WASHINGTON STATE BOARD OF HEALTH

Notice of Public Meeting

Wednesday, June 12, 2024, 9:30 a.m. – 4:40 p.m.
Physical meeting location:
Heathman Lodge
7801 NE Greenwood Drive
Vancouver, WA 98662
Meeting Rooms: Chinook & Klickitat
Virtual meeting: ZOOM Webinar
(hyperlink provided below)
Language interpretation available

Final Agenda

Time	Agenda Item	Speaker
9:30 a.m.	Call to Order & Introductions	Patty Hayes, Board Chair
9:35 a.m.	1. Approval of Agenda – Possible Action	Patty Hayes, Board Chair
9:40 a.m.	2. Approval of April 10, 2024, Minutes – Possible Action	Patty Hayes, Board Chair
9:45 a.m.	3. 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.
10:05 a.m.	4. Announcements and Board Business	Michelle Davis, Board Executive Director
10:25 a.m.	5. Department of Health Update, (Tentative Agency Request Legislation)	Michael Ellsworth, Secretary's Designee, Department of Health Kelly Cooper, Department of Health
10:45 a.m.	6. Clark County Public Health	Dr. Alan Melnick, Director of Public Health Clark County Staff (TBD)
11:10 a.m.	Break	
11:25 a.m.	7. Rules Briefing – Chapter 246-290 WAC, Group A Public Water Supplies, Implementing the EPA's published PFAS standards -Possible Action	Kate Dean, Board Member Shay Bauman, Board Staff Mike Means, Department of Health

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11:55 a.m.	8. Update - Delegated Rulemaking – Engrossed Second Substitute House Bill (E2SHB) 1181, Climate Resilience in Water System Plans, Group A Public Water Supplies, Chapter 246-290-100 WAC	Kate Dean, Board Member Shay Bauman, Board Staff Mike Means, Department of Health
12:10 p.m.	Lunch	
1:30 p.m.	9. Rules Hearing – Abbreviated Rulemaking, Handling of Human Remains Chapter 246-500 WAC Implementing Changes from Substitute House Bill (SHB) 1974 – Public Testimony – Possible Action	Patty Hayes, Board Chair Shay Bauman, Board Staff
2:00 p.m.	10. 2024 State Health Report – Possible Action	Mindy Flores, Board Member Molly Dinardo, Board Staff Hannah Haag, Board Staff
2:20 p.m.	11. School Environmental Health and Safety- Extend Effective Date of Chapter 246-366A WAC – Possible Action	Patty Hayes, Board Chair Andrew Kamali, Board Staff
2:35 p.m.	12. School Rules Review Project	Patty Hayes, Board Chair Andrew Kamali, Board Staff
2:55 p.m.	13. Request for Delegated Rulemaking Authority, Minor Administrative Updates to Immunization Rules, WAC 246-105-040 and 060 – Possible Action	Dimyana Abdelmalek, Board Member Molly Dinardo, Board Staff Meghan Cichy, Department of Health Katherine Graff, Department of Health

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Time	Agenda Item	Speaker
3:15 p.m.	Break	
3:30 p.m.	14. Rules Update – Sanitary Control of Shellfish, Chapter 246-282 WAC	Patty Hayes, Board Chair Shay Bauman, Board Staff Dani Toepelt, Department of Health
4:05 p.m.	15. Possible Schedule Change, July and August Board Meetings – Possible Action	Michelle Davis, Executive Director
4:10 p.m.	16. Petition for Rulemaking – Chapter 246-260-131 WAC, Operation of Water Recreation Facilities – Possible Action	Patty Hayes, Board Chair Andrew Kamali, Board Staff
4:25 p.m.	17. Board Member Comments and Updates	
4:40 p.m.	Adjournment	

- **To access the meeting online and to register:**
  https://us02web.zoom.us/webinar/register/WN_vifXql9mSCGxcB06RcHI0Q
- **You can also dial-in using your phone for listen-only mode:**
  Call in: +1 (253) 215-8782 (not toll-free)
  Webinar ID: 864 1850 4523
  Passcode: 682856

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Important Meeting Information to Know:

- Times are estimates only. We reserve the right to alter the order of the agenda.
- Every effort will be made to provide Spanish interpretation, American Sign Language (ASL), and/or Communication Access Real-time Transcription (CART) services. Should you need confirmation of these services, please email wsboh@sboh.wa.gov in advance of the meeting date.
- If you would like meeting materials in an alternate format or a different language, or if you are a person living with a disability and need reasonable modification, please contact the State Board of Health at (360) 236-4110 or by email wsboh@sboh.wa.gov. Please make your request as soon as possible to help us meet your needs. Some requests may take longer than two weeks to fulfill. TTY users can dial 711.

Information About Giving Verbal Public Comment at Hybrid Meetings:

- Individuals may give verbal public comments at the meeting, in-person or virtually, during the public comment period.
- The amount of time allotted to each person will depend on the number of speakers present (typically 1 to 3 minutes per person). We will first call on those who have signed up in advance.
- Sign up **by 12:00 Noon the day before a meeting** to participate in the public comment period:
    - Email the Board or
    - Register through the **Zoom webinar link. The Zoom webinar link is in the meeting agenda located on the** Meeting Information webpage**.**
    - If you are **attending the meeting in person** and did not sign up in advance, you may write your name on the sign-in sheet to provide comments if time allows.

Information About Giving Written Public Comment:

- Please visit the Board's Public Comment webpage for details.

WASHINGTON STATE BOARD OF HEALTH

Draft Minutes of the State Board of Health
April 10, 2024
Hybrid Meeting
ASL (or CART) and Spanish interpretation available
Spokane Public Library
906 W. Main Ave, Spokane, WA, 99201
Rooms: Central Events A & B
Virtual meeting: ZOOM Webinar

State Board of Health Members present:

Patty Hayes, RN, MSN, Chair
Kelly Oshiro, JD, Vice Chair
Stephen Kutz, BSN, MPH
Kate Dean, MPA
Dimyana Abdelmalek, MD, MPH
Scott Lindquist, MD, MPH, Secretary's Designee
Michael Ellsworth, JD, MPA, Secretary's Designee
Socia Love, MD
Paj Nandi, MPH

State Board of Health Members absent:

Umair A. Shah, MD, MPH
Mindy Flores, MHCM (unable to connect virtually due to technical difficulties)

State Board of Health staff present:

Michelle Davis, Executive Director
Melanie Hisaw, Executive Assistant
Michelle Larson, Communications Manager
Anna Burns, Communications Consultant
Heather Carawan, Communications Consultant
Molly Dinardo, Health Policy Advisor
Shay Bauman, Health Policy Advisor
Jo-Ann Huynh, Administrative Assistant
Lilia Lopez, Assistant Attorney General
Ashley Bell, Equity & Engagement Manager

Guests and other participants:

Scott Lindquist, Department of Health
Kelly Cooper, Department of Health
Toni Lodge, Chief Executive Officer, NATIVE Project
Joseph Hunter, Recovery Coach Network Manager, Thriving Together North Central Washington
Kim Wilson, Community Health Worker Training Project Director, Better Health Together
Anastacia Lee, Board Member, Asians for Collective Liberation
Desiree Crawford, Infant and Child Support Specialist, Health Justice Recovery Alliance

Patty Hayes, Board Chair, called the public meeting to order at 9:38 a.m. and read from a prepared statement (on file). Board Members gave introductions and Michelle Davis, Board Executive Director, provided a land acknowledgement.

1. **APPROVAL OF AGENDA**
   Motion: Approve April 10, 2024 agenda
   Motion/Second: Member Kutz/Member Dean. Approved unanimously.

2. **ADOPTION OF MARCH 13, 2024 MEETING MINUTES**
   Motion: Approve the March 13, 2024 minutes
   Motion/Second: Member Dean/Member Abdelmalek. Minutes approved as corrected. Approved unanimously.

3. **PUBLIC COMMENT**
   Patty Hayes, Board Chair opened the meeting for public comment and read from a prepared statement (on file).

   Jim Sledge, former Board Member and retired Spokane dentist, thanked the Board for continued support for two of the most successful public health measures; vaccinations and community water fluoridation. J. Sledge said over 80 years of studies show the effectiveness and safety of fluoride and ¾ of the U.S. population consumes community fluoridated drinking water. J. Sledge said the Environmental Protection Agency has recent rigorous reviews that demonstrate the safety. J. Sledge hopes Spokane will add fluoridated water.

   Melissa Leady talked about obesity rates rising and that current data by the state on this issue has not been updated since 2016. M. Leady said it is a disservice to the communities affected. M. Leady said issues like this should be considered in the Pro-Equity Anti-Racism plan. M. Leady referenced a study that shows states that impose vaccine mandates have significantly lower vaccination rates. M. Leady voiced support for comments saying there is an abundance of research showing fluoride lowers IQ and has other health hazards.

   Natalie Chavez talked about a COVID-19 related court case and considered it a big win for transparency. N. Chavez said a Centers for Disease Control and Prevention (CDC) app allowed people to self-report and in January 2024 a judge ordered CDC to release the data. N. Chavez said it was horrifying, 3,200 entries mentioned shortness of breath, reports of heart palpitation and arrhythmia (symptoms of myocarditis), and ringing of the ears. N. Chavez said the CDC court-ordered release can be found at Icandecide.org.

   Gerald Braude, Jefferson County, talked about a study showing that the Vaccine Adverse Event Reporting System (VAERS) detects less than 1% of vaccine injuries. G. Braude said that VAERS has on record over 7,000 deaths following COVID-19 shots with over 200 in Washington. G. Braude gave examples of death from blood clotting and aortic complications and asked Board Members to look into their hearts and ask about the 200+ deaths in Washington.

Lisa Templeton, Informed Choice Washington, talked about the presenters at the March Board meeting from the Tubman Center for Health & Freedom. L. Templeton talked about their development of the center, cultivating of the garden, natural lighting, connection, and recognition of wellness. L. Templeton talked about the Center honoring each patient in charge of their own bodies, and how they trust their patients to make the best decisions for their health. L. Templeton said each of us has an ancestry of our health and healing. L. Templeton said people everywhere deserve access to the healing modalities that have stood the test of time.

Elisabeth Warder, dentist in Spokane and Cheney, works at a community health center. Elisabeth has seen firsthand the terrible disease of dental health, saying that water fluoridation can help prevent it. E. Warder said Cheney, WA provides water fluoridation and has seen much better dental health in Cheney than in Spokane. E. Warder said there is a preponderous of evidence that shows that systemic use of fluoride is effective and critical to preventing dental decay and making teeth stronger.

4. BOARD ANNOUNCEMENTS AND OTHER BUSINESS

Michelle Davis, Board Executive Director, welcomed Heather Carawan, the Board's newest Communications Consultant and final Foundational Public Health Services (FPHS) funded position for this fiscal year. Executive Director Davis provided additional work updates, including the approaching review of school environmental health and safety rules and branched-chain keto acid dehydrogenase kinase (BCKDK) newborn screening. The Board will hire five additional staff for the school review and one additional staff for newborn screening. The newborn screening staff member will also lend support to the review of the newborn screening process criteria and congenital cytomegalovirus (cCMV). Executive Director Davis informed the Board that the report for the BCKDK review is due to the legislature in June 2025 and cCMV is due December 2025. Executive Director Davis is working on the position development and postings, intending to hire by June 1 to use the unspent FPHS budget.

Executive Director Davis shared the Health Disparities Council (Council) received new funding this legislative session, and that it is the first additional funding the Council has received since its creation. Executive Director Davis explained that this will allow the Council to hire staff for community engagement, policy development, and other needs, which was previously supplemented as needed by Board staff. Executive Director Davis shared the positions that the Council will hire and that they are posted.

Executive Director Davis shared the Health Impact Review (HIR) team's interim plans. The interim plans include meeting with legislators who have requested HIRs to get feedback on results and processes, discussing potential interim requests with legislators, and updating outreach materials and methods. Executive Director Davis shared sponsorship updates for the HIR staff and informed the Board that the team will provide members with an annual update in August.

Executive Director Davis noted that the petition denial regarding the request to review WAC 246-290-220 from the March Board meeting is in their packets.

Steve Kutz, Board Member, expressed support for hiring additional staff to review the school rules and asked what skillset and qualifications the Board requires for the review.

Executive Director Davis responded that there are four elements to the proviso. The four elements include convening a technical advisory committee to review WAC 246-266 and WAC 246-366A; conducting an environmental justice assessment in coordination with the Department of Health (Department); working with the Office of Superintendent of Public Instruction (OSPI) to conduct a fiscal assessment of the costs of proposed changes to Washington schools; and assembling findings and recommendations into a report. Executive Director Davis shared that these tasks and the short timeframe require skill in time management, literature reviews, convening diverse groups of people and ideas, close attention to detail, and the ability to identify what schools need. Executive Director Davis asked Board Members to share the position postings across their networks and inform staff of any experts they may know that can help in the review.

Member Kutz commented that it would be helpful to have a briefing on the rule and review requirements. Executive Director Davis responded that it is a priority to keep the Board Members informed and that this will likely be a standing item at most meetings going forward.

Kate Dean, Board Member, shared that the Environmental Protection Agency (EPA) released new standards for per- and polyfluoroalkyl substances (PFAS) and asked what the timeline might look like for a state rulemaking process. Executive Director Davis responded that PFAS standards are Board rule, and we would have to look at what the standards are, then bring a briefing in front of the Board to discuss the next steps. Executive Director Davis shared that it will likely be brought up first in the Environmental Health committee meeting. Member Dean shared that the new standards are more stringent than Washington's current standards, so it will be important to take a deeper look.

