WASHINGTON STATE BOARD OF HEALTH

Notice of Public Meeting

Wednesday, October 12, 2022
9:00 a.m. – 12:25 p.m.
Virtual Meeting via ZOOM Webinar
(hyperlink provided below)

Proposed Final Agenda

Time	Agenda Item	Speaker
9:00 a.m.	Call to Order & Introductions	Keith Grellner, Board Chair
9:05 a.m.	1. Approval of Agenda—Possible Action	Keith Grellner, Board Chair
9:10 a.m.	2. Approval of August 10, 2022, Minutes – Possible Action	Keith Grellner, Board Chair
9:15 a.m.	3. Announcements and Board Business	Board Executive Director
9:30 a.m.	4. Department of Health Update	Umair A. Shah, Secretary of Health Tao Sheng Kwan-Gett, Chief Science Officer and Secretary's Designee
10:00 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.
10:20 a.m.	6. Health Impact Review—Introduction and Fiscal Year 2022 Update	Board Staff
10:50 p.m.	Break	
11:00 a.m.	7. Emergency Rulemaking – On-Site Sewage Systems, WAC 246-272A-0110, Proprietary Treatment Products and Supply Chain Shortages – Possible Action	Tao Sheng Kwan-Gett, Chief Science Officer and Secretary's Designee Board Staff Department Staff
11:25 a.m.	8. Briefing – Newborn Screening and Early Hearing Detection, Diagnosis, and Intervention Programs	Kelly Oshiro, Board Vice Chair Board Staff Department Staff
11:40 a.m.	9. Briefing – Technical Advisory Committee Recommendation: Congenital Cytomegalovirus – Possible Action	Kelly Oshiro, Board Vice Chair Board Staff Department Staff
12:10 p.m.	10. Board Member Comments	
12:25 p.m.	Adjournment	

- **To access the meeting online and to register:**
  https://us02web.zoom.us/webinar/register/WN_rIbXbe0xTamZ-aWlKEQGBw

- **You can also dial-in using your phone for listen-only mode:**
  Call in: +1 (253) 215-8782 (not toll-free)
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  Passcode: 557001

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 October 5, 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

Proposed Final Minutes of the State Board of Health
August 10, 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
Kaitlyn Donahoe, Health Policy Advisor
Nathaniel Thai, Communications Coordinator
LinhPhung Huỳnh, Manager, Health Disparities Council
Cait Lang, Health Policy Analyst
Jo-Ann Huynh, Administrative Assistant
Hannah Haag, Community Outreach Coordinator
Lilia Lopez, Assistant Attorney General

Guests and other participants:
Kristin Peterson, Chief of Policy, Department of Health
Lacy Fehrenbach, Chief of Prevention, Department of Health
Mike Means, Capacity Development & Policy Manager, Office of Drinking Water, 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 August 10, 2022, agenda
Motion/Second: Member Kwan-Gett/Member Crawford. Approved unanimously

2. ADOPTION OF JUNE 8, 2022, MEETING MINUTES

Motion: Approve the June 8, 2022, minutes.
Motion/Second: Member Hayes/Member Crawford. 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 began with staff updates. She welcomed Jo-Ann Huynh to the team. Ms. Huynh will offer administrative support, including a major archival project. Ms. Davis shared two staff vacancies; the policy advisor position formerly held by Sam Pskowski, and the HIR position formerly held by Tracy Schreiber. She thanked Board members for sharing the recruitments with their networks.

Ms. Davis directed Board members to the CR-103, order of adoption to extend the effective date of the school environmental health and safety rule. She said the Board took action to extend the school rule effective date at its June meeting.

Ms. Davis said the meeting packets also includes the CR-103E, emergency rule related to proprietary products under the on-site sewage rule. She reminded the Board of the adoption of this emergency rule at its June meeting to address supply chain shortage issues for proprietary treatment products.

Ms. Davis said the final item in the Board packets is a one pager about Board member sponsorship and includes a list of current rule projects and their sponsors. She said we are fortunate to have Stephen Kutz, Board Member and Chair Grellner, however their terms have expired. She noted they have agreed to continue to serve until their successors are appointed. Ms. Davis said that staff are looking for other Board members to let us know of their willingness to sponsor these important rule projects.

Ms. Davis said our office has received over 20 public records requests since January, and some of these requests are very broad and are seek information regarding Board actions over the last 10 years. She said this volume of requests is not typical and processing these requests will take time.

4. DEPARTMENT OF HEALTH UPDATE

Tao Sheng Kwan-Gett, Chief Science Officer and Secretary's Designee, provided an overview of MPV (monkeypox virus) in the U.S. and Washington. He reported as of August 8, 2022, the U.S. had over 8,900 confirmed MPV cases and no MPV deaths had been recorded in the nation. He shared that on August 4, 2022, the federal government declared a public health emergency, authorizing the U.S. Department of Health and Human Services (HHS) to take increased action to allocate resources to combat MPV. He noted that MPV cases were predominantly occurring among men who have sex with men, in people who have multiple sex partners, and people who practice unprotected sex. Member Kwan-Gett explained that despite the disproportionate impact to gay and bisexual men, MPV is not a sexually transmitted infection, and experts are emphasizing

that anyone is at risk of being infected with MPV. He further added that as of late July, the first two U.S. cases in children were confirmed and suspected to be caused by household transmission. Member Kwan-Gett said these cases highlight that transmission can also occur through shared items such as towels, clothing, or utensils.

Member Kwan-Gett reported that on August 9, 2022, the U.S. Food and Drug Administration issued an emergency use authorization (EUA) allowing healthcare providers to use an alternative dosing regimen of the Jynneos Vaccine. He said Jynneos is the only vaccine approved by HHS to prevent MPV and requires two doses for immunization. He further stated that the new dosing regimen will expand the total number of doses available for use by up to five-fold for individuals 18 years of age and older determined to be at high risk of MPV infection. He said the announcement means that vials in the U.S. Government's inventory hold the potential to provide up to 2 million doses, up from 400,000 doses. He outlined the federal government's plans to doses to local health departments and the Department's work with LHJs and tribal and community partners to develop equitable and need-driven distribution in phase II. Member Kwan-Gett said, to inform the response, representatives of Seattle's LGBTQ+ community met with state government officials in early August to address growing concerns about MPV and the harmful misinformation being spread about its transmission nationwide. He noted the Department is conscious of the threat of stigma for people who get infected with MPV. He explained that together, with the help of the LGBTQ+ community through listening sessions and other outreach events, the Department is working to ensure we've learned from the mistakes made during the early days of the HIV epidemic.

Member Kwan-Gett then provided a brief update on the state of COVID-19 cases nationwide. He reported that in Washington cases have begun to plateau and are hopefully starting to decrease. He noted that hospital systems are still strained due to decreased capacity and difficult to discharge patients who are healthy enough to leave the hospital but who have not found placements in long-term care or nursing home facilities. He explained that the Department has been working with DSHS, HCA, and hospital partners to understand and problem solve how best to meet the need of difficult to discharge patients. He also outlined the state's expanded telehealth capabilities providing free telehealth services for COVID-19 treatments. Previously, telehealth for COVID-19 was only available to insured individuals who receive care through a health care provider who offered telehealth visits. Member Kwan-Gett said the new program makes telehealth consultations for COVID-19 available to everyone, regardless of insurance status, with no out-of-pocket costs.

Finally, Member Kwan-Gett explained the Department is preparing for a fall rollout of a new bivalent COVID-19 vaccine that is variant specific for the original and Omicron strains.

Lacy Fehrenbach, Chief of Prevention, provided an update on the national 988 Suicide & Crisis Lifeline, adopted in 2020 as the national suicide crisis prevention lifeline to direct callers to resources in their local area. She noted that call volume was expected to increase following the public promotion and easy to remember number, and they've seen a 50% increase in calls, with some test calls. She said lines include options specifically for Veterans (1) and Spanish speakers (2). Ms. Fehrenbach added that

other language services are also available for 250 languages. Ms. Fehrenbach also discussed Engrossed Substitute Senate Bill 1477, which the Washington Legislature passed to enhance, expand, and coordinate crisis services in the state. Additionally, she said funding also supports the Native and Strong Lifeline, a service of the Washington Indian Behavioral Health Hub, which supports American Indian and Alaska Native people by providing culturally relevant telephone support. Ms. Fehrenbach said Washington is the first state in which a line tailored to indigenous communities' needs is available.

Ms. Fehrenbach also noted that the Department is working to address common concerns of communities of color, which are informed by historical racism and systems of marginalization. She stated the Department is proactively sending out information to address available misinformation and communities' questions and is broadly working to build trust and ensure equity.

Kristin Peterson, Chief of Policy, shared the Department's Strategic Plan or Transformational Plan vision for Health in Washington state. She explained the plan focuses on what the agency wants to achieve and how to achieve it—through the values of equity, innovation, and engagement. Ms. Peterson stated the Department is now in the phase of sharing the plan broadly for feedback, areas of collaboration, and areas to strengthen. Ms. Peterson described the five priority areas: 1) health and wellness; 2) health systems and workforce transformation; 3) environmental health; 4) emergency response and resilience; and 5) global and one health. She also provided an overview of the internal agency components to achieve these goals.

Elisabeth Crawford, Board Member thanked Ms. Peterson for presenting and asked how the plan may affect current services offered by Department. Ms. Peterson clarified that the plan does not represent all that the agency does or plans to do. She said rather than an interruption in services, the Department views the plan as roadmap for future expansion.

Chair Grellner thanked Department staff for their presentation.

5. PUBLIC COMMENT

Sue Coffman, WA state citizen and parent and grandparent, spoke in support of natural immunity. She said coercion is not consent, and the constitution protects the right to choose.

Bill Osmunson, general and cosmetic dentist in Bellevue, said he treats dental fluorosis. Dr. Osmunson said that dental fluorosis is caused by ingesting too much fluoride, he shared statistics, and he talked about the harm to the public more than the alleged benefit.

Nancy Callihan said there is great distrust with federal and medical institutions that began with the Covid rollout. She talked about the pharmaceutical industry profits, lies and fake news. She talked about Seattle parents withdrawing 50,000 children from the school system and she talked about the harm of the Covid vaccine.

Lisa Templeton said she credits Dr. Toby Rodgers with her comments today. Ms. Templeton talked about vaccines and variants and said there has not been proper safety or efficacy data available. She asked the agency to not be part of these liability free products.

Chair Grellner closed public comment at 10:53 a.m.

The Board took a break at 10:53 a.m. and reconvened at 11:20 a.m.

6. UPDATE—STRATEGIC PLAN STATUS REPORT

Keith Grellner, Chair, provided a brief overview of the Board's 2017-2022 Strategic Plan, adopted in 2016, and introduced Kaitlyn Donahoe, Board Staff, who gave an overview of the Board's goals, objectives, and activities over the last five years.

Ms. Donahoe outlined each goal and associated objectives and discussed the status of each activity and noted that many of the activities considered complete are ongoing work by the Board. She outlined factors that impacted the Board's ability to complete activities in the Strategic Plan, including routine rulemaking, legislative directives for the Board and Governor's Interagency Council on Health Disparities, and COVID-19 pandemic response. Ms. Donahoe noted that the Board completed significant work over the last five years in addition to accomplishing the majority of its strategic initiatives.

Ms. Donahoe proposed that the Board extend its current Strategic Plan through 2023 to address activities considered outstanding or underway and begin the process for developing the Board's next Strategic Plan. She noted that community engagement is critical to inform future strategic priorities, and staff can use the Board's existing committee structure to work closely with Board members to identify new objectives and goals.

Member Crawford thanked Board staff for their work and noted the amount of work accomplished in the face of a pandemic. She recommended the Board follow staff's recommendation to extend the Plan through 2023 and begin conversations for what the next iteration may look like.

Member Kwan-Gett suggested alignment between the state Department of Health's Transformational Plan and Board's Strategic Plan and suggested a crosswalk between the two to prevent duplication or gaps in the two agencies' efforts.

Member Hayes expressed her support for staff's recommendation for next steps, noting the number of new Board members prepared to shape the future strategic plan with that process. She commended staff on their hard work and dedication

Vice Chair Oshiro applauded staff on their work and agreed with the recommendation to extend the plan. She asked whether an extra year is feasible to accomplish outstanding tasks. Ms. Donahoe noted that the team would take a holistic approach in which the Board may not accomplish all activities as stated in the Strategic Plan but will find appropriate ways to address them.

Member Kutz thanked staff and noted that the goals within the Strategic Plan involve a lot of work and acknowledged that some items are better aligned with other agencies. He if the inability to accomplish all activities was due to insufficient staffing. Michelle Davis, Executive Director, noted the pandemic was quite disruptive for Board staff and narrowed the scope of the Board's work. She agreed that capacity is a challenge for the small team and acknowledged staff turnover and shared that staff are working on ways to better respond to team vacancies.

Member Love-Thurman agreed that additional time for new Board members would be helpful and asked for clarification regarding community engagement goals. Ms. Donahoe said community engagement would inform the next Strategic Plan and certain activities that are underway. Ms. Davis noted that funding for Ms. Haag's position was secured through the Legislature's funding of Engrossed Second Substitute House Bill 1152, but funding will end in 2023. She shared that the team is a stronger staff with Ms. Haag's community engagement and outreach work and expertise. Ms. Davis stated that she plans to submit a Foundational Public Health Services budget request to maintain the position to provide community engagement support to benefit the team's work.

Recommended Board Actions

The Board may wish to consider, amend if necessary, and adopt one of the following motions:

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.

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

7. **UPDATE—PER- AND POLYFLUOROALKYL SUBSTANCES (PFAS) RULE IMPLEMENTATION AND RELATED ISSUES—GROUP A PUBLIC WATER SUPPLIES GROUP A PUBLIC WATER SUPPLIES, CHAPTER 246-290 WAC**

Chair Grellner gave brief background and introduced the informational presentation. Mike Means, Department of Health, gave an update on PFAS in drinking water, covering uses/sources of PFAS and related health concerns; the Board's drinking water rulemaking completed in 2021; early results and responses to voluntary PFAS drinking water testing in Washington; new federal PFAS health advisory levels (HALs); and upcoming drinking water activities and issues for Board consideration. Mr. Means also briefly addressed PFAS contamination at the Yakima Training Center; a new state forum to discuss solutions to PFAS in surface and drinking water; and the Department of Ecology's PFAS groundwater cleanup levels. (see presentation on file)

Chair Grellner asked if there was an appeal of EPA's recent action (updated HALs) and, if accurate, what it means. Mr. Means said it's not surprising that the chemical industry appealed the interim HALs given knowledge that the numbers are likely to change. He added that the numbers might change a little, but not enough to effectively change our

work in Washington, even if the numbers rise to the detection limits. Mr. Means further added that HALs are a first step toward developing an MCL.

Member Kwan-Gett asked if the science/data is developed enough to express the health benefit (e.g., cancer or birth defects prevented) for a given drop in exposure when PFAS levels decrease—framing that would help in decision making. Mr. Means agreed it would help and why he suspects the determination for an MCL will be delayed. He said such information is key to cost-benefit analysis and added that he has not heard of information that correlates reduction and benefit. Mr. Means furth stated there is discussion whether PFOA will be pursued based on its chronic impact or its carcinogenic impact. If the latter then, by rule, the MCL goal is zero.

Member Lutz missed part of the presentation and asked a question after completion of the agenda item. After recessing for lunch, Mr. Means returned at 1:35 p.m. to resume discussion with the Board. Member Lutz mentioned a recently released report by the National Academy of Sciences on PFAS and recommendations to the CDC. He commended the Department for its work on community outreach and education. He mentioned a recent Supreme Court decision on West Virginia v. EPA where the court said EPA overreached in regulatory areas unless determined by Congress and connected it with EPA's slow action on PFAS and lawsuits by the chemical industry. Member Lutz asked if the agency had any concerns or saw any change in plans if PFAS regulation becomes a source of litigation. Mr. Means said the new HALs are interim and are expected to change, which seems to be the basis of the chemical industry's lawsuit. Mr. Means said he thinks the Safe Drinking Water Act provides clear authority for EPA to establish standards for chemical contaminants in drinking water based on rules and established law. He stated it's prescriptive regarding EPA's authority, including prescribed methods for cost-benefit analysis when adopting a new chemical contaminant rule, so he doesn't see any effect. Member Lutz said he wanted to put the hypothetical out there for consideration. Mr. Means said that any outcome on a standard will need consideration by the Board to adopt the standard or to take other action to protect public health.

Member Kutz asked what is being done in areas with groundwater contamination such as the area around Fairchild Air Force Base. Mr. Means said the Department of Defense is generally following the Superfund process, which may be under EPA oversight or not, to halt exposure and to determine options for remediation. Fairchild is under EPA oversight. He further stated that the Yakima Training Center is not yet and the Department of Ecology has asked for action under the Model Toxics Control Act (MTCA). Member Kutz said so the Board's PFAS standards only address when it's safe to drink the water but nothing else. Mr. Means clarified that those standards are now the basis for Ecology's proposed cleanup levels that can be applied under MTCA. Superfund and MTCA are the two legal processes to address chemical contamination in the environment.

The Board recessed for lunch at 12:38 p.m. and reconvened at 1:35 p.m.

8. EMERGENCY RULE—NOTIFIABLE CONDITIONS, COVID-19 REPORTING, WAC 246-101-017

Chair Grellner introduced Kaitlyn Donahoe, Board Staff, who gave a brief overview of prior COVID-19 emergency rule adoption by the Board since July 2020. She discussed the changes in reporting requirements for COVID-19 test results since the first emergency rule and reminded Board members of the recent change in requirements in alignment with federal guidance. Ms. Donahoe stated there were no proposed changes to the language in the eighth emergency rule and reminded Board members of the differences in the Board's emergency rule and federal guidance. She reminded Board members that on January 1, 2023, COVID-19 will be a permanent notifiable condition as a result of prior rulemaking in this chapter.

Member Kwan-Gett thanked the Board for past filed emergency rules and said it has been important for obtaining COVID-19 data for the department's surveillance.

Chair Grellner, Member Kwan-Gett, and Member Kutz discussed missing surveillance data due to the prevalence and use of COVID-19 home tests. Member Kwan-Gett noted that the Department of Health likely only captures 12 to 18 percent of true infections due to home testing. Member Kutz followed up with a question regarding long-term requirements for COVID-19 reporting once the state of emergency expires. Member Kwan-Gett responded that the Department of Health may focus its attention on hospitalizations and deaths, as well as updating systems to better understand those data.

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.

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

9. 2022 STATE HEALTH REPORT

Keith Grellner, Board Chair, introduced the purpose and scope of the report. Kaitlyn Donahoe, Board Staff, said staff worked very closely with Board members, community groups and public health partners to develop the 2022 report. Ms. Donahoe said she is pleased how the report has shaped up in its current form, and that staff will continue to work with the Chair and Executive Director to format and finalize the report prior to transmitting it to the Governor's Office.

Michelle Davis, Board Executive Director, said this is a longstanding report required in statute to provide recommendations to the Governor and legislature regarding public health priorities in Washington state. She acknowledged Ms. Donahoe for her leadership and to Hannah Haag, Board Staff, for her work in engaging with community.

Chair Grellner said it is an excellent report and he looks forward to sending it to the Governor's office and the state Legislature.

Stephen Kutz, Board Member, said Board members and contributors were given ample opportunity to comment and he feels comfortable with the final product.

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.

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

10. BOARD MEMBER COMMENTS

Keith Grellner, Board Chair called for any comments.

Tao Sheng Kwan-Gett, Board Member, shared an update regarding the Emergency Rule for On-Site Sewage Systems. He said this rule, adopted in June 2021, allowed sewage treatment machinery manufacturers to use substitute components for repairs and maintenance as supply-chain issues have created difficulties acquiring parts. Member Kwan-Gett shared that in July 2022, the state Department of Health (DOH) approved one application for substitute UV bulbs, which play a key role in killing pathogens in water, and whose adoption may affect hundreds of thousands of water systems. Member Kwan-Gett said that DOH expects more applications, which they will process as quickly as possible. He flagged that the Department will present a second emergency rule proposal at the next Board meeting in October 2022.

Chair Grellner stated his appreciation of DOH staff and acknowledged the positive impact the adoption of the substitute UV bulbs has made in his own county.

Stephen Kutz, Board Member, encouraged new Board members to participate in the Governor's Health Disparities Council (Council). He shared that he was invited to join the Council early on in his tenure on the Board and has remained on since for 11 years. He stated that the Council has been one of the most fulfilling parts of his work at the Board and clarified that his participation was not as a tribal liaison, but as a Board representative.

Chair Grellner seconded Member Kutz's comments and briefly discussed the Council's Health Promotion and Environmental Health subcommittees. He stated that joining the Council is a great way to increase topic knowledge on various issues and to get to know Board and Department staff.

Chair Grellner offered his thanks to Board members and staff for their work today.

Michelle Davis, Board Executive Director, announced that the next regularly scheduled meeting will be October 12. She informed Board members to let staff know if they are interested in any rules sponsorship or committees.

ADJOURNMENT

Keith Grellner, Board Chair, adjourned the meeting at 2:21 p.m.

WASHINGTON STATE BOARD OF HEALTH

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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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POLICIES, PROCEDURES, AND BYLAWS COMMITTEE SPECIAL MEETING SUMMARY NOTES

What: Policies, Procedures, and Bylaws Committee

When: September 7, 2022

Participating via Zoom: Board members Keith Grellner, Mindy Flores, Stephen Kutz, and Kelly Oshiro; Board staff Kaitlyn Donahoe, Michelle Davis, Jo-Ann Huynh, and Nathaniel Thai; Assistant Attorney General Lilia Lopez; and approximately 10 members of the public.

Summary Notes:

Selection of Committee Chair

- Committee members selected Member Oshiro to serve as the committee chair.

Committee Scope and Objectives

- Ms. Donahoe shared information about the Board's committee structure as stated in the Board's bylaws. She recapped discussion at the Board's June 2022 meeting to convene an ad-hoc committee to further discuss and recommend revisions to the Board's Policy Number 2015-001: Responding to Complaints Against a Local Health Officer or Administrative Officer. Ms. Donahoe provided background information about the Board's policy, its use in recent years, and scope of potential revisions.

Board Complaint Policy Discussion

- Ms. Donahoe opened discussion with questions raised in the June 2022 Board meeting related to Policy Number 2015-001.
- Board Members discussed adopting a procedural rule related to designating a presiding officer to oversee complaint hearings. Specifically, they discussed the procedures around appointing an Administrative Law Judge as the presiding officer and whether these procedures need greater detail. Members Kutz, Oshiro, and Grellner made recommendations around the procedure and the generality of the language.
- Board Members discussed the procedure for notifying complainants of hearing outcomes. Member Kutz recommended that the Board give notice to complainants about the outcome of their hearings. All Board Members supported

(Continued on the next page)

this recommendation. Board Members and staff discussed the possibility of staff notifying complainants.
- Member Kutz asked a question regarding appeal processes for complainants and the Board. Assistant Attorney General Lopez clarified that appeal processes are not generally available for complainants in appeals-driven administrative investigations, and that she would investigate potential appeals processes for the Board.

Next Steps

- Ms. Donahoe and Assistant Attorney General Lopez will review the recommendations from this meeting and draft language to be considered at a future Board Meeting.
- Assistant Attorney General Lopez will investigate potential appeals processes for the Board in complaint hearings.

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. TTY users can dial 711

WASHINGTON STATE BOARD OF HEALTH

August 18, 2022

TO: Kathleen Buchli
Code Reviser

FROM: Michelle Davis, Executive Director
State Board of Health

SUBJECT: WITHDRAWAL OF CR-101 FOR CHAPTER 246-272A WAC, ON-SITE SEWAGE SYSTEMS (WSR 06-12-108)

This memo serves as notice that the Washington State Board of Health (Board) is withdrawing the CR-101 for on-site sewage system drainfield remediation technologies, which was filed June 7, 2006, and published in WSR 06-12-108.

The Board is withdrawing this CR-101 because the regulation of on-site sewage system drainfield remediation technologies is being addresses in the permanent rulemaking for chapter 246-272A WAC, On-site Sewage Systems, that is currently underway. The CR-101 for that rulemaking was filed as WSR 18-06-082 on March 6, 2018.

Individuals requiring information on this rulemaking should contact Stuart Glasoe at stuart.glasoe@SBOH.wa.gov or 360-236-4111. Thank you.

cc: Tami Thompson, Washington State Department of Health
Theresa Phillips, Washington State Department of Health
Jeremy Simmons, Washington State Department of Health

WASHINGTON STATE
BOARD OF HEALTH

2022 STATE HEALTH REPORT

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EXECUTIVE SUMMARY

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 Inequties 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.

Acknowledgements

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.

RECOMMENDATIONS

RECOMMENDATION 1:
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 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]

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

RECOMMENDATION 1:
Improving Public Health's Response to Health Inequities through Data Reform (cont'd)

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 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.

RECOMMENDATION 2:
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 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.

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.
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.

RECOMMENDATION 2:
Removing Barriers to Health Care Insurance and Care Coverage (cont'd)

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, 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.

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.
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.

RECOMMENDATION 2:
Removing Barriers to Health Care Insurance and Care Coverage (cont'd)

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.
- 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.

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.

RECOMMENDATION 3:
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 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

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

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.

RECOMMENDATION 4:
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 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.

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.

RECOMMENDATION 4:
Making School Environments Healthy and Safe (cont'd)

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 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.

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.
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.

RECOMMENDATION 5:
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 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.

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.
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

RECOMMENDATION 5:
Decreasing Youth Use of Tobacco, Nicotine, and Vapor Products (cont'd)

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]

Among other requirements, this bill would have prohibited the sale of flavored vapor products and flavored cannabis vapor products and regulated vapor product advertising.

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.

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, these bills would have banned the sale of vapor products containing vitamin E acetate and flavored vapor products, other than tobacco flavored products.

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.

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.

RECOMMENDATION 5:
Decreasing Youth Use of Tobacco, Nicotine, and Vapor Products (cont'd)

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 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]

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.
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/pcd18.210026
64 Ibid.

RECOMMENDATION 5:
Decreasing Youth Use of Tobacco, Nicotine, and Vapor Products (cont'd)

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.

RECOMMENDATION 6:
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[68]
2017-2019	$18 million
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 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.

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.

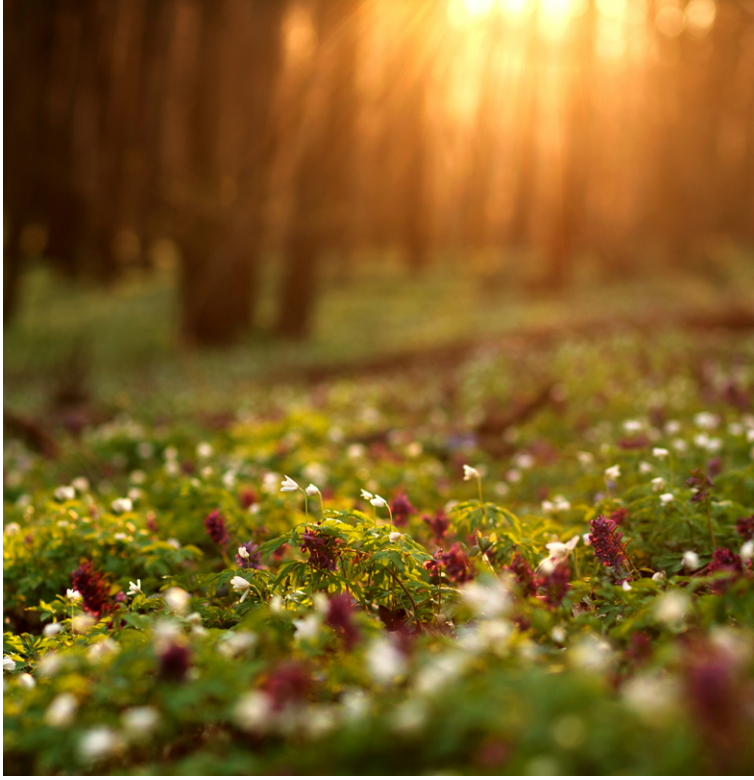
RECOMMENDATION 6:
Strengthening Washington's Public Health System through Continued Investments (cont'd)

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 take action to:

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



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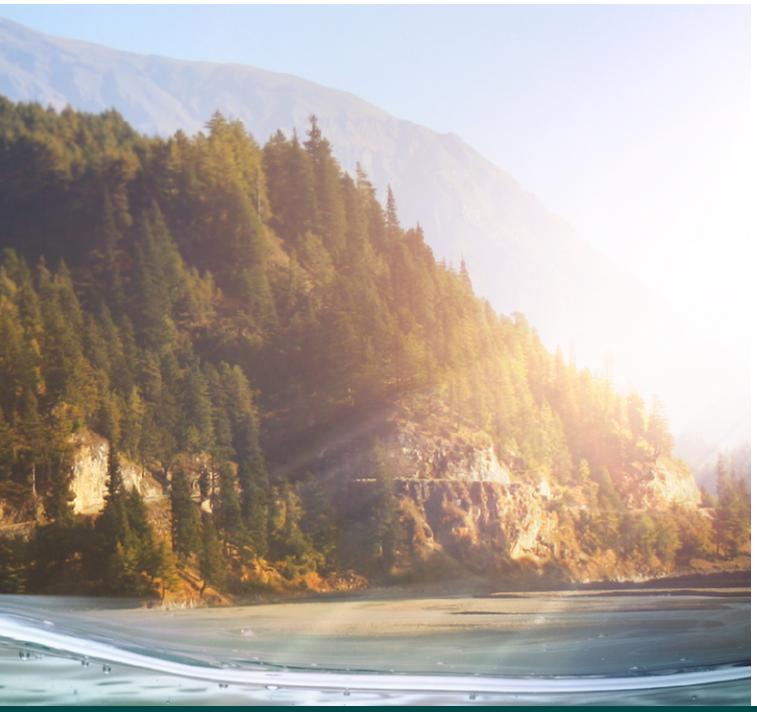

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WASHINGTON STATE BOARD OF HEALTH

ENVIRONMENTAL HEALTH COMMITTEE SPECIAL MEETING SUMMARY NOTES

What: Environmental Health Committee

When: September 19, 2022

Participating via Zoom: Board of Health (Board) members Keith Grellner, Chair, Patty Hayes, Steve Kutz; Board staff Kaitlyn Donahoe, Stuart Glasoe, Michelle Davis, Nathan Thai, Hannah Haag, and Melanie Hisaw; Department of Health (Department) staff Theresa Phillips, Joe Laxson, Laura Johnson, Peter Beaton, Todd Phillips, Mike Means, Holly Meyers, Dani Toepelt, Jeremy Simmons, Ashlie Laydon, Brad Burnham, and Anna Hidle; and approximately ten members of the public. This meeting was livestreamed by TVW.

Summary Notes:

Environmental Health Rulemaking Project Updates

- Stuart Glasoe provided updates on the close-out of Keeping of Animals (WAC 246-203-130) rulemaking. The Board filed the final rule on September 15, 2022, and will follow with public notice and updates to the rulemaking web page.
- Jeremy Simmons and Theresa Phillips summarized the status of On-Site Sewage System (chapter 246-272A WAC) rulemaking. They noted that a cost survey has been distributed to local health jurisdictions and industry and the team is continuing to work on the significant analysis. The team plans to update the Board at its November meeting.
- Dani Toepelt and Mr. Glasoe shared updates on the Sanitary Control of Shellfish (chapter 246-282 WAC) rulemaking. Ms. Toepelt mentioned activities such as data collection, surveying tribes and shellfish operations, and noted the first rulemaking meetings with these groups have been scheduled to discuss pre-harvest practice and vibrio.
- Kaitlyn Donahoe provided updates on the Water Recreation (chapters 246-260 and 246-262 WAC) rulemaking. She mentioned steps staff are taking to reconcile the two chapters with federal guidance, as well as intention to establish a technical advisory committee to help guide rulemaking.

Emerging Issues, Future Board Meeting Topics

- Mike Means and Ms. Phillips discussed federal lead/copper rule updates and impacts to future Board rulemaking as it relates to public water systems. Member Kutz asked clarifying questions regarding the impact of these federal changes to Washington’s public water systems and homes.

(Continued on the next page)

- Laura Johnson outlined Department activities to mitigate lead, including but not limited to increased testing of children's blood lead levels, testing school drinking water, and working with the Health Care Authority to request Medicaid reimbursement for case management and environmental assessments.
- Member Hayes recommended providing separate briefings on the lead and copper rule as well as Department activities to mitigate lead exposure at future Board meetings.
- Mr. Means provided additional detail regarding per-and polyfluoroalkyl substances (PFAS) as a follow-up to the briefing provided at the Board's August meeting. Member Kutz asked clarifying questions regarding emerging treatment techniques for PFAS contamination.

Preparation for October Board Meeting – Second Emergency Rule (WAC 246-272A-0110), On-Site Sewage System Proprietary Treatment Products

- Mr. Simmons described the original emergency rule for onsite sewage system proprietary treatment products adopted by the Board in June, implementation status of the emergency rule, and the second emergency rule being readied for Board action at its October Board meeting.

Board Initiatives and Priorities

- Ms. Donahoe provided updates on work staff has completed to provide additional guidance for scoping rulemaking projects, expectations of Board members for rulemaking sponsorship, and the format of future policy subcommittee meetings. She and Member Hayes discussed the cadence of future subcommittee meetings. Ms. Donahoe suggested that changes to subcommittee meetings go into effect in early 2023 to allow staff time to consult with committee members on availability and agenda planning.

Committee Member Comments, Questions, and Next Steps

- All board members: Great meeting, appreciate everyone's hard work.

