

Background on 2024 State Health Report Proposed Topics

Staff worked with State Board of Health (Board) Members to identify potential topics to include in its next State Health Report. Topics of interest identified for the report include:

- Maternal and Pregnant Person Health
- Health Justice and Culturally Appropriate Care
- Data Equity
- Substance Use, Prevention, Treatment, and Response
- Environmental Justice and Climate Change
- School Environmental Health and Safety
- Continuing Investments in the Public Health System (Foundational Public Health Services or FPHS)

These topics were selected based on:

- 1) [The Board's authority granted by the Legislature](#),
- 2) [Health Impact Reviews \(HIRs\)](#) completed by Board staff,
- 3) Past State Health Report topics and recommendations,
- 4) Feedback and interests that Board Members, interested parties, and community members expressed during Board rulemaking projects and related work.

The Board recently convened two panels, one in November 2023 focusing on Environmental Justice and Climate Change and another in January 2024 focusing on Indoor Air Quality. Materials for these panels are available on [the Board's meeting webpage](#).

The Board's next two panels will focus on Maternal and Pregnant Person Health, Health Justice and Culturally Appropriate Care, Substance Use, and Data Equity.

This handout includes brief definitions of these topics and background on the Board's authority and work in these areas.

Please note that this information has been compiled by Board staff and is meant to provide a high-level educational overview of these topics. It does not represent the Board's position or understanding of these topics.

Maternal and Pregnant Person Health

Why this topic?

The term "maternal health" typically refers to a person's physical, mental, emotional, and social health and well-being before, during, and after pregnancy.^{1,2} However, as our understanding of the social determinants of health and their impacts on population health have evolved, the definition of maternal health shouldn't be limited to a particular

stage of life. An example of a framework that looks at maternal health more holistically is the life course or life cycle framework.

A life-course framework considers the impact that biological, social, environmental, and behavioral risk and protective factors have on an individual's health throughout their lifetime and how they interact and can contribute to health inequities across generations.^{3,4} A life course framework considers the broad range of factors that impact a person's health. It also acknowledges that maternal, infant, and community health are intertwined. Supporting and promoting maternal health provides a strong foundation for population health.

While the Board's authority is limited to certain areas within maternal and pregnant person health, it is also charged with providing statewide leadership in developing and promoting policies that improve population health in Washington.

The Washington State Board of Health is part of Washington's Governmental Public Health System. Maternal, Child, and Family Health (MCFH) is a core service (or foundational program) within Foundational Public Health Services (FPHS).⁵ MCFH is an essential public health service that must be provided to all residents in Washington, and it is a shared state and local responsibility. The Board's role in the system is specific to specifying the list of conditions for the screening of congenital disorders.⁵ However, as a partner in the governmental public health system, it's important to acknowledge that the Board's role may extend beyond this (e.g., making policy recommendations, supporting state and local partners in their work, and completing Health Impact Reviews on legislation related to this topic).

Key Items to Highlight on this Topic:

- The Board's specific authority related to this topic includes:
 - Defining and adopting rules for testing all newborns in Washington for rare but treatable congenital disorders ([RCW 70.83.050](#)). These rules are under [Chapter 246-650 WAC](#).
 - Adopting rules to establish standards, criteria, and timelines for screening and diagnostic tests for prenatal diagnosis of congenital disorders during pregnancy (RCW 48.21.244) (RCW 48.44.344) (RCW 48.46.375). The Board's rules also establish the standards that certain health insurance providers must follow when determining the medical necessity of screenings and diagnostic procedures. These rules are under [Chapter 246-680 WAC](#).
- Between 2018 and 2024, Board staff have completed five Health Impact Reviews (HIRs) related to maternal and pregnant person health.
- In 2018, Substitute Senate Bill 6219 (SSB 6219) directed the Governor's Interagency Council on Health Disparities (Council) [to conduct a literature review](#) on disparities in access to reproductive healthcare in Washington State and to propose recommendations to reduce those disparities. Board Staff, specifically

the Health Policy Analyst team, led this research on behalf of the Council. The literature review identified 45 unique barriers to reproductive health access in Washington, grouped into three categories: Economic, Structural, or Social. The final report included 14 recommendations and was informed by the literature review findings, conversations with key informants, and reports authored by state agencies and community-based organizations.

Health Justice and Culturally Appropriate Care

Why this topic?

The term health justice builds on the concepts of health equity and social justice. It is broadly defined as “both a community-led movement for power building and transformational change and a community-oriented framework for health law scholarship.”⁶ Health justice focuses on the role that systemic factors, such as laws, policies, and institutions, play in creating, perpetuating, and dismantling health inequities within the healthcare and public health systems, and beyond. Health justice aims to recognize and build the power of individuals and communities directly impacted by health inequities to create and sustain conditions that support health and justice.^{6,7}

Examples of conditions and factors contributing to health inequities and preventing progress toward health justice include barriers to providing and accessing culturally and linguistically appropriate services (CLAS). The goal of CLAS is to provide effective, equitable, understandable, and respectful quality care and services that are responsive to a person’s diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.^{8,9} Research has revealed the persistent gap in the provision of culturally and linguistically appropriate care and the impact it has on equity and health outcomes.^{10,11} For example, the lack of culturally and linguistically appropriate care in the U.S. impacts the quality of care delivery for patients with limited English proficiency (LEP) by increasing time to treatment, reducing the quality of patient-provider communication, and increasing the length of hospitalization stays.^{12–14}

The Board has the authority to serve as a public forum for policy and rulemaking development. The Board has also committed to promoting health equity and addressing racism as a public health crisis. The topics of health justice and promoting culturally and linguistically appropriate services are foundational to these efforts. Additionally, while health justice and culturally appropriate care are not explicitly core programs or foundational capabilities within FPHS, they are integral to providing and supporting foundational public health services across Washington.

Key Items to Highlight on this Topic:

- While the Board doesn’t have explicit statutory authority related to health justice or culturally appropriate care, these topics are integral to our work. To meaningfully engage communities and ensure they are involved in this work,

particularly those who historically have been institutionally underserved and are disproportionately impacted by social determinants of health, the Board must work to remove systemic barriers to participation. This includes, but is not limited to:

- Providing critical and timely public health information in culturally and linguistically appropriate formats,
 - Creating materials that are easy to understand,
 - Offering translation and interpretation support for meetings,
 - Having materials developed in alternative formats,
 - Identifying and creating meeting spaces that are accessible to community members.
- The U.S. Department of Health and Human Services' Office of Minority Health (OMH) developed national [CLAS Standards](#) to advance health equity, improve quality of services, and work toward eliminating health disparities. Any organization or agency can implement CLAS Standards to provide responsive services to the diverse population it serves. The Council was the first state entity to initiate work on language access in Washington [and make recommendations to agencies](#) for adopting CLAS standards in their work. The Council has also developed [training and resources](#) for agencies to learn about CLAS standards.
 - [The Board's 2022 State Health Report](#) had several recommendations related to health justice and culturally appropriate care. These recommendations included removing barriers to health care insurance and improving access to culturally and linguistically appropriate health services.

Data Equity

Why this topic?

Data is an essential component of public health. Public health programs, their funders, program managers, and community partners all rely on data to make decisions about where resources are needed and should be allocated. However, to be a useful tool, data must accurately reflect communities and incorporate considerations of personal data privacy, data sovereignty, and prevent the misuse and misrepresentation of data that can cause harm to communities and individuals.

Data equity can be broadly defined as “a set of principles and practices to guide anyone who works with data...to use a lens of justice, equity, and inclusivity.”¹⁵ This equity lens should be applied when considering data collection, interpretation, distribution, and sharing.^{15,16} It also challenges people and programs working with these data to consider the ways in which data can create and reinforce stereotypes, create stigma, exacerbate existing systemic inequities, or otherwise create harm, even if unintentional.

Data, specifically disaggregated data, are essential to achieving health equity. Disaggregated data can be broken down and analyzed by key demographic categories

such as age, race, ethnicity, sex, gender, disability, income, and veteran status.¹⁷ Disaggregated data can also reveal inequities across and within groups and are instrumental for public health efforts to prevent and control diseases and conditions. These data also offer clearer indicators of community health and well-being, provide perspective into who is accessing public health programs, and whether services reach institutionally underserved or underrepresented communities.

Data are fundamental to making visible the longstanding inequities in the health care and public health system and their impacts on communities, particularly Black and Indigenous communities, and communities of color. Collecting these data in greater detail is essential to identifying and eliminating health inequities, undoing institutional racism, and advancing equity within public health and the broader governmental system. In addition, respect must be given to Tribal sovereignty, including data sovereignty. Tribes are sovereign nations that own the rights to their own stories and data. Governmental entities may only collect Tribal data with Tribal approval, consultation, and guidance.

While data equity and data disaggregation are not explicitly named as core programs or foundational capabilities within FPHS, data are a foundational component across all core programs and capabilities within Foundational Public Health Services (FPHS), from vital records and communicable diseases to assessment and policy development. Public health services cannot be effective without disaggregated data. Additionally, disaggregated data allows public health and governmental entities to provide more tailored, culturally relevant, linguistically appropriate, and effective services to communities. The Board's statutory authority is limited to certain areas within data equity, specifically data disaggregation for race, ethnicity, language, and other key demographic reporting in specific Board rules (notifiable conditions and vital statistics). However, as a partner in the governmental public health system, the Board has the opportunity to provide input, support, and recommendations on this topic.

Unfortunately, the governmental public health system is limited in the data it can collect. In many instances, governmental entities must follow federal statistical standards set by the Office of Management and Budget (OMB). This impacts how data can be collected, analyzed, and reported at the state and local levels. 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 for race (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White). OMB does permit additional granularity where it is supported by sample size and if the additional detail can be aggregated back to the minimum standard set of race and ethnicity categories.

Until OMB revises its standards to require the uniform collection of detailed disaggregated data across federal, state, and local public health and governmental

agencies, the Washington governmental public health system will continue to face challenges in achieving data equity and health equity more broadly.

Key Items to Highlight on this Topic:

- The Board's authority related to this topic includes:
 - Adopting rules for the prevention and control of infectious and non-infectious diseases ([RCW 43.20.050\[2\]\[f\]](#)). This includes establishing rules for notifiable conditions in Washington. The Board shares this authority with the Department of Health, which has the authority to establish requirements for some notifiable conditions within [Chapter 246-101 WAC](#).
 - Adopting rules related to the statistical information to be collected on the confidential section of Washington State live birth and fetal death certificates ([RCW 70.58A.020](#)). Specifically, the Board has authority over data items related to birth and the manner of delivery necessary for statistical study ([WAC 246-491-029](#)).
- Recently, the Board adopted revisions to the Notifiable Conditions rule, Chapter 246-101 WAC. As part of the recent revisions, the Board included the requirement for reporting patient-identified race, ethnicity, and preferred language based on community feedback ([WAC 246-101-011](#)). These updated rules went into effect on January 1, 2023, and include 4 reporting categories for the patient's ethnicity (OMB standard plus "patient declined to respond" and "unknown"), 72 reporting categories for the patient's race (categories include and reaggregate to the OMB standard plus "other race", "patient declined to respond", and "unknown"), and 50 categories for the patient's preferred language.
- [The Board's 2022 State Health Report](#) had several recommendations related to the topic of data equity. These recommendations included improving public health's response to health inequities through data reform. In April 2023, the Board and Council submitted comments on the OMB's Initial Proposals for Updating Race and Ethnicity standards ([SPD 15](#)). The OMB Interagency Workgroup are reviewing feedback and comments on the proposal to put together final recommendations for revising OMB's race/ethnicity statistical standards for the Chief Statistician of the U.S. The OMB has a goal to revise SPD 15 by Summer 2024.

Substance Use, Prevention, Treatment, and Response

Why this topic?

Substance use is broadly defined as “the use of selected substances, including alcohol, tobacco products, drugs, inhalants, and other substances that can be consumed, inhaled, injected, or otherwise absorbed into the body.”¹⁸ These substances may also have the potential to cause dependence or other detrimental effects. If recurring substance use becomes harmful to a person's health and well-being and or they are

unable to control or stop their use of these substances, substance use can turn into substance use disorder (SUD). The CDC defines SUD as “a cluster of cognitive, behavioral, and physiological symptoms indicating that [an] individual continues using the substance despite harmful consequences.”¹⁹

According to findings from the most recent National Survey on Drug Use and Health (NSDUH), more than 1 in 6 people in the U.S. aged 12 or older reported having a substance use disorder in the past year (SUD).²⁰ Substance use disorders are a pervasive public health issue in the U.S. and will continue to be until the root causes of the issue are addressed. Social and political determinants of health, such as economic instability, lack of affordable housing, high costs and inaccessibility of health and social services, experiences with systemic racism and generational trauma, and targeted product marketing, are all examples of factors that can contribute to and exacerbate substance use disorders. When discussing the topic of substance use, prevention, treatment, and response, it's essential to look at the topic holistically, and look at the range of conditions and factors that cause individuals to use and rely on substances.

Related to the topic of substance use, the Board's work has primarily focused on preventing the use of tobacco, nicotine, and vapor products (also known as commercial tobacco products), particularly among youth. In addition, the Board has supported policy recommendations related to the opioid crisis in Washington, and Board staff have completed Health Impact Reviews (HIRs) on opioid use disorder and alcohol concentration.

While the topic of substance use, prevention, treatment, and response isn't explicitly a core program or foundational capability within FPHS, it is a component of chronic disease, injury, and violence prevention, which is a core FPHS program. As a foundational program, chronic disease, injury, and violence prevention focuses on data, planning, and coordination of core programming and additional importance services (AIS). Additionally, the emphasis of this core FPHS program is *prevention*.

Key Items to Highlight on this Topic:

- The Board doesn't have explicit statutory authority related to the topic of substance use, prevention, treatment, and response. However, in 2019, the Board was [directed by the Governor's Office](#) to use its emergency rulemaking authority to ban the sale of all vapor products and flavors in Washington during an outbreak of e-cigarette or vaping associated lung injury (EVALI).²¹ The emergency rule went into effect on October 10, 2019, for 120 days. When this emergency rule expired in March 2020, the Board subsequently adopted a second emergency rule but instead of a ban on all vapor products, just those containing vitamin E acetate. This is because vitamin E acetate was identified as the substance in products linked to the EVALI outbreak. The second emergency rule was also in place for 120 days. The Board then directed staff to begin the permanent rulemaking process to permanently ban vitamin E from all vapor

products in WA. This rule, [WAC 246-80-012](#), was implemented by LCB in collaboration with the Board.

- Between 2018 and 2024, Board staff have completed twelve Health Impact Reviews (HIRs) related to substance use. One of the HIRs was on Engrossed House Bill 1074 (Chapter 15, Laws of 2019) which raised the minimum age of purchase for tobacco and vapor products in Washington to 21 years (also known as Tobacco 21).
- [The Board's 2022 State Health Report](#) included a recommendation to decrease youth use of tobacco, nicotine, and vapor products (also known as commercial tobacco products). Since its 2018 State Health Report, the Board has included a recommendation related to decreasing the use of commercial tobacco products. Past reports have also included recommendations related to addressing the opioid crisis in Washington.

To request this document in an alternate format or a different language, please contact the Washington State Board of Health at 360-236-4110
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Requests can be made by email at wsboh@sboh.wa.gov



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