Patty Hayes, Board Chair, asked whether Executive Director Davis could arrange for the Chair of the Health Disparities Council to join the Board at its October meeting and provide a briefing. Chair Hayes stated that with the amount of rule work the Board is doing and the new investment in the Council, it is important for the Board to lend support, stay in sync, and stay briefed.

Member Kutz stated concerns regarding PFAS and shared about often forgotten military contamination sites. Member Kutz asked whether there is a database of these contamination sites and whether they were being monitored to hold those accountable responsible. Executive Director Davis responded that the Department of Health (Department) has done PFAS monitoring across the state and has provided a map to Board Members at a previous meeting. Executive Director Davis shared that staff could raise the question with the Department and come back another time to discuss drinking water monitoring. Member Kutz shared that the abundance of water in Washington necessitates the proper thinking.

Scott Lindquist, Secretary's Designee, commented that there are known monitoring sites around, and shared that as a former health officer, Member Lindquist knew where

every site was located within the county. Member Lindquist highlighted the need for an informed answer that utilizes experts so that the Board can make an informed decision.

5. NATIVE Project

Patty Hayes, Board Chair, introduced Toni Lodge, the Chief Executive Officer (CEO) of the NATIVE Project, including information on Executive Director Lodge's background and the mission statement of the NATIVE Project.

Toni Lodge, CEO of the NATIVE Project, thanked the Board, gave a land acknowledgment, and shared that Spokane has been a gathering place for Urban Native people for hundreds of years. Executive Officer Lodge also acknowledged Member Steve Kutz as their elder and asked permission to speak. Executive Officer Lodge shared more about the NATIVE Project's mission statement, talked about their logo, and explained the logo is the organization's representation of the medicine wheel. Executive Officer Lodge then provided an overview of what the NATIVE Project does as a non-profit organization and clarified that when discussing health care delivery for Native people, this encompasses Indian Health Services, Tribal Health Services, and Urban Health Services, also known as the ITU system of care.

Executive Officer Lodge shared background on the genesis of the NATIVE Project, including a timeline of the organization from 1989 to 2022. Executive Officer Lodge also noted that Spokane has the eighth largest Urban Indian community in the United States and that the Urban Native people of Spokane ended up in this area due to federal policy (the Relocation Act). Executive Officer Lodge mentioned that in 2022, the NATIVE Project started to break ground on a new Children and Youth Services and Treatment Center and raised concern that a brewery was recently permitted to be built next to the center.

Executive Officer Lodge then provided an overview of the communities that the organization serves, including about 25,000 American Indian people from over 300 Tribes. Executive Director Lodge briefly touched on the definition of Native people outlined in Title 25 of the Affordable Care Act (ACA), which outlines a comprehensive definition of who is considered Native and brought attention to the issue of "genocide by data." Executive Officer Lodge emphasized that Native people are often erased, undercounted, or not counted at all in Census and other population data, and most data do not do a good job of capturing who Native people are. Executive Officer Lodge also shared more about who the NATIVE Project serves and the types of services provided.

Executive Officer Lodge pointed out pressing health inequities in the Native community in Spokane, such as declines in life expectancy during COVID-19 and Native children losing caregivers at a higher number than any other community group during the pandemic. Executive Officer Lodge underscored the importance of public policy in addressing these inequities and stated that connection to culture can be part of the cure for many communities and that we need to be able to pay for cultural support across all communities. Executive Officer Lodge then outlined areas where the NATIVE Project is going next, a wish list of items for the Board to consider moving forward, and how they can support Native communities and the NATIVE Project (see presentation on file).

Steve Kutz, Board Member, commented on the ITU system's challenges regarding funding. Member Kutz noted that the federal government funds the Indian Health System to meet roughly 38% of the needed funding.

Kate Dean, Board Member, thanked Executive Officer Lodge for the presentation and asked how the NATIVE Project addresses different approaches to culturally appropriate care across the 300 Tribes it serves in Spokane.

Executive Officer Lodge noted that this is a question their team gets frequently and that using a patient-centered model, which the NATIVE Project utilizes, forces providers to slow down during consultations and learn more about the individual, their Tribe, their practices, and their care goals and needs. Executive Officer Lodge emphasized that there isn't a one-size-fits-all model and that they have staff at the organization to work with patients to develop individualized cultural care plans.

Socia Love, Board Member, praised Executive Officer Lodge's presentation and noted that it laid a great foundation for educating people on the history of the NATIVE Project and the ITU system of care. Member Love also appreciated that Executive Officer Lodge emphasized that state agencies and other entities must be inclusive in their legislative or policy language around the full gamut of care that Washingtonians receive from Tribal, Urban, and Indian Health Services. Member Love concluded by expressing excitement about the NATIVE Project's focus on youth and children and that the Board continues to explore maternal and child health as a topic of interest.

Paj Nandi, Board Member, thanked Executive Officer Lodge and appreciated the reminder that culture is prevention. Member Nandi stated that providing culturally responsive care should be part of reimbursement mechanisms in the health care system. Member Nandi emphasized that the Board should be doing more, given its authority and sphere of influence, to work with state agencies and other partners on this issue and other topics that Executive Officer Lodge highlighted at the end of the presentation. Member Nandi said that these issues are not new to the Board and that the Board is aware of the inequities in Native communities due to racism, marginalization, and cultural erasure, and honored and acknowledged everything that Executive Officer Lodge shared.

Chair Hayes expressed gratitude to Executive Officer Lodge and acknowledged that integrating traditional medicine practices into health care and the need for reimbursement has come up several times at recent Board meetings. Chair Hayes said that the Board needs to see how they can elevate this. Chair Hayes noted that the Board may seek the NATIVE Project's advice on framing recommendations related to this topic for its next State Health Report.

Member Kutz stated that Tribes have been working on the issue of integrating traditional medicine into Medicaid reimbursements at the national level for quite some time. Member Kutz said that Washington Tribes could put in a Medicaid waiver to the Centers for Medicare and Medicaid Services (CMS). Member Kutz also recognized that Tribal governments have this ability, while Urban Native communities do not, and that Tribal governments should support Urban Native communities in any way they can.

Member Dean asked if each Tribe needs to consult individually with CMS.

Member Kutz responded that one Tribe can call for consultation, and other Tribes can join as interested. Member Kutz added that this consultation would be with the Washington Health Care Authority (HCA) since they are the agency responsible for submitting Medicaid waivers to CMS. The hope is to put together a workgroup to work on this issue.

Chair Hayes noted that the Board could potentially highlight the need for HCA to submit a Medicaid waiver requesting this coverage in its State Health Report.

Member Kutz added that Tribes are not the only people who use traditional medicine or want it incorporated into their care, and if Tribes move this work forward, it could hopefully pave the way for other communities to do the same.

Executive Officer Lodge said that Member Dean brought up a good point and reminded Board Members of the "three Cs" for working with Tribes and Urban Native communities. Tribes get consultation, Urban Natives get confers, and all should get communications. Executive Officer Lodge said from a policy position if you want to talk to someone or get feedback, this is how you do it.

The Board took a break at 11:20 a.m. and reconvened at 11:30 a.m.

6. DEPARTMENT OF HEALTH UPDATE

Scott Lindquist, Secretary's Designee, provided an update from the Department of Health (Department) regarding their work on respiratory diseases and the Vaccine Adverse Event Reporting System (VAERS) (see presentation on file).

Kelly Cooper, Department of Health, provided an update regarding the Department and key partners' legislative outcomes from the 2024 legislative session (see presentation on file).

Steve Kutz, Board Member, spoke about how many people who have been vaccinated with the COVID-19 vaccine have also had COVID-19. Member Kutz asked about the Center for Disease Control's (CDC) process for understanding adverse events as a result of the vaccine versus the disease through the VAERS. Member Kutz also asked about the potential confounding effects of long-term COVID. Member Lindquist said that the CDC compares the signals for vaccine-associated deaths and deaths in the non-vaccinated population. They found that there was a higher rate of deaths as a result of COVID-19 in the non-vaccinated population than the rate of COVID-19 vaccine-associated deaths. Member Lindquist said that the effect of long-term COVID on this analysis is more difficult to parse out. Member Lindquist said that with more data, the VAERS will help public health practitioners better understand the effects of the vaccine, COVID-19, and their mixed effects, as well as to identify early signals.

Member Kutz then spoke about the need for contact tracing and expedited treatment for syphilis cases in primary care settings, not just public health. Member Lindquist agreed.

Dimyana Abdelmalek, Board Member, thanked Member Lindquist for the presentation. Member Abdelmalek praised the VAERS for its ability to capture such a wide range of inputs. Member Abdelmalek asked how much capacity is required to understand this data set. Member Lindquist said that there is a massive team working on this at the federal level and that the COVID-19 vaccine is the most extensively studied vaccine in the history of the United States.

Kate Dean, Board Member, asked if the avian flu is showing signs of increasing in Washington State. Member Lindquist said that Washington State is in the flight path of birds transmitting highly pathogenic avian flu. Member Lindquist said that the Department has seen this disease in domestic birds and commercial flocks, for which they have a monitoring system with the Department of Agriculture. Member Lindquist said the Department has seen this disease in sea mammals, dairy cows, and dairy products in states as close as Idaho. Member Lindquist said that the Department has called for counties to be ready to monitor cattle and to treat exposed persons. Member Lindquist does not encourage consumption of raw milk at this point.

7. **NOTIFIABLE CONDITIONS IMPLEMENTATION UPDATE – CHAPTER 246-101 WAC**
Scott Lindquist, Secretary's Designee, described the law that has a list of diseases that must be reported by physicians, facilities, and labs. Member Lindquist stated that the conditions are the responsibility of the Board and that the information may get complicated, so Board Members are encouraged to ask questions during the presentation. Member Lindquist presented the notifiable conditions WAC and recent changes as of January 1, 2023. Member Lindquist discussed electronic lab reporting and how it is more complete and timelier, and noted they are receiving feedback from laboratories asking why providers and facilities can't do the reporting (see presentation on file).

Steve Kutz, Board Member asked where the ultimate responsibility for the reporting lies.

Member Lindquist stated that timeliness and demographic information reporting are poor, and that labs are the most complete and timely. Member Lindquist said many states have mandated electronic laboratory reporting. Member Lindquist recommended mandating electronic reporting if the Board opens these rules.

Member Kutz asked about mandatory reporting extending beyond the physician. Member Lindquist responded that there is a lot more work to get everyone to report than moving to an electronic system. Data modernization is the direction that this country will go.

Kate Dean, Board Member asked if Member Lindquist could speak to the purpose of collecting information on patient ethnicity, given that both race and ethnicity are constructs. Member Lindquist referenced the earlier discussion on data genocide and the push from advocates to collect information in context. Member Lindquist stated that if you don't understand the difference of diseases in different populations, then you don't understand the impact of that disease and it goes unfunded, unseen, and unprioritized. Epidemiology is looking at a disease in three dimensions, person, place, and time.

Member Dean asked about the modern epidemiological utility of collecting data on ethnicity, given there is also a requirement to collect data on patient race. Member Lindquist does not believe they are the best to answer the question but recommends getting a workgroup together if the Board were to open the rules. Member Lindquist said the workgroup should be diverse (based on ethnicity, race, Native identity, lab directors from around the state, and additional groups) that informs these questions before making recommendations.

Paj Nandi, Board Member, referenced a slide from the presentation (Recent Changes, slide #5) and said that race and ethnicity are distinct terms. When people think about their race and ethnicity, they may also consider cultural expression, preferred language, and place of origin. This is an important conversation and if we don't record this data, then we will miss the knowledge to inform equitable health outcomes. Member Nandi said we need to consider the burden that has been on communities and how communities have been made invisible by a system that wasn't designed to account for them. Member Nandi appreciated the Board for unpacking this.

Member Kutz commented that the way we unpack this is derived by the way the federal government tells us to unpack this. Member Kutz made a point about the way Native Americans have been categorized inappropriately and miscounted based on certain federal data standards. Member Kutz suggested that we won't be allowed to make the system our way, but we can influence the Centers for Disease Control and Prevention (CDC). Member Kutz asked if this was correct.

Member Lindquist said the national notifiable conditions system is not set by CDC, but Council of State and Territorial Epidemiologists (CSTE). We have a different reportable disease system. CTSE is looking to Washington right now. We can and have included a lot more granularity. There is a chance at a state system that sets precedence. Member Lindquist advised a workgroup would be needed.

Patty Hayes, Board Chair, commented on the importance of this conversation and the need for more discussion.

Dimyana Abdelmalek, Board Member, asked about systems that health data are received from. Member Abdelmalek asked about other means beyond basic case reporting.

Member Lindquist answered it's currently up to physicians calling and facilities faxing, and electronic lab reporting. Data modernization will change that. We need to think to the future or we'll get left behind. Member Abdelmalek recognized healthcare providers for their contributions to reporting. From the view of a local health officer, while it takes a lot of effort, it is essential to have the human element of reporting suspect cases. Member Lindquist agreed and shared the first case of anthrax was reported by a provider. Don't undervalue the role, but ask what the role for providers, labs, and facilities is. Member Lindquist recommended the Board establish a workgroup to come up with good recommendations.

Member Lindquist, continued to share that everyone must report A -T on the Completeness of Data slide (#11). Member Lindquist showed a slide on the count of

completeness and that half of the data coming in for the preferred language is missing. Member Lindquist shared they don't have a way to enforce the rule that was put in place by the Board. Member Lindquist recommended changes to conditions, a standard definition of what a notifiable condition is, and electronic reporting. The pandemic is over so many providers are not testing or reporting COVID-19. Member Lindquist showed flu, RSV, and COVID respiratory activity levels and how syndromic surveillance is done. Member Lindquist also showed places in school, childcare, and temporary housing rules that reference notifiable conditions that will need to be cleaned up.

Chair Hayes thanked Member Lindquist. Chair Hayes shared that it was amazing information to think about and have further conversations on.

Member Kutz shared about whether pharmacies reported how much Paxlovid was dispensed, same with Tamiflu. We are not reporting based on that. If you are treating a condition, then you ought to report it.

Member Lindquist shared we have a rule in place that requires them to report but makes no sense to the people who need to report it. Syndromic surveillance is when you come into the emergency room, and if you are there for COVID-19 or flu they need to report directly to the Department.

Chair Hayes said the Board will revisit this.

8. STATE HEALTH REPORT COMMUNITY PANEL, CONTINUED

Patty Hayes, Board Chair, introduced the community panel and reminded Board Members of the Board's statutory responsibility to provide a biennial State Health Report with recommended policy directions for the Governor's consideration. Chair Hayes noted that these community panels offer opportunities for Board Members to hear about how different issues affect communities across the state and how this information can help inform the State Health Report.

Molly Dinardo, Board staff, introduced the topics selected by Board Members to inform the 2024 State Health Report. Molly shared themes from the March panel and noted some were reflected in the presentation from the NATIVE Project.

Ashley Bell, Board staff, outlined the structure and agenda for the panel. Ashley noted the panel would provide opportunities for reflection, questions, and discussion to inform the next steps. Ashley posed guiding questions for panelists to consider while discussing their work and for Board Members to consider during the discussion (see presentation on file).

Anastacia ("Stacia") Lee, Board Member of Asians for Collective Liberation (ACLS), described ACLS and noted that the organization is one of seven chapters of a larger statewide coalition, the Asian and Pacific Islander Coalition. Stacia discussed the topics of culturally appropriate care, health justice, and data equity. Stacia raised the issue that there's this monolithic sense of an "Asian" community in health care and public health, which does more harm than good when caring for Asian and Pacific Islander communities. For example, Stacia noted there are many differences in the needs and types of care that people in the Hmong community need or people in Southeast Asian

communities are experiencing when trying to access healthcare, and what larger populations of Chinese, Korean, Japanese, Vietnamese, and other populations need or experience. Stacia discussed ACLS recent community health assessment of Asian and Pacific Islander communities in Spokane that found community members reported being treated similarly and were not offered appropriate interpretation services. Stacia said that during direct patient care appointments, silence is often assumed to be understanding. It could be that a patient cannot communicate with their provider or feels they cannot question the patient-provider power dynamic. Stacia emphasized that language services and patient support are essential to promoting culturally appropriate care.

Stacia said that ACLS focuses on racial equity, community health and wellness, and advancing human rights across Washington. Understanding a person's culture of origin and the language they need to access care is essential to the organization's efforts. Stacia commented on the need for data disaggregation and the ability for individuals to self-report and select multiple categories for race, ethnicity, and place of origin to account for all the different identities and lived experiences that people hold. Stacia highlighted the importance of including qualitative data and people's stories in data and equity discussions.

Stacia shared additional findings from the recent ACLS community health assessment, including themes related to the need for multi-generational care, the long-term impacts of generational trauma on Asian and Pacific Islander communities, and financial security. Stacia discussed the issue of the "model minority myth" in Asian communities and emphasized that just because people might not be speaking up doesn't mean they aren't experiencing harm or barriers in the care they're receiving. Stacia noted that ACLS's recent assessment found that Asian and Pacific Islander communities were among the least likely to seek mental health services compared to data available from Spokane Regional Health District and other data sources. Stacia noted the stigma in the Asian, Asian American, and Pacific Islander communities when it comes to accessing mental health services.

Joseph Hunter, Thriving Together North Central Washington, introduced Thriving Together North Central Washington (NCW), and mentioned the organization is one of nine Accountable Communities of Health (ACH) in Washington, supporting Okanogan, Chelan, Douglas, and Grant counties. Joseph described the community members with whom they work, and identified the limited opportunities for linkage to care for people with substance use, a history of, or homelessness. Joseph described work with the University of Washington CLEARS project, a relationship building project between those with lived experience and law enforcement. Joseph shared personal lived experience cycling in and out of services. Joseph understands lived experience from both sides - law enforcement and folks interacting with law enforcement, learning from one another. Joseph described developing compassion and wellness care training as well as trauma informed care for law enforcement as a work in progress. Thriving Together hires based on lived experience and looks at solutions from a different perspective. Joseph leads The Recovery Coach Network that uses nationally recognized training with embedded work in treatment centers, emergency rooms and jails. Recovery coaches with lived experience build back trust. They have trained over 200 coaches across 4 counties. This takes collaboration and a holistic approach, working with treatment and mental

health teams. Joseph discussed un-siloing the work and building connection with each individual who comes through the referral process. This can take 6 months, coming up with a plan before release, treatment, housing, transport, etc. Joseph explained that when someone is in jail, detoxing, or in a hospital bed, it's one of the few opportunities to make a significant change. Joseph also described the importance of distributing NARCAN to the populations who need it, and the development of vending machines that they first implemented in Chelan County. Joseph described 120 overdose reversals. This is a trusted resource that is tearing down stigma in our communities.

Kim Wilson, Better Health Together, said they cover six counties of Eastern Washington and they are community based. Kim is joined by Desiree Crawford, Health Justice Recovery Alliance, who supports pregnant and perinatal people.

Steve Kutz, Board Member, noted that there are many services under the title of Community Health Worker (CHW). Member Kutz asked whether these services are reimbursable by insurance, and whether people in the process of getting their license are allowed to bill for their services. Joseph replied that the Recovery Coach classification does not allow for reimbursement. Joseph added that many workers doing grassroots-level work cannot bill because they are busy providing services.
Kim said that there is currently no reimbursement mechanism or certification process for CHWs in Washington state. Kim said that nationally there is an effort to expand access to CHWs by developing a billing strategy through Medicare and Medicaid. Kim noted, however, that finding funding is a challenge for employers who see the benefit of CHWs. Desiree said that Doulas County experiences similar issues. Desiree said that while there are private pay doulas, doulas working with low-income populations are not able to be reimbursed for their services.

Chair Hayes spoke about the breadth of the CHW classification and the need for these services in communities. Chair Hayes said that it is unclear how the state is approaching policy development around this classification. Chair Hayes said it seems that policies are being driven towards bundled payment, which stresses the system to decide what services within that bundle are payable. Chair Hayes suggested the Board's State Health Report should highlight the limitations and potential harms of that payment model.

Member Kutz asked what interventions would best support pregnant people who use opioids and their babies. Desiree discussed their work supporting parents undergoing detox and Medication-Assisted Treatment therapy during pregnancy and about the "Eat, Sleep, Console" protocol. Desiree said these interventions allow for the family to remain together while providing care for the baby.

Scott Lindquist, Secretary's Designee, said that supporting people with complex health and social issues requires advocates with lived experience. Member Lindquist recommended the Board's State Health Report call out the need for lived experiences in this work. Member Kutz said that it should add the expectation of funding for this work.

Dimyana Abdelmalek, Board Member, spoke about their work as a local health officer, and mentioned the demand for family health programs is greater than their office can

meet. Member Abdelmalek asked about the CHW network's role for parents in the postpartum period and in the first two years.

Desiree said that their program does not limit the timeline where families can access support. Desiree said they continue to provide community case management and support at the level the family desires. Kim spoke about the formal and informal networks that CHWs create at the regional, state, and national levels.

Social Love, Board Member, spoke about the innovations that CHWs have discovered that they try to incorporate into their primary care practice. This includes having supporters on speed dial when people need services, or having a CHW like Desiree present to support pregnant parents make informed decisions and advocate for themselves. Member Love suggested the Board could include these innovative health practices in the State Health Report.

Kate Dean, Board Member, asked about the workforce development perspective, and said the current legislature funding for behavioral health work is not enough for the needed crisis response. Member Dean spoke about identifying skills that a CHW workforce needs. Such as language interpretation and culturally competent and trauma informed care. Member Dean said these positions should be well-paid and provide opportunities for development. Member Dean also spoke about best practices for workforce development, such as proper training and certification, while noting that more structure comes with its risks to consider.

Kim said that CHWs do have a Standard Occupational Classification profile but noted that there are 80 different job profiles under this classification. Kim spoke about the emotion-driven nature of CHW work and the trade-offs that may come with certification. Kim said that CHWs are naturally trusted members of their community, and some think that getting certified may change that. Kim described Oregon's tiered model, which offers different levels of certification based on the CHW's desired goals.
Stacia spoke about seeing burnout among workers while working at a refugee resettlement agency. Stacia spoke of the need for adequate pay and full benefits for workers. Stacia said that these measures help workers protect themselves against burnout and show workers there is a higher level of investment in their services.
Joseph commented on the need for recognition of the different kinds of CHWs. Joseph said that Recovery Coaches and other CHWs responding to crisis calls are just as valuable as those working in clinical settings.

Paj Nandi, Board Member, said that these conversations about CHWs have been happening for over a decade and that many policies haven't shifted in desired ways. Member Nandi said that many communities are dealing with this issue, especially communities of color. Member Nandi asked what the national landscape around CHWs looks like and whether there are best practices the Board should be more informed about.

Kim said that the national landscape on this issue is varied, but there are measures like the Community Health Worker Access Act focused on a national standard. Kim said the National Association of Community Health Workers has a policy workgroup that is sharing innovations and best practices around payment, professional development,

training, and more. Joseph said that there is also a National Peer Support Network. Joseph said that they were recently in a meeting with the Washington State Health Care Authority where they shared best practices. Joseph spoke about the different types of issues CHWs face as vulnerable populations working with other vulnerable populations and the support they need. Stacia added that for many CHWs, their work goes beyond a job. Stacia spoke about the need for a compensation model that recognizes the work that gets done outside of traditional working hours.

Molly summarized the next steps for this project. Molly said that the Board needs to understand the landscape of CHWs and see what work has been done in Washington. After that, the Board will write a report to submit to the Governor's Office and send out a community responsiveness survey. Molly said the Board will discuss the State Health Report again at their June 2024 public meeting.

Member Kutz said that the time needed to build trust the way that CHWs do is not typical in the medical provider community.

9. MEMORANDUM OF UNDERSTANDING WITH THE DEPARTMENT OF HEALTH – POSSIBLE ACTION

Michelle Davis, Executive Director, directed Board Members to the memo describing the Memorandum of Understanding (MOU) (on file), and provided a brief background on the MOU and the Board's relationship with the Department of Health (Department), and the services the Department provides to the Board. Executive Director Davis shared that the MOU was last updated in 2019, and further updates were delayed due to the pandemic. Executive Director Davis shared that many of the changes are associated with organizational changes at the Department, including a Deputy Chief of Policy that serves as a conduit to the Departments organizational processes. Executive Director Davis stated that the MOU also includes new work that the Board will conduct related to the Healthy Environment for All (HEAL) Act.

Kelly Oshiro, Vice Chair, expressed support for updating the MOU and inquired about plans after this update given anticipated further changes at the Department in 2025. Executive Director Davis responded that the current MOU includes a commitment to review every two years, so it will be reviewed again at that time. Executive Director Davis shared that any urgent issues could be brought back before the two-year deadline.

Steve Kutz, Board Member, shared that the MOU outlines support specific to Board staff, and therefore did not have input. Kate Dean, Board Member, asked whether the redlines provided in the packet were made only by Board staff or if they had already been vetted by the Department as well. Executive Director Davis responded that the edits had been reviewed by Board staff internally and that Todd Mountin, Deputy Policy Director at the Department, has worked with each division within the Department to identify changes as well. Executive Director Davis stated that once the MOU is finalized, it is important to communicate to people that the Board is an independent body and that this commitment exists.

Member Dean clarified that the Board is passing the MOU, knowing that minor edits could be made but that it would remain substantively the same.

Patty Hayes, Board Chair, responded that it would be preferable to bring it back if major changes were made. Member Kutz agreed and added that it should be brought back if there is any additional support needed. Executive Director Davis agreed to follow these requests.

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

The Board directs staff to develop a final Memorandum of Understanding between the Board and Department, in close consultation with the Chair. The Chair is authorized to negotiate a final agreement and approve the MOU on behalf of the Board.

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

The Board took a break at 3:15 p.m. and reconvened at 3:25 p.m.

10. **RULES BRIEFING – HANDLING OF HUMAN REMAINS WAC 246-500, ABBREVIATED RULEMAKING TO IMPLEMENT CHANGES FROM SHB 1974**

Patty Hayes, Board Chair, introduced the Handling of Human Remains rules briefing and said today's discussion is to harmonize our rules with the statutory changes made by the legislature.

Shay Bauman, Board staff, provided background on the rule and the potential motion. Shay said the Substitute House Bill 1974 (SHB 1974) passed during the 2024 legislative session (Chapter 58 Laws of 24) and amends RCW 68.50.230. The changes specified in SHB 1974 reduce the holding period to 45 days and adds counties to the list of entities that may lawfully dispose of unclaimed human remains after 45 days (see presentation on file).

Kate Dean, Board Member, said as a county representative, they fully support this measure and said it's a good idea for a small rural county.

Paj Nandi, Board Member, asked why 45 days, saying our neighbor in Oregon is 10 days. Shay said the proposed legislation was 30 days, and the legislature recommended 45 days to be respectful.

Motion: The Board directs staff to file a CR-102 to initiate rulemaking for chapter 246-500 WAC to consider reducing the holding period for unclaimed human remains from 90 days to 45 days and add counties to the list of entities that may lawfully dispose of human remains after 45 days.

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

11. BOARD MEMBER COMMENTS

Patty Hayes, Board Chair, talked about the national interest in Foundational Public Health Services (FPHS). The National Accreditation Board did a podcast and Jeff Ketchel participated. Chair Hayes said that Jeff shared this great opportunity and recommended other partners talk about it. Chair Hayes had the opportunity to be filmed recently, along with other partners such as Vicki Lowe from the American Indian Health Commission (AIHC). Chair Hayes said the questions gave her the opportunity to put on record that the Board is in the state constitution and discuss the work funded through FPHS. This opportunity allowed for a conversation about the importance of communication and work with the Legislature and Governor.

Steve Kutz, Board Member, said former Secretary Wiesman had a significant part in pulling Tribes into FPHS. Member Kutz said there is still not a good understanding in the 29 Tribes across the state of what FPHS looks like. Chair Hayes agreed on the significance of Secretary Wiesman's work and talked about how the AIHC and Tribes are working to build their public health system. Chair Hayes said that building relationships takes time and leadership. Member Kutz said the difference is that we are building a partnership.

Chair Hayes mentioned her presentation about the Board at a breakout session at the Washington State Rural Health Conference in Spokane. Chair Hayes asked Board staff to circulate the presentation so Board Members could see it. Chair Hayes said attendees ranged from public health to hospitals to local health to private corporations. Chair Hayes said these opportunities help to get the word out regarding who we are, how we are structured, and our work.

Member Kutz said it's not well understood what the Board can't do, and that some folks use the Board as a conduit to get to the Department of Health. Chair Hayes said it is a positive experience to share what we can do.

Chair Hayes talked about the FPHS steering committee preparing to look at strategic planning as a system. Chair Hayes talked about thinking visionary down the road and working on a Decision Package (DP) for the 2025 legislative session. Chair Hayes said that Executive Director Davis has done a great job but could use more support with an Operational Deputy role at the Board. Chair Hayes talked about how to frame this to be successful.

Kate Dean, Board Member, asked if the steering committee is statewide. Chair Hayes said yes.

Member Kutz asked who began the Health Impact Reviews (HIRs). Michelle Davis, Executive Director, said the HIR work was created during the same time as the Health Disparities Council was formed by Senator Rosa Franklin and Representative Sharon Tomiko Santos. When created, there was 1 FTE and the other FTE was swept away by budget reductions. The Board later gained 1.6 FTE, through FPHS, bringing the current HIR budget to 2.6 FTEs. Executive Director Davis said the HIR staff is remarkable and they do a ton of work.

Chair Hayes said the HIRs are attached to an independent board that has the type of membership that is very unique. In Colorado, HIRs are attached to the legislature. It's a model we should be talking about. Member Kutz talked about one in Cowlitz County. Executive Director Davis indicated that the work in Cowlitz County was a Health Impact Assessment (HIA) which is different than an HIR. Executive Director Davis said sometimes the county or other organizations do the HIA's which is a very helpful tool.

Member Dean talked about the County Health rankings and the focus this year on the correlation of public health, including isolation and deaths of despair. Member Dean asked for advice from the Public Health Officer and Administrator.

Member Kutz talked about Tribes formalizing titles for health care workers and trying to have certification training and reimbursements. Member Kutz talked about missing Keith Grellner and the impact of the work Keith started around assessment and health care. Member Kutz said it caused the system to start talking about possible solutions. Member Kutz said that having Tribes on the Local Boards of Health has made a difference to the Tribes and county.

ADJOURNMENT

Patty Hayes, Board Chair, adjourned the meeting at 4:00 p.m.

WASHINGTON STATE BOARD OF HEALTH

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Patty Hayes, Chair

From: Bob Runnells
Sent: 4/8/2024 5:58:50 PM
To: DOH WSBOH
Cc:
Subject: For all board members: Children's Health Defense Events in the Northwest

External Email

Dear Washington State Board of Health Members,

I am writing on behalf of the new Washington chapter of Children's Health Defense (CHD), https://wa.childrenshealthdefense.org/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwa.childrenshealthdefense.org%2 to invite you see the unique Vax-UnVax RV (https://live.childrenshealthdefense.org/chd-tv/the-peoples-study/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Flive.childrenshealthdefense.org%2 tv%2Fthe-peoples-study%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7C691e7743f04945a444de08dc58303565%7C11) on it's tour through the Northwest.

This People's Study RV is concluding its nationwide tour to collect stories of people's experience with vaccines and COVID-19 hospital protocols. The 42-foot long custom-wrapped RV will stop from noon to 2:00 PM at the State Capitol on Tuesday, April 16. We invite you to stop by, ask questions, and witness this epic traveling memorial for those who have been harmed, then marginalized or silenced, for doing what they thought was the right thing.

We are concerned that public health employees ignore or understate the downside of public health measures. We are hoping that this RV, and the more than one thousand signatures of those attesting to personal or family injury, will be a sober reminder that medical interventions should always be freely chosen.

And please note the option of attending other stops in Seattle on the 17th or Spokane on the 19th.

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Sincerely,
Bob Runnells
Washington State Chapter of Children's Health Defense
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwa.childrenshealthdefense.org%2

The CHD mission includes ending childhood health epidemics through elimination of harmful exposures and establishing safeguards to prevent future harms.

BMJ Public Health

Excess mortality across countries in the Western World since the COVID-19 pandemic: 'Our World in Data' estimates of January 2020 to December 2022

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To cite: Mostert S, Hoogland M, Huibers M, *et al*. Excess mortality across countries in the Western World since the COVID-19 pandemic: 'Our World in Data' estimates of January 2020 to December 2022. *BMJ Public Health* 2024;**2**:e000282. doi:10.1136/bmjph-2023-000282

► Additional supplemental material is published online only. To view, please visit the journal online (https://doi.org/10.1136/bmjph-2023-000282).

Received 9 June 2023
Accepted 20 March 2024

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ABSTRACT

Introduction Excess mortality during the COVID-19 pandemic has been substantial. Insight into excess death rates in years following WHO's pandemic declaration is crucial for government leaders and policymakers to evaluate their health crisis policies. This study explores excess mortality in the Western World from 2020 until 2022.

Methods All-cause mortality reports were abstracted for countries using the 'Our World in Data' database. Excess mortality is assessed as a deviation between the reported number of deaths in a country during a certain week or month in 2020 until 2022 and the expected number of deaths in a country for that period under normal conditions. For the baseline of expected deaths, Karlinsky and Kobak's estimate model was used. This model uses historical death data in a country from 2015 until 2019 and accounts for seasonal variation and year-to-year trends in mortality.

Results The total number of excess deaths in 47 countries of the Western World was 3 098 456 from 1 January 2020 until 31 December 2022. Excess mortality was documented in 41 countries (87%) in 2020, 42 countries (89%) in 2021 and 43 countries (91%) in 2022. In 2020, the year of the COVID-19 pandemic onset and implementation of containment measures, records present 1 033 122 excess deaths (P-score 11.4%). In 2021, the year in which both containment measures and COVID-19 vaccines were used to address virus spread and infection, the highest number of excess deaths was reported: 1 256 942 excess deaths (P-score 13.8%). In 2022, when most containment measures were lifted and COVID-19 vaccines were continued, preliminary data present 808 392 excess deaths (P-score 8.8%).

Conclusions Excess mortality has remained high in the Western World for three consecutive years, despite the implementation of containment measures and COVID-19 vaccines. This raises serious concerns. Government leaders and policymakers need to thoroughly investigate underlying causes of persistent excess mortality.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Excess mortality during the COVID-19 pandemic has been substantial. Insight into excess death rates in years following WHO's pandemic declaration is crucial for government leaders and policymakers to evaluate their health crisis policies.

WHAT THIS STUDY ADDS

⇒ Excess mortality has remained high in the Western World for three consecutive years, despite the implementation of containment measures and COVID-19 vaccines. This raises serious concerns.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Government leaders and policymakers need to thoroughly investigate the underlying causes of persistent excess mortality.

INTRODUCTION

Excess mortality is internationally recognised as an accurate measure for monitoring and comparing health crisis policies across geographic regions.[1–4] Excess mortality concerns the number of deaths from all causes during a humanitarian emergency, such as the COVID-19 pandemic, above the expected number of deaths under normal circumstances.[5–7] Since the outbreak of the COVID-19 pandemic, excess mortality thus includes not only deaths from SARS-CoV-2 infection but also deaths related to the indirect effects of the health strategies to address the virus spread and infection.[1–4] The burden of the COVID-19 pandemic on disease and death has been investigated from its beginning. Numerous studies expressed that SARS-CoV-2 infection was likely a leading cause of death among older patients with pre-existing comorbidities and obesity in the early phase of the pandemic, that various containment measures were effective in reducing viral transmission and that COVID-19 vaccines prevented severe disease, especially among the elderly population.[1 8–14] Although COVID-19 containment measures and

COVID-19 vaccines were thus implemented to protect citizens from suffering morbidity and mortality by the COVID-19 virus, they may have detrimental effects that cause inferior outcomes as well.[1 2 15] It is noteworthy that excess mortality during a crisis points to a more extensive underlying burden of disease, disablement and human suffering.[16]

On 11 March 2020, WHO declared the COVID-19 pandemic.[17] Countries in the Western World promptly implemented COVID-19 containment measures (such as lockdowns, school closures, physical distancing, travel restrictions, business closures, stay-at-home orders, curfews and quarantine measures with contact tracing) to limit virus spread and shield its residents from morbidity and mortality.[18] These non-pharmaceutical interventions however had adverse indirect effects (such as economic damage, limited access to education, food insecurity, child abuse, limited access to healthcare, disrupted health programmes and mental health challenges) that increased morbidity and mortality from other causes.[19] Vulnerable populations in need of acute or complex medical treatment, such as patients with cardiovascular disease, cerebrovascular conditions, diabetes and cancer, were hurt by these interventions due to the limited access to and delivery of medical services. Shortage of staff, reduced screening, delayed diagnostics, disrupted imaging, limited availability of medicines, postponed surgery, modified radiotherapy and restricted supportive care hindered protocol adherence and worsened the condition and prognosis of patients.[19–26] A recent study investigated excess mortality from some major non-COVID causes across 30 countries in 2020. Significant excess deaths were reported from ischaemic heart diseases (in 10 countries), cerebrovascular diseases (in 10 countries) and diabetes (in 19 countries).[27] On 14 October 2020, Professor Ioannidis from Stanford University published an overall Infection Fatality Rate of COVID-19 of 0.23%, and for people aged <70 years, the Infection Fatality Rate was 0.05%.[28] Governments in the Western World continued to impose lockdowns until the end of 2021.

In December 2020, the UK, the USA and Canada were the first countries in the Western World that started with the roll-out of the COVID-19 vaccines under emergency authorisation.[29–31] At the end of December 2020, a large randomised and placebo-controlled trial with 43 548 participants was published in the *New England Journal of Medicine*, which showed that a two-dose mRNA COVID-19 vaccine regimen provided an absolute risk reduction of 0.88% and relative risk reduction of 95% against laboratory-confirmed COVID-19 in the vaccinated group (8 COVID-19 cases/17 411 vaccine recipients) versus the placebo group (162 COVID-19 cases/17 511 placebo recipients).[32 33] At the beginning of 2021, most other Western countries followed with rolling out massive vaccination campaigns.[34–36] On 9 April 2021, the overall COVID-19 Infection Fatality Rate was reduced to 0.15% and expected to further decline with the widespread use of vaccinations, prior infections and the evolution of new and milder variants.[37 38]

Although COVID-19 vaccines were provided to guard civilians from suffering morbidity and mortality by the COVID-19 virus, suspected adverse events have been documented as well.[15] The secondary analysis of the placebo-controlled, phase III randomised clinical trials of mRNA COVID-19 vaccines showed that the Pfizer trial had a 36% higher risk of serious adverse events in the vaccine group. The risk difference was 18.0 per 10 000 vaccinated (95% CI 1.2 to 34.9), and the risk ratio was 1.36 (95% CI 1.02 to 1.83). The Moderna trial had a 6% higher risk of serious adverse events among vaccine recipients. The risk difference was 7.1 per 10 000 vaccinated (95% CI −23.2 to 37.4), and the risk ratio was 1.06 (95% CI 0.84 to 1.33).[39] By definition, these serious adverse events lead to either death, are life-threatening, require inpatient (prolongation of) hospitalisation, cause persistent/significant disability/incapacity, concern a congenital anomaly/birth defect or include a medically important event according to medical judgement.[39–41] The authors of the secondary analysis point out that most of these serious adverse events concern common clinical conditions, for example, ischaemic stroke, acute coronary syndrome and brain haemorrhage. This commonality hinders clinical suspicion and consequently its detection as adverse vaccine reactions.[39] Both medical professionals and citizens have reported serious injuries and deaths following vaccination to various official databases in the Western World, such as VAERS in the USA, EudraVigilance in the European Union and Yellow Card Scheme in the UK.[42–48] A study comparing adverse event reports to VAERS and EudraVigilance following mRNA COVID-19 vaccines versus influenza vaccines observed a higher risk of serious adverse reactions for COVID-19 vaccines. These reactions included cardiovascular diseases, coagulation, haemorrhages, gastrointestinal events and thromboses.[39 49] Numerous studies reported that COVID-19 vaccination may induce myocarditis, pericarditis and autoimmune diseases.[50–57] Post-mortem examinations have also ascribed myocarditis, encephalitis, immune thrombotic thrombocytopenia, intracranial haemorrhage and diffuse thrombosis to COVID-19 vaccinations.[58–67] The Food and Drug Administration noted in July 2021 that the following potentially serious adverse events of Pfizer vaccines deserve further monitoring and investigation: pulmonary embolism, acute myocardial infarction, immune thrombocytopenia and disseminated intravascular coagulation.[39 68]

Insight into the excess death rates in the years following the declaration of the pandemic by WHO is crucial for government leaders and policymakers to evaluate their health crisis policies.[1–4] This study therefore explores excess mortality in the Western World from 1 January 2020 until 31 December 2022.

MATERIALS AND METHODS

Setting

The Western World is primarily defined by culture rather than geography. It refers to various countries in Europe and to countries in Australasia (Australia, New Zealand) and North America (the USA, Canada) that are based on European cultural heritage. The latter countries were once British colonies that acquired Christianity and the Latin alphabet and whose populations comprised numerous descendants from European colonists or migrants.[69]

Study design

All-cause mortality reports were abstracted for countries of the Western World using the 'Our World in Data' database.[12] Only countries that had all-cause mortality reports available for all three consecutive years (2020–2022) were included. If coverage of one of these years was missing, the country was excluded from the analysis.

The 'Our World in Data' database retrieves their reported number of deaths from both the Human Mortality Database (HMD) and the World Mortality Dataset (WMD).[5] HMD is sustained by research teams of both the University of California in the USA and the Max Planck Institute for Demographic Research in Germany. HMD recovers its data from Eurostat and national statistical agencies on a weekly basis.[5 70] The 'Our World in Data' database used HMD as their only data source until February 2021.[5] WMD is sustained by the researchers Karlinsky and Kobak. WMD recovers its data from HMD, Eurostat and national statistical agencies on a weekly basis.[5 71] The 'Our World in Data' database started to use WMD as a data source next to HMD since February 2021.[5]

'Excess mortality' is assessed as the deviation between the reported number of deaths in a country during a certain week or month in 2020 until 2022 and the expected or projected number of deaths in a country for that period under normal conditions.[5] For the baseline of expected deaths, the estimate model of Karlinsky and Kobak was used. This linear regression model uses historical death data in a country from 2015 until 2019 and accounts for seasonal variation in mortality and year-to-year trends due to changing population structure or socioeconomic factors.[5 7]

Karlinsky and Kobak fit their regression model separately for every country: $D_{t,Y}=\alpha_t+\beta \cdot Y+\epsilon$. In this formula, $D_{t,Y}$ is the number of deaths observed on week (or month) t in year Y, β is a linear slope across years, α_t are separate intercepts (fixed effects) for each week (month/quarter) and $\epsilon \sim N(0,\sigma^2)$ is the Gaussian noise.[7] The model prediction for 2020 is taken as the baseline for the excess mortality calculations: $\widehat{B}_t = \widehat{\alpha}_t + \widehat{\beta} \cdot 2020$.[7] The final excess mortality estimate is as follows: $\sum_{t \geq t_1} \left(D_{t,2020} - \widehat{B}_t\right) + \sum_t \left(D_{t,2021} - \widehat{B}_t\right)$, where t_1 indicates the summation onset in 2020.[7] The variance $\mathrm{Var}[\Delta]$ of estimator Δ is computed as follows: X is the predictor matrix in the regression, y is the response vector, $\widehat{\beta} = \left(X^T X\right)^{-1} X^T y$ is the vector of estimated regression coefficients, and $\widehat{\sigma}^2 = \|y - X\hat{\beta}\|^2/(n-p)$ is the unbiased estimate of noise variance, in which n is the sample size and P is the number of predictors. $\mathrm{cov}[\hat{\beta}] = \widehat{\sigma}^2 \left(x^T x\right)^{-1}$ is the covariance matrix of $\hat{\beta}$. $S = \mathrm{Cov}\left[\hat{\beta}_t\right] = \mathrm{Cov}\left[X_{2020}\hat{\beta}\right] = \widehat{\sigma}^2 X_{2020}\left(X^T X\right)^{-1} X_{2020}^T$ is the covariance matrix of predicted baseline values $\hat{\beta}_t$, where X_{2020} is the predictor matrix for 2020. Karlinsky and Kobak depict vector w with elements w_t of length equal to the number of rows in X_{2020}. They set all elements before t_1 to zero, all elements from t_1 forward to 1, and raise by one all elements corresponding to 2021 data.[7] The predictive variance of Δ is denoted as follows: $\mathrm{Var}[\Delta] = \mathrm{Var}\left[\sum_t w_t \widehat{B}_t\right] + \sum_t w_t \widehat{\sigma}^2 = w^T S w + \widehat{\sigma}^2 \|w\|_1$ in which the first term represents the uncertainty of $\hat{\beta}_t$ and the second term represents the additive Gaussian noise. The square root of $\mathrm{Var}[\Delta]$ is regarded as the standard error of Δ. When the fraction $z = |\Delta| / \sqrt{\mathrm{var}[\Delta]}$ is below 2, the excess mortality of that country is considered not significantly different from zero.[7]

The model regards excess mortality during the COVID-19 pandemic as the sum of the following factors: (a) deaths directly generated by SARS-CoV-2 infection, (b) deaths generated by medical system overload owing to the pandemic, (c) excess deaths from other natural causes (eg, influenza and other infectious respiratory diseases during winter seasons), (d) excess deaths from unnatural causes (eg, traffic accidents, homicides, suicides, deaths from drug overdoses and unintentional injuries) and (e) excess deaths from extreme events (such as heat waves, wars, power outages and natural disasters).[7] Karlinsky and Kobak's model expressly takes factor (e) into account and acknowledges that the contribution of factors (b), (c) and (d) is in general minor for the majority of nations compared with factor (a).[7] The researchers have used the officially reported national COVID-19 death counts from the WHO dataset.[72] In their model, common seasonal influenza during 2015 and 2019 contributes to the projected baseline of expected deaths.[7] In addition, the model corrects for peaks of excess deaths during heat waves.[7] Because the number of excess deaths is impacted by the population size of a nation, the excess mortality estimates have been normalised by the population size.[7] Population size estimates of the United Nations World Population Prospect dataset have been used to estimate excess deaths per 100 000 population for 2020 until 2022.[7 73] Because the Infection Fatality Rate of SARS-CoV-2 is age dependent and nations have different age structures, the excess mortality estimates have been normalised by the yearly sum of the baseline mortality to account for the nation's age structure.[7] Because the projected baseline uses a linear trend, the model can also reckon for ameliorations in death registration across recent years.[7] For each country separately, Karlinsky and Kobak have taken these various factors into account when predicting the baseline mortality for 2020 until 2022. If required, adjustments

have been made accordingly.[7] For example, in the USA, the weekly death data (R^2=0.89, F=31.7) give rise to the following: $\hat{\beta}$=773±57. This implies that every year, the number of weekly deaths rises on average by ~800. The predicted weekly deaths for 2020 are thus higher than the 2015–2019 average. Regarding the strong and statistically significant annual trend, it is therefore not accurate to employ the 2015–2019 data as a baseline.[7] Another example of correction concerns Belgium, the Netherlands, France, Luxembourg and Germany. In August 2020, a peak of excess deaths was observed during a heat wave in these countries. To account for this, weeks 32–34 were excluded from the excess mortality calculation in these nations. This decreased the excess mortality estimates for these countries by 1500 for Belgium, 660 for the Netherlands, 1600 for France, 35 for Luxembourg and 3700 for Germany.[7] Karlinsky and Kobak present more details about the used method in their joint publication.[7]

'Excess mortality P-score' concerns the percentage difference between the reported number of deaths and the projected number of deaths in a country.[5] This measure permits comparisons between various countries. Although presenting the raw number of excess deaths provides insight into the scale, it is less useful to compare countries because of their large population size variations.[5] The 'Our World in Data' database presents P-scores in a country during a certain week or month in 2020 until 2022.[5] These P-scores are calculated from both the reported number of deaths in HMD and WMD and the projected number of deaths using the estimate model of Karlinsky and Kobak in WMD.[5 7 70 71]

For correct interpretation of excess mortality provided by the 'Our World in Data' database, the following needs to be taken into consideration: the reported number of deaths may not represent all deaths, as countries may lack the infrastructure and capacity to document and account for all deaths.[5] In addition, death reports may be incomplete due to delays. It may take weeks, months or years before a death is actually reported. The date of a reported death may refer to the actual death date or to its registration date. Sometimes, a death may be recorded but not the date of death. Countries that provide weekly death reports may use different start and end dates of the week. Most countries define the week from Monday until Sunday, but not all countries do. Weekly and monthly reported deaths may not be completely comparable, as excess mortality derived from monthly calculations inclines to be lower.[5 7]

For our analysis, weekly all-cause mortality reports from the 'Our World in Data' database were converted to monthly reports. Subsequently, the monthly reports were converted to annual reports.

Patient and public involvement

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

RESULTS

The 'Our World in Data' database contained all-cause mortality reports of 47 countries (96%) in the Western World for the years 2020, 2021 and 2022. Only Andorra and Gibraltar were excluded. Both countries lacked all-cause mortality reports for the year 2022. Most countries (n=36, 77%) present weekly all-cause mortality reports, whereas 11 countries (23%) report monthly. The latter countries include the following: Albania, Bosnia Herzegovina, Faeroe Islands, Greenland, Kosovo, Liechtenstein, Moldova, Monaco, North Macedonia, San Marino and Serbia.

The all-cause mortality reports were abstracted from the 'Our World in Data' database on 20 May 2023. At this date, four countries (9%) still lacked all-cause mortality reports for various periods: Canada (1 month), Liechtenstein (3 months), Monaco (3 months) and Montenegro (4 months). It is noteworthy that all-cause mortality reports are also still being updated for the other countries due to registration delays which may take weeks, months or even years.

Excess mortality

Online supplemental table 1 illustrates that the total number of excess deaths in the 47 countries of the Western World was 3 098 456 from 1 January 2020 until 31 December 2022. Excess mortality was documented in 41 countries (87%) in 2020, in 42 countries (89%) in 2021 and in 43 countries (91%) in 2022.

In 2020, the year of the COVID-19 pandemic and implementation of the containment measures, 1 033 122 excess deaths (P-score 11.4%) were recorded. In 2021, the year in which both COVID-19 containment measures and COVID-19 vaccines were used to address virus spread and infection, a total of 1 256 942 excess deaths (P-score 13.8%) were reported. In 2022, the year in which most containment measures were lifted and COVID-19 vaccines were continued, preliminary available data counts 808 392 excess deaths (P-score 8.8%).

Figure 1 presents the excess mortality and cumulative excess mortality in 47 countries of the Western World over the years 2020, 2021 and 2022. The linear excess mortality trendline is almost horizontal.

Excess mortality P-scores

Figure 2 shows the excess mortality P-scores per country in the Western World. Only Greenland had no excess deaths between 2020 and 2022. Among the other 46 countries with reported excess mortality, the percentage difference between the reported and projected number of deaths was highest in 13 countries (28%) during 2020, in 21 countries (46%) during 2021 and in 12 countries (26%) during 2022. Figure 3 exemplifies excess mortality P-score curves of the highest-populated country of North America (the USA), the four highest-populated countries of Europe (Germany, France, the UK and Italy) and the highest-populated country of Australasia (Australia).

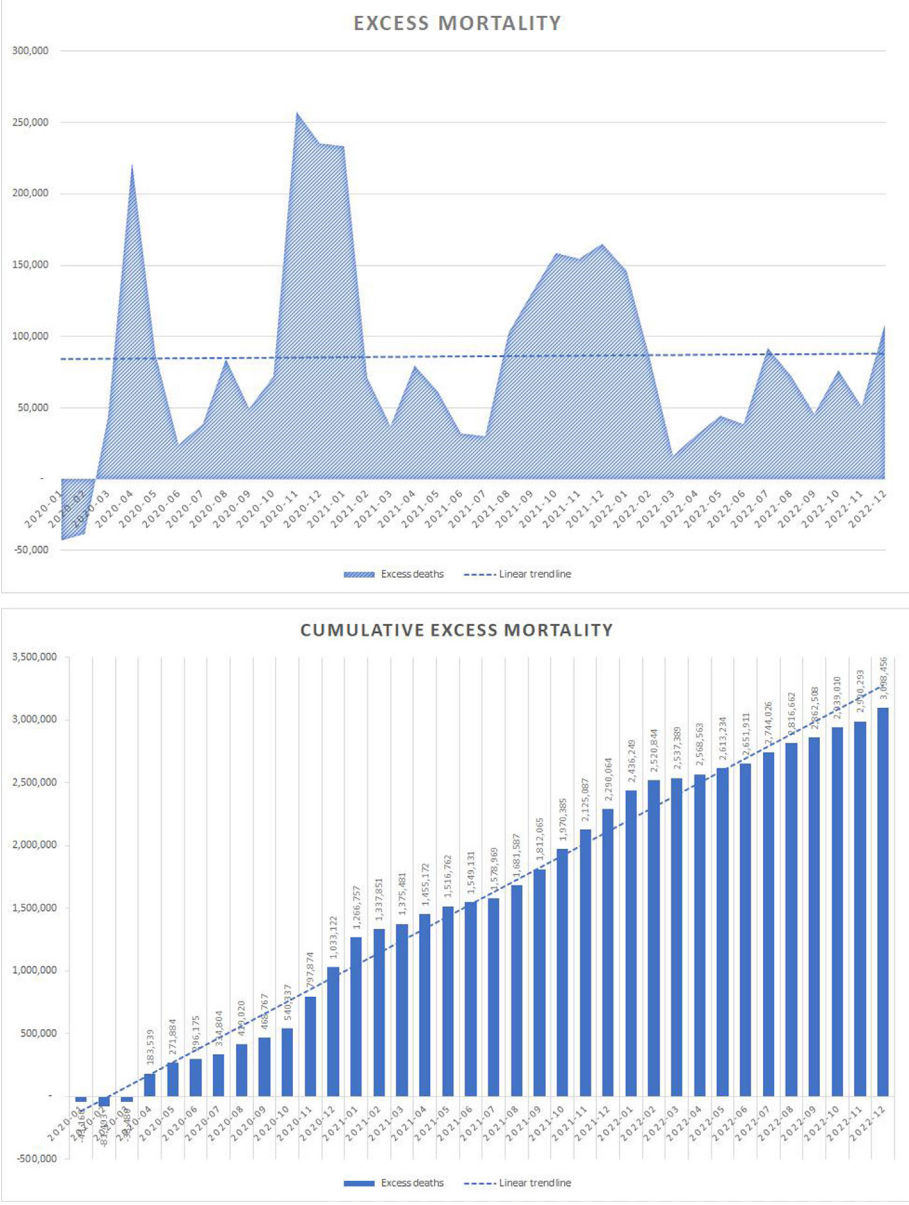

Figure 1 Excess mortality and cumulative excess mortality in the Western World (n=47 countries). Preliminary and incomplete all-cause mortality reports are available for 2022.

Figure 4 highlights a map of excess mortality P-scores in the Western World over the years 2020, 2021 and 2022.[74] Table 1 presents a classification of excess mortality P-scores in the Western World.

DISCUSSION

This study explored the excess all-cause mortality in 47 countries of the Western World from 2020 until 2022. The overall number of excess deaths was 3 098 456. Excess mortality was registered in 87% of countries in 2020, in 89% of countries in 2021 and in 91% of countries in 2022. During 2020, which was marked by the COVID-19 pandemic and the onset of mitigation measures, 1 033 122 excess deaths (P-score 11.4%) were to be regretted.[17 18] A recent analysis of seroprevalence studies in this prevaccination era illustrates that the Infection Fatality Rate estimates in non-elderly populations were even lower than prior calculations suggested.[37] At a global level, the prevaccination Infection Fatality Rate was 0.03% for people aged <60 years and 0.07% for people aged <70 years.[38] For children aged 0–19 years, the Infection Fatality Rate was set at 0.0003%.[38] This implies that children are rarely harmed by the COVID-19 virus.[19 38] During 2021, when not only containment measures but also COVID-19 vaccines were used to tackle virus spread and infection, the highest number of excess deaths was recorded: 1 256 942 excess deaths (P-score 13.8%).[26 37] Scientific consensus regarding the effectiveness of non-pharmaceutical interventions in reducing viral transmission is currently lacking.[75 76] During 2022, when most mitigation measures were negated and COVID-19 vaccines were sustained, preliminary available data count 808 392

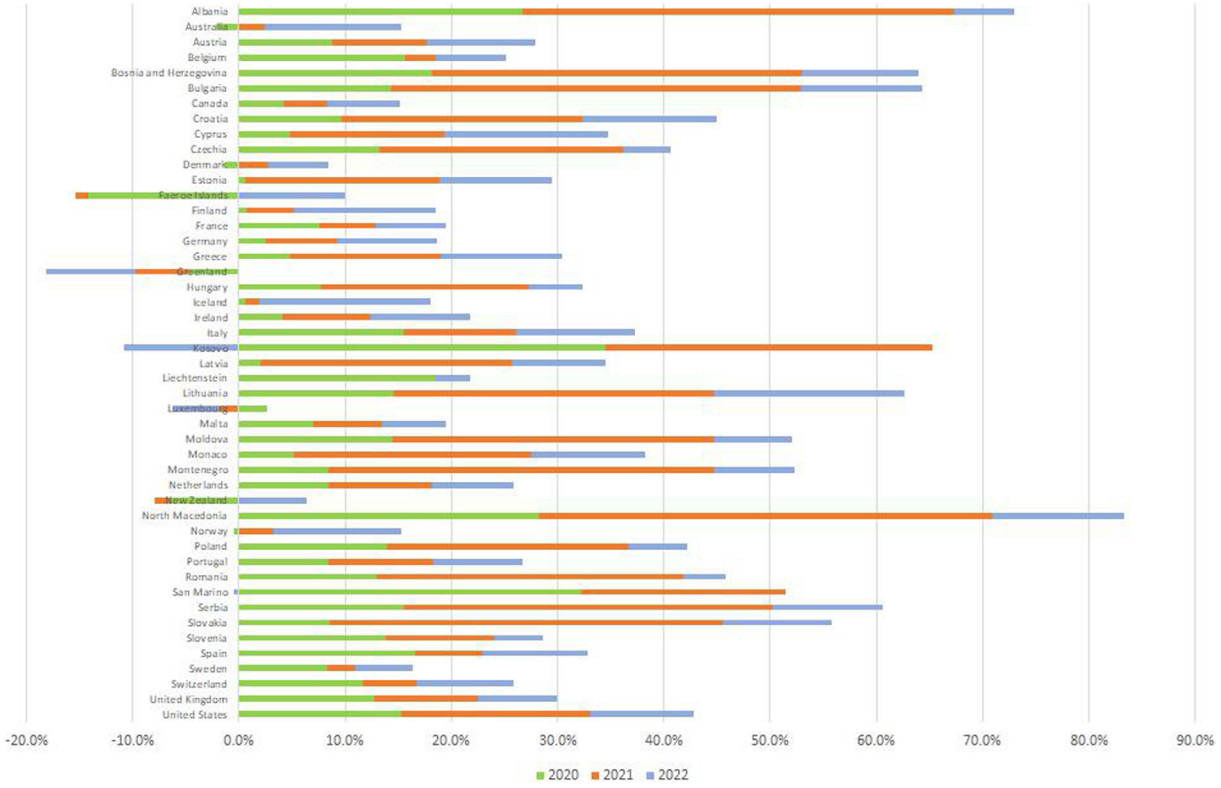

Figure 2 Excess mortality P-scores per country in the Western World (n=47 countries). Preliminary and incomplete all-cause mortality reports are available for 2022.

excess deaths (P-score 8.8%).[39] The percentage difference between the documented and projected number of deaths was highest in 28% of countries during 2020, in 46% of countries during 2021, and in 26% of countries during 2022.

This insight into the overall all-cause excess mortality since the start of the COVID-19 pandemic is an important first step for future health crisis policy decision-making.[1–4] The next step concerns distinguishing between the various potential contributors to excess mortality, including COVID-19 infection, indirect effects of containment measures and COVID-19 vaccination programmes. Differentiating between the various causes is challenging.[16] National mortality registries not only vary in quality and thoroughness but may also not accurately document the cause of death.[1 19] The usage of different models to

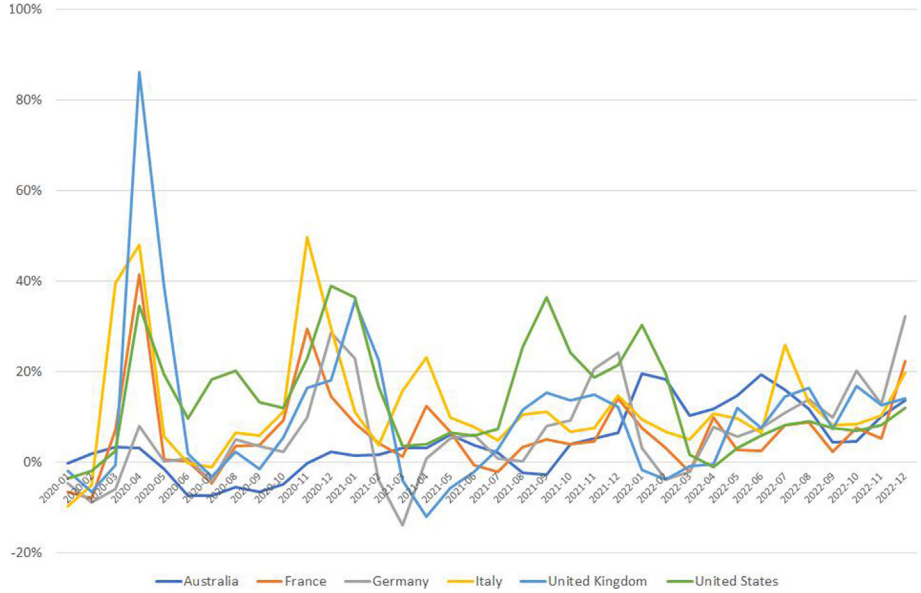

Figure 3 Excess mortality P-score curves of six countries in the Western World. Preliminary and incomplete all-cause mortality reports are available for 2022.

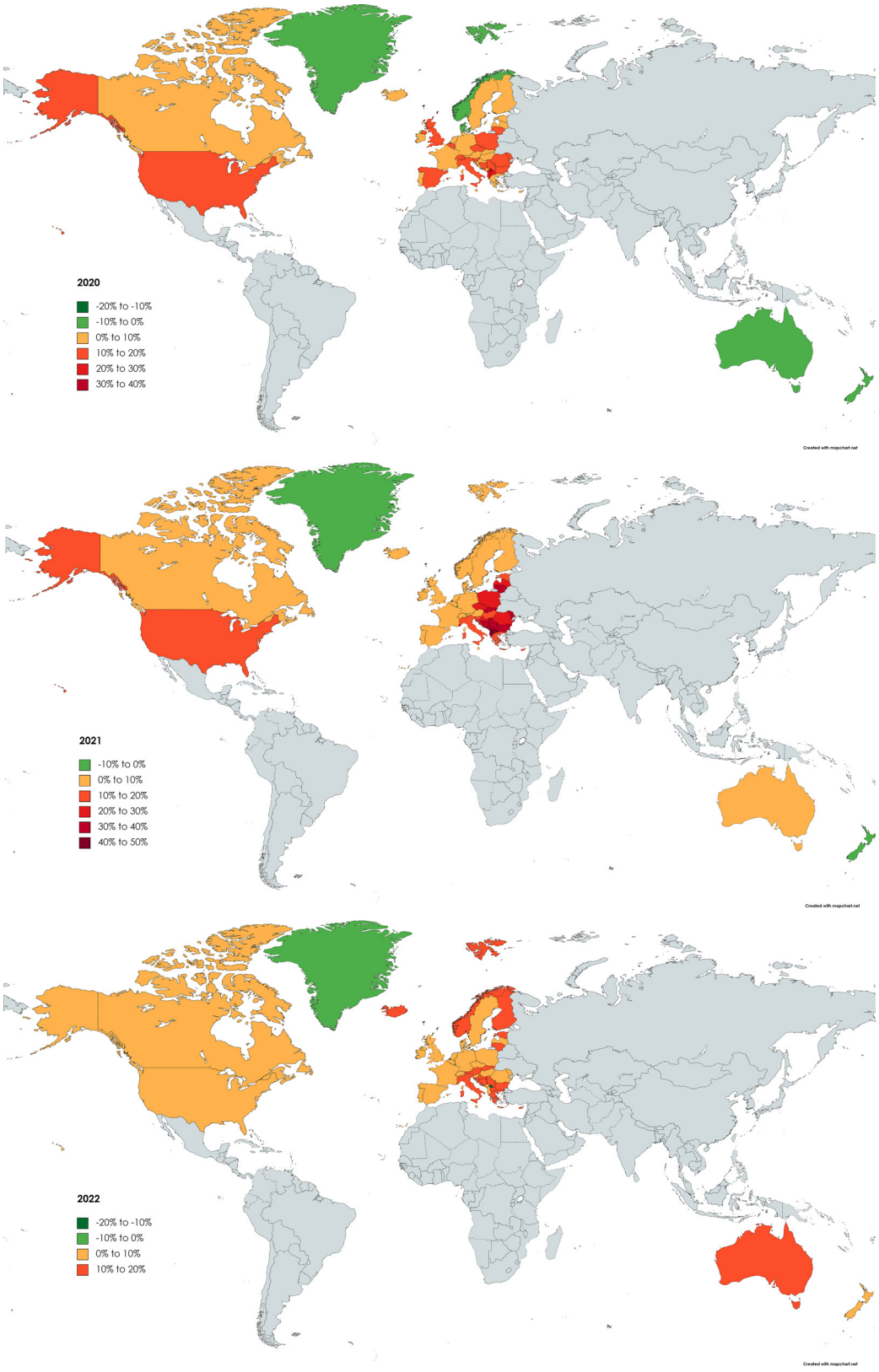

Figure 4 Map of excess mortality P-scores in the Western World (n=47 countries).[74] Preliminary and incomplete all-cause mortality reports are available for 2022.

investigate cause-specific excess mortality within certain countries or subregions during variable phases of the pandemic complicates elaborate cross-country comparative analysis.[1 2 16] Not all countries provide mortality reports categorised per age group.[2 12] Also testing policies for COVID-19 infection differ between countries.[1 2] Interpretation of a positive COVID-19 test can be intricate.[77] Consensus is lacking in the medical community

Table 1 Classification of excess mortality P-scores in the Western World (n=47 countries)

Excess mortality P-scores	2020		2021		2022*	
	Number of countries	Excess deaths	Number of countries	Excess deaths	Number of countries	Excess deaths
–20% to –10%	1 (2%)	–60	0 (0%)	0	1 (2%)	–1,112
–10% to 0%	5 (11%)	–6,583	5 (11%)	–660	3 (6%)	–256
0% to 10%	21 (45%)	149276	18 (38%)	249071	25 (53%)	631094
10% to 20%	16 (34%)	875598	8 (17%)	639757	18 (38%)	178666
20% to 30%	2 (4%)	11478	6 (13%)	215497	0 (0%)	0
30% to 40%	2 (4%)	3414	8 (17%)	135905	0 (0%)	0
40% to 50%	0 (0%)	0	2 (4%)	17373	0 (0%)	0

*Preliminary and incomplete all-cause mortality reports are available for 2022.

regarding when a deceased infected with COVID-19 should be registered as a COVID-19 death.[1 77] Indirect effects of containment measures have likely altered the scale and nature of disease burden for numerous causes of death since the pandemic. However, deaths caused by restricted healthcare utilisation and socioeconomic turmoil are difficult to prove.[1 78–81] A study assessing excess mortality in the USA observed a substantial increase in excess mortality attributed to non-COVID causes during the first 2 years of the pandemic. The highest number of excess deaths was caused by heart disease, 6% above baseline during both years. Diabetes mortality was 17% over baseline during the first year and 13% above it during the second year. Alzheimer's disease mortality was 19% higher in year 1 and 15% higher in year 2. In terms of percentage, large increases were recorded for alcohol-related fatalities (28% over baseline during the first year and 33% during the second year) and drug-related fatalities (33% above baseline in year 1 and 54% in year 2).[82] Previous research confirmed profound under-reporting of adverse events, including deaths, after immunisation.[83 84] Consensus is also lacking in the medical community regarding concerns that mRNA vaccines might cause more harm than initially forecasted.[85] French studies suggest that COVID-19 mRNA vaccines are gene therapy products requiring long-term stringent adverse events monitoring.[85 86] Although the desired immunisation through vaccination occurs in immune cells, some studies report a broad biodistribution and persistence of mRNA in many organs for weeks.[85 87–90] Batch-dependent heterogeneity in the toxicity of mRNA vaccines was found in Denmark.[48] Simultaneous onset of excess mortality and COVID-19 vaccination in Germany provides a safety signal warranting further investigation.[91] Despite these concerns, clinical trial data required to further investigate these associations are not shared with the public.[92] Autopsies to confirm actual death causes are seldom done.[58 60 90 93–95] Governments may be unable to release their death data with detailed stratification by cause, although this information could help indicate whether COVID-19 infection, indirect effects of containment measures, COVID-19 vaccines or other overlooked factors play an underpinning role.[1 8–14 20–25 39–60 68 90] This absence of detailed cause-of-death data for certain Western nations derives from the time-consuming procedure involved, which entails assembling death certificates, coding diagnoses and adjudicating the underlying origin of death. Consequently, some nations with restricted resources assigned to this procedure may encounter delays in rendering prompt and punctual cause-of-death data. This situation existed even prior to the outbreak of the pandemic.[1 5]

A critical challenge in excess mortality research is choosing an appropriate statistical method for calculating the projected baseline of expected deaths to which the observed deaths are compared.[96] Although the analyses and estimates in general are similar, the method can vary, for instance, per length of the investigated period, nature of available data, scale of geographic area, inclusion or exclusion of past influenza outbreaks, accounting for changes in population ageing and size and modelling trend over years or not.[7 96] Our analysis of excess mortality using the linear regression model of Karlinsky and Kobak varies thus to some extent from previous attempts to estimate excess deaths. For example, Islam *et al* conducted an age- and sex-disaggregated time series analysis of weekly mortality data in 29 high-income countries during 2020.[97] They used a more elaborate statistical approach, an overdispersed Poisson regression model, for estimating the baseline of expected deaths on historical death data from 2016 to 2019. In contrast to the model of Karlinsky and Kobak, their baseline is weighing down prior influenza outbreaks so that every novel outbreak evolves in positive excess mortality.[7 97] Islam's study found that age-standardised excess death rates were higher in men than in women in nearly all nations.[97] Alicandro *et al* investigated sex- and age-specific excess total mortality in Italy during 2020 and 2021, using an overdispersed Poisson regression model that accounts for temporal trends and seasonal variability. Historical death data from 2011 to 2019 were used for the projected baseline. When comparing 2020 and 2021, an increased share of the total

excess mortality was attributed to the working-age population in 2021. Excess deaths were higher in men than in women during both periods.[98] Msemburi *et al* provided WHO estimates of the global excess mortality for its 194 member states during 2020 and 2021. For most countries, the historical period 2015–2019 was used to determine the expected baseline of excess deaths. In locations missing comprehensive data, the all-cause deaths were forecasted employing an overdispersed Poisson framework that uses Bayesian inference techniques to measure incertitude. This study describes huge differences in excess mortality between the six WHO regions.[99] Paglino *et al* used a Bayesian hierarchical model trained on historical death data from 2015 to 2019 and provided spatially and temporally granular estimates of monthly excess mortality across counties in the USA during the first 2 years of the pandemic. The authors found that excess mortality decreased in large metropolitan counties but increased in non-metropolitan counties.[100] Ruhm examined the appropriateness of reported excess death estimates in the USA by four previous studies and concluded that these investigations have likely understated the projected baseline of excess deaths and therewith overestimated excess mortality and its attribution to non-COVID causes. Ruhm explains that the overstatement of excess deaths may partially be explained by the fact that the studies did not adequately take population growth and age structure into account.[96 101–104] Although all the above-mentioned studies used more elaborate statistical approaches for estimating baseline mortality, Karlinsky and Kobak argue that their method is a trade-off between suppleness and chasteness.[7] It is the simplest method to captivate seasonal fluctuation and annual trends and more transparent than extensive approaches.[7]

This study has various significant limitations. Death reports may be incomplete due to delays. It may take weeks, months or years before a death is registered.[5] Four nations still lack all-cause mortality reports for 1–4 months. Some nations issue complete data with profound arrears, whereas other nations publish prompt, yet incomplete data.[5 7] The presented data, especially for 2022, are thus preliminary and subject to backward revisions. The more recent data are usually more incomplete and therefore can undergo upward revisions over time. This implies that several of the reported excess mortality estimates can be underestimations.[7] The completeness and reliability of death registration data can also differ per nation for other reasons. The recorded number of deaths may not depict all deaths accurately, as the resources, infrastructure and registration capacity may be limited in some nations.[5 7] Most countries report per week, but some per month. Weekly reports generally provide the date of death, whereas monthly reports often provide the date of registration. Weekly and monthly reports may not be entirely comparable.[5 7] Our data are collected at a country level and provide no detailed stratification for sociodemographic characteristics, such as age or gender.[5 7]

In conclusion, excess mortality has remained high in the Western World for three consecutive years, despite the implementation of COVID-19 containment measures and COVID-19 vaccines. This is unprecedented and raises serious concerns. During the pandemic, it was emphasised by politicians and the media on a daily basis that every COVID-19 death mattered and every life deserved protection through containment measures and COVID-19 vaccines. In the aftermath of the pandemic, the same morale should apply. Every death needs to be acknowledged and accounted for, irrespective of its origin. Transparency towards potential lethal drivers is warranted. Cause-specific mortality data therefore need to be made available to allow more detailed, direct and robust analyses to determine the underlying contributors. Postmortem examinations need to be facilitated to allot the exact reason for death. Government leaders and policymakers need to thoroughly investigate underlying causes of persistent excess mortality and evaluate their health crisis policies.

Dissemination to participants and related patient and public communities

We will disseminate findings through a press release on publication and contact government leaders and policymakers to raise awareness about the need to investigate the underlying causes of persistent excess mortality.

Acknowledgements We are grateful for the support received from the Foundation World Child Cancer NL.

Contributors SM, MH and GK conceived and designed the study. SM and MH acquired and analysed the data. All authors interpreted the results. SM wrote the first draft of the manuscript. All other authors provided feedback and approved the final version of the manuscript. The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted. SM is responsible for the overall content as guarantor.

Funding The study was supported by the Foundation World Child Cancer NL. The sponsor had no role in the design and conduct of the study; collection, management, analysis and interpretation of the data; preparation, review or approval of the manuscript; and decision to submit the manuscript for publication.

Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available in a public, open access repository. The data for this study have been retrieved from the 'Our World in Data' database and are publicly available at: https://ourworldindata.org/excess-mortality-covid#.

terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

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From: Sarah Nau
Sent: 4/5/2024 4:55:26 PM
To: DOH WSBOH
Cc:
Subject: Letter of Support from WCAAP

attachments\57E7974A291B4485_SBOH community water fluoridation.pdf

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External Email

To whom it may concern,

Attached, please find a letter of support for community water fluoridation from the Washington Chapter of the American Academy of Pediatrics.

Please reach out with any questions.

Warmly,
Sarah Nau

<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwcaap.org%2F&data=05%7C02%7

Sarah Nau, MSW

She/her

Director of Communications

snau@wcaap.org <mailto:snau@wcaap.org>

Advocating for children, adolescents, families, and all who care for kids

WASHINGTON CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

Incorporated in Washington

WASHINGTON CHAPTER
AMERICAN ACADEMY OF PEDIATRICS

4616 25th Ave NE, #594
Seattle, WA 98105
wcaap.org

Chair Hayes and members of the board:

The Washington Chapter of the American Academy of Pediatrics (WCAAP) has a membership of more than 1,200 pediatric healthcare providers from around the state, including general pediatricians, sub-specialists, hospitalists, family physicians, and advanced practice providers. We care about children's whole health, ensuring that they thrive. WCAAP echoes the recommendations of the Centers for Disease Control and Prevention (CDC), the American Dental Association, and the American Academy of Pediatrics in stating that community water fluoridation is proven and effective for preventing unnecessary dental disease, a costly and painful condition.

Children with chronic tooth pain have difficulty learning, eating, and building self-esteem. They are more likely to miss school, earn lower grades, not graduate, and have lower incomes later in life. Adults with missing or visibly decayed teeth are at a disadvantage when seeking jobs. Seniors without teeth have a harder time getting the nutrition they need to be healthy. People of all ages with cavities can't receive transplants or have heart surgery without healthy teeth. Access to fluoridated water can help address all these problems.

When communities provide fluoridated water, it is available to everyone, regardless of age, income, or insurance status. It is an equitable solution. Unfortunately, in Washington State, only 56% of people on public water systems have community water fluoridation. Progress is needed to improve the equitable distribution of community water fluoridation across the state. It should not be harder to be healthy, simply because of a zip code.

As healthcare providers, we see firsthand the negative effects tooth decay has on people's oral and overall health. The good news is that tooth decay is preventable, and community water fluoridation is a safe and cost-effective way to promote good oral health and overall health for people of all ages and income groups.

WCAAP commends the State Board of Health for your ongoing recognition of the public health benefits of community water fluoridation. We ask for your continued support for proven measures like community water fluoridation for Washington.

Thank you,

Beth Ebel, MD, FAAP, MSc, MPH
WCAAP Board President

From: Arne Christensen
Sent: 4/18/2024 10:22:34 AM
To: DOH WSBOH
Cc:
Subject: floppy blue surgical masks

External Email

Last month King County's public health officer, Dr. Jeff Duchin, wrote this: "Consider one of those floppy blue surgical masks. They're not snug and air flows right around the sides, so no increase in work of breathing. Of course, no protection from CoV-19, but should do the trick."

The source is https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ftwitter.com%2FDocJeffD%2Fstatus

The state's health department surely was aware, in 2020, of the ineffectiveness against respiratory viruses of "floppy blue surgical masks," and yet it forced people to wear them. When you try to figure out why a large slice of the state's population no longer trusts the department; well, consider the false claims that were made about face mask effectiveness to be one glaring instance of giving us good reason to disregard what the department tells us.

Arne Christensen

From: lisa@informedchoicewa.org
Sent: 6/7/2024 9:11:29 AM
To: DOH WSBOH
Cc:
Subject: Public comment for 6.12.24 BOH meeting re VAERS


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External Email

Will you please place this in the Board's packet for the 6.12.24 meeting. Thank you.

Dear Members of the Board,

On behalf of Informed Choice Washington, I am writing in response to some of the statements that State Epidemiologist Dr. Scott Lindquist made regarding VAERS during his presentation to the Board at the April 10, 2024, meeting in Spokane.
vaers.hhs.gov/data.html
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvaers.hhs.gov%2Fdata.html&data

Dr. Lindquist confirmed that the Vaccine Adverse Events Reporting System (VAERS) is a federal-government-run program where practitioners, manufacturers, and members of the public report negative health incidents associated with administration of a vaccine product. The system does not establish causation, but it was designed to identify post-market safety signals in the public, after injuries have occurred.

VAERS is a passive system, established by Congress pursuant to the National Childhood Vaccine Injury Act of 1986, which shields childhood vaccine manufacturers from legal liability for the harms caused by their products. By providing a means of recording such deaths and injuries, VAERS was intended to mitigate the removal of product makers' accountability to consumers. While it's not perfect, the system does provide trends that public health is tasked with investigating. Absent investigations of each temporally-associated injury and death, causality cannot be denied. (An HHS-sponsored Harvard study noted "fewer than 1% of vaccine adverse events are reported [to VAERS]." In other words, 99% of adverse events go unreported.
https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
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lazarus-final-report-
2011.pdf&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0
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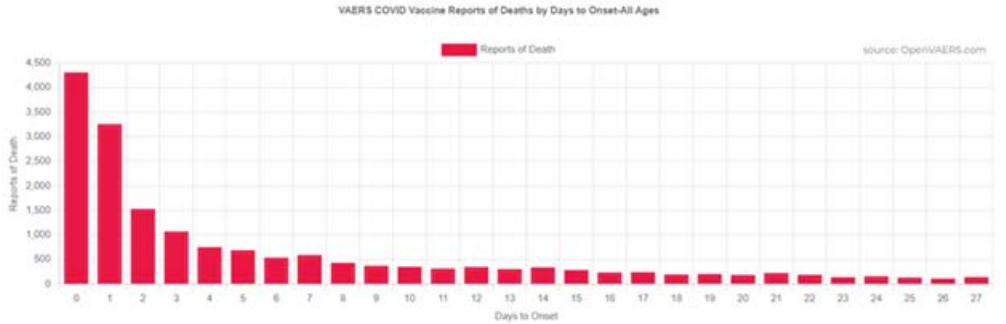

VAERS COVID Vaccine Reports of Deaths by Days to Onset-All Ages
Reports of Death
source: OpenVAERS.com
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Reports of Death
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27
Days to Onset

We appreciate Dr. Lindquist's encouraging clinicians and patients to report all post-vaccine events, regardless of their opinion of a causal link. Unfortunately, there is no legal ramification for practitioners who fail to do so. Nonetheless, the U.S. government's Healthy People 2020 site states that 83% of the reporters to the system were health care workers or pharmaceutical and government-based sources during the years 1990-2010. "The majority of VAERS reports are submitted by vaccine manufacturers (37%) and health care providers (36%). The remaining reports are obtained from state immunization programs (10%), vaccine recipients (or their parents/guardians, 7%), and other sources (10%)." Office of Disease Prevention and Health Promotion, Vaccine Adverse Reporting System, https://www.healthypeople.gov/2020/data-source/vaccine-adverse-event-reporting-system <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.healthypeople.gov%2F2020%
source%2Fvaccine-adverse-event-reporting-system&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0e2
, archived at https://wayback.archive-it.org/5774/20220414030910/https://www.healthypeople.gov/2020/data-source/vaccine-adverse-event-reporting-system <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwayback.archive-it.org%2F5774%2F20220414030910%2Fhttps%3A%2Fwww.healthypeople.gov%2F2020%2Fdata-source%2Fvaccine-adverse-event-reporting-system&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0e2

Pertaining specifically to Covid injections, 72% of a sampling of 250 of the 1,644 VAERS reports of early death received in the first three months of 2021 were filed either by health service employees or pharmaceutical employees. "We identified health service employees as the reporter in at least 67% of the reports, while pharmaceutical employees were identified as the reporter in a further 5%." Even though the sample contained only people vaccinated early in the rollout, i.e., those who were elderly or with significant health conditions, an adverse vaccine reaction could be ruled out in only 14% of the cases. Mclachlan, et al., Analysis of COVID-19 vaccine death reports from the Vaccine Adverse Events Reporting System (VAERS) Database Interim: Results and Analysis. 10.13140/RG.2.2.26987.26402. (2021), https://www.researchgate.net/publication/352837543_Analysis_of_COVID-19_vaccine_death_reports_from_the_Vaccine_Adverse_Events_Reporting_System_VAERS_Database_Inter

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.researchgate.net%2Fpublica
19_vaccine_death_reports_from_the_Vaccine_Adverse_Events_Reporting_System_VAERS_Database_Inter

If there were no causal link between Covid vaccination and death, one would expect to see the occurrence randomized with respect to days post-vaccine. Instead, most death reports occur in the first few days:

VAERS COVID Vaccine Reports of Death by Days to Onset—All Ages—as of April 26, 2024.

Source: https://openvaers.com/covid-data <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fopenvaers.com%2Fcovid-

KEY TAKE AWAYS

- Updated guidance streamlines for multiple respiratory diseases. Protect yourself and loved ones from respiratory diseases by getting updated vaccines, washing your hands, covering cough.
- The Washington State Legislature had a productive session passing bills to increase access to syphilis treatment, enhance response to opioid crisis, and strengthen public health capacity.
- VAERS has been around for more than 30 years and is one tool of many to make sure vaccines are safe and efficacious.

10/04/24
11:59:27 AM

Washington State Board of Health
April 10, 2024, 9:30 am - Spokane Public Library

2:09:20 / 5:06:25

data&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0e217

We respectfully disagree with Dr. Linquist's Key Take Away that VAERS "is one tool . . . to make sure vaccines are safe and efficacious." (See slide below.) VAERS is not designed to assess efficacy, and it does not in itself confer safety on these products. Instead, it passively gathers reports that collectively may bring to light a troubling signal. However, discovery of the signal depends on CDC investigations of the injurious events. Given that the CDC is in the business of promoting and selling these products, its ability to impartially attribute causation of injury is compromised and coming under increasing scrutiny from the public.

TVW recording of the April 10 BOH meeting

at tvw.org/video/washington-state-board-of-health-2024041039/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ftvw.org%2Fvideo%2Fwashington-state-board-of-health-2024041039%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%

In addition, the VAERS reporting program does not conduct studies comparing vaccinated and vaccine-free outcomes, as Dr. Lindquist alluded to at approximately 2:06 in the above recording.

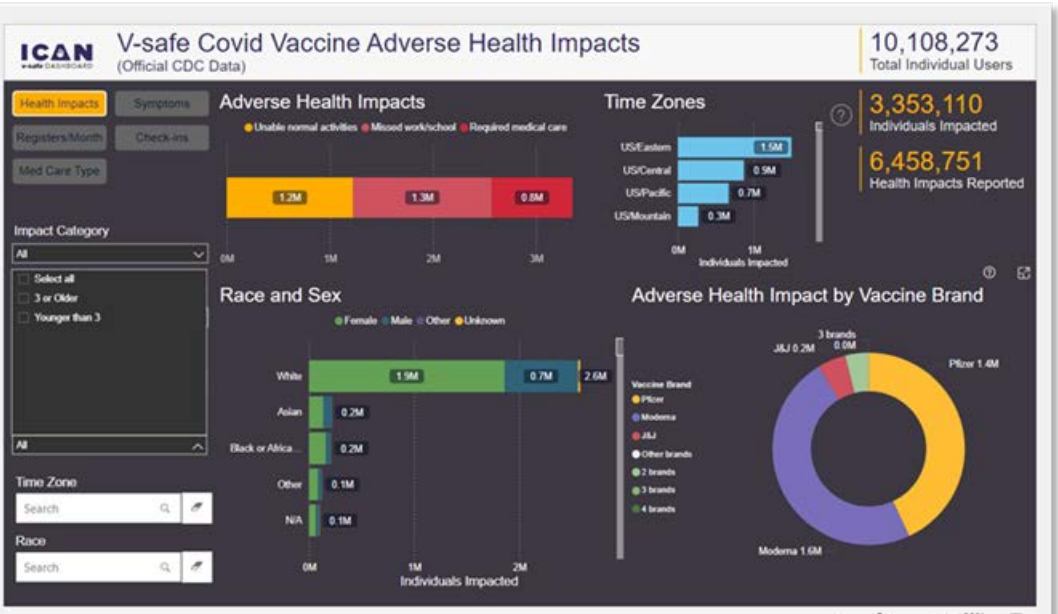
Here are some websites where medical professionals and/or individuals have documented their experiences with reactions from the Covid-19 injections:

* react19.org
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Freact19.org%2F&data=05%7C02%

* RealNotRare.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.realnotrare.com%2F&data=0

* anecdotalsmovie.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.anecdotalsmovie.com%2F&da

Pursuant to a FOIA request, additional context regarding injuries is available at icandecide.org/v-safe-data/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ficandecide.org%2Fv-safe-data%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0


ICAN
V-safe DASHBOARD
V-safe Covid Vaccine Adverse Health Impacts
(Official CDC Data)
10,108,273
Total Individual Users
Health Impacts
Symptoms
Registers/Month
Check-ins
Med Care Type
Impact Category
All
Select all
3 or Older
Younger than 3
All
Time Zone
Search
Race
Search
Adverse Health Impacts
Unable normal activities
Missed work/school
Required medical care
1.2M
1.3M
0.8M
0M
1M
2M
3M
Time Zones
US/Eastern
1.5M
US/Central
0.9M
US/Pacific
0.7M
US/Mountain
0.3M
0M
1M
Individuals Impacted
3,353,110
Individuals Impacted
6,458,751
Health Impacts Reported
Race and Sex
Female
Male
Other
Unknown
White
1.9M
0.7M
2.6M
Asian
0.2M
Black or Africa...
0.2M
Other
0.1M
N/A
0.1M
0M
1M
2M
Individuals Impacted
Adverse Health Impact by Vaccine Brand
Vaccine Brand
Pfizer
Moderna
J&J
Other brands
2 brands
3 brands
4 brands
3 brands
0.0M
J&J 0.2M
Pfizer 1.4M
Moderna 1.6M
83%
Microsoft Power BI
1 of 5

, which sets forth data collected by the CDC through its V-Safe app, a smartphone-based program that collected health assessments from approximately 10 million of the very first Covid vaccinees, who likely had the most favorable attitudes toward the products. In addition to downloading the free-text comments, you may view summaries of the following:

* Adverse health impacts;

* Covid-19 vaccine symptoms;

* Registrations per month;

* User check-ins; and

* Breakdown of type of medical care sought by V-Safe users.

<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ficandecide.org%2Fv-safe-data%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0

Dashboard at icandecide.org/v-safe-data/
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ficandecide.org%2Fv-safe-data%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cae1ac68a547c427f752d08dc870c6ca3%7C11d0

Of 10,108,273 V-Safe users, over 3.3% reported that they were unable to do their normal activities, missed work or school, or required medical care.

We want our public health community to acknowledge that injuries secondary to vaccine products do exist, and we appreciate that Dr. Lindquist does so. The message becomes diluted, however, when captured agencies do not carry out sufficient investigation and attribute almost all injury to coincidence, underlying cause, the illness itself, etc.

In any event, it is of paramount importance that no one be coerced into medical risk-taking. Informed Choice Washington and our members advocate for the removal of all vaccine mandates.

I would like to leave you with a question to ponder: why do you suppose the U.S. swine flu vaccination program of 1976 was halted after 53 deaths, but today the establishment mercilessly presses forward despite over 37,500 reports of deaths?

Thank you for taking the time to read and consider my comment.

Sincerely,

Lisa Templeton

Director

InformedChoiceWashington.org
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.informedchoicewa.org%2F&

From: bill teachingsmiles.com
Sent: 6/7/2024 9:07:44 AM
To: DOH WSBOH
Cc:
Subject: Public Comment for June Board Meeting

External Email

What are the Fed's doing about the National Toxicology Report on Fluoride as a Developmental Neurotoxin?

If you rely to some extent on other "authorities," to evaluate the science on fluoridation for public health policy, and to some degree we all should, you need to watch the video:

Fluoride On Trial: The Censored Science on Fluoride and Your Health | Childrens Health Defense
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Flive.childrenshealthdefense.org%2tv%2Fevents%2Ffluoride-on-trial-the-censored-science-on-fluoride-and-your-health%2Ffluoride-on-trial%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7Cadd84eb48f9f425d643408dc870ba25b%7C11d0

What are some of the Fed's saying about the current understand of the benefit and risks of fluoridation?

When I and others nominated fluoride to the NTP for evaluation of developmental neurotoxicity back in 2015, the NTP Board of Advisors agreed and we were told by the Director it would take perhaps 2 years for the final report.

As of June, 2024, over eight years after NTP started, the final report on fluoride's developmental neurotoxicity has not been published because (based on FOI documents) it was quashed and the scientific integrity compromised by the Assistant Secretary for Health, Admiral Rachel Lavine.

Anyone evaluating fluoridation's benefit and risks must watch the interview of Michael Connett JD by Mary Holland, JD. An interview examining under oath the Director of CDC's Oral Health Division, Casey Hannan, EPA's Representative Dr. Edward Ohanian, EPA's Neurotoxicologist, Dr. