii) Asked, but unknown.

(3) Unless a health care facility has assumed the notification duties of the principal health care provider under subsection (7) of this section, or a laboratory director in a health care facility where laboratory point-of-care testing occurs under a certificate of waiver as described in WAC 246-338-020 has fulfilled the laboratory notification requirements as described in subsection (9) of this section, the principal health care provider shall submit individual case reports of novel coronavirus (SARS-CoV-2) to the local health department via secure electronic data transmission using a file format or template specified by the department:

(a) Within 24 hours of receiving a laboratory confirmed positive test result; and

(b) Following the requirements of this section, WAC 246-101-105, and WAC 246-101-120; excluding the requirements in WAC 246-101-105(10).

(4) The local health officer may waive or partially waive subsection (3) or (5) of this section, or both if the local health officer determines individual case reports of novel coronavirus (SARS-CoV-2) submitted by health care providers or health care facilities are not needed and are not promoting public health for any reason including, but not limited to, the local health department being unable to process the volume of case reports. The local health officer shall notify health care providers and health care facilities upon their determination.

(5) A health care facility shall submit individual case reports of novel coronavirus (SARS-CoV-2) to the local health department via

secure electronic data transmission using a file format or template specified by the department:

(a) Within 24 hours of receiving a laboratory confirmed positive test result; and

(b) Following the requirements of this section, WAC 246-101-305, and WAC 246-101-320; excluding the requirement in WAC 246-101-305(4).

(6) Health care providers and health care facilities shall provide the local health department with the information identified in Column A of Table 1 in this section for individual case reports concerning novel coronavirus (SARS-CoV-2).

(7) A health care facility may assume the notification requirements established in this section for a health care provider practicing within the health care facility.

(8) A health care facility shall not assume the notification requirements established in this section for a laboratory that is a component of the health care facility.

(9) A principal health care provider is not required to submit individual case reports of novel coronavirus (SARS-CoV-2) to the local health department when the provider practices in a health care facility where laboratory point-of-care testing occurs under a certificate of waiver as described in WAC 246-338-020 and the laboratory director has fulfilled the laboratory notification requirements under subsections (12), (13), and (14) of this section.

(10) Health care providers and health care facilities shall provide the laboratory with the information identified in Column A of Table 1 in this section for each test ordered for novel coronavirus (SARS-CoV-2).

(11) For specimens associated with novel coronavirus (SARS-CoV-2) sent to a laboratory outside of Washington state, health care providers, health care facilities, and laboratories shall provide the out-of-state laboratory with a copy of chapter 246-101 WAC if they arrange for the out-of-state laboratory to report the test results consistent with WAC 246-101-105 (5)(a), 246-101-205 (1)(f)(i), or 246-101-305 (1)(e)(i) to the local health department as required under this subsection.

(12) For laboratories licensed to conduct moderate or high complexity testing, the laboratory director shall submit individual laboratory reports of positive, negative, and inconclusive test results from all NAAT and antigen tests performed for novel coronavirus (SARS-CoV-2) to the local health department:

(a) Via secure electronic data transmission using a file format or template specified by the department;

(b) Within 24 hours of results being known or determined; and

(c) Following the requirements of this section, WAC 246-101-205, and WAC 246-101-230; excluding the requirements in WAC 246-101-205(3).

(13) For laboratories licensed to conduct waived tests under a certificate of waiver, a laboratory director shall submit individual laboratory reports of positive test results from all waived tests, excluding antibody testing, for novel coronavirus (SARS-CoV-2) to the local health department:

(a) Via secure electronic data transmission using a file format or template specified by the department;

(b) Within 24 hours of results being known or determined; and

(c) Following the requirements of this section, WAC 246-101-205, and 246-101-230; excluding the requirements in WAC 246-101-205(3).

(14) A laboratory director shall provide the information identified in Column B of Table 1 in this section to the local health department with each novel coronavirus (SARS-CoV-2) laboratory report.

(15) A laboratory director, upon request by the local health department or the department, shall submit novel coronavirus (SARS-CoV-2) presumptive positive isolates or, if no isolate is available, the specimen associated with the presumptive positive result to the Washington state public health laboratories within two business days of request. Specimens shall be sent to:

Washington State Public Health Laboratories
Washington State Department of Health
1610 N.E. 150th Street
Shoreline, WA 98155

(16) If the local health department or the department requests a specimen under subsection (15) of this section, a laboratory director shall provide the Washington state public health laboratories with the information identified in Column C of Table 1 in this section with each specimen submitted.

(17) When referring a specimen to another laboratory for a test for novel coronavirus (SARS-CoV-2), a laboratory director shall provide the reference laboratory with the information identified in Column D of Table 1 in this section for each test referral.

(18) The department of agriculture shall submit individual case reports for each animal case of novel coronavirus (SARS-CoV-2) to the department via secure electronic data transmission using a file format or template specified by the department within twenty-four hours of being notified of the animal case.

(19) The department of agriculture shall call the department and confirm receipt immediately after submitting a case report for each animal case of novel coronavirus (SARS-CoV-2).

(20) When the department of agriculture submits information under subsection (18) of this section, the department shall:

(a) Consult with the department of agriculture on all animal cases; and

(b) Notify the local health department of animal cases submitted to the department.

(21) A local health department shall, using a secure electronic disease surveillance system:

(a) Notify the department within one business day upon receiving a case, laboratory, or animal case report of positive test results, excluding antibody testing, for novel coronavirus (SARS-CoV-2); and

(b) Notify the department within five business days upon receiving a laboratory report of negative or inconclusive test results for novel coronavirus (SARS-CoV-2); and

(c) Submit individual investigation reports of novel coronavirus (SARS-CoV-2) to the department within one business day upon completing the case investigation.

(22) Notifications required under subsection (21)(a) and (b) of this section must include the information identified in Column E of Table 1 in this section.

(23) Investigation reports required under subsection (21)(c) of this section must include the information identified in Column F of Table 1 in this section.

(24) A local health department shall, within one business day, reassign cases to the department upon determining the patient who is the subject of the case:

(a) Is a resident of another local health department; or

(b) Resides outside Washington state.

(25) A local health department, upon consultation with the department, may forward novel coronavirus (SARS-CoV-2) individual laboratory or case reports submitted by laboratories, health care providers, and health care facilities to the department for data entry and processing.

(26) The local health officer or the state health officer may request additional information of epidemiological or public health value when conducting a case investigation or otherwise for prevention and control of a specific notifiable condition.

(27) Health care providers, health care facilities, laboratories, and the department of agriculture may provide, via secure electronic data transmission using a file format or template specified by the department, additional health information, demographic information, or infectious or noninfectious condition information than is required under this section to the department, local health department, or both when it determines that the additional information will aid the public health authority in protecting the public's health and preventing the spread of novel coronavirus (SARS-CoV-2).

Table 1
Required Reporting for Health Care Providers, Health Care Facilities, Laboratories, and Local Health Departments

	Column A: Health care providers and health care facilities shall provide the following information to the local health department with each case report, and to the laboratory with each test ordered:	**Column B: Laboratory directors shall provide the local health department with the following information with each laboratory report:**	**Column C: Laboratory directors shall provide the department with the following information with each specimen submitted:**	**Column D: Laboratory directors shall provide the following information when referring a specimen to another laboratory:**	**Column E: Local health department notifications to the department must include:**	**Column F: Local health department investigation reports to the department must include:**
Patient's name (last name, first name, middle initial)	X	X	X	X	X	X
Patient's street address, including residence zip code and county	X	X	X	X	X	X
Patient's telephone number with area code	X	X	X	X	X	X
Patient's age and date of birth	X	X	X	X	X	X
Patient's ethnicity, using the categories described in subsection (2)(k) of this section	X	X	X	X	X	X

	Column A: Health care providers and health care facilities shall provide the following information to the local health department with each case report, and to the laboratory with each test ordered:	**Column B: Laboratory directors shall provide the local health department with the following information with each laboratory report:**	**Column C: Laboratory directors shall provide the department with the following information with each specimen submitted:**	**Column D: Laboratory directors shall provide the following information when referring a specimen to another laboratory:**	**Column E: Local health department notifications to the department must include:**	**Column F: Local health department investigation reports to the department must include:**
Patient's race, using the categories described in subsection (2)(l) of this section	X	X	X	X	X	X
Patient's sex	X	X	X	X	X	X
Test ordered, performed, and resulted, using appropriate LOINC codes as defined by the Laboratory in Vitro Diagnostics (LIVD) Test Code Mapping for SARS-CoV-2 tests provided by the CDC		X	X	X	X*	X*
Test result (values) using appropriate SNOMED-CT codes as defined by the LIVD Test Code Mapping for SARS-CoV-2 tests provided by the CDC		X	X	X	X*	X*
Test result date (date format)		X	X		X*	X*
Device identifier		X	X		X*	X*
Accession number or specimen ID		X	X		X*	X*
Date of specimen collection (date format)	X	X	X	X	X	X
Specimen source, using appropriate SNOMED-CT, SPM4 codes, or equivalently detailed alternative codes		X	X	X	X*	X*
Ordering organization or health care provider's name	X	X	X	X	X	X

	Column A: Health care providers and health care facilities shall provide the following information to the local health department with each case report, and to the laboratory with each test ordered:	**Column B: Laboratory directors shall provide the local health department with the following information with each laboratory report:**	**Column C: Laboratory directors shall provide the department with the following information with each specimen submitted:**	**Column D: Laboratory directors shall provide the following information when referring a specimen to another laboratory:**	**Column E: Local health department notifications to the department must include:**	**Column F: Local health department investigation reports to the department must include:**
Ordering organization or health care provider's National Provider Identifier (as applicable) and affiliated organization (specific facility)	X	X	X	X	X	X
Ordering organization or health care provider's telephone number	X	X	X	X	X	X
Ordering organization or health care provider's address including zip code	X	X	X	X	X	X
Performing laboratory or facility name and CLIA number		X	X		X*	X*
Performing laboratory or facility address including zip code		X	X		X*	X*
Performing laboratory or facility phone number		X	X		X*	X*
Reporting entity name and CLIA number (or appropriate ID)		X	X	X	X*	X*
Reporting entity address including zip code		X	X	X	X*	X*
Reporting entity phone number		X	X	X	X*	X*
Name and telephone number of the person providing the report	X					
Patient's notifiable condition	X				X	X
Patient's diagnosis of disease or condition	X					
Date specimen received by reporting laboratory		X	X		X*	X*

	Column A: Health care providers and health care facilities shall provide the following information to the local health department with each case report, and to the laboratory with each test ordered:	**Column B: Laboratory directors shall provide the local health department with the following information with each laboratory report:**	**Column C: Laboratory directors shall provide the department with the following information with each specimen submitted:**	**Column D: Laboratory directors shall provide the following information when referring a specimen to another laboratory:**	**Column E: Local health department notifications to the department must include:**	**Column F: Local health department investigation reports to the department must include:**
Type of specimen tested	X	X	X	X	X*	X*
Pertinent laboratory data	X					
Initial notification source					X	X
Date local health department was notified						X
Condition symptom onset date (preferred), or alternatively, diagnosis date						X
Hospitalization status of the patient						X
Whether the patient died during this illness						X
Source or suspected source						X

* Local health departments are not required to submit this information if the notification came from a health care provider or health care facility. All other information indicated in Columns E and F is still required in these instances.

CODE REVISER USE ONLY

RULE-MAKING ORDER
EMERGENCY RULE ONLY

CR-103E (December 2017)
(Implements RCW 34.05.350 and 34.05.360)

Agency: State Board of Health

Effective date of rule:

Emergency Rules

☐ Immediately upon filing.

☒ Later (specify) 08/18/2022

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: WAC 246-101-017, Novel coronavirus (SARS-CoV-2), coronavirus disease 2019 (COVID-19) reporting. The Washington State Board of Health has adopted an eighth emergency rule to continue to designate COVID-19 as a notifiable condition and establish reporting requirements for health care providers, health care facilities, laboratories, local health jurisdictions, and the Department of Agriculture to report certain data with COVID-19 test results, including relevant demographic details (e.g., patient's age, race, ethnicity, sex), and testing information. The rule allows for certain waivers by a local health officer. The rule establishes what testing and demographic data need to be reported as well as the timing and mechanism of reporting in accordance with Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

Citation of rules affected by this order:

New: WAC 246-101-017
Repealed: None
Amended: None
Suspended: None

Statutory authority for adoption: RCW 43.20.050(2)(f)

Other authority:

EMERGENCY RULE

Under RCW 34.05.350 the agency for good cause finds:

☒ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

☒ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding: The immediate adoption of a rule to designate COVID-19 as a notifiable condition, and require the reporting of demographic, testing, and other relevant data by health care providers, health care facilities, laboratories, local health jurisdictions, and the Department of Agriculture for each COVID-19 test is necessary to comply with federal law and related guidance. Immediate adoption of this rule is necessary for the preservation of the public health, safety and general welfare of the State of Washington during the global COVID-19 pandemic.

The CARES Act requires "every laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19" to report the results from each such test to the Secretary of the U.S. Department of Health and Human Services (HHS). The Act authorizes the HHS Secretary to prescribe the form, manner, timing, and frequency of such reporting. The HHS Secretary released laboratory data reporting guidance for COVID-19 on June 4, 2020, and later updated the guidance on January 8, 2021, and March 8, 2022. The guidance requires all COVID-19 test results and accompanying data be reported through existing state, territorial, local, and Tribal public health data reporting methods. Of these requirements, any person or entity ordering a test, registering an individual to be tested, collecting a specimen, or performing a test should make every reasonable effort to collect complete demographic data of the patient (e.g., ethnicity, race, age, sex). Updated guidance specifies which test results must be reported by entities based on entity and test type, and refines the list of reportable data components that must accompany test results.

In September 2020, the Centers for Medicare and Medicaid Services (CMS) published an interim final rule in Federal Register 54826, Volume 85, Number 171, to update requirements for reporting SARS-CoV-2 test results by laboratories. The interim final rule states all laboratories conducting SARS-CoV-2 testing and reporting patient-specific results, including

hospital laboratories, nursing homes, and other facilities conducting testing for COVID-19, who fail to report information required under the CARES Act will be subject to monetary penalties. The interim final rules became effective September 2, 2020.

Adoption of an eighth emergency rule ensures continued compliance with the CARES Act, including updated HHS guidance, CMS requirements, and maintain the necessary public health response to COVID-19. The Board intends to incorporate these provisions into permanent rule, and filed a CR-101 on July 20, 2021 as WSR 21-15-105.

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	1	Amended	0	Repealed	0
Federal rules or standards:	New	1	Amended	0	Repealed	0
Recently enacted state statutes:	New	0	Amended	0	Repealed	0

The number of sections adopted at the request of a nongovernmental entity:

	New	1	Amended	0	Repealed	0

The number of sections adopted on the agency's own initiative:

	New	1	Amended	0	Repealed	0

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	0	Amended	0	Repealed	0

The number of sections adopted using:

Negotiated rule making:	New	0	Amended	0	Repealed	0
Pilot rule making:	New	0	Amended	0	Repealed	0
Other alternative rule making:	New	1	Amended	0	Repealed	0

Date Adopted:	**Signature:**
Name: Michelle A. Davis	
Title: Executive Director, Washington State Board of Health	

RCW 43.20.050

Powers and duties of state board of health—Rule making—Delegation of authority—Enforcement of rules.

(1) The state board of health shall provide a forum for the development of public health policy in Washington state. It is authorized to recommend to the secretary means for obtaining appropriate citizen and professional involvement in all public health policy formulation and other matters related to the powers and duties of the department. It is further empowered to hold hearings and explore ways to improve the health status of the citizenry.

In fulfilling its responsibilities under this subsection, the state board may create ad hoc committees or other such committees of limited duration as necessary.

(2) In order to protect public health, the state board of health shall:

(a) Adopt rules for group A public water systems, as defined in RCW 70.119A.020, necessary to assure safe and reliable public drinking water and to protect the public health. Such rules shall establish requirements regarding:

(i) The design and construction of public water system facilities, including proper sizing of pipes and storage for the number and type of customers;

(ii) Drinking water quality standards, monitoring requirements, and laboratory certification requirements;

(iii) Public water system management and reporting requirements;

(iv) Public water system planning and emergency response requirements;

(v) Public water system operation and maintenance requirements;

(vi) Water quality, reliability, and management of existing but inadequate public water systems; and

(vii) Quality standards for the source or supply, or both source and supply, of water for bottled water plants;

(b) Adopt rules as necessary for group B public water systems, as defined in RCW 70.119A.020. The rules shall, at a minimum, establish requirements regarding the initial design and construction of a public water system. The state board of health rules may waive some or all requirements for group B public water systems with fewer than five connections;

(c) Adopt rules and standards for prevention, control, and abatement of health hazards and nuisances related to the disposal of human and animal excreta and animal remains;

(d) Adopt rules controlling public health related to environmental conditions including but not limited to heating, lighting, ventilation, sanitary facilities, and cleanliness in public facilities including but not limited to food service establishments, schools, recreational facilities, and transient accommodations;

(e) Adopt rules for the imposition and use of isolation and quarantine;

(f) Adopt rules for the prevention and control of infectious and noninfectious diseases, including food and vector borne illness, and rules governing the receipt and conveyance of remains of deceased persons, and such other sanitary matters as may best be controlled by universal rule; and

(g) Adopt rules for accessing existing databases for the purposes of performing health related research.

(3) The state board shall adopt rules for the design, construction, installation, operation, and maintenance of those on-site sewage systems with design flows of less than three thousand five hundred gallons per day.

(4) The state board may delegate any of its rule-adopting authority to the secretary and rescind such delegated authority.

(5) All local boards of health, health authorities and officials, officers of state institutions, police officers, sheriffs, constables, and all other officers and employees of the state, or any county, city, or township thereof, shall enforce all rules adopted by the state board of health. In the event of failure or refusal on the part of any member of such boards or any other official or person mentioned in this section to so act, he or she shall be subject to a fine of not less than fifty dollars, upon first conviction, and not less than one hundred dollars upon second conviction.

(6) The state board may advise the secretary on health policy issues pertaining to the department of health and the state.

[**2011 c 27 § 1; 2009 c 495 § 1; 2007 c 343 § 11; 1993 c 492 § 489; 1992 c 34 § 4.** Prior: **1989 1st ex.s. c 9 § 210; 1989 c 207 § 1; 1985 c 213 § 1; 1979 c 141 § 49; 1967 ex.s. c 102 § 9; 1965 c 8 § 43.20.050;** prior: (i) **1901 c 116 § 1; 1891 c 98 § 2;** RRS § 6001. (ii) **1921 c 7 § 58;** RRS § 10816.]

COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115

March 8, 2022

Effective date: April 4, 2022

Introductory Information

Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires "[e]very laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19" to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS). The statute authorizes the Secretary to prescribe the form and manner, and timing and frequency, of such reporting. This updated guidance outlines requirements for data submission to HHS as authorized under this law.

In an effort to receive these data in the most efficient and effective manner, the Secretary is requiring that data elements be reported through existing public health data reporting methods, namely through reporting to state, territorial, local, and Tribal (STLT) public health departments as described in this guidance. As a guiding principle, data must be sent to STLT health departments using existing reporting channels to ensure rapid public health response by those departments (in accordance with STLT law, policies, and procedures). This reporting should be conducted concurrent to test results being shared with an ordering provider or patient, as applicable. HHS acknowledges that reporting laboratories rely on information they receive from ordering health care providers with patient specimens, as laboratories do not typically interact with patients. To enable and effectuate the purpose of § 18115(a), HHS strongly encourages ordering providers to collect and transmit the required data elements to laboratories with test orders.

This guidance outlines federal HHS laboratory reporting requirements under Section 18115 of the CARES Act; STLT jurisdictions may have additional laboratory reporting requirements applicable to testing entities subject to their jurisdiction. Part A, Section 2 of this guidance requires laboratories and testing entities to comply with applicable STLT test reporting requirements. Nothing in this guidance limits or prohibits STLT health departments from requesting or requiring additional SARS-CoV-2 result and/or data element reporting.

Part A of this guidance specifies:

- Laboratory reporting requirements, including reporting requirements by entity and type of testing (Section 1);
- Reporting results required by STLT health departments (Section 2);
- Timing, frequency, and methods of submission (Section 3);
- Minimum required data elements (Section 4);
- Data reporting and transmission requirements (Section 5); and
- Guidance on laboratory reporting and electronic health records (Section 6).

Part B of this guidance provides recommendations for developers and manufacturers of SARS-CoV-2 self-administered tests to facilitate improved capture and reporting of high quality testing data and inform national efforts at the prevention and control of COVID-19.

Note on viral genomic sequencing and variant surveillance
Viral genomic sequencing and variant surveillance are outside the scope of this guidance but are recognized as vital parts of the COVID-19 response and have become increasingly important as the response evolves. While deidentified viral genomic sequencing data has additional complexities compared with other laboratory test result reporting, laboratories that perform sequencing should engage with STLT health departments to identify means of variant surveillance reporting to effectively facilitate public health action by STLT health departments, including responding to specific outbreaks. Timelines and processes for reporting lineages determined through viral genomic sequencing to STLT health departments should be established in accordance with relevant STLT laws or regulations. Additional information on reporting SARS-CoV-2 sequencing results can be found at Guidance for Reporting SARS-CoV-2 Sequencing Results.

Contents

A. Reporting Requirements

The sections below outline HHS SARS-CoV-2 laboratory reporting requirements.

Section 1: Reporting Requirements by Entity and Type of Testing

Federal HHS SARS-CoV-2 laboratory reporting requirements are based on (1) the entity that performs the testing and (2) the type of test being performed.

Guidance for tests that are entirely self-administered are addressed in Part B of this guidance.

i. SARS-CoV-2 Nucleic Acid Amplification Test (NAAT) testing conducted in a facility certified under CLIA to perform moderate- or high-complexity tests
Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories that are certified to perform moderate- or high-complexity testing ***must report all test results (i.e., positive, negative, inconclusive) from NAAT testing (e.g., RT-PCR)***.

This includes, but is not limited to, NAAT testing performed for SARS-CoV-2 by clinical laboratories, including public health, commercial, healthcare system, and academic laboratories.

ii. All other SARS-CoV-2 testing (except antibody and self-administered testing)

Entities conducting all other SARS-COV-2 testing (e.g., testing conducted in a setting operating under a CLIA certificate of waiver, non-NAAT testing conducted in a facility certified under CLIA to perform moderate- or high-complexity tests) except antibody and self-administered testing, ***must report positive test results***. Reporting of negative results, either individual test results or in aggregate, is optional. This includes rapid testing conducted in many settings (e.g., screening testing at schools, correctional facilities, employee testing programs, long-term care facilities, and point-of-care testing performed in pharmacies, medical provider offices, and drive-through testing sites). Negative result reporting may still be required by applicable state or local law, and entities should check with the applicable STLT jurisdiction for specific reporting requirements.

Note, entities that are using digitally enabled diagnostic tests or automated devices are encouraged to identify potential avenues for reporting aggregate negative totals and/or individual negative test results in collaboration with STLT jurisdictions and public health authorities.

iii. SARS-CoV-2 antibody testing

This guidance does not require entities to report SARS-CoV-2 antibody test results unless required by applicable STLT law or regulation.

Table 1. Reporting Requirements by Entity and Type of Testing			
	Is Reporting Required Under this Guidance?		**Examples**
	Positive Results	**Negative & Inconclusive Results**	
NAAT-testing conducted in a facility certified under CLIA to perform moderate- or high-complexity tests	**Required**	**Required**	• Laboratory-based Nucleic Acid Amplification Test (NAAT) testing, including RT-PCR, TMA, LAMP, and SDA tests • See https://www.cdc.gov/coronavirus/2019-ncov/lab/naats.html for more information
All other testing (except antibody)	**Required**	**Optional***	• Testing conducted in a setting operating under a CLIA certificate of waiver such as rapid tests used in many settings (e.g., screening testing at schools, correctional facilities, employee testing programs, long-term care facilities, and point-of-care testing performed in pharmacies, medical provider offices, and drive-through and pop-up testing sites) • Non-NAAT (e.g., high throughput antigen) testing conducted in a facility certified under CLIA to perform moderate or high-complexity tests
Antibody testing	**Optional***	**Optional***	• Tests used to determine previous infection with SARS-CoV-2 in any setting

* State, local, territorial, and Tribal jurisdictions may have additional laboratory reporting requirements applicable to testing entities subject to their jurisdiction. Refer to the applicable jurisdiction's reporting requirements.

Section 2: Reporting Results Required by STLT Health Departments

Generally, this guidance is intended to provide minimum test result and diagnostic data reporting requirements as set by HHS consistent with the CARES Act. **However, testing entities must follow all SARS-CoV-2 test-result reporting requirements issued by STLT health departments in addition to the minimum reporting requirements in Section 1.**

Section 3. Timing, Frequency, and Methods of Submission

For test results that are required to be reported under Section 1, entities must report:

(1) information for each individual test,
(2) within 24 hours of results being known or determined,
(3) at least on a daily basis, and
(4) to the appropriate STLT health department based on the individual's residence.

Entities required to report results under Section 1 of this guidance must submit test results to STLT health departments using one of the existing reporting channels below:

i. **Submission directly to a STLT health department**: Submission of laboratory testing data as set forth in this guidance directly to STLT health departments. These health departments will then submit deidentified data to the Centers for Disease Control and Prevention (CDC) on a daily basis using either Health Level 7 (HL7®) messaging or the CDC-provided CSV format.

ii. **Submission to STLT health agency via a centralized platform:** Submission of laboratory testing data to STLT health departments through a centralized platform, for example through APHL Informatics Messaging Services (AIMS) or the CDC-provided ReportStream tool. These health departments will then submit deidentified data to the CDC on at least a daily basis using either Health Level 7 (HL7®) messaging or the CDC-provided CSV format.

iii. **Submission through state or regional health information exchange**: Submission of laboratory testing data through a state or regional health information exchange (HIE) to the appropriate STLT health department and to the CDC, as directed by the state.

iv. **Submission through the National Healthcare Safety Network (long-term care facilities only):** Centers for Medicare & Medicaid Services (CMS)-certified long-term care (LTC) facilities may submit point-of-care SARS-CoV-2 testing data, including antigen testing data, to CDC's National Healthcare Safety Network (NHSN). This CDC- and CMS-preferred pathway to submit data to CDC's NHSN applies only to CMS-certified LTC facilities. Test data submitted to NHSN will be reported to appropriate STLT health departments using standard electronic laboratory messages. Other types of LTC facilities may also report testing data in NHSN for self-tracking or to fulfill STLT reporting requirements, if any.

Section 4. Minimum Required Data Elements

Required Data Elements and Data Harmonization

The following data elements must be collected and reported for SARS-CoV-2 laboratory tests (as required under Section 1) for the transmission of complete laboratory testing data to the appropriate STLT health departments. STLT health departments may vary in their reporting requirements. Technical Specifications for Implementation for COVID-19 Data Reporting for Laboratory-Based Testing are available to support stakeholder adoption of standardized and harmonized coding for diagnostic data elements. STLT health departments will send deidentified data to CDC or the Secretary's designee. (Note: Additional data elements may be requested at a future date).

1. Patient name (last name, first name, middle initial)*
2. Patient street address*
3. Patient phone number with area code*
4. Patient date of birth*
5. Patient age
6. Patient race
7. Patient ethnicity
8. Patient sex
9. Patient residence zip code
10. Patient residence county
11. a) Test ordered and b) test resulted– use appropriate LOINC codes, as defined by the Laboratory In Vitro Diagnostics (LIVD) Test Code Mapping for SARS-CoV-2 Tests provided by CDC
12. Device identifier
13. Test result (values) – use appropriate SNOMED-CT codes, as defined by the Laboratory In Vitro Diagnostics (LIVD) Test Code Mapping for SARS-CoV-2 Tests provided by CDC
14. Test result date (date format)
15. Date specimen collected (date format)
16. Accession #/Specimen ID
17. Ordering organization or ordering provider name and NPI (as applicable), address, phone number, zip code along with affiliated organization (specific facility)
18. Performing facility name and CLIA number, address, phone number, code
19. Specimen Source - use appropriate SNOMED-CT, LOINC, or SPM4 codes, or equivalently detailed alternative codes
20. Reporting entity name and CLIA number (or appropriate ID), and address.

*Personally identifiable information (PII) is suppressed before data transmission to CDC.

In order for all of these data elements to be available for laboratories to report, it is critical that these data be collected at the time the test is ordered and provided by the submitter to the laboratory performing the test. **Any person or entity ordering a test, registering an individual to be tested, collecting a specimen, or performing a test subject to the guidance and these reporting**

requirements should make every reasonable effort to collect complete demographic information and should include such data when ordering a laboratory test to enable the entities performing the test to report these data to STLT health departments and to comply with this guidance.

To protect patient privacy, any data that STLT health departments send to CDC will not include some patient-level information. The data shared with CDC will contribute to understanding COVID-19's impact, positivity trends for NAAT testing, testing coverage, and will help identify supply chain issues for reagents and other materials. Additional data elements, including "ask on entry" questions, are no longer requested, given the volume of COVID-19 testing in the United States.

Section 5. Data Reporting and Transmission Requirements

When possible, all information and elements set out above should be collected using health information technology certified to the Office of the National Coordinator for Health Information Technology (ONC) 2015 Edition certification criteria, and all information and elements set out above should be structured in accordance with the US Core Data for Interoperability (USCDI) when available or when possible. All data transmission in furtherance of the reporting set out above should occur electronically using Health Level 7 (HL7®) electronic laboratory reporting (ELR) implementation guides when possible, but a pre-defined flat file format may also be acceptable. In addition, clinical/point-of-care testing facilities using electronic health records (EHRs) are encouraged to use electronic case reporting (eCR) standards to report laboratory testing data, at the receiver's discretion, provided the above data elements and timeliness requirements can be met.

For home-based collection of specimens that are sent to a laboratory for testing, the laboratory must be able to collect the required information to comply with required reporting. To accommodate this required reporting, the process for specimen collection should include collection and submission of all the data elements above (along with the specimen) to the laboratory performing the test, which will then report to the STLT health department consistent with this guidance. For point-of-care testing, the laboratory (including a facility or setting with a CLIA certificate of waiver) must ensure the test is set up and operational to deliver timely and complete electronic results (with identifiers) per the methods of submission.

Links to the relevant applicable standards:

- Guidance for mapping to SARS-CoV-2 LOINC terms – LOINC
- LOINC In Vitro Diagnostic (LIVD) Test Code Mapping for SARS-CoV-2 Tests | CDC
- PHIN VADS - Search All Vocabulary (cdc.gov)
- Transmission to public health agencies — reportable laboratory tests and value/results | HealthIT.gov
- HL7 Standards Product Brief - HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm) | HL7 International
- ELR Validation Tool @ NIST
- COVID-19 Novel Coronavirus Pandemic | Interoperability Standards Advisory (ISA) (healthit.gov)

Additional Resources provided by CDC and FDA:

- In vitro diagnostic commercial test developers with questions about coding can send questions to: SHIELD- LabCodes@fda.hhs.gov.
- Test users (e.g., laboratories/healthcare providers) can send questions to: dlsinquiries@cdc.gov.

Section 6. Guidance on Laboratory Data Reporting and Electronic Health Records

To ensure that data are captured in the EHR, HHS also recommends, but does not require, that the transmission of laboratory results back to the ordering provider (whenever possible) include the following information:

1. Test result – use appropriate SNOMED codes, as defined by the Laboratory In Vitro Diagnostics (LIVD) Test Code Mapping for SARS-CoV-2 Tests provided by CDC
2. Test result date (date format)
3. Unique patient identifier
4. Test ordered – use appropriate LOINC codes
5. Device Identifier
6. Accession #/Specimen ID

These data fields represent the minimum information, and any data transmission should be in accordance with the HL7 Lab Results Interface (LRI) implementation guide and standard. To ensure that patients receive timely and critical information regarding their own health condition and status, HHS also recommends, but does not require, the transmission of laboratory results be sent directly to the patient (or parent/guardian), either by mail (in writing), email (electronically), and/or via a patient portal or secure standard-based application programming interface (electronically), using commonly available standards such as FHIR® (Fast Healthcare Interoperability Resources) (for instance, the Argonaut Data Query Implementation Guide).

LOINC and SNOMED-CT codes, as defined by the Laboratory In Vitro Diagnostics (LIVD) Test Code Mapping for SARS-CoV-2 Tests provided by CDC, should be used to help ensure normalization and harmonization of data elements related to laboratory test and results.

Laboratories that meet the definition of a covered entity under the HHS Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations are permitted to disclose this protected health information (i.e., laboratory results and other data elements described above) as provided in this guidance under the HIPAA Privacy Rule. A laboratory's business associate also is permitted to disclose this protected health information if their business associate agreement allows the disclosure, or if the disclosure is pursuant to HHS Office of Civil Rights' (OCR) Notification of Enforcement Discretion for Business Associates. Nothing in this guidance changes the existing requirements for HIPAA-covered entities and business associates to comply with the applicable HIPAA Privacy, Security, and Breach Notification Rules.

B. Self-Administered Tests

Self-administered SARS-CoV-2 home use tests (not including self-collected specimens where the test is performed at a laboratory)

Home use tests that are entirely self-administered (i.e., a test that allows for self-collection and testing at home, also known as home use or over the counter tests) have been authorized for emergency use by the federal Food and Drug Administration (FDA), and tests from additional test developers may be authorized in the future. While self-administered tests are outside the reporting requirements for laboratories in Section 18115 of the CARES Act as articulated in this guidance, these tests are of enormous potential public health and clinical value and utility.

Developers of self-administered tests are strongly encouraged to consider ways in which the data elements and information described in this guidance could be enabled to be collected and reported to public health authorities given their importance to current and future public health efforts. This might be accomplished through applications on a personal smartphone or tablet, a patient portal, direct transmission from the test platform itself, or other innovative technologies. Manufacturers working to enable automated, digital and/or wireless reporting from these at home or point-of-care technologies are strongly recommended to ensure the collection of all the data elements in Section 4 is enabled and data systems have the capacity to securely transfer data to a centralized platform as described in Section 3. Technical specifications for implementation for COVID-19 data reporting for non-laboratory-based testing are available to support stakeholder adoption of standardized and harmonized coding for diagnostic data elements.

WASHINGTON STATE BOARD OF HEALTH

Date: August 10, 2022

To: Washington State Board of Health Members

From: Michelle Davis, Executive Director

Subject: 2022 Draft State Health Report

Background and Summary:

RCW 43.20.100 requires the Washington State Board of Health (Board) to develop a State Health Report by July 1 of each even-numbered year. The report includes "suggestions for public health priorities for the following biennium and such legislative action as it deems necessary." Staff worked with Board members to identify potential topics to include in the 2022 report.

Topics in the draft 2022 report include:

- Improving public health's response to health inequities through data reform.
- Removing barriers to health care insurance and care coverage.
- Improving access to culturally and linguistically appropriate health services.
- Making school environments healthy and safe.
- Decreasing youth use of tobacco, nicotine, and vapor products.
- Strengthening Washington's public health system through continued investments.

I have invited Kaitlyn Donahoe, Board Staff, to review recommendations in the 2022 State Health Report for the Board's consideration.

Recommended Board Actions:

The Board may wish to consider and amend, if necessary, the following motion:

The Board directs staff to finalize the 2022 State Health Report in close consultation with the Chair. The Chair is authorized to approve a final report with any further revisions based on today's conversation, and transmit the report to the Governor, Legislature, and appropriate state agencies by September 1, 2022.

To request this document in an alternate format or a different language, please contact Kelie Kahler, Washington State Board of Health Communication Manager, at 360-236-4102 or by email at kelie.kahler@sboh.wa.gov. TTY users can dial 711.

PO Box 47990 • Olympia, WA 98504-7990
360-236-4110 • wsboh@sboh.wa.gov • sboh.wa.gov

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:

    - 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.

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.

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.

[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.

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

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.

[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

[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.

[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.

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).