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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: September 15, 2022
TIME: 9:38 AM

WSR 22-19-043

Agency: State Board of Health

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) **(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:

Purpose: WAC 246-203-130. The adopted rule amendments modernize the language, structure, and standards of the keeping of animals rule. The revision changes the rule title to Domestic Animal Waste. The rule serves as the State Board of Health's (Board) cornerstone rule on the safe handling and disposal of animal waste and is one section of the Board's rules on General Sanitation, chapter 246-203 WAC. The rule establishes minimum standards to help prevent, control, and abate health hazards and nuisance associated with the handling and disposal of domestic animal waste. This includes waste from livestock animals such as horses and cattle, and waste from nonlivestock animals such as dogs and cats. The rule includes standards to: (1) avoid unsanitary accumulations of waste in containment areas where animals are held or housed for a period of time; (2) prevent contamination of other people's property, drinking water sources, and surface water bodies with potential to affect human health; (3) promote safe handling and disposal of nonlivestock waste; and (4) promote safe stockpiling of livestock waste.

Citation of rules affected by this order:

New: none
Repealed: none
Amended: WAC 246-203-130
Suspended: none

Statutory authority for adoption: RCW 43.20.050

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 22-08-003 on 03/23/2022 (date).

Describe any changes other than editing from proposed to adopted version: The adopted rule includes the following clarifying, non-substantive changes.

WAC 246-203-130(3) pertaining to overlap with more stringent standards in federal, state, or municipal law, is amended to include examples of laws and regulations with more stringent standards that supersede the rule.

WAC 246-203-130(3) pertaining to exempt diffuse sources of animal waste is amended to replace the term "free-range" grazing with "open-range" grazing to more accurately describe this grazing practice.

WAC 246-203-130(3)(c) pertaining to not stockpiling nonlivestock waste is deleted to avoid internal conflict with the definition of stockpiling.

WAC 246-203-130(3)(c)(ii) pertaining to nonlivestock waste disposal is amended to avoid conflict with other state rules regarding commercial composting of nonlivestock waste.

WAC 246-203-130(3)(d)(i) pertaining to odor and pest control of livestock waste stockpiles is amended to clarify the standard as a performance standard to control odors and pests with livestock waste stockpiles to the extent reasonable.

WAC 246-203-130(4) pertaining to enforcement is amended to emphasize voluntary compliance via education.

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

Name: Stuart Glasoe
Address: PO Box 47990 Olympia WA 98504-7990
Phone: (360) 236-4111
Fax: N/A
TTY: 711
Email: stuart.glasoe@sboh.wa.gov
Web site: https://sboh.wa.gov/rulemaking/agency-rules-and-activity/keeping-animals
Other:

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	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: 06/08/2022	**Signature:** 
Name: Michelle A. Davis	
Title: Executive Director	

AMENDATORY SECTION (Amending WSR 91-02-051, filed 12/27/90, effective 1/31/91)

WAC 246-203-130 ((~~Keeping of animals.~~)) Domestic animal waste. ((~~(1) Any person, firm or corporation is prohibited from keeping or sheltering animals in such a manner that a condition resulting from same shall constitute a nuisance.~~

~~(2) In populous districts, stable manure must be kept in a covered watertight pit or chamber and shall be removed at least once a week during the period from April 1st to October 1st and, during the other months, at intervals sufficiently frequent to maintain a sanitary condition satisfactory to the health officer. Manure on farms or isolated premises other than dairy farms need not be so protected and removed unless ordered by the health officer.~~

~~(3) Manure shall not be allowed to accumulate in any place where it can prejudicially affect any source of drinking water.~~)) (1) A person may not keep or shelter animals in such a manner that the domestic animal waste creates a nuisance or health hazard. The purpose of this section is to establish standards for the prevention, control, and abatement of health hazards and nuisance detrimental to human health related to the disposal of domestic animal waste, including handling and storage of domestic animal waste, as described in subsection (3) of this section.

(2) The following definitions apply throughout this section unless the context clearly indicates otherwise.

(a) "Containment area" means an area where domestic animals are held, housed, or kept for a period of time and includes, but is not limited to, stables, corrals, confinement areas, kennels, pens, and yards.

(b) "Domestic animal" means an animal domesticated to live and breed in a tame condition under the care of humans. Domestic animal includes livestock and nonlivestock such as dogs and cats.

(c) "Domestic animal waste" means excreta from a domestic animal and includes associated wash water, feed, and bedding soiled with the excreta.

(d) "Health hazard" includes any organism, chemical, condition, or circumstance that poses a direct and immediate risk to human health.

(e) "Livestock" means domestic animals raised for use or for profit, especially on a farm, and includes horses, mules, donkeys, cattle, bison, sheep, goats, swine, rabbits, llamas, alpacas, ratites, poultry, waterfowl, and game birds.

(f) "Local health officer" means the legally qualified physician appointed as a health officer pursuant to chapter 70.05, 70.08, or 70.46 RCW, or an authorized representative.

(g) "Nuisance" includes an act or omission that harms, endangers, or interferes with the health or safety of another person.

(h) "Person" means any individual, corporation, company, association, society, firm, partnership, joint stock company, or any governmental agency, or the authorized agents of these entities.

(i) "Sanitary" means of or relating to conditions that affect hygiene and health, especially relating to cleanliness and other precautions against disease.

(j) "Stockpiling" means the temporary piling of domestic animal waste from livestock prior to use or disposal. Stockpiling does not

include active composting or lagoon storage of domestic animal waste from livestock.

(k) "Surface water" means a body of water open to the atmosphere and subject to surface runoff including, but not limited to, lakes, ponds, streams, rivers, and marine waters.

(3) Unless a standard is superseded by a more stringent standard in federal, state, or municipal law, a person must meet the following standards in order to help prevent, control, and abate nuisance and health hazards related to the disposal of domestic animal waste. For purposes of these rules, examples of more stringent standards include, but are not limited to, the Dairy Nutrient Management Act, chapter 90.64 RCW, the state Water Pollution Control Act (WPCA), chapter 90.48 RCW, agricultural activities nuisance law under RCW 7.48.300 through 7.48.320, concentrated animal feeding operations permits issued by the department of ecology under the federal Clean Water Act and/or the WPCA, and fugitive dust or air emission plans approved by the department of ecology or a local government agency under the Washington Clean Air Act, chapter 70A.15 RCW. Except for open-range grazing, livestock trails, trail riding, and other diffuse sources of domestic animal waste, a person must:

(a) Collect domestic animal waste at intervals sufficient to maintain sanitary conditions in containment areas;

(b) Handle domestic animal waste to prevent deposition, leaching, and runoff to:

(i) Another person's property;

(ii) Drinking water sources; and

(iii) Surface water bodies used for swimming, shellfish harvesting, or other activity with potential to affect human health;

(c) Handle domestic animal waste from nonlivestock as follows:

(i) Hold the waste in a watertight container if stored for more than one day prior to proper disposal; and

(ii) Bag and dispose of the waste as solid waste, unless waste is composted by a regulated compost facility per WAC 173-350-220; and

(d) Handle domestic animal waste from livestock that is collected and stockpiled for later use or disposal as follows:

(i) Apply control measures as reasonable to minimize and reduce odors and attraction of flies and rodents;

(ii) Store the waste no longer than one year; and

(iii) Site the stockpile:

(A) One hundred feet or more from a drinking water well;

(B) Two hundred feet or more from a public drinking water spring;

(C) Outside the sanitary control area of a public drinking water source if different from the areas set forth in (d)(iii)(A) and (B) of this subsection;

(D) One hundred feet or more from a surface water body unless:

(I) The surface water body is upgradient or is protected by a levee or other physical barrier; or

(II) The surface water body is protected by one or more control or treatment practices that capture and prevent leachate. Practices include, but are not limited to, storage pads, covers, storage structures, and filter strips; and

(E) Outside seasonally or frequently flooded areas unless used or disposed of prior to flooding.

(4) The local health officer may investigate and enforce this section. Enforcement actions may include any proceeding within the local health officer's statutory authority. Before taking enforcement action the local health officer must attempt to communicate with the

person who may be in violation of this section to explore the facts and, if the local health officer determines that a violation has occurred, seek voluntary compliance by education and allow the person reasonable time to correct the violation.

Department of Health Updates

Washington State Department of Health

www.doh.wa.gov

State Board of Health Meeting

October 12, 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

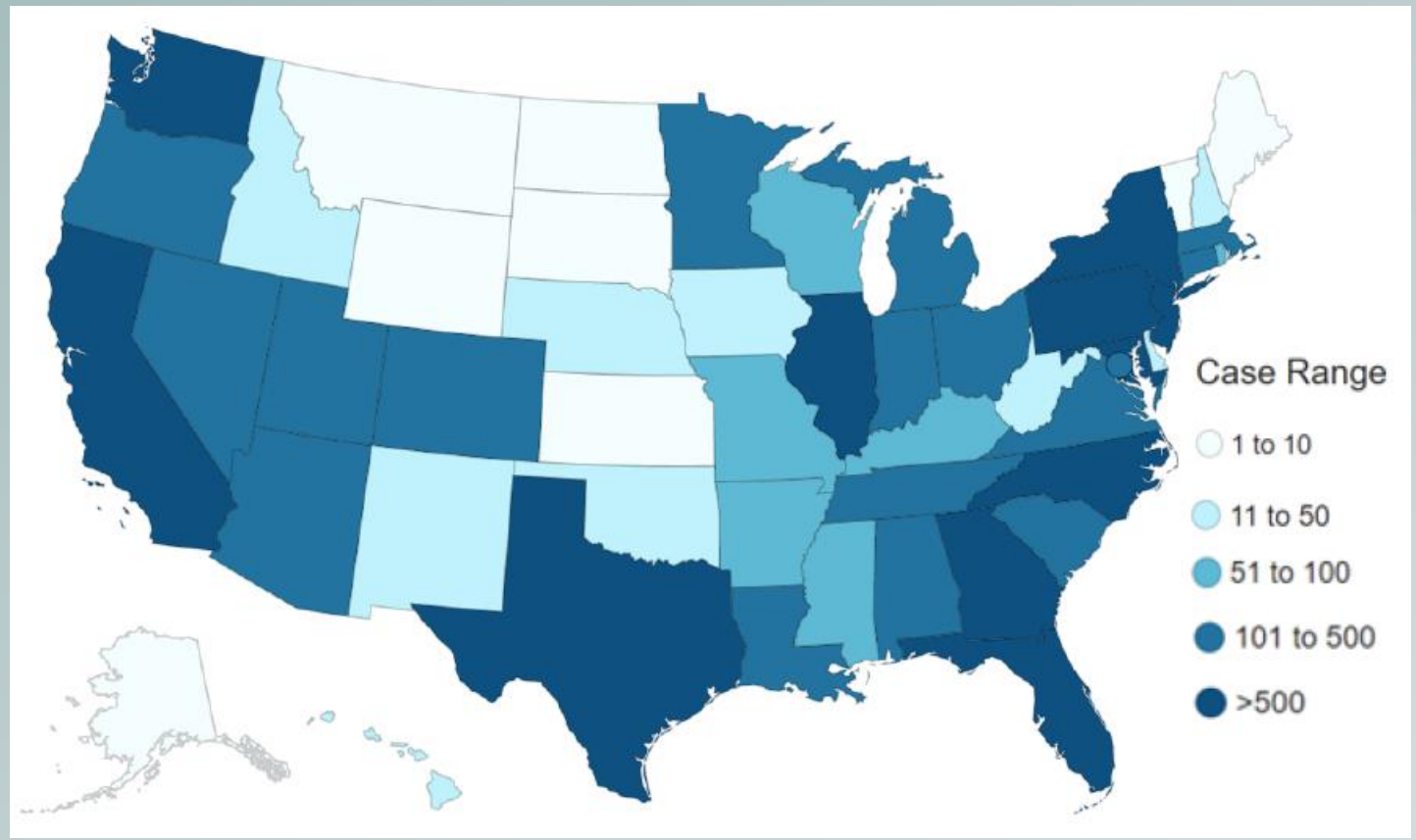
Chief Science Officer


Health
Where Equity,
Innovation and
Engagement meet

MPV
(Monkeypox)

MPV Cases in US

25,162 Confirmed and Probable Monkeypox Cases



Top 10 US Jurisdictions with Monkeypox Cases (as of 9/29/22)		
1	California	4,886
2	New York	3,881
3	Florida	2,445
4	Texas	2,268
5	Georgia	1,764
6	Illinois	1,284
7	Pennsylvania	727
8	New Jersey	695
9	Maryland	647
10	Washington	583

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

DOH activates MPV Incident Command Team

August 4th

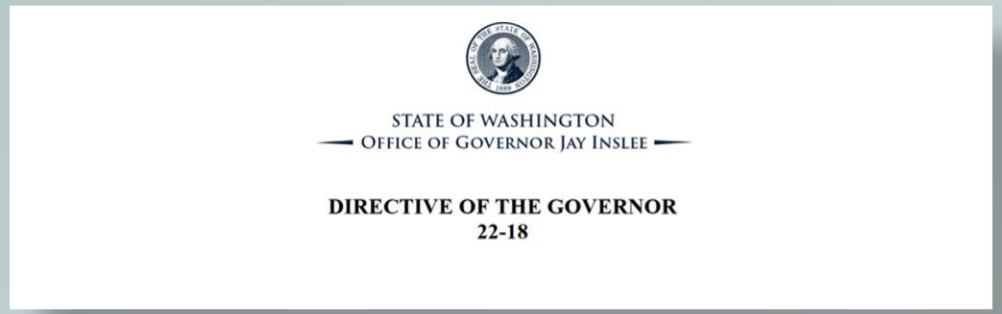
United States declares federal public health emergency

August 12th

WA Governor Inslee issues MPV Plan of Action Directive to WA DOH

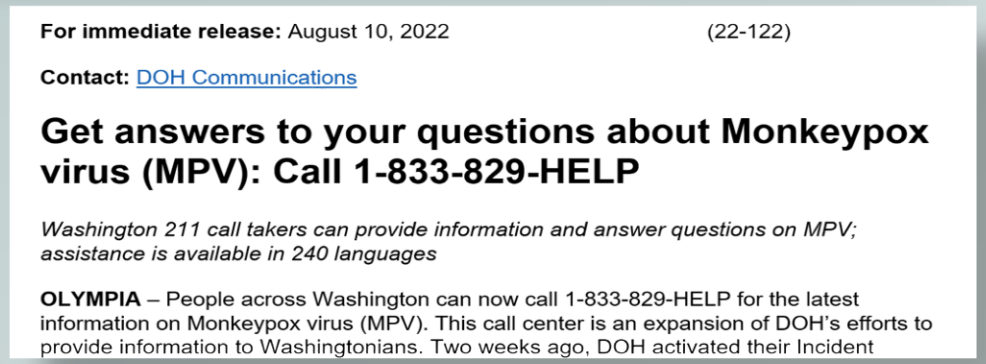
MPV State Plan of Action

- Directive of the Governor 22-18
- 211 MPV Call line
- MPV Community Collaborative
- MPV Data Dashboard



STATE OF WASHINGTON
OFFICE OF GOVERNOR JAY INSLEE

DIRECTIVE OF THE GOVERNOR
22-18



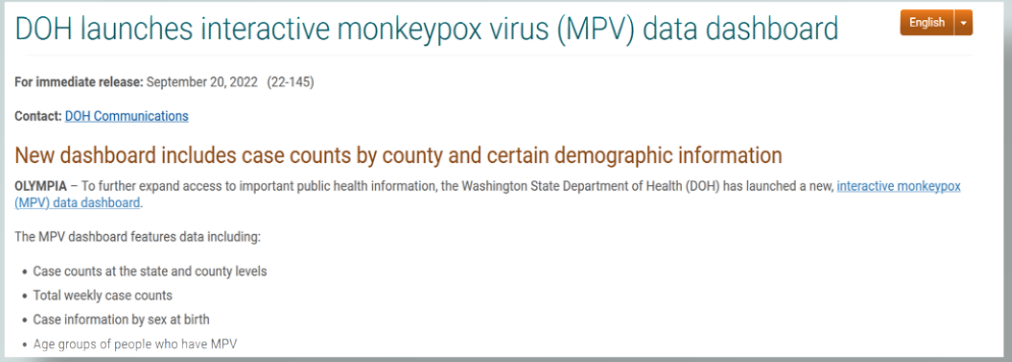
For immediate release: August 10, 2022 (22-122)

Contact: DOH Communications

Get answers to your questions about Monkeypox virus (MPV): Call 1-833-829-HELP

Washington 211 call takers can provide information and answer questions on MPV; assistance is available in 240 languages

OLYMPIA – People across Washington can now call 1-833-829-HELP for the latest information on Monkeypox virus (MPV). This call center is an expansion of DOH's efforts to provide information to Washingtonians. Two weeks ago, DOH activated their Incident



DOH launches interactive monkeypox virus (MPV) data dashboard

English

For immediate release: September 20, 2022 (22-145)

Contact: DOH Communications

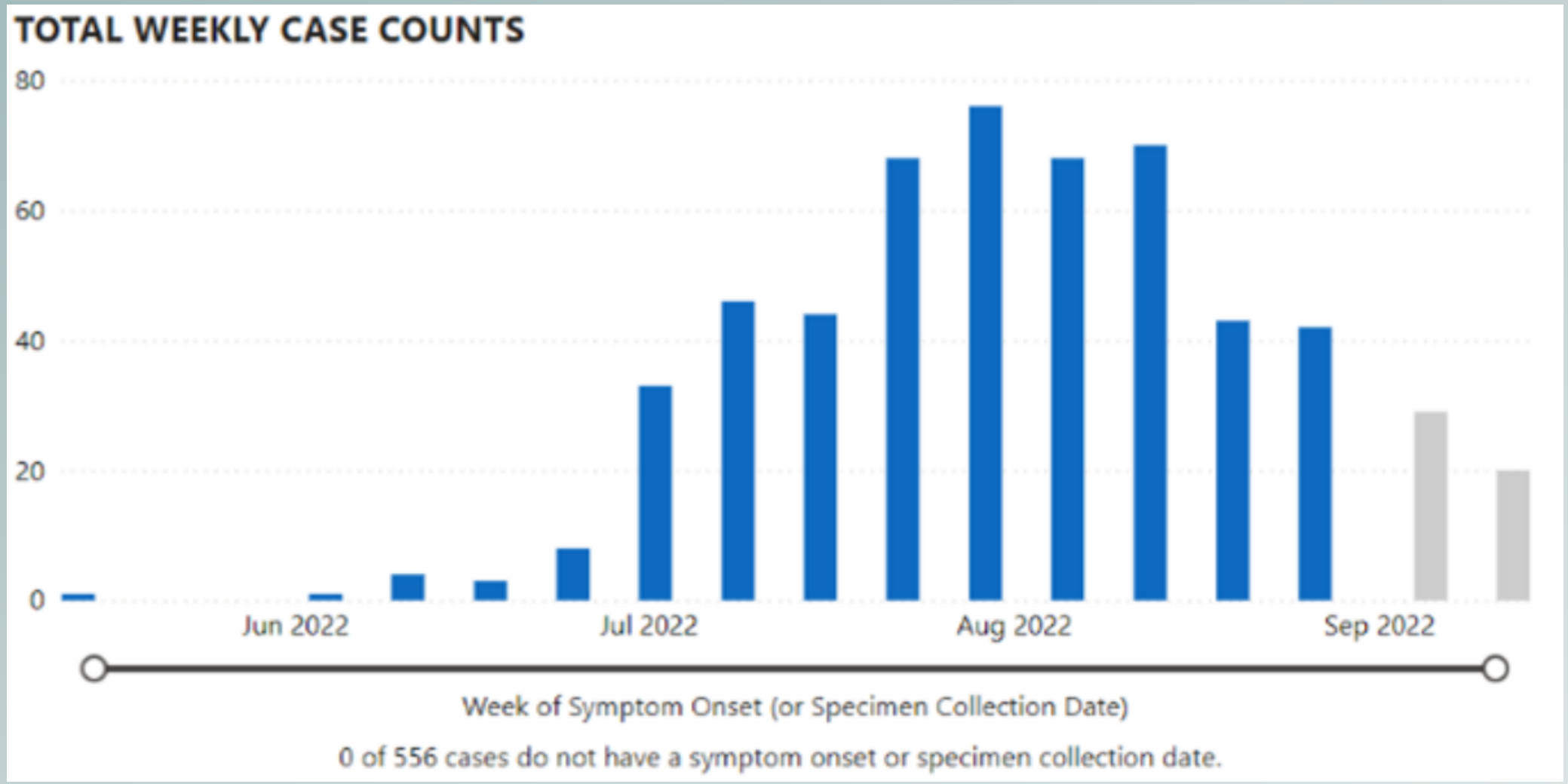
New dashboard includes case counts by county and certain demographic information

OLYMPIA – To further expand access to important public health information, the Washington State Department of Health (DOH) has launched a new, interactive monkeypox (MPV) data dashboard.

The MPV dashboard features data including:

- Case counts at the state and county levels
- Total weekly case counts
- Case information by sex at birth
- Age groups of people who have MPV

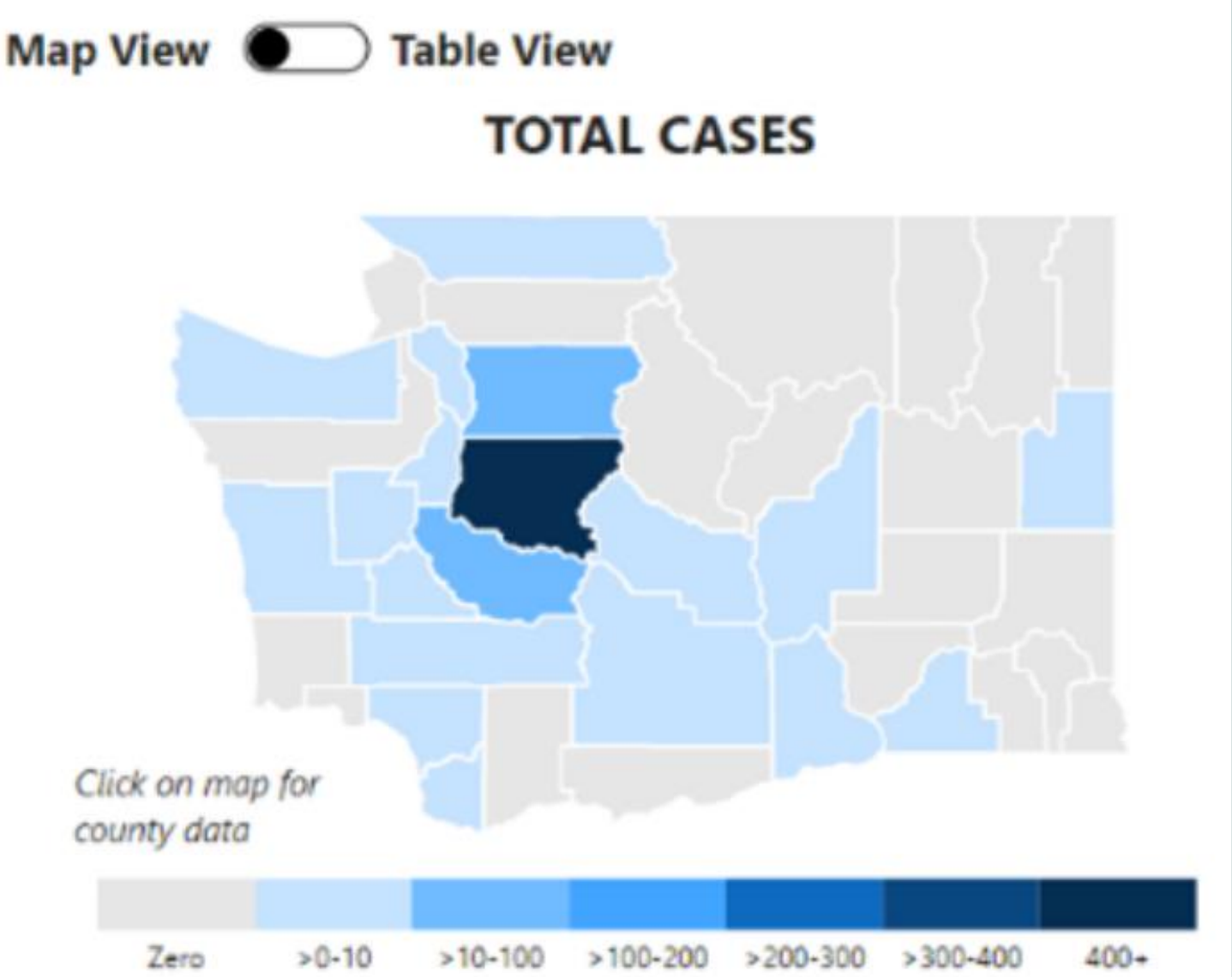
MPV Weekly Case Count in Washington State



Source: DOH MPV data dashboard https://doh.wa.gov/you-and-your-family/illness-and-disease-z/monkeypox/monkeypox-mpv-data (9/29/2022)

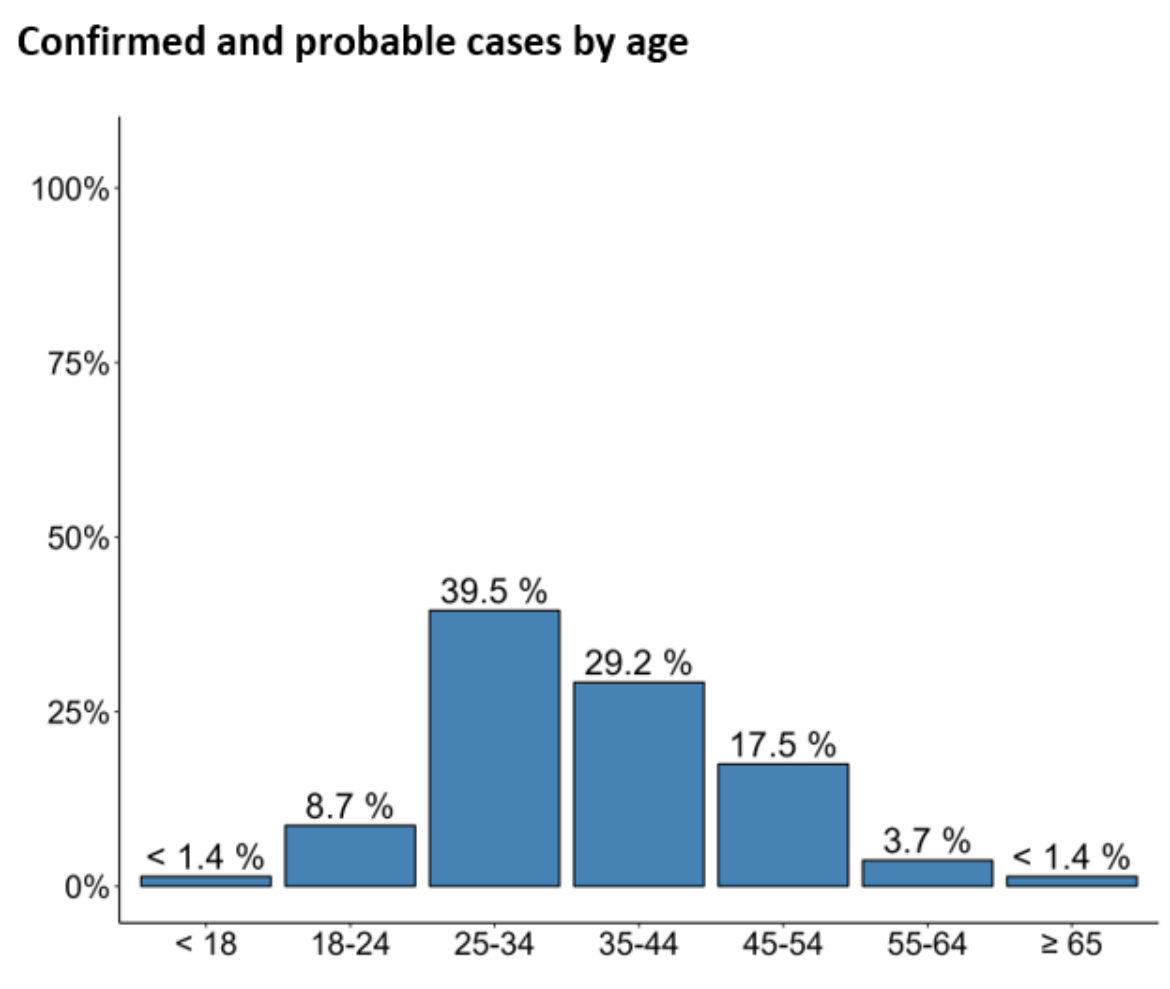
Cases by County in Washington State

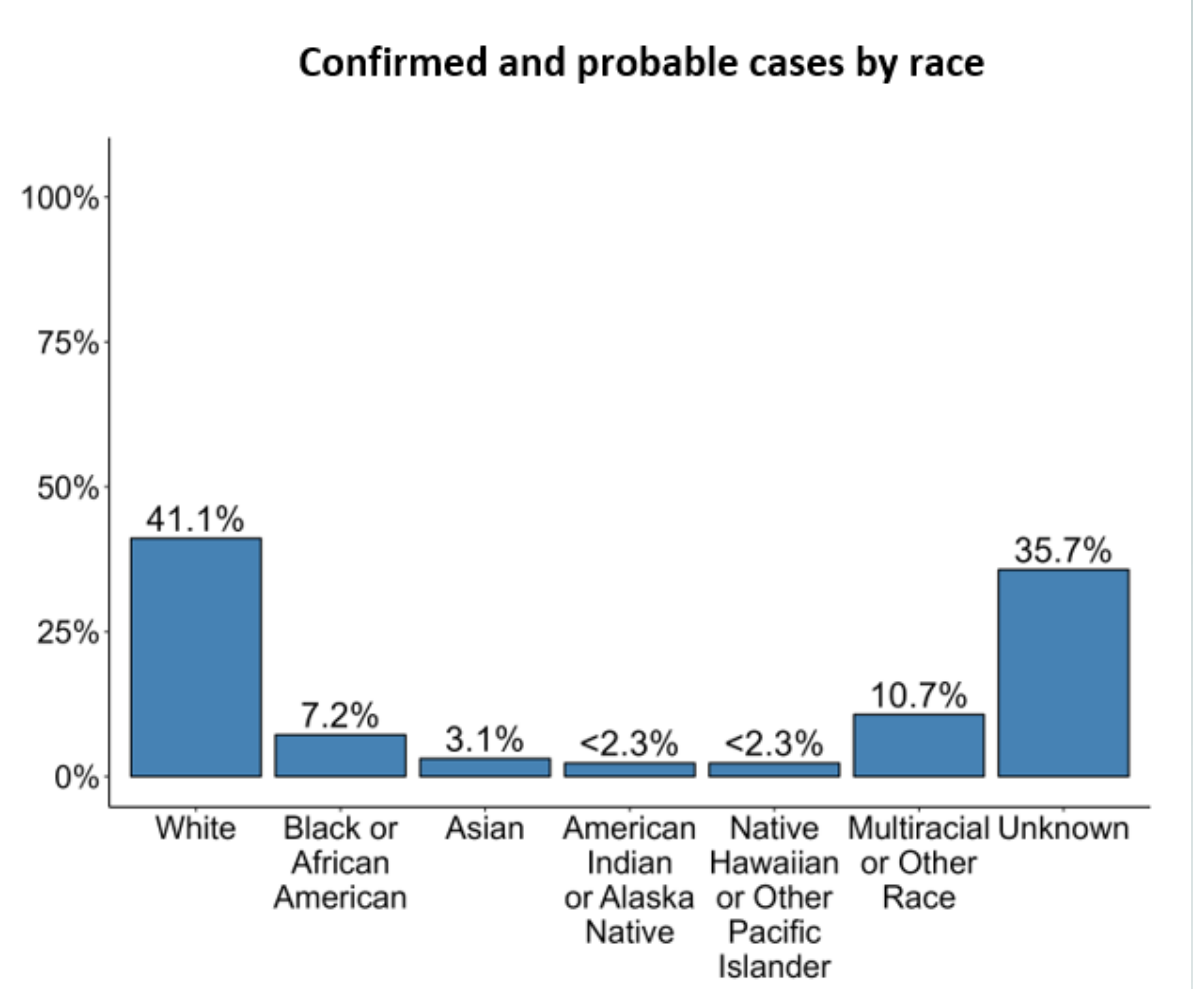
County	Number of cases
Benton	2
Clallam	1
Clark	10
Cowlitz	1
Grant	1
Grays Harbor	1
Island	1
King	455
Kitsap	4
Kittitas	1
Lewis	2
Mason	1
Pierce	47
Skagit	2
Snohomish	27
Spokane	7
Thurston	1
Walla Walla	1
Whatcom	2
Yakima	5
Total cases	**572**



Source: DOH MPV data dashboard https://doh.wa.gov/you-and-your-family/illness-and-disease-z/monkeypox/monkeypox-mpv-data (9/29/2022)

Cases Demographics in Washington State





MPV Vaccines

JYNNEOS Allocations to Washington State

Phase 2A	Phase 2B	Phase 3A	Phase 3B + 3C	Phase 4a
2,710	3,680	6,900	2,080	2,580

96% of allocated vaccines have been ordered and distributed

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

DONATE NOW

SGN

SEATTLE'S LGBTQIA+ NEWS & ENTERTAINMENT WEEKLY SINCE 1974

VOLUME 50 ISSUE 31

HOME A&E LOCAL NATIONAL INTERNATIONAL OP-ED TRAVEL OBITUARY COMICS PODCAST SPECIAL ISSUES FIND OUR PAPER

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

COVID-19

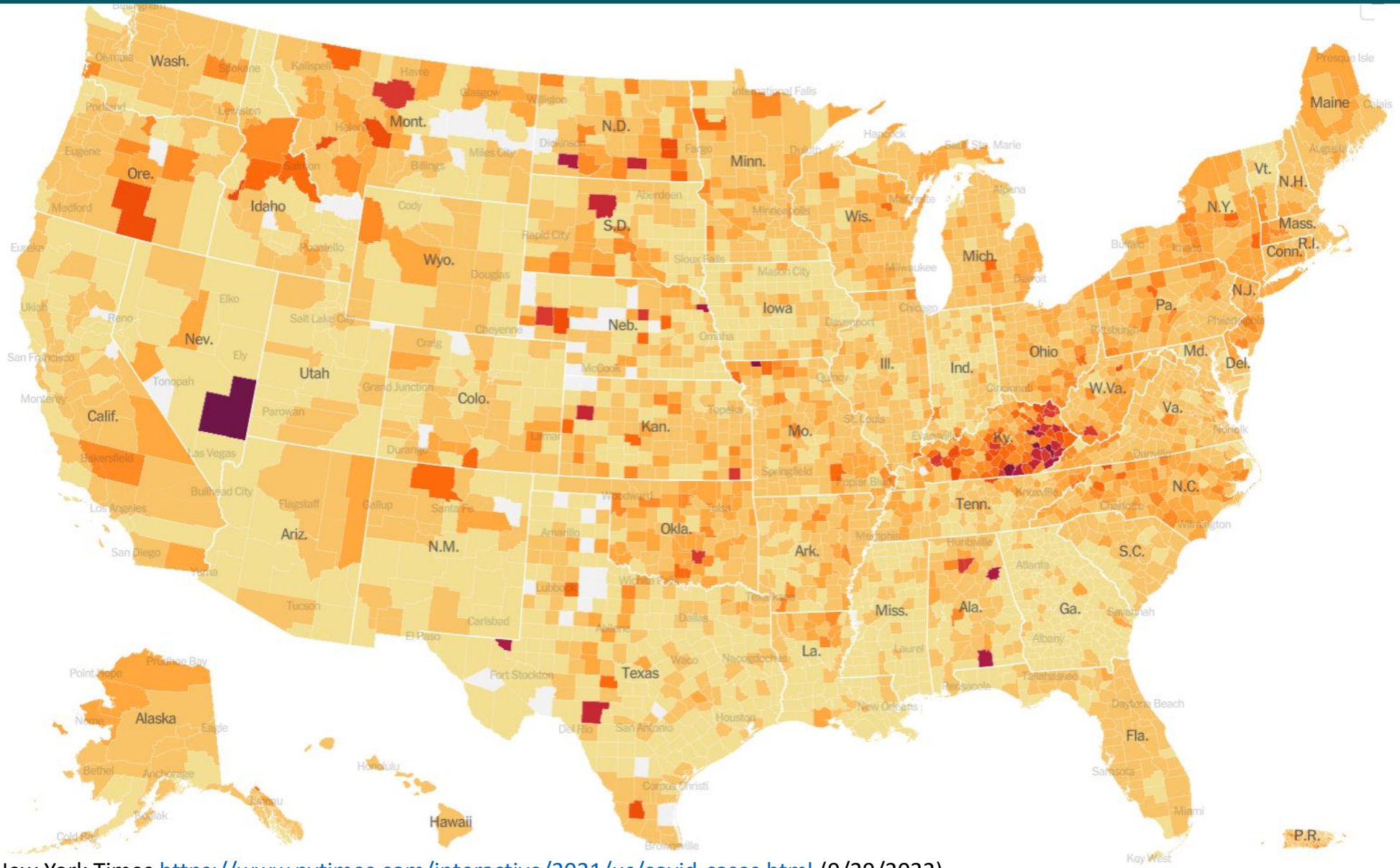
Washington State Department of Health

Mask Up, Washington.

Visit www.doh.wa.gov

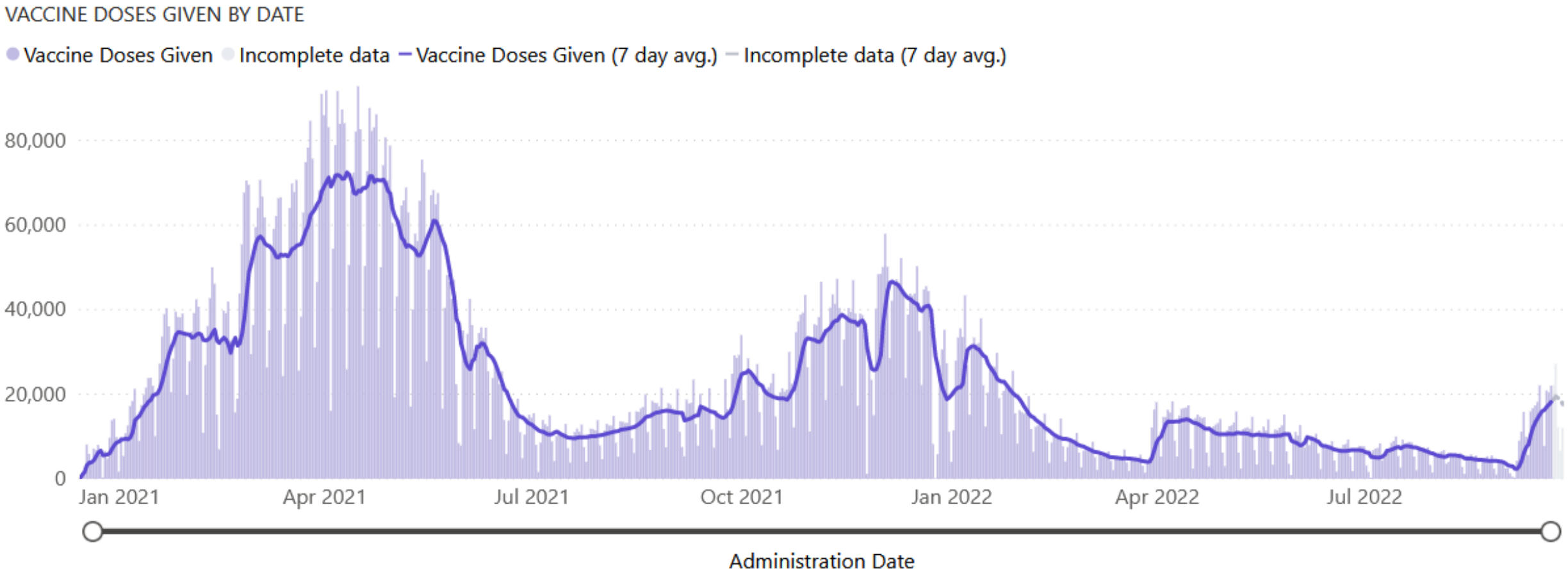
@WaDeptHealth
@WaHealthSec

October 2022 – U.S. COVID-19 hot spots



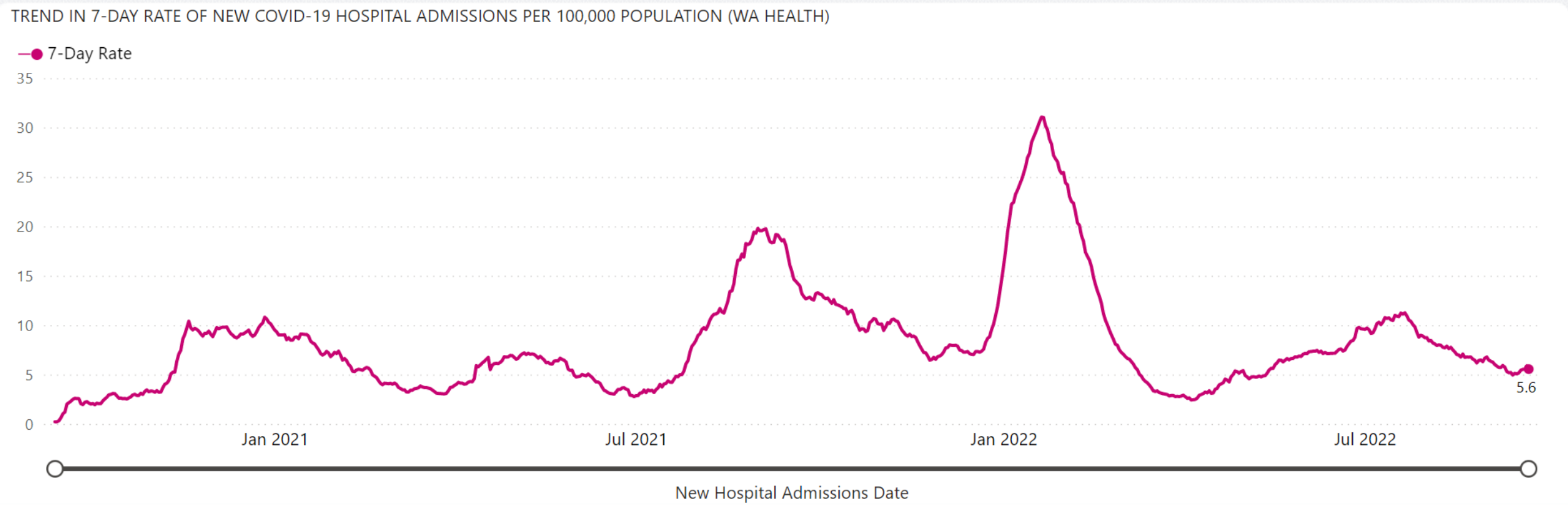
Source: The New York Times https://www.nytimes.com/interactive/2021/us/covid-cases.html (9/29/2022)

Vaccines Doses Given Washington State



Source: DOH COVID-19 data dashboard https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard (9/29/2022)

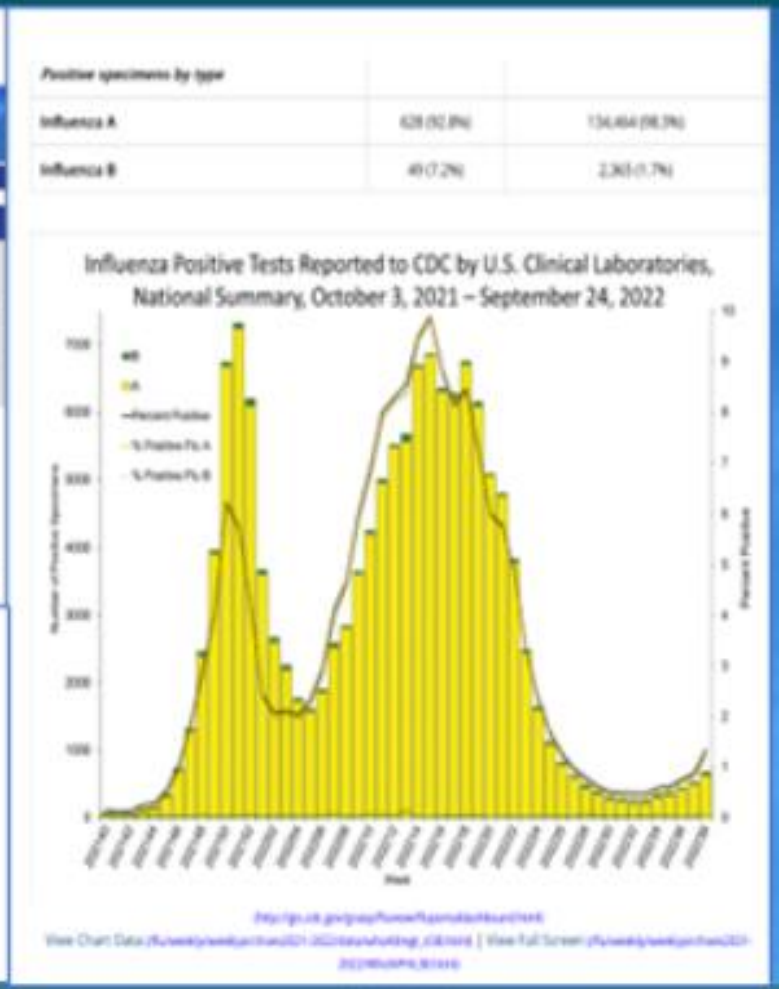
COVID-19 Hospitalizations in Washington State



Source: DOH COVID-19 data dashboard https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard (9/29/2022)

COVID-19 Bivalent Booster Dose

Concern for Flu/Respiratory Season



Transformational Plan

Commitment to Washington

Office of the Secretary of Health
Umair A. Shah, MD, MPH
Secretary of Health

Washington State Department of Health

Executive Leadership Team Office & Functions

Office of Chief of Staff

Jessica Todorovich

- Budget, Finance & Contracts
- Risk Management & Business Services
- Adjudicative Services
- People & Culture
- Regional Health Offices

Office of Innovation & Technology

Les Becker

- Informatics
- Technology
- Innovation
- Data & System Modernization

Office of Prevention, Safety & Health

Lacy Fehrenbach

- Environmental Public Health
- Prevention & Community Health
- Health Systems Quality Assurance

Office of Strategic Partnerships

Kris Holiday *(acting)*

- Private Partnerships
- Local Health
- Tribal Health
- Academic Partnerships

Office of Science & Health

Tao Sheng Kwan-Gett

- Data Science
- Disease Control & Health Statistics
- Medical Science
- Non-Infectious Disease Epi

Office of Public Affairs & Equity

Liz Perez

- Communications
- Health Education
- Health Promotion
- Community Engagement
- Equity

Office of Policy, Planning & Evaluation

Kristin Peterson

- Policy & Regulatory Development
- Public Health Law
- System Transformation
- Economic Analysis & Evaluation
- Legislative & Federal Affairs

Office of Resilience & Health Security

Nate Weed

- COVID
- Readiness & Response
- Emergency Logistics
- Resiliency & Recovery
- Preparedness Grants & Contracts

WASHINGTON STATE DEPARTMENT OF HEALTH

TRANSFORMATIONAL PLAN

A VISION FOR HEALTH IN WASHINGTON STATE

HEALTH AND WELLNEESS

GLOBAL AND ONE HEALTH

HEALTH SYSTEMS AND WORKFORCE TRANSFORMATION

EMERGENCY RESPONSE AND RESILIENCE

ENVIRONMENTAL HEALTH

CORNERSTONE VALUES: EQUITY • INNOVATION • ENGAGEMENT

VISION: EQUITY AND OPTIMAL HEALTH FOR ALL

WASHINGTON STATE DEPARTMENT OF HEALTH

TRANSFORMATIONAL PLAN

A VISION FOR HEALTH IN WASHINGTON STATE

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

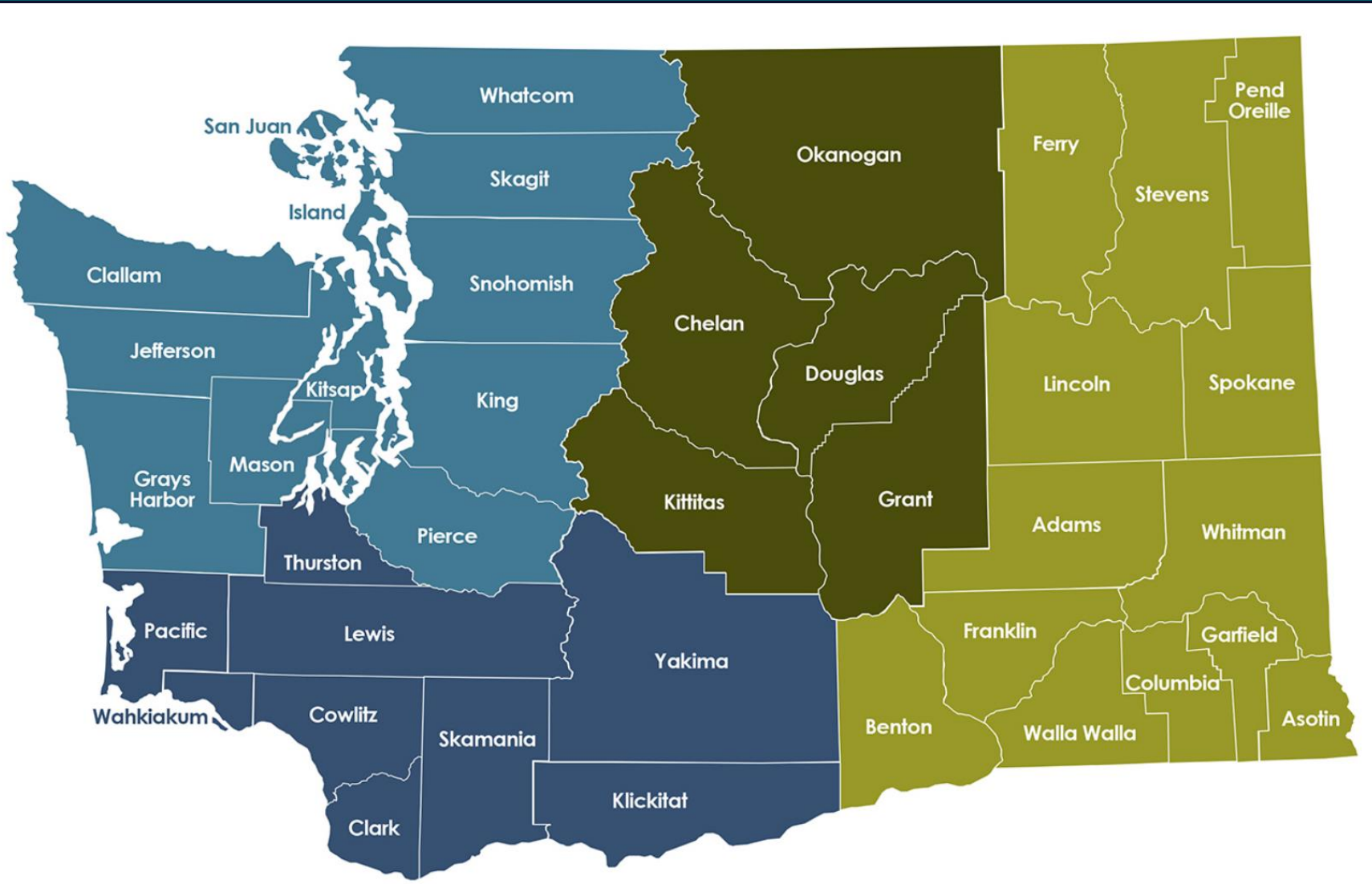
COMMUNITY CENTERED

VISIBILITY AND VALUE

EQUITY DRIVEN

COLLABORATIVE ENGAGEMENT

Regional Health Officers



2022 – Working together for a brighter tomorrow

Washington State Department of Health

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Visit www.doh.wa.gov

@WaDeptHealth
@WaHealthSec

From: Don Jacobson <desert.don@gmail.com>
Sent: Wednesday, October 5, 2022 11:09 AM
To: DOH WSBOH
Subject: "Covid 19-20-21-22-As Long As Needed Edicts

External Email

Jay Inslee's Directive 22-13.1, Washington's Office of Financial Management (OFM) is attempting to circumvent the Legislature by filing proposed WACs (starting at page 97 HERE) to permanently require small and executive cabinet agency employees to be "fully vaccinated" for Covid in perpetuity.

American citizens instead DEMAND that the Constitution is upheld and obeyed.
Each citizen will make their OWN choices regarding health care choices, including when and if we choose to inject non-approved, non-animal-tested experimental mRNA drugs.

Enough! If we must replace you with Leaders who obey our nation's laws, we will.

Don Jacobson
117 NW 101 St
Vancouver, WA 98685

From: Lisa Templeton <lisa@informedchoicewa.org>
Sent: Friday, October 7, 2022 11:02 AM
To: DOH WSBOH
Subject: Comment for BOH members for October 12 meeting
Attachments: ICWA comments to BOH 10.7.22.pdf

External Email

Good morning,

Attached is Informed Choice Washington's public comment for Board members for its meeting next Wednesday. Will you kindly ensure they receive it, and send me confirmation that you have done so?

Thank for your help,

Lisa Templeton
Executive Secretary to the Board

InformedCHOICEWA.org
PROTECTING OUR MEDICAL FREEDOM

InformedCHOICEWA.org

October 7, 2022

Washington Board of Health
Washington Secretary of Health Shah

RE: Public comment for October 12, 2022, meeting

Via email only

Dear BOH Members and Secretary Shah:

We write to provide you with some of the most recent published studies and data on COVID-19 shots. We also include a recent study by the CDC that shows an association between exposure to aluminum-adjuvanted vaccines and persistent asthma, and a list of other aluminum studies the FDA, CDC, and Washington State health agencies have ignored.

The day is coming when the harm caused by unscientific and unethical public health policies will be brought to court and legal justice will be won. Tragically, this will be of minimal comfort to the injured and those who lost loved ones.

We earnestly ask you to review information beyond what federal agencies provide and to take steps to reverse the reckless promotion of products whose risks far outweigh any perceived benefits. Early treatment with nutrients and safe repurposed drugs, such as the Nobel-prize winning ivermectin, and naturally acquired immunity, should be part of public health's approach to communicable infection and the education of the public and medical community.

The marketing of the COVID-19 genetic therapies as "safe and effective vaccines" by public health agencies has eroded public trust, increased the number of individuals looking closely at the full body of knowledge on the science, history, and politics of vaccine products and the infections they target. Many are understanding for the first time what "fully informed consent" means, and why it is so important to protect it.

Sincerely,

The ICWA Board

Attachments

COVID-19 Shot Data and Recent Studies

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COVID VAERS Reports by STATE

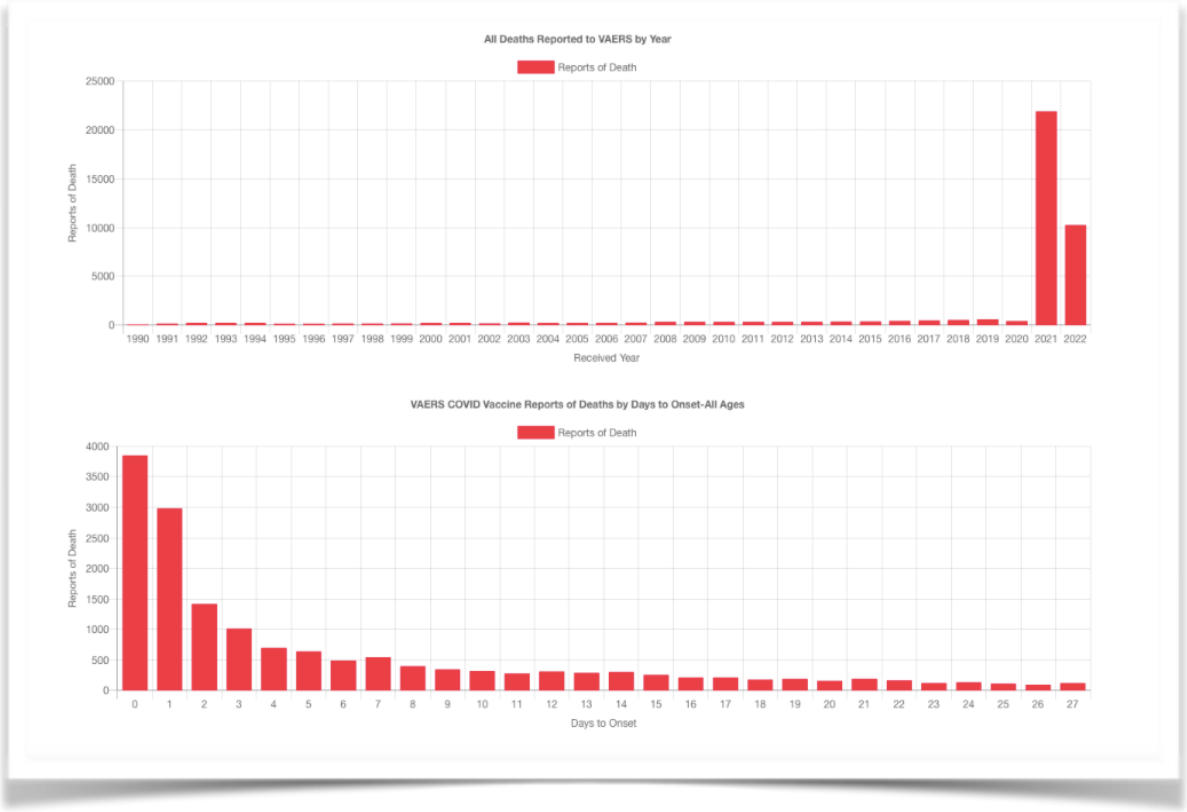
COVID VAERS reports by **Age Range**, **Adverse Event** and **State**. To find the results for your state enter its two-letter abbreviation in the search box on the left.

Through September 23, 2022

Search: WA Show 25 entries

AGE RANGE	STATE	DIED	LIFE THREAT	PERM. DISABLED	HOSPITALIZED	MYOCARDITIS	ANAPHYLAXIS	MISCARRIAGE	TOTAL REPORTS
6 MO-5 YR	WA	0	1	1	2	0	1	0	197
5-11	WA	1	1	2	5	4	0	0	519
12-18	WA	1	9	5	67	59	1	0	1,182
19-30	WA	1	34	52	107	75	6	11	2,362
31-49	WA	14	117	167	254	91	25	54	6,307
50-64	WA	32	111	169	263	52	15	0	4,569
65-80	WA	63	88	80	316	43	4	0	3,845
81-121	WA	72	20	16	138	10	0	0	652
ALL AGES	WA	206	384	496	1174	344	56	65	20,494

https://openvaers.com/covid-data

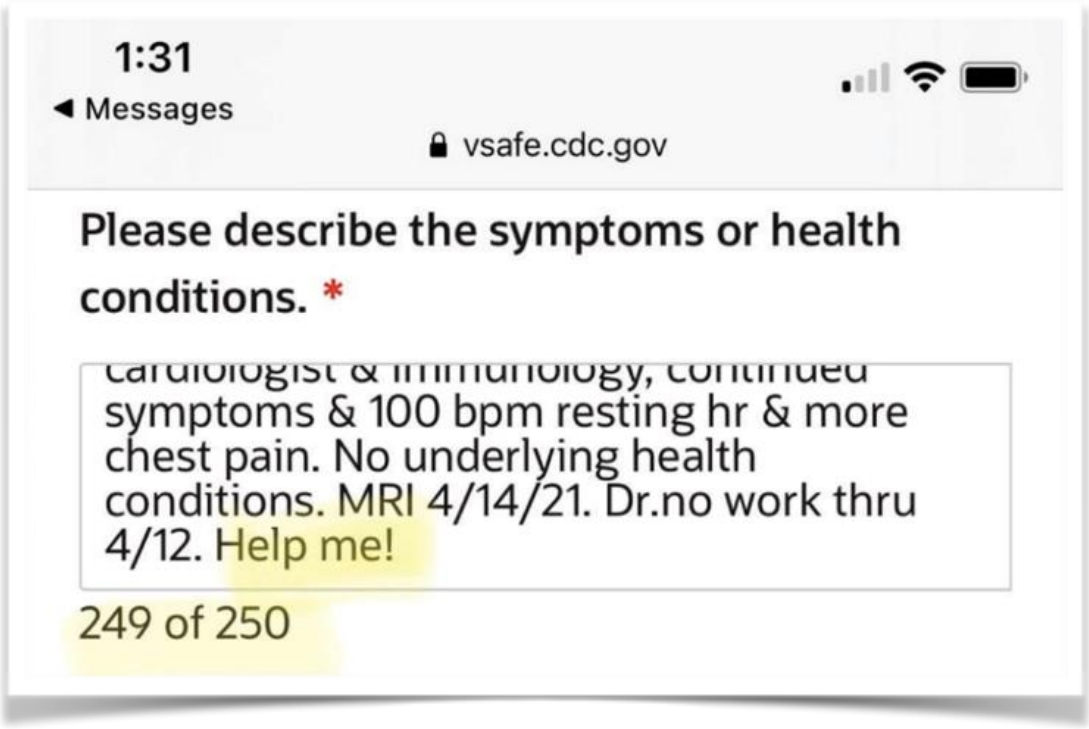


After over a year and two lawsuits, the CDC has released the raw, de-identified data from its V-Safe app.

https://www.icandecide.org/v-safe-data/

This data does not include the “free text” portions. The app provided limited choices to indicate symptoms, and it was insufficient to capture most severe reactions and outcomes. Please see ICWA’s post from 2021 about “R,” a woman in Washington State injured by the J&J shot.

In April of 2021, CDC stated: “Limitations of v-safe include voluntary participation via an opt-in smartphone-based system that includes less than 10% of vaccinated persons.”



“Increased emergency cardiovascular events among under-40 population in Israel during vaccine rollout and third COVID-19 wave”

https://www.nature.com/articles/s41598-022-10928-z

> Abstract:
>
> Cardiovascular adverse conditions are caused by coronavirus disease 2019 (COVID-19) infections and reported as side-effects of the COVID-19 vaccines. Enriching current vaccine safety surveillance systems with additional data sources may improve the understanding of COVID-19 vaccine safety. Using a unique dataset from Israel National Emergency Medical Services (EMS) from 2019 to 2021, the study aims to evaluate the association between the volume of cardiac arrest and acute coronary syndrome EMS calls in the 16–39-year-old

population with potential factors including COVID-19 infection and vaccination rates. An increase of over 25% was detected in both call types during January–May 2021, compared with the years 2019–2020. Using Negative Binomial regression models, the weekly emergency call counts were significantly associated with the rates of 1st and 2nd vaccine doses administered to this age group but were not with COVID-19 infection rates. While not establishing causal relationships, the findings raise concerns regarding vaccine-induced undetected severe cardiovascular side-effects and underscore the already established causal relationship between vaccines and myocarditis, a frequent cause of unexpected cardiac arrest in young individuals. Surveillance of potential vaccine side-effects and COVID-19 outcomes should incorporate EMS and other health data to identify public health trends (e.g., increased in EMS calls), and promptly investigate potential underlying causes.

“Serious Adverse Events of Special Interest Following mRNA Vaccination in Randomized Trials”

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4125239

Abstract:

Introduction: In 2020, prior to COVID-19 vaccine rollout, the Coalition for Epidemic Preparedness Innovations and Brighton Collaboration created a priority list, endorsed by the World Health Organization, of potential adverse events relevant to COVID-19 vaccines. We leveraged the Brighton Collaboration list to evaluate serious adverse events of special interest observed in phase III randomized trials of mRNA COVID-19 vaccines.

Methods: Secondary analysis of serious adverse events reported in the placebo-controlled, phase III randomized clinical trials of Pfizer and Moderna mRNA COVID-19 vaccines (NCT04368728 and NCT04470427), focusing analysis on potential adverse events of special interest identified by the Brighton Collaboration.

Results: Pfizer and Moderna mRNA COVID-19 vaccines were associated with an increased risk of serious adverse events of special interest, with an absolute risk increase of 10.1 and 15.1 per 10,000 vaccinated over placebo baselines of 17.6 and 42.2 (95% CI -0.4 to 20.6 and -3.6 to 33.8), respectively. Combined, the mRNA vaccines were associated with an absolute risk increase of serious adverse events of special interest of 12.5 per 10,000 (95% CI 2.1 to 22.9). The excess risk of serious adverse events of special interest surpassed the risk reduction for COVID-19 hospitalization relative to the placebo group in both Pfizer and Moderna trials (2.3 and 6.4 per 10,000 participants, respectively).

Discussion: The excess risk of serious adverse events found in our study points to the need for formal harm-benefit analyses, particularly those that are stratified according to risk of serious COVID-19 outcomes such as hospitalization or death.

“Multisystem Inflammatory Syndrome Following SARS-CoV-2 Vaccination in Two Children”

https://publications.aap.org/pediatrics/article/150/2/e2021055956/188099/Multisystem-Inflammatory-Syndrome-Following-SARS?autologincheck=redirected

Abstract:

This report presents 2 pediatric cases of multisystem inflammatory syndrome in children and adults (MIS-C/A) post severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) vaccination (MIS-V). Both children presented with MIS-V within 6 weeks of receiving their first and only dose of Pfizer-BioNTech’s SARS-CoV-2 vaccine. The first patient had symptoms of MIS-C/A with peri-myocarditis and shock, and the second 1 had classic Kawasaki disease features. Both responded well to intravenous immunoglobulins and/or systemic corticosteroids. Both children were positive only for SARS-2-CoV antispike (S) (and not for antinucleocapsid [NC]) antibodies consistent with a postvaccine, and not a postinfection, event. Surveillance for rare adverse events following immunization should continue, especially now that SARS-CoV-2 vaccination is approved in the 5 to 11 year age group that has had the highest risk of developing MIS-C post SARS-CoV-2 infection. Our patients did not receive any further SARS-CoV-2 vaccines. Our report highlights the importance of measuring differentiating antibodies (anti-S and anti-NC) that can be used within a specific timeframe to help determine if a patient has MIS-V post vaccine (only anti-S present), or MIS-C/A post SARS-CoV-2 infection (both anti-S and anti-NC present).

The following paper pertains to naturally acquired immunity:

“Children develop robust and sustained cross-reactive spike-specific immune responses to SARS-CoV-2 infection”

https://www.nature.com/articles/s41590-021-01089-8

Abstract:

SARS-CoV-2 infection is generally mild or asymptomatic in children but a biological basis for this outcome is unclear. Here we compare antibody and cellular immunity in children (aged 3–11 years) and adults. Antibody responses against spike protein were high in children and seroconversion boosted responses against seasonal Beta-coronaviruses through cross-recognition of the

S2 domain. Neutralization of viral variants was comparable between children and adults. Spike-specific T cell responses were more than twice as high in children and were also detected in many seronegative children, indicating pre-existing cross-reactive responses to seasonal coronaviruses. Importantly, children retained antibody and cellular responses 6 months after infection, whereas relative waning occurred in adults. Spike-specific responses were also broadly stable beyond 12 months. Therefore, children generate robust, cross-reactive and sustained immune responses to SARS-CoV-2 with focused specificity for the spike protein. These findings provide insight into the relative clinical protection that occurs in most children and might help to guide the design of pediatric vaccination regimens.

“Predominance of antibody-resistant SARS-CoV-2 variants in vaccine breakthrough cases from the San Francisco Bay Area, California”

https://www.nature.com/articles/s41564-021-01041-4

Abstract:

Associations between vaccine breakthrough cases and infection by different SARS coronavirus 2 (SARS-CoV-2) variants have remained largely unexplored. Here we analysed SARS-CoV-2 whole-genome sequences and viral loads from 1,373 persons with COVID-19 from the San Francisco Bay Area from 1 February to 30 June 2021, of which 125 (9.1%) were vaccine breakthrough infections. Vaccine breakthrough infections were more commonly associated with circulating antibody-resistant variants carrying ≥1 mutation associated with decreased antibody neutralization (L452R/Q, E484K/Q and/or F490S) than infections in unvaccinated individuals (78% versus 48%, $P = 1.96 \times 10^{-8}$). Differences in viral loads were non-significant between unvaccinated and fully vaccinated cases overall ($P = 0.99$) and according to lineage ($P = 0.09–0.78$). Symptomatic vaccine breakthrough infections had comparable viral loads ($P = 0.64$), whereas asymptomatic breakthrough infections had decreased viral loads ($P = 0.023$) compared with infections in unvaccinated individuals. In 5 cases with serial samples available for serologic analyses, vaccine breakthrough infections were found to be associated with low or undetectable neutralizing antibody levels attributable to an immunocompromised state or infection by an antibody-resistant lineage. Taken together, our results show that vaccine breakthrough infections are overrepresented by antibody-resistant SARS-CoV-2 variants, and that symptomatic breakthrough infections may be as efficient in spreading COVID-19 as unvaccinated infections, regardless of the infecting lineage.

“DECREASED BREADTH OF THE ANTIBODY RESPONSE TO THE SPIKE PROTEIN OF SARS-CoV-2 AFTER REPEATED VACCINATION”

https://www.medrxiv.org/content/10.1101/2021.08.12.21261952v3

Abstract:

The rapid development of vaccines to prevent infection by SARS-CoV-2 virus causing COVID-19 makes necessary to compare the capacity of the different vaccines in terms of development of a protective humoral response. Here, we have used a highly sensitive and reliable flow cytometry method to measure the titers of antibodies of the IgG1 isotype in blood of healthy volunteers after receiving one or two doses of the vaccines being administered in Spain. We took advantage of the multiplexed capacity of the method to measure simultaneously the reactivity of antibodies with the S protein of the original strain Wuhan and the variants B.1.1.7 (Alpha), B.1.617.2 (Delta) and B.1.617.1 (Kappa). We found significant differences in the titer of anti-S antibodies produced after a first dose of the vaccines ChAdOx1 nCov-19/AstraZeneca, mRNA-1273/Moderna, BNT162b2/Pfizer-BioNTech and Ad26.COV.S/Janssen. Most important, we found a relative reduction in the reactivity of the sera with the Alpha, Delta and Kappa variants, versus the Wuhan one, after the second boosting immunization. These data allow to make a comparison of different vaccines in terms of anti-S antibody generation and cast doubts about the convenience of repeatedly immunizing with the same S protein sequence.

“Detection of Messenger RNA COVID-19 Vaccines in Human Breast Milk”

https://jamanetwork.com/journals/jamapediatrics/fullarticle/2796427

Results:

Of 11 lactating individuals enrolled, trace amounts of BNT162b2 and mRNA-1273 COVID-19 mRNA vaccines were detected in 7 samples from 5 different participants at various times up to 45 hours postvaccination (Table 2). The mean (SD) yield of EVs isolated from EBM was 9.110 (5.010) particles/mL, and the mean (SD) particle size was 110.0 (3.0) nm. The vaccine mRNA appears in higher concentrations in the EVs than in whole milk (Table 2). No vaccine mRNA was detected in prevaccination or postvaccination EBM samples beyond 48 hours of collection. Also, no COVID-19 vaccine mRNA was detected in the EBM fat fraction or the EBM cell pellets.

“Myopericarditis After the Pfizer Messenger Ribonucleic Acid Coronavirus Disease Vaccine in Adolescents”

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8253718/

> Conclusion:
>
> Although a causal relationship between vaccination and the development of myopericarditis cannot be concluded from a case series, the clustering in time as well as the uncommon occurrence of myopericarditis and the rapid resolution of symptoms and findings likely make this a unique vaccine-related event. Identification of myopericarditis as an adverse event should have high priority during investigations before and after authorization of COVID-19 vaccines and be considered by policy makers in the risk/benefit ratio in adolescents and children.

Aluminum Toxicity Studies

Questions for BOH Members and Secretary Shah:

Are public health vaccination programs trading incidents of transient infections and subsequent natural immunity for epidemics of lifelong chronic health problems, such as asthma?

Is it time for public health to move away from mass vaccination programs and their unintended consequences and instead support healthy immunity via proper nutrients and early treatment?

2002 “Neurological adverse events associated with vaccination”

2002 “The potential role of aluminium in Alzheimer’s disease”

2004 “Chronic exposure to aluminum in drinking water increases inflammatory parameters selectively in the brain”

2004 “Neurotoxic effects of aluminium among foundry workers and Alzheimer’s disease”

2007 “Aluminum adjuvant linked to Gulf War illness induces motor neuron death in mice”

2007 “Neurological adverse events of immunization: experience with an aluminum adjuvanted meningococcal B outer membrane vesicle vaccine”

2007 “Mechanisms of aluminum-induced neurodegeneration in animals: Implications for Alzheimer’s disease”

2007 "Inflammation, neurodegenerative diseases, and environmental exposures"

2008 "Role of metal ions in the abeta oligomerization in Alzheimer's disease and in other neurological disorders"

2009 "Long-term persistence of vaccine-derived aluminum hydroxide is associated with chronic cognitive dysfunction"

2009 "Aluminum hydroxide injections lead to motor deficits and motor neuron degeneration"

2009 "Aluminum-induced defective mitochondrial metabolism perturbs cytoskeletal dynamics in human astrocytoma cells"

2011 "Aluminum toxicity and astrocyte dysfunction: a metabolic link to neurological disorders"

2011 "Aluminum vaccine adjuvants: are they safe?"

2011 "Metal ions affecting the neurological system"

2013 "Autoimmune/autoinflammatory syndrome induced by adjuvants (ASIA syndrome) in commercial sheep"

2013 "How aluminum, an intracellular ROS generator promotes hepatic and neurological diseases: the metabolic tale"

2014 "Aluminum-induced entropy in biological systems: implications for neurological disease"

2014 "Are there negative CNS impacts of aluminum adjuvants used in vaccines and immunotherapy?"

2014 "A sudden onset of a pseudo-neurological syndrome after HPV-16/18 AS04-adjuvated vaccine: might it be an autoimmune/inflammatory syndrome induced by adjuvants (ASIA) presenting as a somatoform disorder?"

2014 "Elevated brain aluminium and early onset Alzheimer's disease in an individual occupationally exposed to aluminium: a case report"

2014 "Prolonged exposure to low levels of aluminum leads to changes associated with brain aging and neurodegeneration"

2014 "Administration of aluminium to neonatal mice in vaccine-relevant amounts is associated with adverse long term neurological outcomes"

2014 "Oxidative stress and mitochondrial dysfunction in aluminium neurotoxicity and its amelioration: a review "

> "Being involved in the production of reactive oxygen species, aluminium may impair mitochondrial bioenergetics and may lead to the generation of oxidative stress. In this review, we have discussed the oxidative stress and mitochondrial dysfunctions occurring in Al neurotoxicity. In addition, the ameliorative measures undertaken in aluminium induced oxidative stress and mitochondrial dysfunctions have also been highlighted."

2014 "Aluminum in the central nervous system (CNS): toxicity in humans and animals, vaccine adjuvants, and autoimmunity"

2014 "Aluminium Induced Endoplasmic Reticulum Stress Mediated Cell Death in SH-SY5Y Neuroblastoma Cell Line Is Independent of p53"

2015 "Trace elements in scalp hair samples from patients with relapsing-remitting multiple sclerosis"

2015 "Correlation of aluminum and manganese concentration in scalp hair samples of patients having neurological disorders"

2015 "*Biopersistence and brain translocation of aluminum adjuvants of vaccines*"

> "We previously showed that poorly biodegradable aluminum-coated particles injected into muscle are promptly phagocytosed in muscle and the draining lymph nodes, and can disseminate within phagocytic cells throughout the body and slowly accumulate in brain. This strongly suggests that long-term adjuvant biopersistence within phagocytic cells is a prerequisite for slow brain translocation and delayed neurotoxicity."

2016 "*Insight into the cellular fate and toxicity of aluminum adjuvants used in clinically approved human vaccinations*"

> "We demonstrate that not all aluminium adjuvants are equal neither in terms of their physical properties nor their biological

> reactivity and potential toxicities both at the injection site and beyond. High loading of aluminium oxyhydroxide in the cytoplasm of THP-1 cells without immediate cytotoxicity might predispose this form of aluminium adjuvant to its subsequent transport throughout the body including access to the brain.”.

2016 “Behavioral abnormalities in female mice following administration of aluminum adjuvants and the human papillomavirus (HPV) vaccine Gardasil”

> “Vaccine adjuvants and vaccines may induce autoimmune and inflammatory manifestations in susceptible individuals. To date most human vaccine trials utilize aluminum (Al) adjuvants as placebos despite much evidence showing that Al in vaccine-relevant exposures can be toxic to humans and animals. We sought to evaluate the effects of Al adjuvant and the HPV vaccine Gardasil versus the true placebo on behavioral and inflammatory parameters in female mice.”

2016 “Aluminum adjuvants of vaccines injected into the muscle: Normal fate, pathology and associated disease”

> “Although generally well tolerated on the short term, it has been suspected to occasionally cause delayed neurologic problems in susceptible individuals. In particular, the long-term persistence of aluminic granuloma also termed macrophagic myofasciitis is associated with chronic arthromyalgias and fatigue and cognitive dysfunction. Safety concerns largely depend on the long biopersistence time inherent to this adjuvant, which may be related to its quick withdrawal from the interstitial fluid by avid cellular uptake; and the capacity of adjuvant particles to migrate and slowly accumulate in lymphoid organs and the brain, a phenomenon documented in animal models and resulting from MCP1/CCL2-dependant translocation of adjuvant-loaded monocyte-lineage cells (Trojan horse phenomenon). These novel insights strongly suggest that serious re-evaluation of long-term aluminum adjuvant phamacokinetics and safety should be carried out.”

2017 “Effects of Aluminium on Rat Brain Mitochondria Bioenergetics: an In vitro and In vivo Study”

> “The observed effects also included both an alteration in mitochondrial transmembrane potential and a decrease in oxidative phosphorylation capacity when relatively high concentrations of aluminium were added to the isolated mitochondria. These findings contribute to explain both the ability of aluminium to generate oxidative stress and its suggested potential to act as an etiological factor by promoting the progression of neurodegenerative disorders such as Parkinson’s disease.”

2017 “The putative role of environmental aluminium in the development of chronic neuropathology in adults and children. How strong is the evidence and what could be the mechanisms involved?”

> “Evidence of the neurotoxicity of aluminium cations (Al^{3+}) includes: an association between chronic aluminium exposure and the development of AD; the involvement of aluminium adjuvants in the development of ASIA; and epidemiological evidence pointing to an association between the use of aluminium adjuvants and ASD.”
>
> “Aluminium has no known beneficial physiological action in the human body and some genetic polymorphisms predispose to a greater susceptibility to its adverse effects. Therefore, a strong case can be made for avoiding unnecessary exposure to environmental sources of aluminium salts, especially on the part of children, pregnant mothers and women of child-bearing age who may become pregnant. Such avoidance need not lead to hardship or inconvenience; aluminium cookware may be replaced by safer alternatives, while aluminium-containing antiperspirants, potentially implicated in the rise of cases of breast cancer particularly affecting the upper outer quadrant of the mammary gland, may be replaced by non-aluminium versions. The use of aluminium salts in medical products is a more contentious issue. While antacids are available which do not contain aluminium salts, the avoidance of immunisations which do not contain aluminium salts as adjuvants has wider

political and financial implications. It would seem prudent to try to find an alternative to aluminium adjuvants as soon as possible and phase out their use."

"Moreover, aluminium exposure is associated with the production of pro-inflammatory cytokines and chemokines and with the development of chronic oxidative stress, mitochondrial dysfunction and glial activation or dysfunction; these changes in turn are associated with ASD."

2017 "Aluminium in brain tissue in autism"

"The pre-eminence of intracellular aluminium associated with non-neuronal cells was a standout observation in autism brain tissue and may offer clues as to both the origin of the brain aluminium as well as a putative role in autism spectrum disorder."

2018 "Reconsideration of the immunotherapeutic pediatric safe dose levels of aluminum"

"Our calculations show that the levels of aluminum suggested by the currently used limits place infants at risk of acute, repeated, and possibly chronic exposures of toxic levels of aluminum in modern vaccine schedules. Individual adult exposures are on par with Provisional Tolerable Weekly Intake "limits", but some individuals may be aluminum intolerant due to genetics or previous exposures. Vaccination in neonates and low birth-weight infants must be re-assessed; other implications for the use of aluminum-containing vaccines, and additional limitations in our understanding of neurotoxicity and safety levels of aluminum in biologics are discussed."

2020 “Acute exposure and chronic retention of aluminum in three vaccine schedules and effects of genetic and environmental variation”

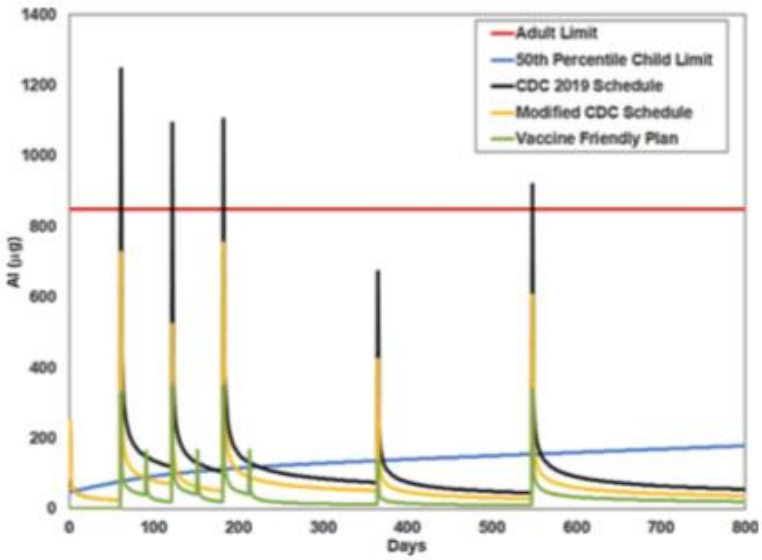


Fig. 2. Aluminum Content in Body over First Two Years for Three Vaccine Schedules.

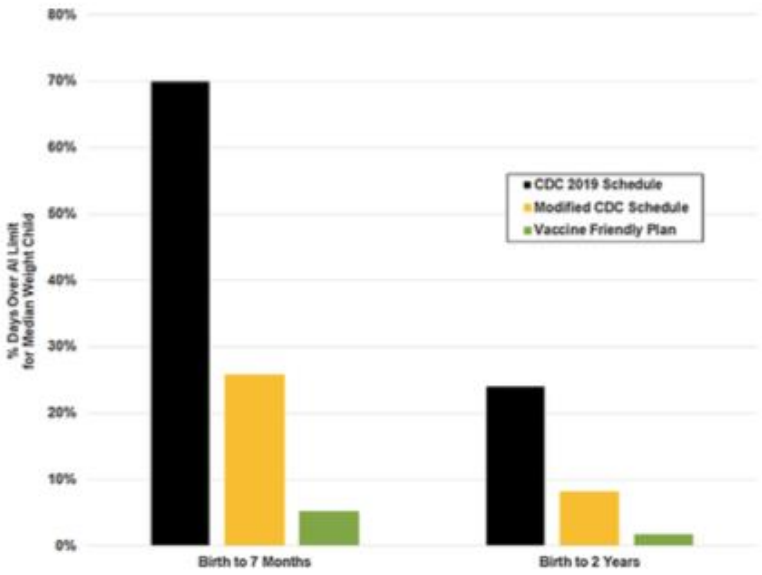


Fig. 3. Percent Days Over aluminum Limit (*%alumTox*) Birth to 7 Months and 2 Years.

2022 "Metabolic and Cellular Compartments of Acetyl-CoA in the Healthy and Diseased Brain"

> "However, SN56 cholinergic neurons with a high expression of cholinergic phenotype appeared to be more susceptible than nondifferentiated ones or glial cells to several neurotoxic signals that inhibited the PDHC, resulting in the suppression of acetyl-CoA synthesis in mitochondria. Such alterations took place in cholinergic neurons or brain nerve terminals upon exposure to several **common neurotoxic signals**, such as Aβ, Zn, NO-excess, Ca overload, thiamine deficiency, **aluminium exposure** and hypoxia." (emphasis added).

2022 "Towards novel nano-based vaccine platforms for SARS-CoV-2 and its variants of concern: Advances, challenges and limitations"

> "Similarly, aluminium NPs were studied for their ability to deliver the antigenic components of MERS-CoV and SAR-CoV to the host cells [13]. However, the cellular toxicity of these nanocarriers and/or the need for an adjuvant may be considered as significant limitations of such nano-based vaccines."

2022 "Clearance, biodistribution, and neuromodulatory effects of aluminum-based adjuvants. Systematic review and meta-analysis: what do we learn from animal studies?"

> "Aluminum (Al) salts are commonly used as adjuvants in human and veterinary vaccines for almost a century. Despite this long history of use and the very large number of exposed individuals, data in the literature concerning the fate of these molecules after injection and their potential effects on the nervous system is limited. In the context of (i) an increase of exposure to Al salts through vaccination; (ii) the absence of safety values determined by health regulators; (iii) the lack of robustness of the studies used as references to officially claim Al adjuvant innocuity; (iv) the publication of several animal studies investigating Al salts clearance/biopersistence and neurotoxicity; we have examined in this review all published studies performed on animals and assessing Al adjuvants kinetics, biodistribution, and neuromodulation since the first work of A. Glenny in the 1920s.

> The diversity of methodological approaches, results, and potential weaknesses of the 31 collected studies are exposed. A large range of protocols has been used, including a variety of exposure schedule and analyses methods, making comparisons between studies uneasy. Nevertheless, published data highlight that when biopersistence, translocation, or neuromodulation were assessed, they were documented whatever the different in vivo models and methods used. Moreover, the studies pointed out the crucial importance of the different Al adjuvant physicochemical properties and host genetic background on their kinetics, biodistribution, and neuromodulatory effects. Regarding the state of the art on this key public health topic, further studies are clearly needed to determine the exact safety level of Al salts."

2022 "Association Between Aluminum Exposure From Vaccines Before Age 24 Months and Persistent Asthma at Age 24 to 59 Months"

> "CONCLUSION: In a large observational study, a positive association was found between vaccine-related aluminum exposure and persistent asthma. While recognizing the small effect sizes identified and the potential for residual confounding, additional investigation of this hypothesis appears warranted."

From: Kd Jojo <kd12385@yahoo.com>
Sent: Tuesday, October 4, 2022 10:02 AM
To: DOH WSBOH
Subject: 8 Mice

External Email

Hello,

Please see my comments for the upcoming meeting regarding Covid shots/boosters which I'm surprised and dismayed that our state would be pushing these shots that were tested on 8 mice. The original mRNA shots have caused numerous harms and should be taken off of the market immediately and doctors and scientists throughout the world have called for just that. We have learned how deep Pfizer and big pharma have corrupted medicine and health departments. It would behoove WA to get a financial disclosure and statement from every board member who has accepted any funds from Big Pharma and they should be immediately recused from the board. Our health should not be at the mercy of profiteers, and our boards should be consisted only of people who have NO financial ties to big pharma in any way. It has recently been shown that the Fauci's had their wealth double during the pandemic, and this is a gross misconduct of public trust in doctors and health officials.

Why hasn't the Covid jab been pulled when history shows us others have been for less harm? Why don't we have access to Ivermectin? Why don't you talk about vitamin D, exercise, or other nutraceuticals.

Swine Flu vx (1976) - Pulled after a 1 in 100,000 risk of Guillain-Barré syndrome Rotavirus vx (1999) - Pulled after a 1 in 10,000 risk of bowel obstruction C0VID vx - (2021) Serious adverse events between 1 in 800 and 1 in 1,000 and we are still pushing?

Computational studies suggest compounds restoring function of p53 cancer mutants can bind SARS-CoV-2 spike protein - PubMed

New Covid boosters, which target BA.5, haven't yet been tested in people. How well will they work?

New Covid boosters, which target BA.5, haven't yet been tested in people...

The lack of human data means officials likely won't know how much better the new shots are — if at all — until t...

[Great Barrington Declaration and Petition]

930,000 people and scientists have signed this.

Great Barrington Declaration and Petition

As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging phy...

[Safe & Effective | Oracle Films]

Safe & Effective | Oracle Films

This documentary from Oracle Films shines a light on Covid-19 vaccine injuries and bereavements, but also takes ...

America is waking up to the fact that SIDS and SADS have a whole lot of things in common. Why do babies vaccines including aluminum?

Sincerely,

Catherine Jodoin

From: Callie Batts <calliejh@gmail.com>
Sent: Tuesday, October 4, 2022 12:19 PM
To: DOH WSBOH
Subject: Comments for BOH meeting 10/12/22

External Email

October 2, 2022

To WA State Department of Health,

The CDC updated its recommendations last week for universal masking for healthcare workers. Now, healthcare workers in areas without low or medium COVID-19 transmission rates can opt out of requiring doctors, patients, and visitors to mask up.

I am writing to urge that Washington State consider following the CDC's guidance. I work in an outpatient pediatric occupational therapy client. Many of the children we work with have sensory processing difficulties and disabilities that make it difficult for them to wear a mask. Additionally, half of the clients we serve have Autism Spectrum Disorder with challenges with language and social communication. Not being able to see their therapist's face and facial expression is detrimental to their progress. We are a "healthcare facility" however, we do not treat sick clients. We have a strict sick policy and children do not come into the clinic experiencing any symptoms of COVID-19. Many healthcare facilities covered under the WA DOH mask mandate do not see or treat sick or symptomatic clients.

With low community transmission, high vaccine and infection-induced immunity and available effective treatments, it is my belief that masking in healthcare settings like therapy clinics is causing more harm to the patients we serve than good.

Thank you for your consideration,

Callie Batts, OTR/L

Pediatric occupational therapist

From: Melissa Moser <mmoser.moser@aol.com>
Sent: Friday, September 9, 2022 3:54 AM
To: DOH WSBOH
Subject: Communicating With Board Members

External Email

Hello,
Thank you for all you do and your consideration with this information regarding Covid vaccines:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9012513/

Respectfully,
Melissa Moser

From: Garry Blankenship <hisgarness@comcast.net>
Sent: Monday, September 12, 2022 11:09 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@co.clallam.wa.us; shahidafatin@gmail.com; gbsjrmd@sisna.com; ncarr@cityofpa.us; dclawley@msn.com; aunthank@co.clallam.wa.us; secretary@health.gov.bz; Van De Wege, Kevin; Chapman, Mike
Subject: Current Study Data on the Lack of mRNA Drug Efficacy

External Email

The stories here-in are not complete, but easily found should you want to see the rest. These are a very small sample of a multitude of data demonstrating these drugs cause more harm than good. Post mRNA introduction all cause death is up dramatically. Sudden Adult Death Syndrome, life insurance pay-out data, young athletes in the prime of their lives dropping on courts and fields from cardiac death or harm; coroners and embalmers finding blood clots of unprecedented size in cadavers; these are all post mRNA drug introduction events. It is now fact that the drug batches vary dramatically. Some with no adverse reactions and others with high death and harm results. Which batch will you get next ? The known death and harm statistics from mRNA drugs have exponentially exceed numbers that previously mandated the pulling of drugs from the market. Please investigate on your own, if you are not already convinced these drugs are toxic.

HEALTH VIEWPOINTS

'Unethical' and up to 98 Times Worse Than the Disease: Top Scientists Publish Paradigm-Shifting Study About COVID-19 Vaccines

BY JENNIFER MARGULIS AND JOE WANG TIMESEPTEMBER 10, 2022 PRINT

A team of nine experts from Harvard, Johns Hopkins, and other top universities has published paradigm-shifting research about the efficacy and safety of the COVID-19 vaccines and why mandating vaccines for college students is unethical.

This 50-page study, which was published on The Social Science Research Network at the end of August, analyzed CDC and industry-sponsored data on vaccine adverse events, and concluded that mandates for COVID-19 boosters for young people may cause 18 to 98 actual serious adverse events for each COVID-19 infection-related hospitalization theoretically prevented. The paper is co-authored by Dr. Stefan Baral, an epidemiology professor at Johns Hopkins University; surgeon Martin Adel Makary, M.D., a professor at Johns Hopkins known for his books exposing medical malfeasance, including "Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Heath Care"; and Dr. Vinayak Prasad, a hematologist-oncologist, who is a professor in the UCSF Department of Epidemiology and Biostatistics, as well as the author of over 350 academic and peer-reviewed articles.

But among this team of high-profile international experts who authored this paper, perhaps the most notable is Salmaan Keshavjee, M.D., Ph.D., current Director of the Harvard Medical School Center for Global Health Delivery, and professor of Global Health and Social Medicine at Harvard Medical

School. Keshavjee has also worked extensively with Partners In Health, a Boston-based non-profit co-founded by the late Dr. Paul Farmer, on treating drug-resistant tuberculosis, according to his online biography.

‘Irrefutable Proof’ That mRNA Vaccines Cause Vascular and Organ Damage: Study

By Enrico Trigoso

September 9, 2022 Updated: September 10, 2022

biggersmaller

Print

0:009:00

1

A recent study claims to have found “irrefutable proof of causality” that the mRNA vaccines cause vascular and organ damage.

The study, conducted by microbiologists Dr. Michael Palmer and Dr. Sucharit Bhakdi, was mostly based on the findings of German pathologists Dr. Arne Burkhardt and Dr. Walter Lang.

Here is a summary of the findings:

1. mRNA vaccines don’t stay at the injection site; they instead travel throughout the body and accumulate in various organs.
2. mRNA-based COVID vaccines induce long-lasting expression of the SARS-CoV-2 spike protein in many organs.
3. Vaccine-induced expression of the spike protein induces autoimmune-like inflammation.
4. Vaccine-induced inflammation can cause grave organ damage, especially in vessels, sometimes with deadly outcomes.

“This study, by the type of dyes they use, shows *irrefutable* proof that the spike protein goes *everywhere*—heart, ovary, liver, spleen—and to a lesser extent, testes.” Dr. Sherri Tenpenny, an expert in vaccine damage, told The Epoch Times.

“This is what leads to multi-organ system failure. This is what leads to infertility in women.”

From: horseshoebill <horseshoebill@protonmail.com>
Sent: Thursday, October 6, 2022 12:33 PM
To: DOH WSBOH
Subject: Ending medical tyranny, leave people alone

External Email

Washington State Board of Health Members,

I have been quite disappointed in the extreme to how our State Board of health has totally failed the constituency of Washington State.

Per the Federal Constitution, the State is the ultimate authority regarding health measures and not the Federal bureaucracy.

With these facts in mind, it is you, the Washington State Board members whom may be held liable for not using due diligence to protect your constituency.

Some areas of concern and possible liability include:

- Covid shots/boosters
- monkey pox
- shutting down schools and letting the elderly die alone
- natural immunity
- ivermectin and other early treatments
- injuries from the shots and treatment of the injured

I urge ALL members of the Board, especially new members, to use due diligence and the principal of do no harm as any new actions or rescinding of past Board actions be contemplated.

The last time unwanted medical experiments were forced on large populations was delt with in 1947 during The Nuremberg trials.

“The world won’t be destroyed by those that do evil but by those that watch & do nothing”

Albert Einstein

And;

“Be ashamed to die until you’ve won some victory for humanity”

Horace Mann

Societies do very poorly under dictatorships,

Regards,

Bill Becht

Blaine WA

From: cuanabear <cuanabear@protonmail.com>
Sent: Monday, October 3, 2022 4:40 PM
To: DOH WSBOH
Subject: For WA BOH October 12, 2022 agenda

External Email

Hello. I understand there are new members on the Board, so let me bring you up to speed on some of the issues.

Covid shots/boosters - As you know, the Constitution of the United States grants inalienable rights to the people, among them freedom of religion and bodily autonomy, as supported by Supreme Court decisions as well. No medical treatment, especially one that is experimental or on an EUA can be mandated, and the CDC on August 11, 2022 stated that the unvaccinated and vaccinated can be treated no differently. Therefore, no shots or boosters can be required for participation in society, schools or businesses. Additionally, the covid injections DO NOT PREVENT INFECTION OR CONTAGION WHILE DELIVERING SEVERE ADVERSE REACTIONS.

Monkey pox - This is a sham and scare tactic to push more shots that benefit pharma. Monkey pox is EXTREMELY RARE and contracted by intimate contact, most notably in the gay community. The people will not fall for this hoax and no injections can be mandated.

Can we learn no lessons from mistakes made during covid? Shutting down schools was a disaster for our children, who have a risk factor of @.03% and only among children with serious medical conditions. Closing businesses was disastrous to the people and the economy. And letting the elderly die alone is CRIMINAL! None of this will be tolerated again. Be sure of that.

Natural immunity has been shown over and over to be superior to anything that comes from a needle. Other countries that did not lockdown and let the robust young get natural immunity did FAR better than the US.

Ivermectin and other early treatments have over a 90% success rate. The data is there if you're not too afraid to look because it's not in agreement with the agenda.

The injuries from the shots and treatment of the injured has been staggering. According to VAERS (who admit after a massive study that only .3 of injuries are actually reported. I read the study. Did you?) vaccine injuries went up 300% AFTER the covid injections started, that is there were 300% more in 2021 than in the past 30 years! And all cause mortality has also skyrocketed. The treatment for the covid vaccine injured will be a major challenge in the years to come, and the deaths after injection continue to mount.

Even the current childhood vax program is damaging children as validated by the new CDC aluminum preprint study that shows a significantly increased risk of asthma associated with aluminum adjuvants. CDC's recommended pediatric schedule includes six doses of aluminum-containing vaccines. The shots do not prevent infection or transmission of pertussis or diphtheria, and tetanus is not communicable.

The people are watching and taking note of continued assaults on their human rights, health and welfare. There are numerous lawsuits ongoing. I assume you would rather not be a defendant in one of these. Choose wisely. Protect the people and protect yourself.

From: j <mehath1@aol.com>
Sent: Tuesday, August 23, 2022 3:16 PM
To: j
Subject: Fwd: 2 minutes
Attachments: VIDEO-2022-07-01-08-14-53.mp4

External Email

If someone has not figured this out.g

Good truth from an Aussie Nurse!

From: Callie Batts <calliejh@gmail.com>
Sent: Tuesday, October 4, 2022 12:18 PM
To: DOH WSBOH
Subject: Letter urging updates to healthcare mask mandate

External Email

October 2, 2022

To WA State Department of Health,

The CDC updated it recommendations last week for universal masking for healthcare workers. Now, healthcare workers in areas without low or medium COVID-19 transmission rates can opt out of requiring doctors, patients, and visitors to mask up.

I am writing to urge that Washington State consider following the CDC's guidance. I work in an outpatient pediatric occupational therapy client. Many of the children we work with have sensory processing difficulties and disabilities that make it difficult for them to wear a mask. Additionally, half of the clients we serve have Autism Spectrum Disorder with challenges with language and social communication. Not being able to see their therapist's face and facial expression is detrimental to their progress. We are a "healthcare facility" however, we do not treat sick clients. We have a strict sick policy and children do not come into the clinic experiencing any symptoms of COVID-19. Many healthcare facilities covered under the WA DOH mask mandate do not see or treat sick or symptomatic clients.

With low community transmission, high vaccine and infection-induced immunity and available effective treatments, it is my belief that masking in healthcare settings like therapy clinics is causing more harm to the patients we serve than good.

Thank you for your consideration,

Callie Batts, OTR/L

Pediatric occupational therapist

From: happydog023@centurylink.net
Sent: Tuesday, October 4, 2022 11:47 AM
To: DOH WSBOH
Subject: mandatory Covid biologic requirement

External Email

Hello,

I am one of the people residing in Washington state who is deeply troubled and concerned regarding the unlawful directives of our Governor and state agencies regarding mandatory Covid Biologics. The most important point is that any requirement to accept an unproven, EUA, or medical procedure that has the ability to cause harm, even death to one of the people is a direct violation of our Bill of Rights, our Constitution, the Nuremberg Code, and the following: Title Code 21 violates 4 sections, sec. 502 false and misleading labeling. The Covid biologic does not meet the requirements of a vaccine, does not prevent infection, transmission, or death from Covid.
Sec. 501, the Covid biologic does contain adulterated graphene oxide and toxic ingredients.
31213 Must prove safety in animals
31242 Clinical research holds when safety risks occur, which they most certainly have.
April 2003 filing a naturally occurring substance cannot be patented, violation of 35 US Code sec 101 Patent #7220852 &4659 &2703P &776521. These patents cover gene sequencing and means of detecting it. Covid has been part of a sequence of proteins circulating for 20 years.
A protocol design whose forseeable risk is death is a violation of the Nuremberg Code and Federal regulations (45CFR 46). Coercion and uninformed consent has been used to get people to participate in a biomedical research experiment.
SARS was patented in the US April 19, 2002, US patent 7279327, engineered to attack lung tissue.
UNESCO Universal Declaration on Bioethics and Human Rights 2005 states that any preventative, diagnostic, or therapeutic medical intervention must only be carried out WITH the prior, free, and informed consent of the person concerned based on adequate information. The information being disseminated to the public is far from complete or adequate, it is deliberately misleading and fraudulent. Fraud vitiates everything.
Mandatory Federal requirements of Informed Consent: an explanation of the purposes of the research, a description of ANY foreseeable risks and disclosure of alternative courses of treatment 45 CFR 46.116 and restrictions
Risks to subjects are minimized 45 CFR 46.111.
Alternative effective treatments other than the Covid biologic do exist, many naturally occurring, that pose no health threat, and have been purposefully withheld from the public.
18 US Code sec. 175-it is illegal to develop, amplify, or produce a biologic agent known to cause harm to humanity, domestically or in collaboration with a foreign agent.
21 Code Fed regulations sec. 50.23 & 24- it is illegal to make anyone participate in an experimental program using coercion.
You are in violation of 18 US Code 241 & 242.
Proof of harm is recorded in the US VAERS system.
Nullification of ANY of your unlawful WACS or proposed regulations is in order regarding this matter.
Do the right thing. Withdraw any proposed legislation or unlawful orders.
Thank you.

Donna Moore

From: j <mehath1@aol.com>
Sent: Thursday, August 18, 2022 10:39 PM
To: j
Subject: More being DISCLOSED!!! HANG IN THERE!! KNOWLEDGE WILL HELP US BECOME FREE!

External Email

/The DECEPTION and PROPAGANDA has been BRUTAL!! AWAKENING as the 'veils' are being lifted is painful to our egos.....WE have been 'PLAYED" and "DUPED"!!!

Love to all my family and friends, Mary Hath Spokane

INTERNATIONAL GRAND JURY TRIBUNAL for CRIMES AGAINST HUMANITY From The Hague. International Trials Day One -Crimes Against Humanity (rumble.com)

ECONOMIC COLLAPSE?? LAST WARNING: The Great Reset Of 2022 | Robert Kiyosaki - YouTube

HOW TO SAVE YOURSELF FROM HARM OF THE VACCINES:

COVENOM19 - WHAT'S COMING FOR THE VACCINATED? Featuring Film Maker JONATHAN OTTO EPISODE#67 (rumble.com)

COMPREHENSIVE and UPDATED SITE of INTERNATIONAL NEWS: Top experts are warning humanity for a world dictatorship. Will we listen? (stopworldcontrol.com)

From: Frank Bell <frankg_bell@hotmail.com>
Sent: Wednesday, September 21, 2022 7:34 PM
To: DOH WSBOH
Subject: NBS-cCMV-Sept2022

External Email

Sent from Mail for Windows

From: Bell, Francis G <Francis.Bell@swedish.org>
Sent: Wednesday, September 21, 2022 7:48 PM
To: DOH WSBOH
Subject: NBS-cCMV-Sept2022

External Email

As an observer for the meeting of the Technical Advisory Committee considering the addition of congenital CMV infection to the state newborn screen I appreciated the hard work, preparation and transparency that went into today's discussion.

Congenital CMV infection is unlike any other condition currently screened for by the State, in that we are considering screening for a condition that has no health implications for 85-90% of those who 'screen positive'. As a result, we have particular responsibility to consider very carefully the costs and unwanted effects of introducing such screening.

As a Pediatric Infectious Disease provider in the State, I have had experience in tortuous, uncertain discussions around the implications of the diagnosis of congenital CMV for an infant with equivocal clinical features or evidence of 'mild' CMV disease. There is no other current condition for which we screen in which the majority of diagnosed infants will be unaffected, and for whom we have no clear treatment or intervention other than monitoring. I appreciate the benefits of a clear etiology for identified sensorineural hearing loss in newborn infants and the benefit of continued long-term audiologic follow up for infants diagnosed with congenital CMV, but worry about the long term uncertainty, anxiety that comes with a diagnosis and a recommendation to 'follow closely' with many outpatient visits and audiology assessments until school age and possibly beyond.

Although we as pediatric providers, audiologists and parents may have strong feelings about the potential benefits of early diagnosis for infants diagnosed with sensorineural hearing loss, the question of screening for congenital CMV is principally a Public Health Question, with the need to balance potential benefits against the unwanted effects, anxiety and broader costs of 'screening positive', noting that unlike any other currently-screened condition, most infected, identified infants will be unaffected and subject only to prolonged follow up, with associated costs. When considered as a Public Health concern, we have to think carefully about whether or not our healthcare dollars might be better spent elsewhere for the greater public good.

Should in time evidence emerge that antiviral therapy is effective for isolated sensorineural hearing loss in congenital CMV infection there may be a need to reconsider, but for the present time I firmly support the recommendation of the TAC to reject the addition of congenital CMV infection to the list of conditions for which Washington State should screen its newborn infants.

Frank Bell MD
Swedish Pediatric Infectious Disease Physician, Seattle WA

From: Levi Patrick <Levi@LeviPatrick.com>
Sent: Thursday, October 6, 2022 8:57 AM
To: DOH WSBOH
Subject: Oct 12th Meeting Comments

External Email

Washington State Board of Health Members,

I have been quite disappointed in the extreme to how our State Board of health has totally failed the constituency of Washington State. Per the Federal Constitution, the State is the ultimate authority regarding health measures and not the Federal bureaucracy. With these facts in mind, it is you, the Washington State Board members whom may be held liable for not using due diligence to protect your constituency.

Some areas of concern and possible liability include:

- Covid shots/boosters
- monkey pox
- shutting down schools and letting the elderly die alone
- natural immunity
- ivermectin and other early treatments
- injuries from the shots and treatment of the injured

I urge ALL members of the Board, especially new members, to use due diligence and the principal of do no harm as any new actions or rescinding of past Board actions be contemplated.

Regards,

Levi Patrick
Blaine WA

From: sue coffman <doulasue@yahoo.com>
Sent: Thursday, October 6, 2022 8:22 AM
To: DOH WSBOH
Subject: Public Comment for the Record

External Email

Hello,

In addition to the public comment I will be giving next week at your October meeting, I would like each member of the Board to be aware of a current project being unrolled in the coming weeks.

The following website is a concise collection of injuries and deaths that have taken place in our country due to draconian mandate measures during the Covid-19 pandemic. Please be aware that risks of medical protocols have overtaken any benefits claimed, and this is NOT "misinformation," or "disinformation," or crackpot conspiracy theory.

As members of a health board (mostly appointed by a governor who just wants to keep his tyrannical power), you have the responsibility to promote Truth, and stop following what the system demands you to say.

Please be aware of the Crimes of Humanity you are helping to perpetuate in the name of a never-ending series of injections.

https://chbmp.org/about/

Sincerely, and in all Truth,

Sue Coffman
714-337-4331
ICWA Team Leader
Legislative District #24
https://informedchoicewa.org/

From: Ahmad Suhrab <suhrabahmad830@gmail.com>
Sent: Thursday, September 29, 2022 3:56 AM
To: DOH WSBOH
Subject: Public Comment

External Email

Aa : a specific domains abe

From: Mallory Baker <mallory.baker@wacmvproject.org>
Sent: Friday, October 7, 2022 10:37 AM
To: DOH WSBOH
Subject: Public Comments - October 12, 2022 Board of Health Meeting
Attachments: Public Comments 10.12.22 - Baker.docx

External Email

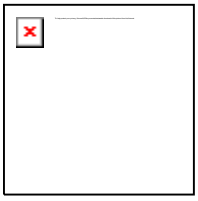
Attached please find my public comments for the October 12, 2022 Board of Health Meeting. Please let me know if I can provide any assistance with this public comment.

Thank you,
Mallory Baker

Mallory Baker, Au.D.
Founder | Pediatric Audiologist
Washington CMV Project
Educate. Advocate. Make A Difference.
mallory.baker@wacmvproject.org

www.wacmvproject.com
206-636-1155
Twitter | Instagram | Facebook

4957 Lakemont Blvd. SE, Ste C-4 #252
Bellevue, WA 98006



October 12, 2022

To the members of the Washington State Board of Health,

My name is Mallory Baker. I am a pediatric audiologist, founder of the Washington CMV Project, and the author of the CMV Screening petition discussed during the September 21 Technical Advisory Committee meeting.

I am writing to provide several additional facts for consideration as you listen to the summary of the Technical Advisory Committee's meeting.

1. ***cCMV is the leading infectious cause of birth defects in children.***
    - Congenital CMV is more prevalent than any of the other disorders currently screened for by the Washington State newborn screening panel.
    - Medical issues caused by cCMV can include cerebral palsy, microcephaly, hepatosplenomegaly, hearing loss, Autism, seizures, death and more.
    - While cCMV is the leading viral cause of hearing loss in children, it is not limited to just hearing loss.
    - cCMV is a serious virus that impacts 1 in every 200 infants. A research study completed in Washington State shows an even higher prevalence of 1.4 in every 100 infants.[1]

2. ***There are many forms of effective treatment beyond antivirals.***
    - Children with cCMV can have a wide range of symptoms and may present with a variety of different medical issues.
    - Early diagnosis allows for early and critical intervention. Early access to seizure medication, consistent and timely monitoring, physical therapy, hearing aids, cochlear implants, speech therapy, and ABA therapy are all versions of treatment that are proven to make a difference in the lives of children dealing with the medical consequences of cCMV.[2]

3. ***13.5% of asymptomatic infants will eventually develop symptoms.[3]***
    - Research divides infants as symptomatic (10%) or asymptomatic (90%).
    - The number of asymptomatic newborns who will later develop serious medical issues is greater than the number of infants born with symptoms. **These are the children who will be missed without CMV screening.**
    - These children will develop late onset symptoms, including seizures, Autism, hearing loss, developmental delays, motor delays, and more.

The Technical Advisory Committee's vote to not recommend CMV screening is disappointing. It is encouraging that the committee also voted to continue this important discussion that impacts the children and families of Washington State.

I would like to thank the members of the Department of Health, the Board of Health, and the Technical Advisory Committee for their time and continued consideration of the important public health crisis of congenital cytomegalovirus (cCMV).

Thank you,

Mallory Baker

Mallory Baker, Au.D, CCC-A
mallory.baker@wacmvproject.org

[1]Misono, S., Sie, K. C., Weiss, N. S., Huang, M. L., Boeckh, M., Norton, S. J., & Yueh, B. (2011). Congenital cytomegalovirus infection in pediatric hearing loss. Archives of Otolaryngology–Head & Neck Surgery, 137(1), 47-53.

[2] Pesch, M. H., Kuboushek, K., McKee, M. M., Thorne, M. C., & Weinberg, J. B. (2021). Congenital cytomegalovirus infection. *BMJ (Clinical research ed.)*, *373*, n1212. https://doi.org/10.1136/bmj.n1212

[3] Dollard, S. C., Grosse, S. D., & Ross, D. S. (2007). New estimates of the prevalence of neurological and sensory sequelae and mortality associated with congenital cytomegalovirus infection. *Reviews in medical virology*, *17*(5), 355–363. https://doi.org/10.1002/rmv.544

From: Jotform <noreply@jotform.com>
Sent: Friday, September 9, 2022 2:45 PM
To: DOH WSBOH
Subject: Re: Stop The Child Vaccine Mandate Petition - Ed McKinnon

External Email

Stop The Child Vaccine Mandate Petition

Name	Ed McKinnon
Email	e.d.mckinnon@comcast.net
Zip	98034
Cell Phone Number	(2069995503)

You can edit this submission and view all your submissions easily.

From: Jotform <noreply@jotform.com>
Sent: Monday, August 22, 2022 8:52 AM
To: DOH WSBOH
Subject: Re: Stop The Child Vaccine Mandate Petition - Rachael Bishop

External Email

Stop The Child Vaccine Mandate Petition

Name	Rachael Bishop
Email	rachaelabishop@gmail.com
Zip	, , , , 98133
Cell Phone Number	(206) 9795683

You can edit this submission and view all your submissions easily.

From: Testify Online Survey <SurveySupport@doh.wa.gov>
Sent: Sunday, October 2, 2022 5:39 PM
To: DOH WSBOH
Subject: Survey Response: Testify Online *

The following survey response is submitted:

1. State Board of Health Meeting Date:

October Meeting

2. Agenda Item or Issue:

Public Health Incarceration

3. Your Name:

Joseph Dehonest Jordan

4. Do you have a professional title?

1. Yes

United States Selective Service Regional Appeals Board Member 53863

5. Are you representing an organization?

1. Yes

Joseph Dehonest Jordan Foundation

6. Address:

PO BOX 642 Redmond, WA 98073

7. Email:

dehonest@outlook.com

8. Phone Number (Include Area Code):

747-276-2185

9. Do you have any special expertise relevant to this topic?

1. Yes

Experienced, misdiagnosis, healthcare billing fraud, incarceration, healthcare record errors and mass healthcare incarceration.

10. Are you testifying on a specific proposal under consideration by the board?

1. Yes

I move to bring forward without objection, a proposal to end the authority for King County and other counties authority to incarcerate under gravely disabled medical status using court commissioners. Board review for Health care incarceration authorities.

11. Are you Pro or Con on the proposal?

2. Con

The health care incarceration authority has to be repealled we cannot allow public to become victims of human traffic behavior or health care fraud. I move to have this on the agenda without objection and begin the discussion as a Regional Appeals board member over local boards for the Selective Service System using the power of such office to begin discussion and have this proposal considered to end health care incarceration authority.

From: Testify Online Survey <SurveySupport@doh.wa.gov>
Sent: Tuesday, October 4, 2022 8:34 PM
To: DOH WSBOH
Subject: Survey Response: Testify Online *

The following survey response is submitted:

1. State Board of Health Meeting Date:

Oct 12

2. Agenda Item or Issue:

Equitable healthcare

3. Your Name:

Lindsay Burmeister

4. Do you have a professional title?

2. No

5. Are you representing an organization?

2. No

6. Address:

4930 Columbus Ave Bellingham 98229

7. Email:

Lindsay.seeka@gmail.com

8. Phone Number (Include Area Code):

369-739-3182

9. Do you have any special expertise relevant to this topic?

2. No

10. Are you testifying on a specific proposal under consideration by the board?

2. No

11. Are you Pro or Con on the proposal?

1. Pro

Not taking a position on the proposal

From: christymit <christymit@gmail.com>
Sent: Wednesday, October 5, 2022 2:40 PM
To: DOH WSBOH
Subject: Vaccines

External Email

It is with great sorrow that I am responding to Governor Inslee's mandate that state workers be vaccinated. In a free society this crosses into over reach. To mandate a vaccine that has many,many negative effects on our health is criminal. Please leave this decision up to the individual. Thank you for taking my comments. Christy Mitchell SEQUIM, WASHINGTON

Sent from my Verizon, Samsung Galaxy smartphone

From: Garry Blankenship <hisgarness@comcast.net>
Sent: Saturday, August 20, 2022 11:44 AM
To: aunthank@co.clallam.wa.us; info@travelbelize.org; Van De Wege, Kevin; OADS@cdc.gov; ombuds@oc.fda.gov; hcinfo.infosc@canada.ca; DOH WSBOH; sheriff@co.clallam.wa.us; Annika.Pederson@leg.wa.gov; mozias@co.clallam.wa.us; rjohnson@co.clallam.wa.us; shahidafatin@gmail.com; gbsjrmd@sisna.com; ncarr@cityofpa.us; dclawley@msn.com; secretary@health.gov.bz; dhsmoh@yahoo.com; Tharinger, Steve; Chapman, Mike
Subject: Video of the very Top U.S. Officials and Media Lying About the mRNA Drugs

That they lied is no longer in question. What's not yet verifiable is did they do so knowingly.

https://www.bitchute.com/video/zUVkJtXAKgMb/

From: Steven Tojekk <monte402@yahoo.com>
Sent: Thursday, October 6, 2022 6:20 PM
To: DOH WSBOH; Rhyan Lopez; Garth Baldwin; Smileyforwashington Info; Steven Tojek; Richard Pettingell; Horseshoebill; Tim Eyman; jackielord@live.com; Scott Michael Duquin; Davidfordistrictjudge Info; Jenkinsfordistrictjudge Info
Subject: Washington State Board Health members - correction

External Email

I am sending a message in regards to the actions taken by leadership regarding Covid-19 mandates and recommendations that were apparently put into place for unethical reasoning.
I noticed certain judge's family members and other influential leaders invested into medical companies/mask, PRC testing and other companies in which absorbed the American tax dollars through medical advice/demands from pushing the Covid-19 shot inoculations, 6 foot distance rules and mask wearing demands. These demands were put into place for many people that did not approve. These are Serious conflicts of interest when government, Federal or State, create influence like offering money to schools that can provide proof that forcing masks on people are being met so as to receive such government benefits. We expect our leadership and medical staff, representing Washington State, to combat these unethical practices whenever possible.
The EUA drugs are not even allowed to be suggested to the public through government influence, let alone mandating such drugs.
Making awareness of such drugs being available on the shelves to purchase by the public is borderline concerning ethical code, especially since government influence shows a conflict of interest when demonstrating favoritism to certain companies concerning the topic. This process requires a selective approved process, and the manner of handling these mandates were very destructive to our society.
No person should be coerced, through government or company entity, concerning medical needs and the government influence should never have such strength over medical interest of the public while Individuals prefer to choose there own medical practices/doctors concerning self-health. There are added complications to consider included other lifeforms such as pregnancy with a human baby when pushing EUA drugs, and this can show detrimental concerns to the future of said lifeforms. That baby is allowed it's own personal choices when it's able to understand the difference, and all including the mother should be required to understand the basic human civil rights of the child up to when the child is old enough to understand for itself.

America's people's choice is the strongest American asset to combat such corruption that appears to have been challenged while being spearheaded by elite influence concerning the importance of Americans individual choice.

The Untested EUA drugs should never be allowed to be a factor in the future of our society on a mass scale and only should be allowed for individual choice by anyone that chooses to do so.

We need to advocate for accountability concerning the mass spending of the American tax dollars toward corrupt backdoor handshake deals concerning Covid-19 shots, medical equipment and the losses/damages caused in all entities related.

Thank you

Steven Tojek

Blaine, WA.

Sent from Yahoo Mail on Android

From: Steven Tojekk <monte402@yahoo.com>
Sent: Thursday, October 6, 2022 5:17 PM
To: DOH WSBOH; Horseshoebill; Steven Tojek; Rhyan Lopez; Garth Baldwin; United States Senate; Smileyforwashington Info; Tim Eyman
Subject: Washington State Board of Health members.

External Email

Hello

I am sending a message in regards to the actions taken by leadership regarding Covid-19 mandates and recommendations that were apparently put into place for unethical reasoning.
I noticed certain judge's family members and other influential leaders invested into medical companies/mask, PRC testing and other companies in which absorbed the American tax dollars through medical advice/demands from pushing the Covid-19 shot inoculations, 6 foot distance rules and mask wearing demands. These demands were put into place for many people that did not approve. These are Serious conflicts of interest when government, Federal or State, create influence like offering money to schools that can provide proof that forcing masks on people are being met so as to receive such government benefits. We expect our leadership and medical staff, representing Washington State, to combat these unethical practices whenever possible.
The EUA drugs are not even allowed to be suggested to the public through government influence, let alone mandating such drugs.
Making awareness of such drugs being available on the shelves to purchase by the public is borderline concerning ethical code, especially since government influence shows a conflict of interest when demonstrating favoritism to certain companies concerning the topic.
No person should be coerced through government or company entity concerning medical needs, and the government influence should never have such strength over medical interest of the public when Individuals prefer to choose there own medical practices/doctors concerning self-health. There are added complications when people need to consider additional concerns included other lifeforms such as pregnancy with a human baby that also show detrimental concerns to our future. That baby is allowed it's own personal choices when it's able to understand the difference, and all including the mother should be required to understand the basic human civil rights of the child until the child is old enough to understand for itself.

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We need to advocate for accountability concerning the mass spending of the American tax dollars toward corrupt backdoor handshake deals concerning Covid-19 shots, medical equipment and the losses/damages caused in all entities related.

Thank you

Steven Tojek

Blaine, WA.

Sent from Yahoo Mail on Android

From: WA.gov <no-reply@watech.wa.gov>
Sent: Friday, September 16, 2022 3:40 PM
To: DOH WSBOH
Subject: Webform submission from the WA.gov website.

External Email

This email was sent from the Government Agency Directory found on WA.gov. The message and details of the person contacting you are as follows:

Your Name
Yujiro Eto

Your Email
realestatecapitaloftheworld@gmail.com

Subject
About smoking in WA

Message
Hello.

People smoke everywhere and they trouble us too much. In addition they throw away cigarettes everywhere. Very very crazy people.
Second-hand smoking everywhere.
Even when they don't smoke, they create bad air due to dirty lung.

Anyway, you need to fine smoking while walking and throwing away cigarettes.
In Japan they sometimes do so.
In Tokyo many areas smoking while walking are strictly prohibited.

In WA and US, there are no restrictions about smoking outside. It is HUGE problems for all of us and the earth.

Please please think of earth and our health very very seriously.

Thank you.

Note: Please do not reply to this email as this inbox is not monitored. If you have questions regarding this service, please use our contact form.

From: j <mehath1@aol.com>
Sent: Friday, August 19, 2022 10:33 PM
To: j
Subject: WISE WORDS from Robert Kennedy Jr.....

External Email

j

letter-to-liberals-ebook-20220802.pdf (childrenshealthdefense.org)

From: Lisa Templeton <lisa.templeton@outlook.com>
Sent: Friday, October 7, 2022 11:06 AM
To: DOH WSBOH
Subject: Written comments to BOH for 10/12/22 meeting

External Email

Good morning,

Will you please provide my comment below to the Board members for their October 12 meeting and confirm that you have done so? Thank you for your help.

Dear Board members,

I wanted to share an announcement from Robert F. Kennedy, Jr., Chairman of Children's Health Defense (CHD):

> I wrote "The Real Anthony Fauci" so that Americans — both Democrat and Republican — can understand Dr. Fauci's pernicious role in allowing pharmaceutical companies to dictate a COVID-19 response that trampled public health, the global economy, our constitutional rights and all the traditional values of liberalism.
>
> Despite the suppression of media coverage, the book became a bestseller.
>
> - Selling over 1,000,000 copies since the release in November 2021.
> - Spending 17 weeks on the New York Times Best Sellers list.
> - Soaring to #1 on Amazon, over three months.
> - Appearing on Wall Street Journal, USA Today, and Publisher's Weekly bestseller lists.
>
> Instead of fostering transparency and respectful debate, and implementing the traditional, well-established public health strategies for countering pandemics, Dr. Fauci promoted a militarized and monetized response including draconian lockdowns, business closures, coercive vaccination with experimental jabs, and a litany of totalitarian controls that transformed our country into a surveillance state and racked up the world's highest COVID-19 body count.
>
> He then worked with Big Pharma, media and social media titans, and Pentagon and intelligence agencies to vilify and marginalize dissent, punish every attempt at questioning, and to gaslight skeptics. Government worked with media and social media titans to ban books, silence physicians and scientists, and condemn artists, writers, poets, and intellectuals who questioned the unscientific orthodoxies of the medical and biosecurity cartels.
>
> CHD has partnered with our friends at Revealed Films to transform my book into a compelling documentary that exposes the corrupt reign of the "nation's most trusted doctor," Dr. Fauci and his accomplices in a coup d'etat that almost developed.
>
> The documentary will stream for FREE on October 18, 2022.
>
> . . . Together we can get the truth to the masses and reveal the story of "The Real Anthony Fauci."

I own and have read Mr. Kennedy's fully-referenced book, and its elucidations are alarming. I will send you the link to the documentary once it's available. My ask: please take the time to view it in order to understand that the system you worked so hard to join, in your well-intended effort to promulgate helpful policies and practices, has been captured by those with profit motives, all at the *expense* of public health and well-being.

Thank you for being willing to consider the evidence that I expect the film to provide. In the spirit of scientific integrity, I want you to have a chance to receive new information, as more and more people are doing, so that you have the opportunity to change course and accordingly guide your public health agency back to the respected and trustworthy institution it was intended to be.

Thank you,

Lisa Templeton

Covington wife, mother, and concerned citizen

Enough already

R

richnoble <richnoble@frontier.com>
To DOH WSBOH

Reply | Reply All | Forward | ...

Tue 9/27/2022 8:55 AM

Follow up. Completed on Friday, October 7, 2022.

External Email

Dr. Shah,
Enough already. This mask mandate for ANYWHERE is ridiculous! Not one person has ever provided a peer reviewed conclusive study that the masks prevent transmission. In fact, the exact opposite can be true in that bacterial pneumonia can be caused by the masks. The study done by a doctor during the Spanish Flu outbreak concluded just that, but conveniently that study has been wiped for the internet. What are you all trying to hide?

You can either be part of the solution or part of the problem. Currently, you are part of the problem in perpetuating the lie that is COVID. Please stop now and do the right thing. Lift all mandates.

Rich E Noble 師範山竜

Founder/Chief Instructor Yama Ryu Aikijutsu Ryu

BSB/SC MSLM/SC

Mobile: ***(425) 220-4695***

Bothell, WA, USA

RichNoble@Frontier.com

Nothing is Impossible!

Be Awesome, Do Awesome!

-2013 SMO Moonshine Team

"Treat the word impossible as nothing more than motivation." – President Donald J. Trump

"The most difficult decision is to act; the rest is merely tenacity." - Amelia Earhart

WWG1WGA

7.5.3.84.70.24.606

Health Impact Reviews

Lindsay Herendeen (she/her), Cait Lang-Perez (she/her)
State Board of Health and Governor's Interagency Council on Health Disparities

October 12, 2022

WASHINGTON STATE BOARD OF HEALTH

133 Years of Public Health

1889
State Constitution Ratified

1891
Legislature Defines Board of Health

1893
No Enforcement of Public Health Rules

1901
Enforcement Authority Granted

1903
Quarantine Authority Expanded

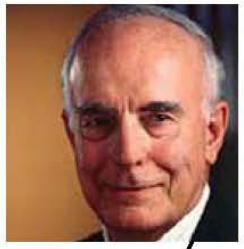
1904
State Health Lab Founded

1918-1919
The Great Pandemic

1921
1st Department of Health Established

1965
Code Reviser

1970
DSHS Established



1984
Board Expanded

1989
2nd Department of Health

1993
Health Reform Act of 1993

2006
Tribal Representation and Health Impact Reviews

2006
Health Disparities Council

2009
Reporting Change

The Legislature created the Governor's Interagency Council on Health Disparities. The Council collaborates with the Board on Health Impact Reviews.

Health Impact Reviews

HIRs can be requested for any bill topic.

- Objective, nonpartisan, evidence-based analysis
- Prospective tool
- Determine how a legislative or budgetary change will likely impact health and equity
- Requested by any Legislator or the Governor
- Must be completed in 10 days during legislative session

(RCW 43.20.285)

HIR Process

Review Bill

Determine how provisions in the bill would change status quo:

- Review the bill
- Interview agencies responsible for implementation

Explore Pathways

Explore potential connections to health:

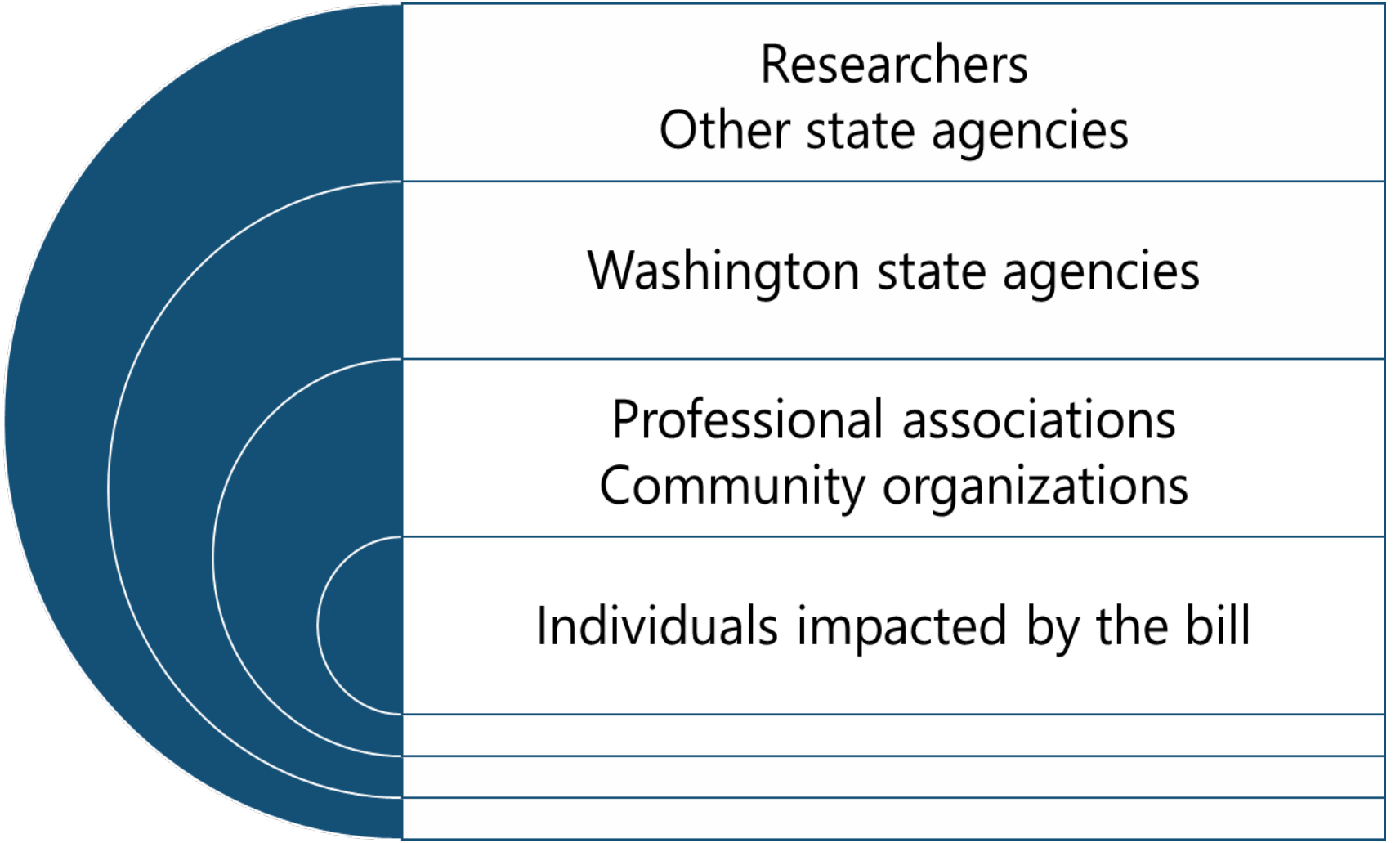
- Conduct initial literature reviews
- Review public testimony and relevant documents
- Draft a logic model
- Consult subject matter experts and key informants

Literature Review

Conduct specific reviews of literature to determine:

- How provisions may impact health
- Who is most likely to be impacted
- How the change may impact equity

Levels of Key Informant Engagement



Priority Considerations for Equity

Inequities are not inherent to a person's unique identity, circumstance, or group affiliation. Rather, they are influenced by social determinants that systematically marginalize groups due to these factors. Inequities can be exacerbated or alleviated by intersecting identities and experiences.

- Age
- Behavioral health status
- Criminal legal system involvement
- Disability status
- Education
- Employment status
- Family status
- Foster care status
- Gender
- Geography
- Housing status
- Immigration status
- Indigeneity
- Language/literacy
- Military/veteran status
- Race/ethnicity
- Religion
- Sex
- Sexual orientation
- Socioeconomic status
- Experience of violence

Applying an equity lens

Guiding questions that center equity are useful in identifying missing perspectives and gaps in knowledge or information. Seeking out key informants, data, and/or other sources to fill information gaps can help preemptively identify and address potential unintended consequences that could undermine equity.

- How does the proposal change the status quo?
- Who is likely to be affected by this change? (populations/groups to consider)
- Who may be affected differently by this change?
- How could this positively affect equity? Negatively affect equity?
- What unintended consequences may result from this change?
- What evidence and/or data could help us fully understand this change?
- Who could provide content expertise or context expertise to help use fully understand potential impacts of this change?

Using data to improve equity

Research and data do not always assess or include information about all communities, and certain populations are more likely to be left out of research published in journals. Be thoughtful about the story that the evidence may not be telling about impacts on diverse communities. Collect evidence from a variety of sources.

- Are quantitative and/or qualitative data available?
- Who collected the data and information?
- What was the intent of data collection?
- Were all individuals given appropriate and adequate opportunity to participate and provide information? Were any groups systematically left out of data collection?
- Do data represent a variety of communities, perspectives, experiences, viewpoints, locations, etc.?
- Are data inclusive of or representative of Washington's population? Generalizable to communities likely to be impacted by the change?
- How were data reported, shared, or made available to community?
- What challenges or limitations were presented?

Strength-of-Evidence Criteria

Ratings are based on criteria which consider:

- the amount of research
- appropriateness of study design
- study execution
- generalizability

VERY STRONG EVIDENCE

STRONG EVIDENCE

A FAIR AMOUNT OF EVIDENCE

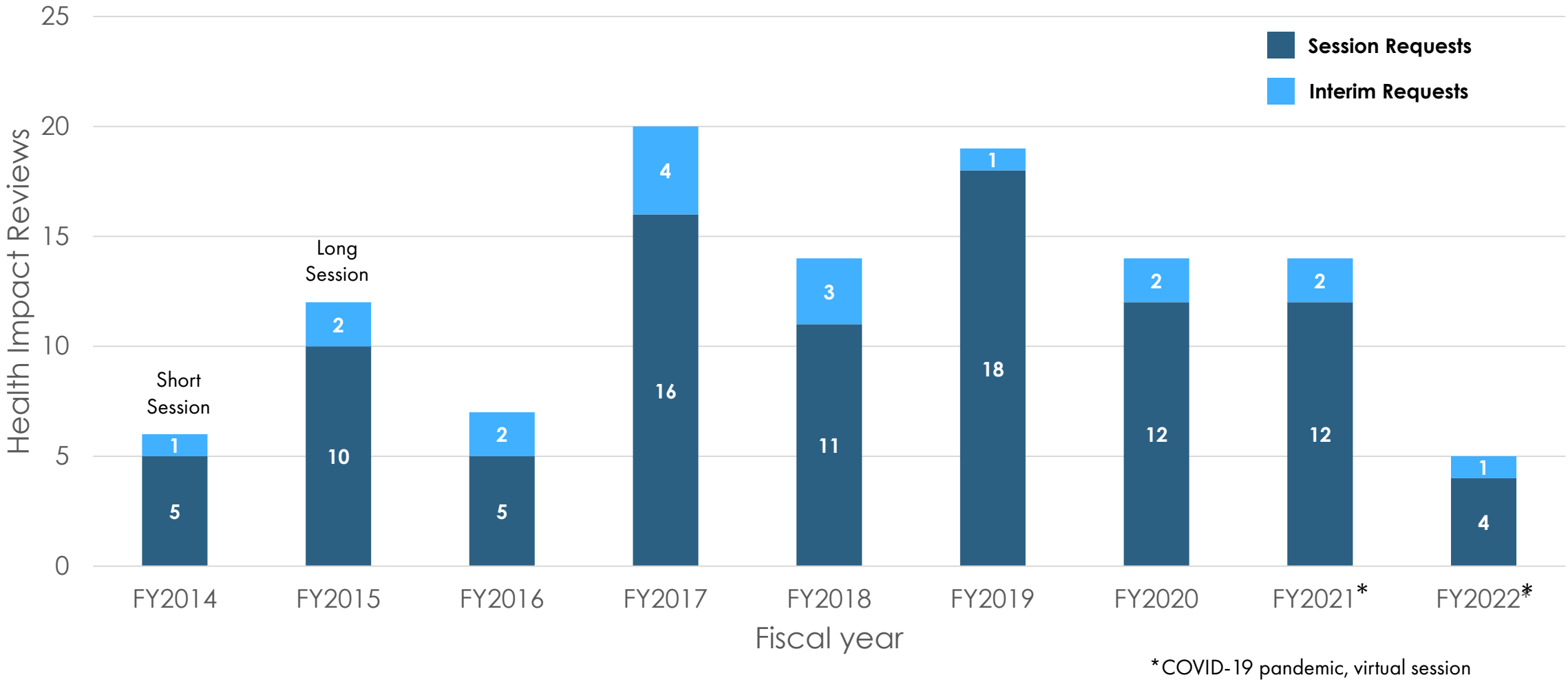
EXPERT OPINION

INFORMED ASSUMPTION

NOT WELL RESEARCHED

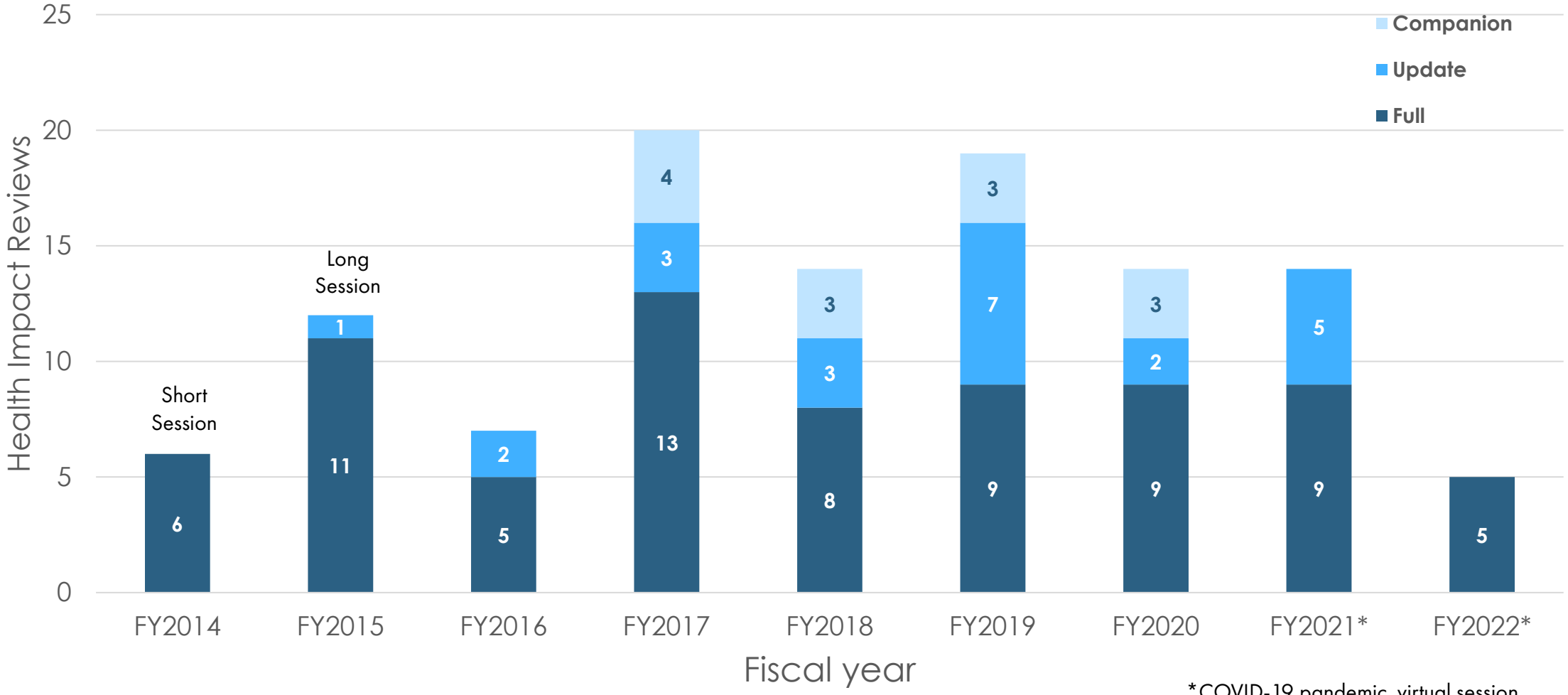
UNCLEAR

112 Completed HIRs



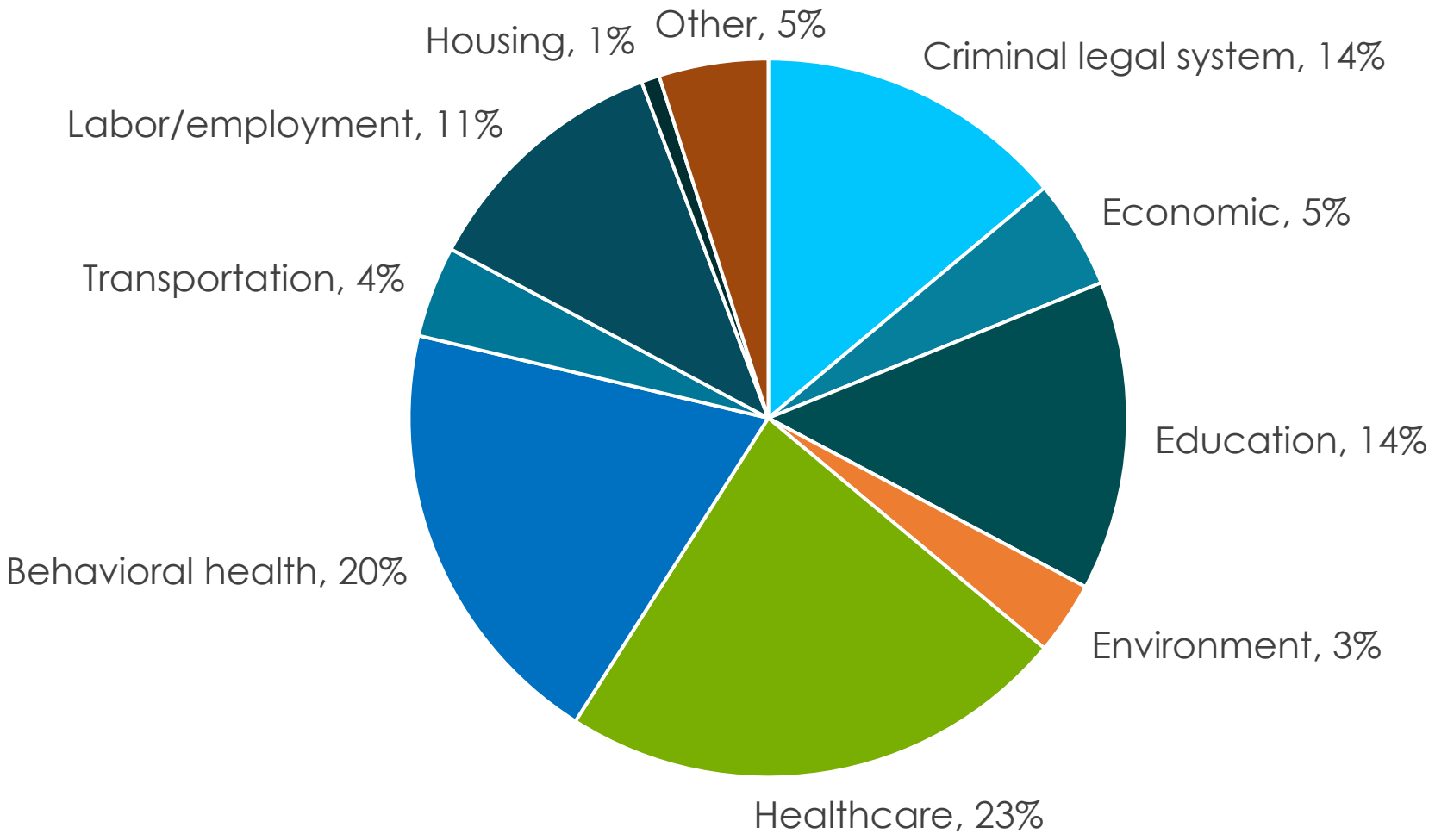
*COVID-19 pandemic, virtual session

Majority of HIRs are full reviews



*COVID-19 pandemic, virtual session

HIR Requests by Topic Area



How HIRs Inform Policy

Requesters have used HIRs to understand:

- The evidence base for a proposal
- If a bill will have the intended impact
- Potential unintended consequences
- Equity implications

Requesters have used HIR findings to:

- Talk with colleagues about a bill
- Refine a policy
- Discuss the bill on the floor
- Develop points for budget negotiations
- Decide how to vote

Contact the HIR Team

Lindsay Herendeen (she/her)
Cait Lang-Perez (she/her)

hir@sboh.wa.gov
360-628-7342

Completed Health Impact Reviews can be found on the Washington State Board of Health website: https://sboh.wa.gov/health-impact-reviews

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

HEALTH IMPACT REVIEWS

RCW 43.20.285

A Health Impact Review (HIR) is an objective, non-partisan, evidence-based analysis that provides the Governor and Legislators with information about how proposed legislation may impact health and equity in Washington state.

The State Board of Health conducts HIRs in collaboration with the Governor's Interagency Council on Health Disparities. Staff complete HIRs on a first-come, first-serve basis. We:

- Work to understand the intent of the proposed legislative or budgetary change.
- Conduct a review of published literature to determine how the bill may impact health and equity.
- Apply objective criteria to evaluate the evidence.
- Talk to key informants to understand how the bill may impact people in Washington state.
- Provide a final report.
- Testify on HIR findings upon request.

Requesters use HIR findings to:

- Understand the evidence to refine a policy direction.
- Determine if a bill will have the intended impact.
- Understand potential unintended consequences of a bill.
- Talk with colleagues about a bill.

Previous requesters have stated that HIRs are an important tool to inform legislative decision-making, provide credible evidence about a bill's potential impacts, and present unbiased data and information

Staff have completed 107 HIRs at the request of 56 different Legislators since 2013.

EXAMPLES OF HEALTH IMPACT REVIEWS

- Improving maternal health outcomes by extending coverage during the postpartum period (SB 5068)- Senator Randall
- Providing a sales and use tax exemption for adult and baby diapers (SB 5309)- Senator Rivers
- Requiring coverage for hearing instruments for children and adolescents (HB 1047)- Representative Wicks
- Concerning solitary confinement (HB 1312)- Representative Peterson
- Requiring the option of in-person learning unless prohibited by the governor, secretary of health, or a local health officer (SB 5464)- Senator L. Wilson

MAKE A REQUEST TODAY

sboh.wa.gov hir@sboh.wa.gov 360-628-7342

WASHINGTON STATE BOARD OF HEALTH

HEALTH EQUITY Governor's Interagency Council on Health Disparities

WASHINGTON STATE BOARD OF HEALTH

Date: October 12, 2022

To: Washington State Board of Health Members

From: Umair A. Shah, MD, MPH, Secretary of Health

Subject: Emergency Rulemaking for On-Site Sewage Systems, WAC 246-272A-0110—Proprietary Treatment Products and Supply Chain Shortages

Background and Summary:

On June 8, 2022, the State Board of Health (Board) adopted an emergency rule to address supply chain shortages associated with on-site sewage system proprietary treatment products regulated under WAC 246-272A-0110. The Washington Department of Health (Department) requested the emergency rule. That emergency rule expires today, October 12, 2022.

The Department is asking the Board to adopt a second emergency rule to allow retrofits and maintenance of proprietary treatment products with comparable components during continued supply chain shortages or similar manufacturing disruptions to avoid public health risks associated with poor system performance. The following information further explains the Department's emergency rule request, concurrent rulemaking on the full chapter, and implementation status of the emergency rule.

The Board has rulemaking authority for on-site sewage systems with design flows less than three thousand five hundred gallons per day. The Board's rules set comprehensive standards for the siting, design, installation, use, care, and management of these small on-site sewage systems. The Department and local health jurisdictions jointly administer the rules.

Under RCW 34.05.350, the Board may adopt emergency rules when it finds that emergency adoption of a rule is necessary for the preservation of 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. Emergency rules are effective for 120 days. Identical or substantially similar emergency rules may be adopted in sequence if conditions have changed or the agency is actively undertaking the appropriate procedures to adopt the rule as a permanent rule.

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, chapter 246-272A WAC. That rulemaking is still underway and is expected to conclude in 2023. Amending WAC 246-272A-0110 to address supply chain shortages associated with on-site sewage system proprietary treatment products fits within the existing CR-101 and staff are working to include it in the permanent rulemaking as previously directed.

(continued on the next page)

The rules require installation of on-site sewage systems that are approved by the Department for use in Washington and that are designed to provide adequate treatment of sewage on the properties they serve. This includes the use of proprietary or trademarked technologies that are properly tested, approved, and registered for use in the state based on the Board's rules.

Homeowners, service providers, and regulators are continuing to experience supply chain shortages and other manufacturing disruptions that are affecting the maintenance and repair of proprietary systems currently in use as well as the installation of new systems. This is due mainly to the shortage of a specific product used in many proprietary systems—a disinfecting ultraviolet light manufactured by Salcor Inc.—as well as other parts and components that continue to be in short supply and are integral to the performance of these on-site sewage systems.

The shortage of replacement parts and components threatens system maintenance and public health and safety due to poor system performance. Failure to maintain on-site sewage systems easily and properly can also impede system inspections associated with property-transfer transactions.

There are thousands of on-site sewage systems in Washington that use the Salcor disinfecting ultraviolet light, and many types of proprietary products serve properties with challenging site conditions such as small lots, poor soils, and proximity to surface waters that compound the public health risks associated with this supply chain shortage.

Jeremy Simmons, Manager of the Department's On-Site Wastewater Management Program, will explain the Department's request for this second emergency rule to continue to allow manufacturers of registered proprietary treatment products to replace system components that are unavailable with comparable components that will not negatively impact performance, treatment, operation, or maintenance of the original registered product. He will also update the Board on activity to date reviewing and approving these component-replacement requests from manufacturers. Given the possibility of continuing or future shortages, staff will continue to research this issue and address it in the permanent on-site sewage system rulemaking.

Recommended Board Actions:

The Board may wish to consider and amend, if necessary, the following motion:

The Board directs staff to file a second CR-103E, Emergency Rulemaking Order, to amend WAC 246-272A-0110 within chapter 246-272A WAC to help ensure on-site sewage system proprietary treatment products continue to function properly without negatively impacting treatment, operation, or maintenance during supply chain shortages.

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.

PO Box 47990 • Olympia, WA 98504-7990
360-236-4110 • wsboh@sboh.wa.gov • sboh.wa.gov

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>

Board Authority

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 70A.125.010, 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 70A.125.010. 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.

[**2021 c 65 § 37**; **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.]

September 2022

On-site Sewage Systems – Emergency Rule

WAC 246-272A-0110

Emergency Rule Summary and Product-Component Approvals

The State Board of Health (Board) adopted an emergency rule on June 8th, 2022, to allow manufacturers of registered proprietary treatment products to replace components of their products that are not available due to supply chain shortages or similar manufacturing disruptions with like components that will not negatively impact performance, treatment, operation, or maintenance of the original registered product. As directed by the Board, the emergency rule amendment will be considered for incorporation into the permanent rulemaking that is currently underway.

To date, three companies have received department approval to substitute the Salcor 3G UV lamp, a disinfecting ultraviolet lamp, as summarized in the table below.

Company	Registered Product	Component to be Substituted	Substitution Component(s)	Approved Treatment Levels
Bio-Microbics	MicroFAST series with Salcor 3G	Salcor 3G UV Unit	Norweco AT 1500 UV & Jet Illumi-jet 952 & 952 Retrofit Kit	Treatment Level A Treatment Level B
Delta	Whitewater DF with Salcor 3G	Salcor 3G UV Unit	Norweco AT 1500 UV & Jet Illumi-jet 952 & 952 Retrofit Kit	Treatment Level A Treatment Level B
Delta	ECOPOD - N with Salcor 3G	Salcor 3G UV Unit	Norweco AT 1500 UV & Jet Illumi-jet 952 & 952 Retrofit Kit	Treatment Level A Treatment Level B
Enviro-Flo	NuWater B 500 with Salcor 3G	Salcor 3G UV Unit	Jet Illumi-jet 952 & 952 Retrofit Kit	Treatment Level B
Enviro-Flo	NuWater BNR 500 / BNR 600 with Salcor 3G	Salcor 3G UV Unit	Jet Illumi-jet 952 & 952 Retrofit Kit	Treatment Level A Treatment Level B

These approvals allow replacement of the Salcor 3G UV lamp on several individual product lines as listed on the List of Registered On-site Treatment and Distribution Products for Washington State.

Link to emergency rule:
Proprietary Treatment Products Emergency Rule | Washington State Department of Health
Emergency Rule OSS Proprietary Treatment Products - CR103 (wa.gov)

Link to permanent rule making:
On-site Sewage System Rule Revision | Washington State Department of Health

For more information, contact Jeremy Simmons, Program manager at (360) 236-3346.

CODE REVISER USE ONLY

RULE-MAKING ORDER
EMERGENCY RULE ONLY

CR-103E (October 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)

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

☐ Yes ☒ No If Yes, explain:

Purpose: The State Board of Health (board) adopted an emergency rule regarding certification and registration of proprietary treatment products used in on-site sewage systems on June 8, 2022 and it was filed on June 15, 2022 (WSR 22-13-101).The emergency rule amended WAC 246-272A-0110 to allow manufacturers to make a written request to the Department of Health (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.

The initial emergency rule expires on October 12, 2022. This second emergency rule adopts without change the same amendments and will continue to allow manufacturers of registered proprietary treatment products to replace components of their products that are not available due to supply chain shortages or similar manufacturing disruptions with like components, as long as the components will not negatively impact performance, treatment, operation, or maintenance of the original registered product.

The underlying justification for the initial emergency rule still applies because without the emergency rule, the current rule would impede 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 ultraviolet (UV) light systems that can be substituted into the proprietary treatment products that use Salcor products. In order to continue to protect the public's health, safety, and welfare, it is necessary to adopt a second emergency rule to allow the department to consider written requests from manufacturers of proprietary treatment products for substitutes to proprietary treatment product components so their systems will be able to function properly without negatively impacting treatment, operation or maintenance during supply chain shortages. To date, three manufacturers have received department approval to substitute the Salcor 3G UV lamp with an alternate UV lamp.

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. As directed by the board at the June 8, 2022 meeting, the emergency rule amendment will be considered for incorporation into the permanent rulemaking that is currently underway.

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 the emergency rule to amend WAC 246-272A-0110 to allow the department to consider written request from manufacturers of proprietary treatment products to substitute a proprietary treatment product component so their systems may 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:	**Signature:** Place signature here
Name: Michelle A. Davis	
Title: Executive Director, State Board of Health	

SAVING LIVES AND PREVENTING DISABILITY

NEWBORN SCREENING

Washington State Department of Health

What is Newborn Screening?

Newborn screening is a public health system that detects infants with serious but treatable conditions that may not be apparent at birth.

There are 3 types of newborn screening programs:

1

Blood-spot

2

Hearing

Pulse Oximetry

Why is Newborn Screening Important?

- It prevents death and disability for **thousands** of infants every year in the USA by providing early treatment
- The public benefits through savings in health care and disability support costs

Two 6 year old girls with Congenital Hypothyroidism
Healthy 18 year old with CH, detected through Washington Newborn Screening as a baby

Mandated Screening for 32 Disorders

Amino Acid Disorders (6)	Fatty Acid Oxidation Disorders (5)	Organic Acid Disorders (8)
Phenylketonuria Homocystinuria Maple syrup urine disease Citrullinemia type I Argininosuccinic acidemia Tyrosinemia type I	Medium-chain acyl-CoA dehydrogenase deficiency Long-chain L-3-hydroxy acyl-CoA dehydrogenase deficiency Trifunctional protein deficiency Very long-chain acyl-CoA dehydrogenase deficiency Carnitine uptake defect	Isovaleric acidemia Glutaric acidemia type I Methylmalonic acidemias (CblA/B and MUT) Propionic acidemia Multiple carboxylase deficiency Beta-ketothiolase deficiency 3-hydroxy-3-methylglutaric aciduria
Endocrine Disorders (2)	**Lysosomal Storage Disorders (2)**	**Other Disorders (10)**
Congenital hypothyroidism Congenital adrenal hyperplasia	Mucopolysaccharidosis type I Glycogen storage disorder type II (Pompe)	Galactosemia Biotinidase deficiency Cystic fibrosis Sickle Cell Diseases & Hemoglobinopathies Severe combined immunodeficiency X-linked adrenoleukodystrophy Spinal muscular atrophy

Immediately Life-Threatening Conditions

Amino Acid Disorders (6)	Fatty Acid Oxidation Disorders (5)	Organic Acid Disorders (8)
Phenylketonuria	Medium-chain acyl-CoA dehydrogenase deficiency	Isovaleric acidemia
Homocystinuria	Long-chain L-3-hydroxy acyl-CoA dehydrogenase deficiency	Glutaric acidemia type I
Maple syrup urine disease	Trifunctional protein deficiency	Methylmalonic acidemias (CblA/B and MUT)
Citrullinemia type I	Very long-chain acyl-CoA dehydrogenase deficiency	Propionic acidemia
Argininosuccinic acidemia	Carnitine uptake defect	Multiple carboxylase deficiency
Tyrosinemia type I		Beta-ketothiolase deficiency
		3-hydroxy-3-methylglutaric aciduria

Endocrine Disorders (2)	Lysosomal Storage Disorders (2)	Other Disorders (10)
Congenital hypothyroidism	Mucopolysaccharidosis type I	Galactosemia
Congenital adrenal hyperplasia	Glycogen storage disorder type II (Pompe)	Biotinidase deficiency
		Cystic fibrosis
		Sickle Cell Diseases & Hemoglobinopathies
		Severe combined immunodeficiency
		X-linked adrenoleukodystrophy
		Spinal muscular atrophy

Coming Soon!

Screening for Ornithine Transcarbamylase Deficiency (OTCD)

Anticipate starting screening in Summer 2023
(pending budget approval)

WA Newborn Screening Process

BABY IS BORN!

18-48
HOURS AFTER BIRTH

Collect first specimen

Dry specimen
for 3 hours

Transport specimen
to the State Lab
ASAP!

BEST PRACTICE

24

HOUR TRANSIT

At the Lab, punches are taken from the dried blood spots to test for each of the disorders

Same day/next day results

Results are mailed back to who submitted the specimen

What happens when a baby has abnormal results?

Dedicated team ensures the baby gets the care they need

- Depends on the results and which condition is suspected

Can include:

- Ensure repeat specimen is submitted to resolve borderline results
- Facilitate prompt diagnostic testing and treatment for non life-threatening conditions
- Call baby's health care provider to check clinical status, recommend immediate evaluation and diagnostics for life-threatening conditions
- After confirmed diagnoses, ensure baby is linked into specialty care

How Much Does Screening Cost?

- Fee for screening: $119.30 as of August 7, 2020
- This one-time fee covers all newborn screens an infant receives in WA

  (No additional charge for 2nd or 3rd screens)

- The Department of Health bills the facility that collected the baby's initial specimen
- The facility then bills the patient's insurance

Quality Assurance & Development

Surveillance

- Ensure every baby in the state receives a valid newborn screen

Education & Outreach

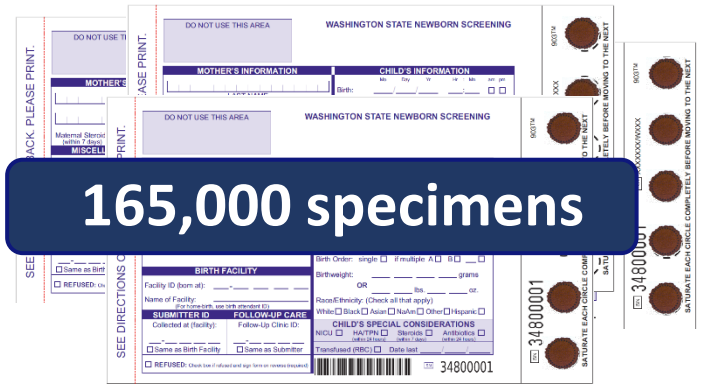
- Provide assistance to health care facilities
- Create educational materials
- Promote newborn screening in the community

Tracking & Reporting

- Send quarterly reports to each facility about their performance in meeting newborn screening guidelines
  - Specimen Collection and Transit Timing Compliance
  - Specimen Quality
  - Demographic Errors

Washington State Numbers

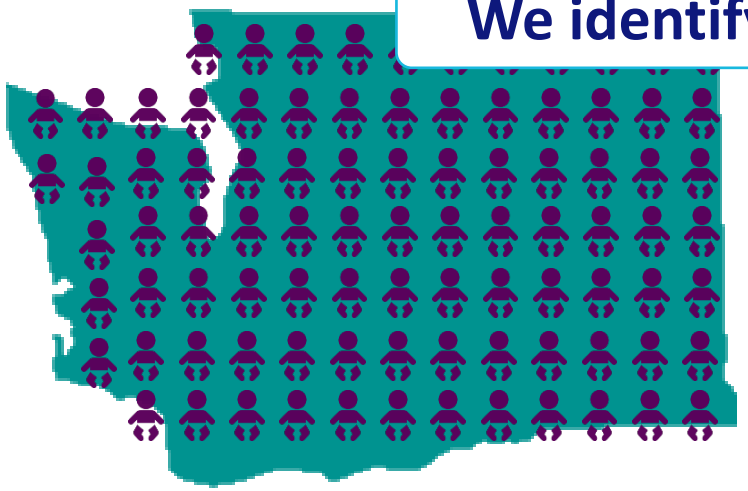
84,000 newborns



165,000 specimens

12 million tests

We identify:



200 infants

with blood spot conditions

170 infants

with early hearing loss

EHDDI Program Overview

Early

Hearing

Detection

Diagnosis

Intervention

EHDDI Program Goals

National 1-3-6 Goals for all state EHDDI Programs

1 All infants receive a hearing screen before they are **one** month old.

3 Infants who do not pass two hearing screens have a diagnostic evaluation before they are **three** months old.

6 Infants who are deaf or hard of hearing start early intervention (EI) services before they are **six** months old.

What's The Rush?

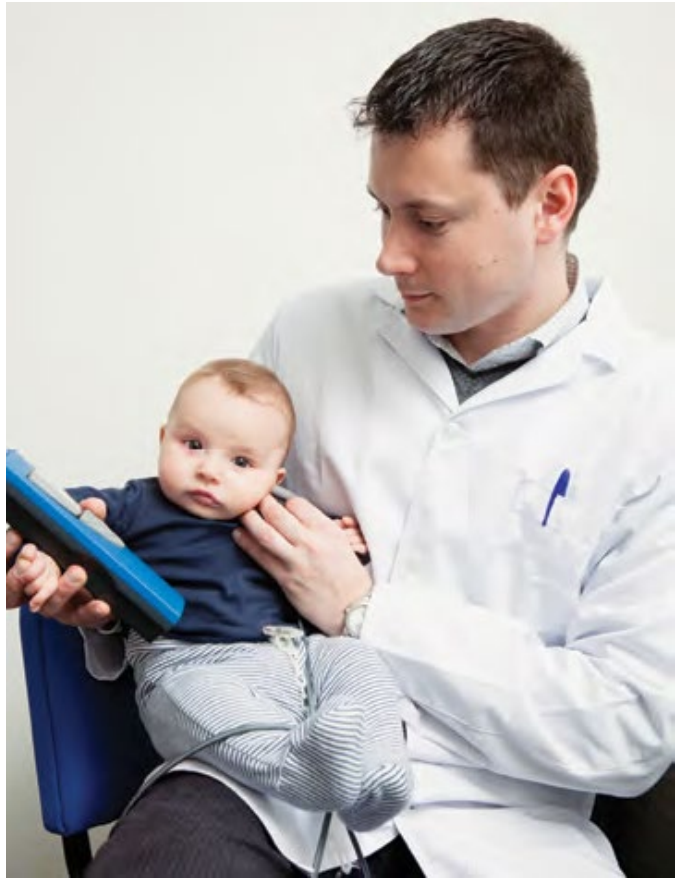
- The first months of an infant's life are a critical time for developing language.
- Delays in identification can lead to developmental delays.
- Research shows that children who are deaf or hard of hearing have better outcomes when they receive early intervention prior to 6 months of age.

Why Screen all infants?

Hearing loss is a common condition present at birth

1-3 per 1000 births

It’s invisible



EHDDI Program Follow-up

- Monitor that EHDDI 1-3-6 goals are met by collecting and reviewing data:
    - Hearing screening results
        - Reported on hearing screen cards by hospitals, midwives, and audiologists
    - Diagnostic hearing evaluation results
        - Reported online and via fax by audiologists
    - Early intervention enrollment data
        - Obtained through an electronic data exchange with the Early Support for Infants and Toddlers (ESIT) program

Risk Factors for Late-Onset Hearing Loss

- Neonatal Intensive Care (NICU) stay of >five days
- Stigmata or other findings associated with a syndrome known to include hearing loss
- Family history of permanent hearing loss
- Craniofacial anomalies
- In-utero infections with cytomegalovirus, herpes, toxoplasmosis, rubella, or syphilis

STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Early Hearing-loss Detection, Diagnosis, and Intervention Program
1610 N.E. 150th Street · Shoreline, Washington 98155
Phone 206-418-5613 Toll Free 1-888-WAEHDDI (1-888-923-4334) Fax 206-364-0074

Action Needed: Passed Hearing Screen but has Risk Factor for Hearing Loss

9/14/2022

TO: WASHINGTON STATE PEDIATRICS

RE: LUKE SKYWALKER
DOB: May 12, 1977
Birth Facility: NEWBORN SCREENING

Mother: TEST MARCIE RIDER
EHDDI #:

Newborn Hearing Screen Results	**PASSED *BUT* AT RISK**
Risk Factor(s) for Late-onset/Progressive Loss	**IN UTERO INFECTION**
Follow-up Needed	**DIAGNOSTIC AUDIOLOGY EVALUATION**
Due Date	**3 MONTHS OF AGE FOR CYTOMEGALOVIRIUS (CMV)** **9 MONTHS OF AGE FOR OTHER IN UTERO INFECTIONS**

For a list of audiology clinics for infants, please visit **www.doh.wa.gov/infantaudiology**.

Children with cytomegalovirus infection, syndromes associated with progressive hearing loss, neurodegenerative disorders, trauma, or culture-positive postnatal infections associated with sensorineural hearing loss may need earlier and more frequent evaluations. For more information about risk factors for late-onset or progressive hearing loss, please visit **www.doh.wa.gov/hearingriskfactors**.

PLEASE FAX THE FOLLOWING INFORMATION REGARDING YOUR ACTIONS TO (206) 364-0074.

[ ] This patient was referred to _____ on _____.
(name of audiology clinic) (date)

[ ] We shared the hearing screen results and recommendations with the patient's parent or legal guardian and they understand the recommendations.

[ ] This patient does not have any of the risk factors indicated.

[ ] This patient's parent or legal guardian declined further testing.

[ ] This patient is not seen at this facility. Current provider (if known):_____

[ ] OTHER_____

If you have any questions, please contact us at (206) 418-5613.

EHDDI Program Follow-up

- Recommend follow-up through primary care providers (PCPs) when an infant needs additional testing or services.
- Work with audiologists, Family Resources Coordinators (FRCs), and PCPs to ensure audiology and early intervention referrals are placed and received.
- Provide families with resources when a child is referred for diagnostic testing and identified as deaf or hard of hearing.
  - ~170 infants are identified each year in Washington

Washington State Department of Health is committed to providing customers with forms and publications in appropriate alternate formats. Requests can be made by calling 800-525-0127 or by email at civil.rights@doh.wa.gov. TTY users dial 711.

WASHINGTON STATE BOARD OF HEALTH

Date: October 12, 2022

To: Washington State Board of Health Members

From: Kelly Oshiro, Board Vice Chair

Subject: Briefing – Recommendations of the Newborn Screening Technical Advisory Committee: Congenital Cytomegalovirus (cCMV)

Background and Summary:

The Washington State Board of Health (Board) has the authority under RCW 70.83.050 to define and adopt rules for screening of Washington-born infants for hereditary conditions using sample blood specimens. WAC 246-650-010 defines the conditions and WAC 246-650-020 lists conditions for which all Washington-born newborns are to be screened. The Board convenes a technical advisory committee (TAC) to inform its decision on which conditions to include in the newborn screening (NBS) panel. The TAC uses available information to evaluate candidate conditions using an established set of criteria.

Congenital cytomegalovirus (cCMV) occurs when a pregnant individual is infected with cytomegalovirus and subsequently passes the infection to their unborn child. cCMV is the most common congenital infection with a birth prevalence of approximately 0.5 percent. cCMV can result in hearing loss and is the leading cause of nonhereditary, sensorineural hearing loss. Additionally, cCMV can lead to developmental delay, vision loss, seizures, and death.

Currently, ten states require targeted newborn screening for cCMV (i.e., a baby who does not pass their hearing screening is subsequently screened for cCMV). Ontario, Canada and Minnesota require universal screening for cCMV using dried blood specimens. Thirteen states require education for the public and health professionals regarding cCMV. In Washington State, some healthcare facilities provide targeted cCMV screening for infants who do not pass the newborn hearing screening, including Seattle Children's Hospital and Valley Medical Center in Renton.

The TAC met on September 21, 2022 to consider cCMV against the Board's criteria. TAC members heard presentations on the natural history of cCMV, targeted and universal screening approaches, and a cost-benefit analysis. The TAC voted on individual criteria as well as an overall recommendation to the Board.

I have invited Dr. John Thompson and Caitlin Maloney from the Department of Health's bloodspot Newborn Screening Program, Marcie Rider and Karin Neidt from the

(continued on the next page)

Department of Health's Early Hearing Detection, Diagnosis, and Intervention (EHDDI) program, and Kaitlyn Donahoe, Policy Advisor to the Board, to present information from the cCMV TAC meeting.

Recommended Board Actions:

The Board may wish to consider one of the following motions:

The Board directs staff to file a CR-101 to initiate rulemaking for chapter 246-650 WAC to consider adding universal congenital cytomegalovirus (cCMV) screening to the Washington State newborn screening panel.

Or

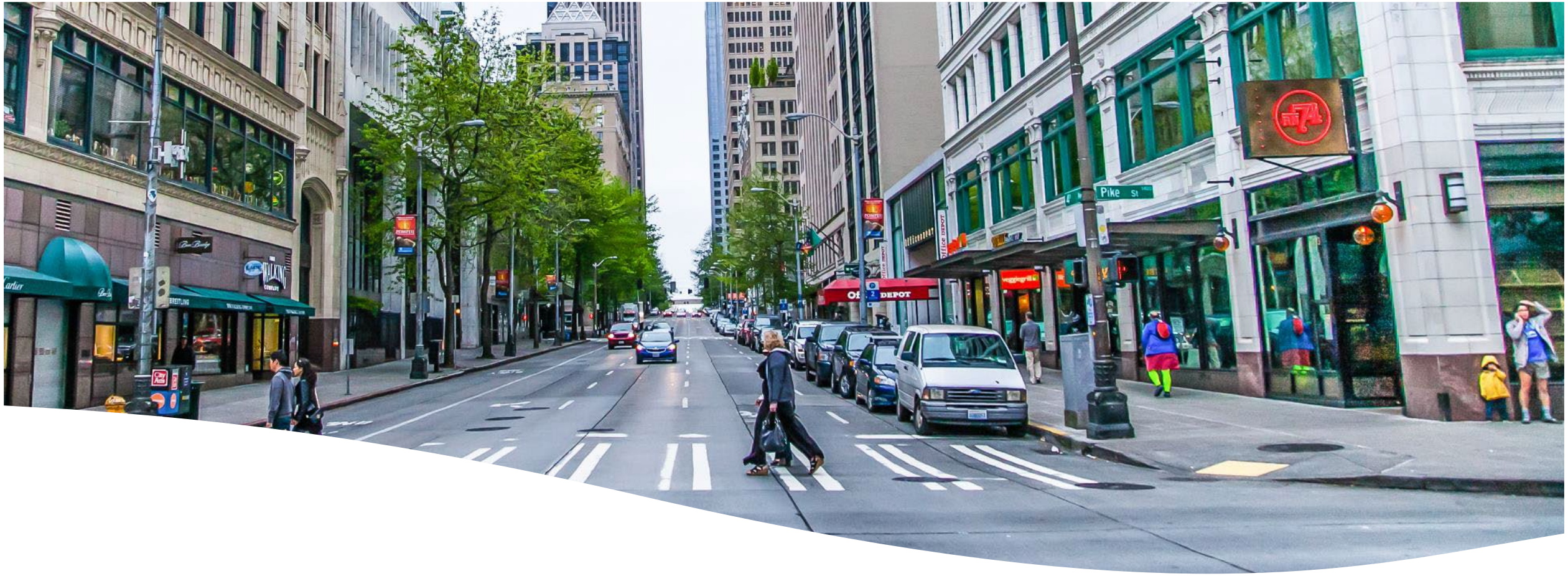
The Board directs staff to explore the possibility of including conditions in the Washington State newborn screening panel that are most appropriately screened in a manner other than through the use of blood samples, including congenital cytomegalovirus (cCMV).

Or

The Board determines that congenital cytomegalovirus (cCMV) should not be considered for addition to the newborn screening panel at this time and moves to reevaluate the condition in three years as a candidate for mandatory newborn screening in Washington State.

Staff

Kaitlyn Donahoe



Washington State Board of Health

Newborn Screening Technical Advisory Committee Recommendation on Congenital Cytomegalovirus(cCMV)

October 12, 2022

Background

- The Board has authority under RCW 70.83.050 to adopt rules for screening Washington-born infants for hereditary conditions using blood samples
- WAC 246-650 defines and lists conditions for which all newborns must be screened
- The Board convenes a technical advisory committee (TAC) to inform its decision on candidate conditions
- The TAC uses available information and data to evaluate candidate conditions using a set of criteria established by the Board

Congenital Cytomegalovirus (cCMV)

- Cytomegalovirus (CMV)
  - Part of the herpes family; easily contracted through exchange of bodily fluids
  - Can result in mild to severe flu-like symptoms; 50-80% of adults have contracted CMV by the age of 40
- Congenital Cytomegalovirus (cCMV)
  - A pregnant person can experience CMV infection and pass to the fetus in utero; their history of infection and fetal gestational age can influence severity of disease
  - cCMV can have severe and life-threatening impacts on infants (e.g., hearing loss, vision loss, cerebral palsy, seizures, developmental delays, microcephaly)
  - ~10% are symptomatic at birth → 50% will develop disabilities
  - ~90% asymptomatic → 10% will develop disabilities

1 in 200 babies are born with cCMV each year

cCMV Screening Methods

Targeted Screening

Testing babies for cCMV when they don't pass their secondary newborn hearing screen

Urine or saliva (97-100% sensitivity) must be tested within 21 days of life

Universal Screening

Testing all babies for cCMV 48 hours after birth

Blood Spot (75% sensitivity); urine or saliva (97-100% sensitivity)

Consideration of cCMV – Timeline

cCMV Technical Advisory Committee

Public Health

- Department of Health (Dr. Kwan-Gett, Co-chair)
- State Board of Health (Kelly Oshiro, Co-chair)

Advocates

- Family Impacted by cCMV
- Save Babies Through Screening
- March of Dimes

State Ethnic Commissions

- Commission on Asian Pacific American Affairs
- Commission on Hispanic Affairs

Insurance

- Health Care Authority
- Association of WA Health Care Plans
- Regence
- Kaiser Permanente

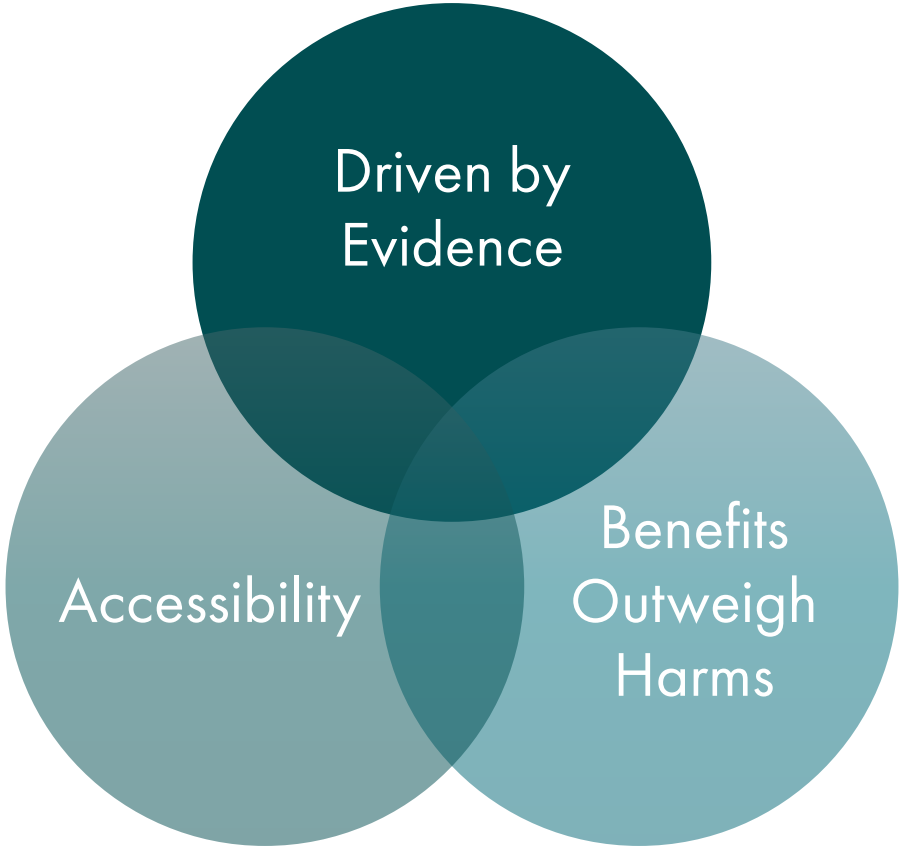
Health Care Providers / Facilities

- WA State Nurses Association
- WA State Hospital Association
- American Academy of Pediatrics, WA Chapter
- WA Association of Naturopathic Physicians

Other

- Audiologist
- Bioethicist

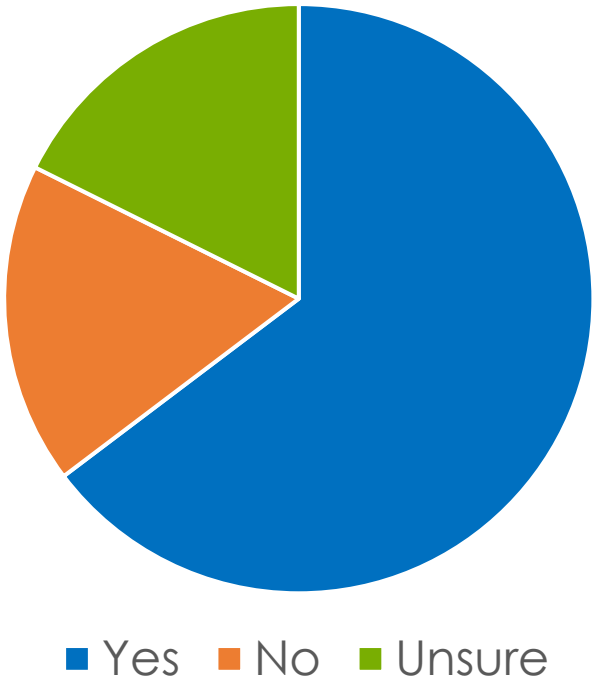
Guiding Principles & Criteria



1. Available Screening Technology
2. Diagnostic Testing and Treatment Available
3. Prevention Potential and Medical Rationale
4. Public Health Rationale
5. Cost-Benefit / Cost-Effectiveness

1 Available Screening Technology

Sensitive, specific and timely tests are available that can be adapted to mass screening.

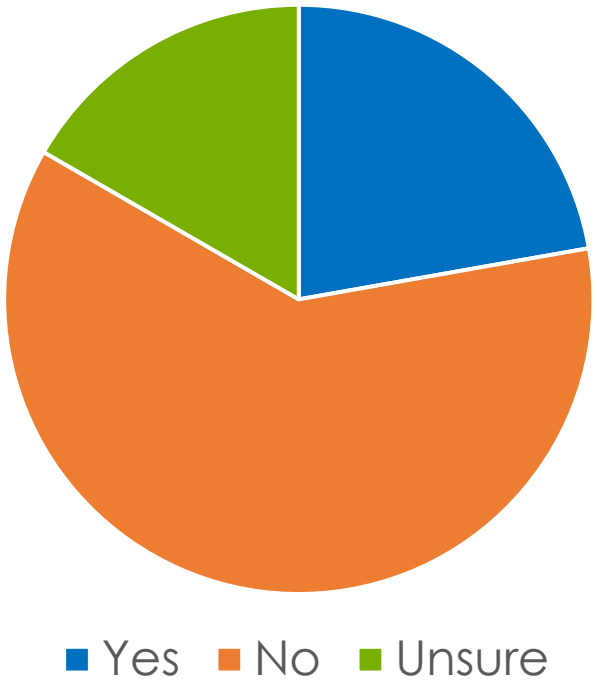


Major themes

- Differing opinions on the sufficiency of the blood spot sensitivity
- Universal screening may not be feasible, but targeted screening could be
- Feasibility/infrastructure to support testing approaches with higher sensitivity (urine or saliva)

2 Diagnostic Testing and Treatment Available

All children who screen positive should have reasonable access to diagnostic and treatment services.

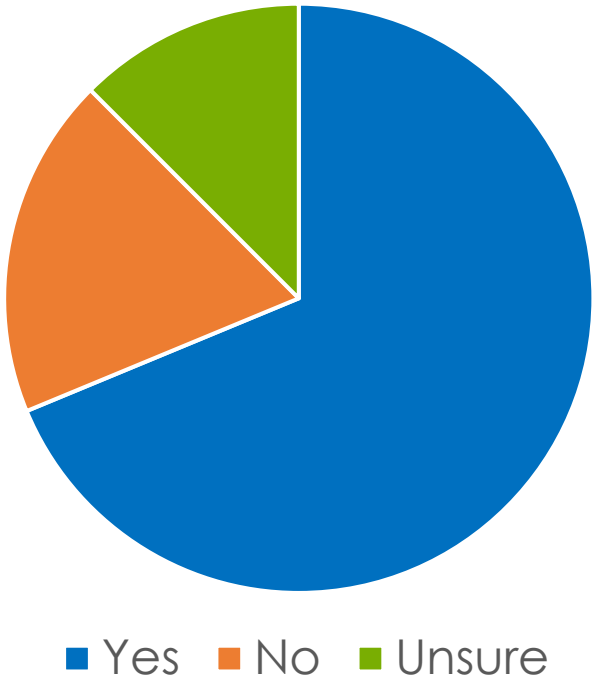


Major themes

- Lack of resources and infrastructure
- Currently no established effective treatment for cCMV
- Unclear how much hearing interventions change outcomes
- Educating/testing for cCMV during pregnancy

3 Prevention Potential and Medical Rationale

The newborn identification of the condition allows early diagnosis and intervention.

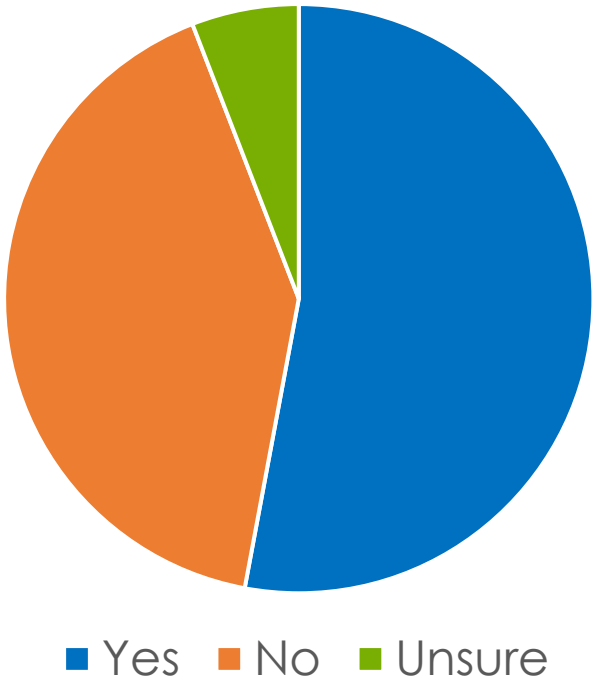


Major themes

- No definitive treatment for cCMV; benefits of early antiviral treatment not well understood
- Blood spot universal screening will not improve early diagnosis
- Benefits of early intervention for late onset hearing loss are clearer
- Early intervention is key

4 Public Health Rationale

Nature of the condition justifies population-based screening rather than risk-based screening or other approaches.

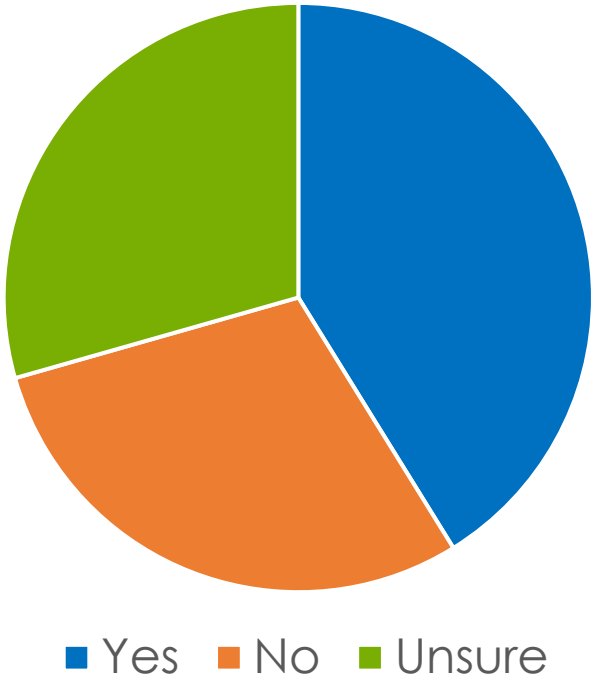


Major themes

- Risk-based or targeted screening would be more effective
- Population-based screening is justified, but not with blood spot
- Diagnostic and treatment technology doesn't exist to realize public health benefit
- Involvement of parents, daycares, schools, pediatricians, etc. in assessments

5 Cost-benefit / Cost-effectiveness

The outcomes outweigh the costs of screening. All outcomes, both positive and negative, need to be considered in the analysis.



Major themes

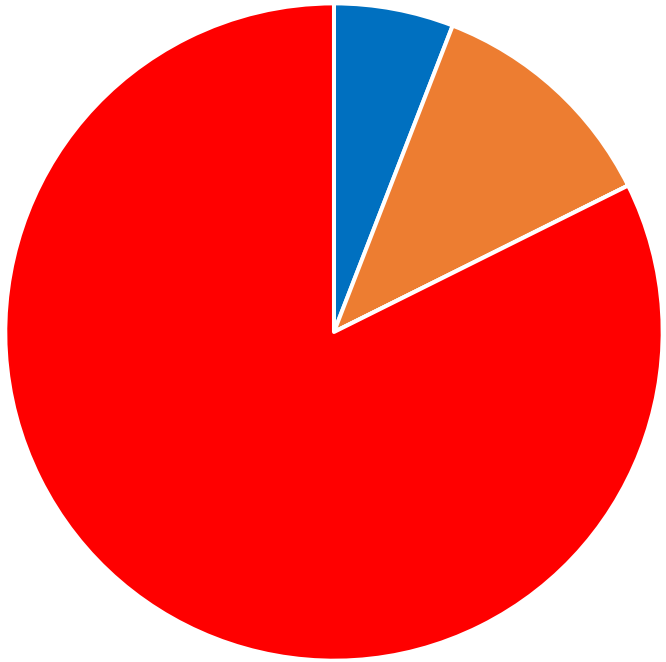
- Based on modeling and data presented, universal screening is not cost-effective
- Cost-benefit ratio is not comparable to other NBS conditions
- Much of the cost effectiveness cannot be quantified (i.e., large emotional cost for families)

cCMV TAC Voting Summary – Criteria

Criteria	Yes	No	Unsure
Available Screening Technology	11	3	3
Diagnostic Testing and Treatment	4	11	2
Prevention Potential and Medical Rationale	11	3	3
Public Health Rationale	9	7	1
Cost-benefit / Cost-effectiveness	7	5	5

cCMV TAC Voting Summary – Recommendation

Option	Vote
I recommend the Board add universal screening of cCMV to the list of conditions for which all Washington-born newborns must be screened.	1
I recommend the Board pursue steps to include targeted screening of cCMV to the list of conditions for which all Washington-born newborns must be screened. Note: this requires a change in the Board's statutory authority via legislation.	2
I do not recommend the Board add cCMV to the list of conditions for which all Washington-born newborns must be screened.	0
At this time, I do not recommend the Board add cCMV to the list of conditions for which all Washington-born newborns must be screened; I recommend the Board revisit cCMV screening at a future date.	14



Next Steps

The Board may consider the following action:

- Direct staff to initiate rulemaking to include universal cCMV screening in the NBS panel
- Direct staff to explore the feasibility of including conditions screened using non-blood specimens
- Determine cCMV should not be considered at this time and revisit the condition in 3 years

QUESTIONS?

THANK YOU

WASHINGTON STATE BOARD OF HEALTH

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TTY users can dial 711

Considering adding congenital cytomegalovirus (cCMV) to the Washington State Newborn Screening Panel

A narrative of an economic analysis for the Department of Health, State Board of Health, and technical advisory committee

October 2022

Proposed Rule and Brief History

The State Board of Health (Board) is authorized by RCW 70.83.050 to adopt rules and regulations relating to congenital newborn screening (NBS). The Board established rules under Chapter 246-650 WAC regarding which conditions to include on the NBS panel. RCW 70.83.020 grants the Board authority to identify which screening the Department of Health (Department) is required to perform for all infants in the state. RCW 70.83.030 tasks the Board with adopting rules related to the reporting of heritable and metabolic disorders to the Department.

In February 2021, the Washington CMV Project petitioned the Board to mandate targeted congenital cytomegalovirus (cCMV) screening for infants who fail newborn hearing screening. After reviewing available evidence in October 2021, the Board directed Department staff to convene a multidisciplinary technical advisory committee (TAC) to consider adding cCMV to the list of mandated NBS conditions in WAC 246-650-010 and WAC 246-650-020. The TAC evaluated cCMV against five Board-approved criteria for potential inclusion in the NBS panel in September 2022.

Overview and Background - Congenital Cytomegalovirus

Cytomegalovirus (CMV) is the most common cause of viral congenital infections and non-genetic sensorineural hearing loss (SNHL) in newborns. CMV is a DNA virus that can be transmitted via two pathways: horizontal and vertical transmission. Horizontal transmission of CMV can occur postnatally via exchange of bodily fluids, e.g., saliva, blood, tears, and urine; these are known as acquired CMV infections. Vertical transmission of CMV can occur between pregnant persons and a fetus prenatally across the placenta (congenital infections) or perinatally during birth or breastfeeding. There is a higher risk of adverse outcomes if a fetus is infected during the first trimester of pregnancy but a higher risk of disease transmission during the third trimester of pregnancy.

CMV can remain dormant and reactivate throughout life. CMV infections are common in adults and many adults may be unaware of their infection status. However, untreated cCMV infections in infants can present serious complications on newborn development, notably hearing loss. Unfortunately, early identification and intervention does not prevent severe disability and death. Early identification of cCMV can allow an infant to receive antiviral treatment for symptoms and intervention services for late onset hearing loss (LOHL); this may improve their language and developmental outcomes later in life.

cCMV is present in approximately 1 in 200 babies, which is a higher prevalence compared to other conditions on NBS panels (1, 2). In 2011, Misono et al. calculated that CMV was present

in 1.4 in 100 babies in Washington State (3). At present, one state (Minnesota) and two Canadian provinces (Ontario and Saskatchewan) universally screen newborns for CMV at birth. Ten states (Utah, Connecticut, Illinois, Iowa, New York, Virginia, Florida, Kentucky, Pennsylvania, and Maine) require targeted CMV testing be offered or conducted after failed newborn hearing screens.

Currently in Washington, there are no state mandates on cCMV education, screening, or reporting (4). CMV testing is up to a provider's discretion and results are not reported to the Department.

While cCMV disease presents as a spectrum, the following categories are commonly used to describe cCMV infections.

- *Moderately to severely symptomatic disease*: numerous visible congenital anomalies or central nervous system involvement
- *Mildly symptomatic disease*: few mild, isolated, observable congenital anomalies
- *Asymptomatic with SNHL*: only observable congenital anomaly is hearing loss
- *Asymptomatic*: no observable congenital anomalies

Most infants with cCMV are asymptomatic and will not develop long-term sequelae. Clinical diagnosis of cCMV is imperfect and relies on a provider recognizing clinical signs and symptoms of cCMV infections, many of which are non-specific. Clinical manifestations of symptomatic cCMV can include small-for-gestational age, microcephaly, hepatosplenomegaly, petechiae, retinitis, and thrombocytopenia. Long-term outcomes differ among symptomatic and asymptomatic infants, with symptomatic infants having higher risk of developing permanent sequelae; sequelae can include SHNL, intellectual disability, vision loss, cerebral palsy, seizures, and death.

There are two common approaches to screening: universal NBS and hearing targeted NBS. Typically, universal screening utilizes dried blood spots (DBS) to screen all infants regardless of presentation of symptoms; less common specimen types for mass newborn screening include saliva and urine. Targeted screening involves testing infants who do not pass their newborn hearing screen(s); targeted screening will not detect infants with asymptomatic cCMV who pass their newborn hearing screen and develop late-onset hearing loss.

Diagnostic laboratory testing for cCMV is a quantitative polymerase chain reaction (qPCR) test on a urine specimen to confirm the presence and quantity of viral DNA. Infants must be tested within the first three weeks of life for a CMV infection to be considered congenital; otherwise, a CMV infection could be acquired from hospitals, nursing parent(s), or other places. Infants who

fail their hearing screen are referred for diagnostic audiologic evaluation, which commonly takes place outside of this critical three-week window in the early infant period (5).

Infants can be treated with antivirals, such as intravenous ganciclovir and/or oral valganciclovir. Current clinical guidelines recommend 6 months of oral valganciclovir for moderately to severely symptomatic infants (6, 7). Initiation of treatment within the first month of life has been shown to improve hearing and developmental outcomes, though long-term effects of antiviral therapy are less clear. Treatment for pregnant persons and asymptomatic infants with or without isolated hearing loss is not currently recommended.

Overview of Cost-Benefit Analysis

The following summary explains the benefit-cost analysis performed for potentially adding cCMV to the mandatory NBS panel. The calculations for this analysis were done in a spreadsheet (available upon request) and describes the medical model for comparing the status quo, or a "No Screening Model" (upper section) with a "Universal Screening Model" (middle section) and a "Hearing Targeted Screening Model" (lower section) (Figure 1). For this analysis on cCMV, the universal screening model is based on DBS testing and the hearing targeted screening model is based on testing infants after two failed hearing screens. The analysis is from the health sector perspective, in which all costs for providing services are estimated, regardless of who pays the costs.

Point estimates and ranges for input variables were derived from primary literature, data from NBS programs piloting cCMV screening, and consultations with expert scientists and clinicians. The universal model predicts a benefit-cost ratio of 0.35 and the hearing targeted model predicts a benefit-cost ratio of 0.00. This means that for every dollar of costs for universal or hearing targeted NBS for cCMV, there will be approximately $0.35 or $0.00, respectively, worth of benefit. The model structure was developed during 2022 by the Washington NBS program and presented to the cCMV NBS TAC on September 21, 2022. It will be presented to the State Board of Health on October 12, 2022.

There are adequate screening tests for finding newborns with cCMV. One of the tricky things about cCMV is that a positive screen cannot predict the onset and severity of disease. Some babies with cCMV will be missed by universal screening because of lower analytical sensitivity using DBS. Similarly, many babies will be missed by hearing targeted screening because they are asymptomatic and pass their hearing screens. Based on current guidelines from the American Academy of Pediatrics, moderate to severely symptomatic infants with cCMV that meet clinical criteria may receive oral valganciclovir.

We constructed an economic model to estimate the benefits and costs of two NBS models for cCMV (Universal Screening Model and Hearing Targeted Screening Model). The analysis compares these costs to what is happening now (No Screening Model).

The first step is to estimate the number of newborns with cCMV. We used information from the Centers for Disease Control and Prevention (CDC) to estimate the number of babies with cCMV born in Washington State this year. We chose to use one year of babies born for this analysis.

The next step is to find out which newborns will be diagnosed early and benefit from intervention. In the No Screening Model, a small percentage of newborns will be diagnosed early because they will be symptomatic at birth (early identification due to onset symptoms). We use the sensitivity of the screening test to estimate the number of newborns diagnosed early in the Universal Screening Model and the prevalence of congenital hearing loss in infants with cCMV to estimate the number of newborns diagnosed early in the Hearing Targeted Screening Model. The sensitivity is the ability of the test to correctly identify newborns with cCMV. Our model predicts that each year there will be about 315 babies with cCMV identified early through universal screening and 52 babies identified through targeted screening, compared to identification through early onset symptoms alone without screening (estimated 52 babies identified).

Next, we compare the medical outcomes for early versus late onset of symptoms. The morbidity estimates are the percentages of infants we expect will develop LOHL from cCMV. These estimates differ among infants depending on their presentation of symptoms at birth. The mortality rates are the percentages of newborns we expect will die from cCMV. There is a larger chance for death in symptomatic cases compared to asymptomatic cases.

We have constructed what is called a decision tree. The next step is to walk through each branch of the decision tree. To do this, we multiply the rates by the number of newborns affected to find out how many newborns have each of the medical outcomes. In the end, we will have estimates for the number of newborns that fall into each category.

Now is the time to compare each of the outcomes. First, we add each of the death estimates together. We subtract the numbers of deaths in each screening model (Universal and Hearing Targeted) from the No Screening Model to find the shift in numbers; this is the difference made by screening. However, screening newborns for cCMV does not have an impact on infant mortality. We also calculate the additional infants identified in both models that will receive diagnostic testing, be treated with antivirals, develop LOHL and receive early intervention, and not develop LOHL but receive extended surveillance for hearing loss.

Next, we assign a value to saving a life. The Federal Government makes estimates for the value of saving a life. We used an estimate of $11.6 million to estimate the value of a life saved through NBS. We also included the annual benefit of $44,200 for early identification for hearing loss.

We need to estimate how much each NBS program costs. Based on information from the Washington NBS program, we estimated that the costs for universal NBS are $31.10 per baby and the costs for hearing targeted NBS are $4.03 per baby. Screening tests are not perfect. This means that some babies who do not have cCMV will have false positive NBS results and some babies with cCMV will have false negative (normal) NBS results. Babies with false positive results need diagnostic testing to rule out CMV (their follow-up diagnostic urine CMV test will be normal).

The next step is to add up all the benefits and the costs (lives saved, LOHL intervention, NBS and diagnostic testing costs, antiviral treatment costs, and cost of surveillance for hearing loss). We divide the benefits by the costs to get a benefit/cost ratio. Our final results are 0.35 for universal screening and 0.00 for hearing targeted screening. This means that for every dollar of costs to provide universal or hearing targeted cCMV screening, there will be $0.35 or $0.00, respectively, worth of benefits. The net benefits for universal and hearing targeted cCMV screening are -$2,249,458.18 and -$744,120.53, respectively. Negative net benefits represent a cost to the overall system.

Technical Explanation of Model Parameters

We chose numbers for a base case analysis: if we had several estimates from the published data, we either used an average or the middle value. Note: the spreadsheet we used calculates the percentages and estimates, which have in some instances been rounded for simplicity. Subsequent calculations are unaffected by this rounding, so sometimes the numbers appear to not match perfectly.

- ***Birthrate.*** This analysis is for a hypothetical birth cohort of **84,000** babies (cells B13, B50, and B92) which is the number of babies expected to be screened per year in Washington State. This number is based on the number of births projected in Washington in 2022.
- ***Prevalence.*** The prevalence used was **0.5% or 1 cCMV case per 200 births** (cells D13, D37, and D79), which is the prevalence reported by the CDC (1). This predicts **420** babies (cells E13, E37, and E79) born with cCMV in Washington each year. Of note, one pilot universal screening program reported 1 cCMV case per 224 births, which is the prevalence found among 12,554 babies (Minnesota).

- ***Percent of babies with cCMV with early-onset clinical symptoms.*** These babies will be treated early because of the presentation of visible clinical symptoms at birth recognized by the provider. The estimate for this parameter (**12.5%**, cells G4, J47, and J89) was derived from primary literature (1, 2).
- ***Sensitivity***. The sensitivity, or the ability of the screen to correctly identify babies with cCMV is estimated at **75%** (cell G34) for universal screening and **12.5%** (cell G76) for hearing targeted screening. The values used are from a pilot universal cCMV study in Minnesota and prevalence estimates of congenital hearing loss in infants with cCMV from primary literature (8-11). The universal sensitivity value predicts **315** true positives (cell H34) identified early and **105** false negatives (cell H48) or missed cases of cCMV per year. The hearing targeted sensitivity value predicts **52.50** true positives (cell H76) identified early and **367.50** false negatives (cell H90) or missed cases of cCMV per year. True positive babies will need diagnostic CMV testing to determine the presence of CMV.
- ***Specificity.*** The specificity, or the ability of the screen to correctly identify babies who do not have cCMV, is estimated at **99.88%** (cell G62) for universal screening and **99.1%** (cell G104) for hearing targeted screening. The values used are from the pilot study in Minnesota and primary literature (10, 12). The specificity values predict **100.19** false positives per year (cell H55) from universal screening and **752.22** false positives per year (cell H97) from hearing targeted screening. False positive babies will also need diagnostic CMV testing to determine the presence of CMV.
- ***Difference in mortality.*** The mortality estimates for symptomatic cases of cCMV (**7%**, cells J3, N45, and N87) and asymptomatic cases of cCMV (**0%**, cells J14, N56, and N98) are from primary literature and expert opinion (13-15). Typically, the benefit for babies identified early is decreased mortality. However at present, there are no reported long-term mortality estimates for infants with cCMV after identification and/or treatment (16). Long-term outcome studies reporting mortality attribute death to non-cCMV causes (9). An estimate for the mortality rate after screening (**0.88%**, cells J27 and J69) was created to show a net zero benefit for mortality between the models.
- ***Percent of babies with cCMV receiving antiviral treatment.*** Antiviral treatment is recommended for infants with moderately to severely symptomatic cCMV. Treatment has been shown to be modestly beneficial, but more studies are needed to assess long-term benefits (9, 15). The estimate for infants not identified through screening (**71%**, cells N5, S47, and S89) was derived from primary literature (8). Preliminary findings from the pilot universal screening study in Minnesota and trends on valganciclovir use in cCMV infants report a lower percentage of infants receiving antivirals in practice (**21%**, cells N29 and N71) (10, 17).
- ***Percent of babies who develop LOHL.*** Some infants in the group of babies who do not receive antiviral treatment will still develop LOHL, regardless if symptoms are present at birth. The estimate for symptomatic cCMV infants with LOHL (**35%**, cells S11 and

W55) was derived from primary literature (18). The upper end of the range for this parameter (**40%**, cell W97) was used for the hearing targeted model in order to show no difference in the number of infants with LOHL between the hearing targeted and no screening models. The estimate for asymptomatic infants with LOHL **12.5%**, cells N17, S36, S59, and S101) was also derived from primary literature (8, 18).

The next step is to evaluate the differences between the models to quantify the benefits and costs of screening. This is done by determining the sum of the following outcomes per model and calculating the differences made between no screening and each screening model.

- ***Deaths Averted.*** There are **3.68** deaths in the no screening Model (cell AD2), universal model (cell AD25), and hearing targeted model (cell AD67); therefore, **0** deaths (cells AD33 and AD74) are averted per year in both screening models. This is based on there being no described improvement in mortality rates from early intervention (13, 16, 19).
- ***Shift in babies with diagnostic testing.*** The number of infants that will require diagnostic testing is **52.50** (cell AD3) in the no screening model, **415.19** (cell AD26) in universal NBS, and **804.72** (cell AD68) in hearing targeted NBS. The additional number of infants needing diagnostic testing annually in universal and hearing targeted NBS is **362.69** (cell AD34) and **752.22** (cell AD75), respectively. Early identification through hearing targeted NBS identifies a higher number of false positive infants when compared to universal NBS.
- ***Shift in babies treated with antivirals.*** The number of infants that will receive antiviral treatment is **34.67** (cell AD4) in the no screening model, **74.24** (cell AD27) in universal NBS, and **41.26** (cell AD69) in hearing targeted NBS. The additional number of infants needing antiviral treatment annually in universal and hearing targeted NBS is **39.57** (cell AD35) and **6.60** (cell AD76), respectively.
- ***Shift in babies surviving with LOHL and early intervention.*** The number of surviving asymptomatic infants that will develop LOHL and receive early intervention for hearing loss is **4.96** (cell AD5) in the no screening model, **32.07** (cell AD28) in universal NBS, and **4.96** (cell AD70) in hearing targeted NBS. The additional number of infants annually with LOHL and early intervention in universal and hearing targeted NBS is **27.12** (cell AD36) and **0** (cell AD77), respectively.
- ***Shift in babies surviving without hearing loss receiving 6 years of surveillance.*** There is a subset of asymptomatic infants with cCMV in the universal screening model that, if identified early, can be placed into 6 years of surveillance to monitor for signs of hearing loss. The number of surviving infants that will not develop hearing loss but receive 6 years of surveillance is **9.20** (cell AD6) in the no screening model and **215.84** (cell AD29) in universal NBS. The number of infants identified through universal NBS that will undergo surveillance for hearing loss is **206.63** (cell AD37).

Benefits are estimated next.

- ***Value of Lives Saved.*** The value of a statistical life is estimated at **$11,600,000.00**; this is per the U.S. Department of Transportation (20). The value of lives saved by screening is the number of deaths averted multiplied by the monetary value of a statistical life. Since newborn screening for cCMV does not prevent infant death, the universal and hearing targeted models estimate yearly benefits of **$0.00** (cells AE42 and AE82) for saving lives of babies with cCMV.
- ***Value per baby with early identification for hearing loss.*** Per Grosse et al. 2018, the value of early intervention services for hearing loss is estimated to be **$44,200** per child. This is the estimated reduced costs for schooling per infant identified by universal newborn hearing screening that received intervention for hearing loss (21). The total value of LOHL intervention is the number of infants identified in the shift (additional babies surviving with LOHL and early intervention) multiplied by the value of early intervention for hearing loss (**$1,198,583.21** (cell AE44) for universal NBS and **$0.00** (cell AE84) for hearing targeted NBS).
- ***Total benefits of Newborn Screening Models.*** The total annual benefits of universal screening (**$1,198,583.21**, cell AE45) and hearing targeted screening (**$0.00**, cell AE85) are the sum of the value of lives saved and the total value of LOHL intervention.

Then, costs are estimated.

- ***Cost of screening.*** The estimated costs of CMV NBS testing are **$31.10** (cell AD49) per baby for universal screening and **$4.03** (cell AD89) per baby for hearing targeted screening. Costs for universal newborn screening includes staffing for laboratory and follow-up services, new instrumentation and kits, and clinical support. Costs for targeted newborn screening includes staffing for follow-up services and clinical support. The total costs for cCMV newborn screening are the birthrate multiplied by cost per baby (**$2,612,121.22** (cell AE50) for universal NBS and **$338,707.97** (cell AE90) for hearing targeted NBS).
- ***Costs of diagnostic testing.*** True and false positive babies are counted for diagnostic testing costs. The estimated cost for diagnostic testing is **$487.50** per baby (cells AD51 and AD91); this is the outpatient cost for CMV qPCR testing for a urine specimen at the Mayo Clinic Laboratories. The total costs of diagnostic testing annually are the number of additional babies identified in the shift (additional babies with diagnostic testing) multiplied by the cost of diagnostic testing (**$176,812.25** (cell AE52) for universal NBS and **$366,707.25** (cell AE92) for hearing targeted NBS).
- ***Costs of antiviral treatment.*** A subset of symptomatic babies receive antiviral treatment. The 6-month cost associated with oral valganciclovir and monitoring laboratory tests is **$4,785.00** per Gantt et al. 2016; monitoring labs include complete blood counts and

chemistry tests to monitor signs of toxicity from antiviral therapy (22). Other symptomatic care costs added to the treatment costs for symptomatic individuals include initial laboratory testing, audiologic follow-up, ophthalmologic examination, cranial ultrasonography, brain magnetic resonance imaging, and a medical evaluation; therefore, the total treatment costs are estimated to be **$5,868.61** (cells AD53 and AD93). The total costs of antiviral treatment annually are the number of additional babies identified in the shift (additional babies treated with antivirals) multiplied by the cost of antiviral treatment (**$232,231.90** (cell AE54) for universal NBS and **$38,705.32** (cell AE94) for hearing targeted NBS).

- ***Costs of surveillance for hearing loss.*** Based on recommendations from the Utah Early Hearing Detection and Intervention Program, a six-year surveillance system was created for asymptomatic infants with cCMV to monitor for signs of hearing loss (23). Type and frequency of audiology tests were recommended by the Washington EHDDI Program. Costs for audiologic services were based on average Medicaid payments per McManus et al. 2010 (24). The total cost for 6 years of hearing surveillance for asymptomatic cCMV infants is estimated to be **$1,826.19** (cells AD55 and AD95); this includes varying audiologic services conducted every 3 months until age 3, then every 6 months until age 6. The total costs for surveillance for hearing loss are the number of additional babies identified in the shift (additional babies without hearing loss but 6 years of surveillance) multiplied by the cost of 6 years of surveillance (**$426,876.02** (cell AE56) for universal NBS and **$0.00** (cell AE96) for hearing targeted NBS).
- ***Total costs of Newborn Screening Models.*** The total annual costs of cCMV screening are the sum of the costs of screening, diagnostic testing, antiviral treatment, and surveillance for hearing loss. The total annual costs for universal and hearing targeted screening are estimated to be **$3,448,041.39** (cell AE57) and **$744,120.53** (cell AE97), respectively.

Finally, the ratio of benefits to costs is calculated. Any ratio greater than 1 signifies that the benefits outweigh the costs.

- ***Benefit/Cost Ratio.*** For universal screening, **$1,198,583.21** of benefits divided by **$3,448,041.39** of costs yields a benefit/cost ratio of **0.35** (cell AE60). For hearing targeted screening, **$0.00** of benefits divided by **$744,120.53** of costs yields a benefit/cost ratio of **0.00** (cell AE100).
- ***Net Benefit.*** The net benefit is the amount of money saved each year by adding screening, and is the total costs subtracted from the total benefits. For universal screening, **$1,198,583.21** minus **$3,448,041.39** gives a net benefit of **-$2,249,458.18** (cell AE62). For hearing targeted screening, **$0.00** minus **$744,120.53** gives a net benefit of **-$744,120.53** (cell AE102). The negative net benefits associated with universal and hearing targeted screening are costs to the public health system.

After completing the base case benefit-cost ratio, we performed a one-way sensitivity analysis to evaluate how the benefit-cost ratio changes when estimates for the parameters are individually varied and all others remain constant.

- ***Sensitivity analysis.*** Table 1 contains three estimates for each parameter, the estimate used in the base case followed by conservative and liberal estimates. Only one parameter was changed at a time to generate unique benefit/cost ratios for each of the scenarios compared to the base case benefit/cost ratio for universal NBS (0.35). The model proved to be very robust and was somewhat sensitive to four parameters: birth prevalence, cost of universal NBS, the percent of asymptomatic infants with LOHL, and the value per baby with early identification for LOHL.

Table 1. Sensitivity analysis

Parameter	Conservative estimate	Base case	Liberal estimate	Benefit/cost ratio swing
Birthrate	73,000	84,000	95,000	No change
Prevalence	1:250	1:200	1:71	0.29 to 0.69
Sensitivity	73.2%	75%	85.7%	0.34 to 0.38
Specificity	99.76%	99.88%	100%	0.34 to 0.35
Cost of universal NBS	$15.55	$31.10	$46.65	0.56 to 0.25
Cost of diagnostic test	$243.75	$487.50	$4,875.00	0.36 to 0.24
Cost of antiviral treatment	$0.00	$5,868.61	$58,686.10	0.37 to 0.22
Cost of surveillance for hearing loss	$792.89	$1,826.19	$2,516.07	0.37 to 0.33
% symptomatic surviving with antiviral treatment	10.5%	21%	42%	0.42 to 0.23
% asymptomatic surviving with late onset hearing loss	6.25%	12.5%	25%	0.15 to 0.74
Value per baby with early identification for late onset hearing loss	$22,100	$44,200	$88,400	0.17 to 0.70

Of the four parameters that have a modest impact on the model, two base case estimates are strongly supported in the literature (birth prevalence and percent asymptomatic with LOHL) (1,

8, 18). The base case value for the cost of universal NBS was estimated by the Department and similar to the cost for universal NBS calculated by the Minnesota Department of Health ($43 per baby) (25). The value per baby with early identification for LOHL comes from one estimate in the literature; however, this point estimate is from a reliable source in health economics (21).

- ***Break even points.*** Table 2 contains the break-even point for each parameter. This is what the estimate would need to be, holding all other parameters constant, to increase the benefit/cost ratio to 1 (meaning it is now beneficial). Of note, the cost for universal NBS would need to be significantly lower than the base case estimate to be influential on the model.

Table 2. Break even points.

Parameter	**Base case**	**Break even point**
Birthrate	84,000	Impossible
Prevalence	1:200	1:31
Sensitivity	75%	Impossible
Specificity	99.88%	Impossible
Cost of universal NBS	$31.10	$4.30
Cost of diagnostic test	$487.50	Impossible
Cost of antiviral treatment	$5,868.61	Impossible
Cost of surveillance for hearing loss	$1,826.19	Impossible
% symptomatic surviving with antiviral treatment	21%	Impossible
% asymptomatic surviving with late onset hearing loss	12.5%	33%
Value per baby with early identification for late onset hearing loss	$44,200	$127,000

Intangible Benefits and Costs

This economic analysis does not address several benefits and costs associated with screening that are difficult to quantify. The majority of infants with cCMV have clinically inapparent infections and diagnosis through newborn screening may or may not be viewed by families as beneficial. Hypothetical and retrospective studies on parental attitudes regarding cCMV NBS show high

acceptability, as parents valued the information in light of heightened anxiety from screening (26-28). Early diagnosis of asymptomatic infants creates an emotional impact on individuals and families affected by cCMV. The establishment of a six-year surveillance system for these asymptomatic infants/children aims to provide more frequent follow-ups and monitoring for signs of LOHL. There is an opportunity to intervene in a critical period of learning and language development for infants who undergo the proposed surveillance and develop LOHL. For families in this situation, the surveillance program will be beneficial. However, the vast majority of asymptomatic infants under surveillance (87.5%) will never develop hearing loss; these families will experience financial and nonfinancial costs associated with surveillance without receiving any benefits.

The adverse psychosocial impact of newborn screening, specifically false-positive results, is well-documented (29). The variability of cCMV infections amplifies these concerns because unlike heritable conditions, a positive cCMV result does not shed light on disease severity or onset. For some families, the value of knowing this result is a benefit; for others, the uncertainty of cCMV infections further complicates the diagnostic odyssey. The value of this knowledge is also contingent upon the severity of symptoms since antiviral treatment is not warranted in all cases of cCMV.

Antiviral treatment, specifically 6 months of valganciclovir, is generally recommended for infants with moderately to severely symptomatic disease or central nervous system involvement (6, 7). It is not currently recommended that mildly symptomatic infants or asymptomatic infants with isolated SNHL receive antiviral treatment (7). Overall, the effects of antiviral therapy may be favorable but there is insufficient evidence of its enduring benefit (9).

The impact of cCMV prevention strategies for pregnant persons is another intangible benefit. The ability to reduce the prevalence of cCMV during pregnancy has the potential to save lives. Some states mandate public health education programming for cCMV to ensure healthcare practitioners, families, and expectant parents receive up-to-date and evidence-based information on cCMV.

Conclusion

Early identification of babies with cCMV is generally regarded as being beneficial to the babies, their families, and the medical professionals caring for them. Although screening newborns for cCMV does not prevent death or disability, it does create an opportunity for monitoring for LOHL in babies with asymptomatic cCMV and providing early language services for those developing hearing loss.

This analysis used data from primary literature, NBS programs piloting screening for cCMV, and expert opinion to quantify benefits and costs for asymptomatic babies with cCMV who may

benefit from early surveillance for hearing loss. Using our best estimates for parameters, the benefit-cost ratio for universal and hearing targeted screening was 0.35 and 0.00, respectively. For every dollar of costs to provide cCMV screening, we predict that there will be $0.35 worth of benefits from universal screening and $0.00 worth of benefits from hearing targeted screening. The net benefits from universal and hearing targeted screening are -$2,249,458.18 and -$744,120.53, respectively. The sensitivity analysis showed that the model is very robust because the benefit-cost ratio did not change much when more conservative or liberal estimates for parameters were made in the model.

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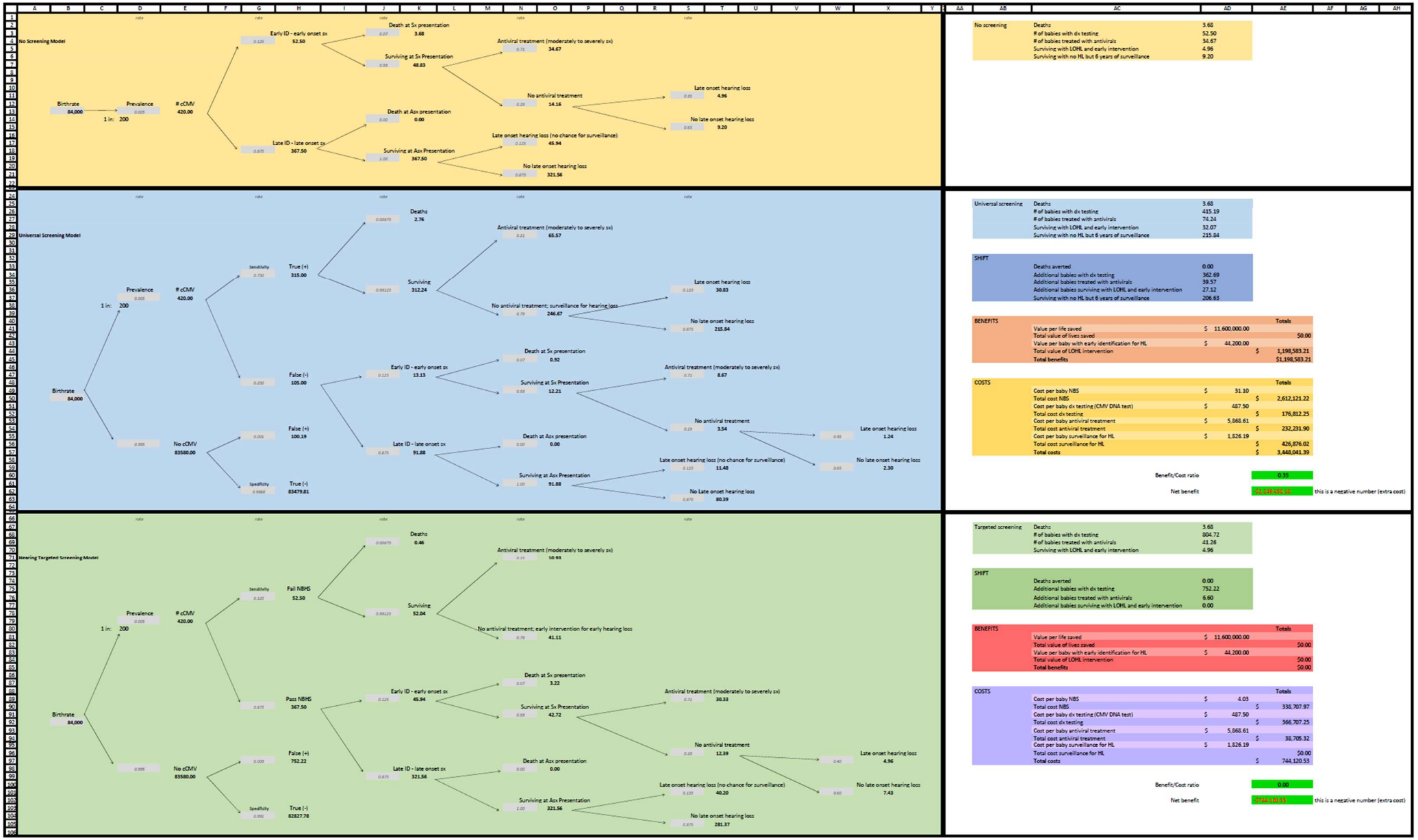
Figure 1. Washington State Benefit-Cost Analysis for potentially adding NBS for cCMV

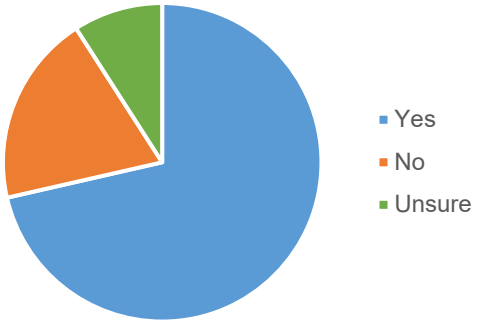


WASHINGTON STATE BOARD OF HEALTH

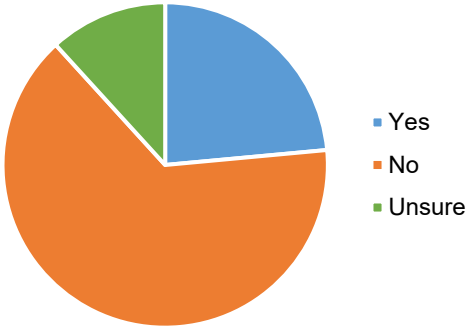
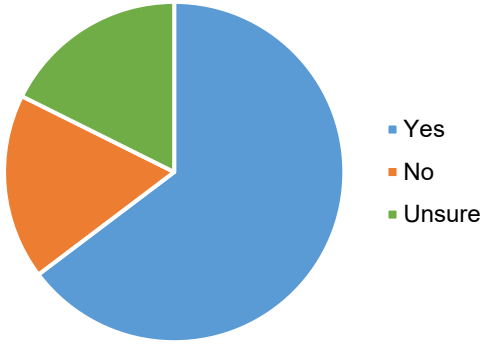
Newborn Screening Technical Advisory Committee: Congenital Cytomegalovirus (cCMV)
Summary of Comments

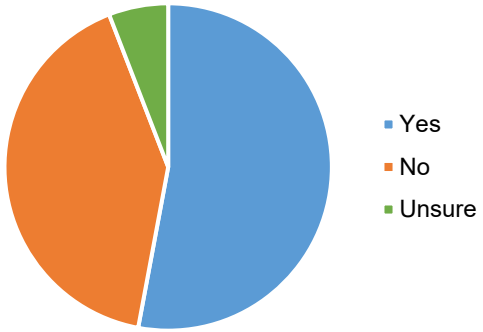
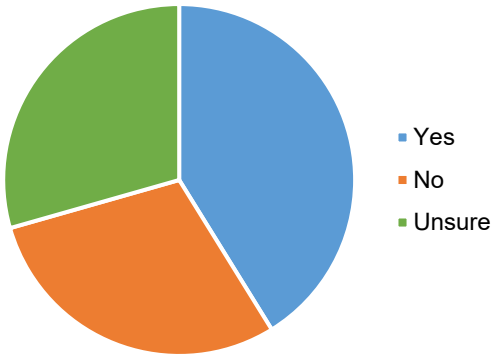
The following is a compilation of comments from technical advisory committee (TAC) members provided when voting on each individual criteria, and an overall recommendation. Comments have been summarized and are organized by each criterion and then overall comments provided.

Criteria Evaluation

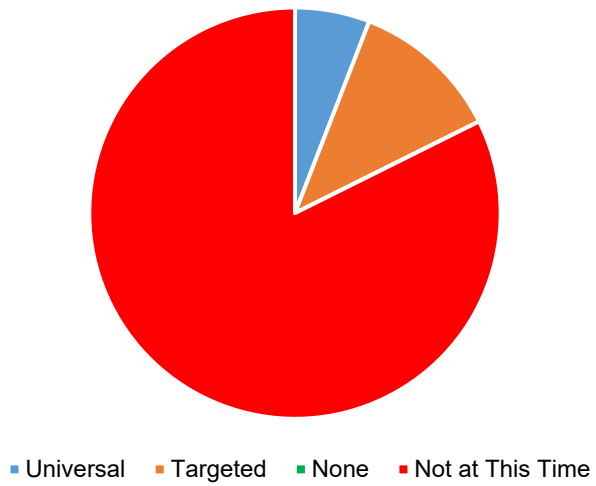
Criteria	Major themes
1. Available Screening Technology 	• The sensitivity of 75% is insufficient for the blood spot assay. Higher sensitivity testing approaches (i.e., urine or saliva PCR testing) are not feasible, as we do not currently have the infrastructure for these approaches. • While the blood spot tests are not as sensitive, universal screening would still identify 27 additional babies with late onset hearing loss and early intervention. • Blood spot test sensitivity is acceptable. • Universal screening may not be feasible, but targeted screening could be feasible.
2. Diagnostic Testing and Treatment Available	• Lack of infrastructure and resources as it relates to increased hearing screening, monitoring, and follow-up; available audiology services in the state; training for

(continued on the next page)

	audiologists and medical providers; availability of treatment; overall personnel for education and training; and alternative models for screening by primary care providers. • While it appears early intervention is effective for infants with late onset hearing loss, there is currently no established effective treatment for cCMV. • Why is cCMV not on the federal Recommended Uniform Screening Panel (RUSP)? • Unclear how much hearing interventions change outcomes. • One thought would be to educate pregnant women and possibly test for CMV during pregnancy.
3. Prevention Potential and Medical Rationale 	• There is no definitive treatment for cCMV; unsure that irreversible harm can be prevented. • Benefits of early antiviral treatment for cCMV are not well understood. As antiviral treatment (i.e., valganciclovir) is only used for patients with moderate to severe symptomatic cCMV, there is limited evidence on effectiveness of antivirals to treat asymptomatic babies. • Dried blood spot universal screening will not improve early diagnosis. Without screening most will be detected and receive care, albeit later. • Benefits of early intervention for late onset hearing loss are more clear. There may be benefits from earlier detection with regard to early childhood intervention and special education interventions on language development and education success. • Hearing is a contested medical goal by the deaf community, and the deaf community would argue for equity education for those with hearing impairment. • Early intervention is key to many problems, and this type of screening is a form of early intervention

4. Public Health Rationale  	• Risked-based or targeted screening would be more effective. • Population-based screening is justified, but not with the blood spot sample. • The public health rationale is present in theory, but the diagnostic and treatment technology doesn't exist at present to realize that benefit. • Hearing screens are done on a routine basis; we have school screenings that can further help with evaluation and detection. I think this would probably overwhelm an already overwhelmed system. • It is not clear that focusing on CMV will change the population of children with hearing loss. Parent-based assessments of hearing and language will allow detection of those with impairments. It may be better to focus on parent, school, and pediatrician education.
5. Cost Benefit / Cost Effectiveness  	• Based on the modeling and data presented, universal screening has a low cost-benefit ratio; does not seem to be very cost-effective. • The cost-benefit ratio is not comparable to other newborn screening conditions. • Even with an early diagnosis of cCMV, only a minority of babies with that diagnosis will develop late onset hearing loss. • Much of the cost effectiveness can't be quantified. There is a large emotional cost for families whose baby is diagnosed with cCMV who then are waiting years to find out whether their child will develop late onset hearing loss.

Overall Recommendation



Recommendation Options	Major themes
1. I recommend the Board add universal screening of cCMV to the list of conditions for which all Washington-born newborns must be screened.	*No comments received.*
2. I recommend the Board pursue steps to include targeted screening of cCMV to the list of conditions for which all Washington-born newborns must be screened. Note: this requires a change in the	If the cost-benefit analysis is not sufficient for universal screening at this time, the targeted screening should be a viable option to pursue, especially given that there are clear actions to take once a newborn fails the initial hearing test. Outside of screening, education and awareness for CMV should be considered as a low-cost 'win' in order to combat this important issue.

Board's statutory authority via legislation.	
3. I do not recommend the Board add cCMV to the list of conditions for which all Washington-born newborns must be screened.	*No votes or comments received.*
4. At this time, I do not recommend the Board add cCMV to the list of conditions for which all Washington-born newborns must be screened; I recommend the Board revisit cCMV screening at a future date.	• Once the technology allows for better sensitivity in blood spot testing, or urine screening becomes a viable option, the Board should revisit this topic. • The Board should continue to follow the data on the benefit of antiviral treatment for children identified with cCMV. • Recommend getting more data from states that have implemented the targeted program and take some of their learnings as well as more studies that are published. • Would support a universal screening option where positive results indicated more close monitoring of speech and language development in a primary care setting, and referral to audiologist would be reserved for those where concerns were present. • Recommend revisiting cCMV when it is included in the RUSP. • Highlighting the need for more awareness and resources on the early childhood detection of hearing loss, as well as the need for more research and advocacy for the prevention of cCMV. • Some concerns that were raised about impact on learning potential and education may be more reflective of other fractured systems; daycares and schools need to be involved for late onset hearing loss. • Need to discuss the availability of prenatal testing, OBGYN education, more training and availability for pediatric audiologists, and vaccination efforts.

Washington State Board of Health

PROCESS TO EVALUATE CONDITIONS FOR INCLUSION IN THE REQUIRED NEWBORN SCREENING PANEL

The Washington State Board of Health has the duty under RCW 70.83.050 to define and adopt rules for screening Washington-born infants for heritable conditions. Chapter 246-650-020 WAC lists conditions for which all newborns must be screened. Members of the public, staff at Department of Health, and/or Board members can request that the Board review a particular condition for possible inclusion in the NBS panel. In order to determine which conditions to include in the newborn screening panel, the Board convenes an advisory committee to evaluate candidate conditions using guiding principles and an established set of criteria.

The following is a description of the Qualifying Assumption, Guiding Principles, and Criteria which the Board has approved in order to evaluate conditions for possible inclusion in the newborn screening panel. The Washington State Board of Health and Department of Health apply the qualifying assumption. The Board appointed Advisory Committee applies the following three guiding principles and evaluates the five criteria in order to make recommendations to the Board on which condition(s) to include in the state's required NBS panel.

QUALIFYING ASSUMPTION

Before an advisory committee is convened to review a candidate condition against the Board's five newborn screening requirements, a preliminary review should be done to determine whether there is sufficient scientific evidence available to apply the criteria for inclusion.

THREE GUIDING PRINCIPLES

Three guiding principles govern all aspects of the evaluation of a candidate condition for possible inclusion in the NBS panel.

- Decision to add a screening test should be driven by evidence. For example, test reliability and available treatment have been scientifically evaluated, and those treatments can improve health outcomes for affected children.
- All children who screen positive should have reasonable access to diagnostic and treatment services.
- Benefits of screening for the disease/condition should outweigh harm to families, children and society.

CRITERIA

1. **Available Screening Technology:** Sensitive, specific and timely tests are available that can be adapted to mass screening.
2. **Diagnostic Testing and Treatment Available:** Accurate diagnostic tests, medical expertise, and effective treatment are available for evaluation and care of all infants identified with the condition.
3. **Prevention Potential and Medical Rationale:** The newborn identification of the condition allows early diagnosis and intervention. Important considerations:
    - There is sufficient time between birth and onset of irreversible harm to allow for diagnosis and intervention.
    - The benefits of detecting and treating early onset forms of the condition (within one year of life) balance the impact of detecting late onset forms of the condition.
    - Newborn screening is not appropriate for conditions that only present in adulthood.
4. **Public Health Rationale:** Nature of the condition justifies population-based screening rather than risk-based screening or other approaches.
5. **Cost-benefit/Cost-effectiveness:** The outcomes outweigh the costs of screening. All outcomes, both positive and negative, need to be considered in the analysis. Important considerations to be included in economic analyses include:
    - The prevalence of the condition among newborns.
    - The positive and negative predictive values of the screening and diagnostic tests.
    - Variability of clinical presentation by those who have the condition.
    - The impact of ambiguous results. For example the emotional and economic impact on the family and medical system.
    - Adverse effects or unintended consequences of screening.

WASHINGTON STATE
BOARD OF HEALTH

RCW 70.83.030

Report of positive test to department of health.

Laboratories, attending physicians, hospital administrators, or other persons performing or requesting the performance of tests for phenylketonuria shall report to the department of health all positive tests. The state board of health by rule shall, when it deems appropriate, require that positive tests for other heritable and metabolic disorders covered by this chapter be reported to the state department of health by such persons or agencies requesting or performing such tests.

[1991 c 3 § 349; 1979 c 141 § 113; 1967 c 82 § 3.]

RCW 70.83.050

Rules and regulations to be adopted by state board of health.

The state board of health shall adopt rules and regulations necessary to carry out the intent of this chapter.

[1967 c 82 § 5.]

RCW 70.83.020

Screening tests of newborn infants.

(1) It shall be the duty of the department of health to require screening tests of all newborn infants born in any setting. Each hospital or health care provider attending a birth outside of a hospital shall collect and submit a sample blood specimen for all newborns no more than forty-eight hours following birth. The department of health shall conduct screening tests of samples for the detection of phenylketonuria and other heritable or metabolic disorders leading to intellectual disabilities or physical defects as defined by the state board of health: PROVIDED, That no such tests shall be given to any newborn infant whose parents or guardian object thereto on the grounds that such tests conflict with their religious tenets and practices.

(2) The sample required in subsection (1) of this section must be received by the department [of health] within seventy-two hours of the collection of the sample, excluding any day that the Washington state public health laboratory is closed.

[2014 c 18 § 1; 2010 c 94 § 18; 1991 c 3 § 348; 1975-'76 2nd ex.s. c 27 § 1; 1967 c 82 § 2.]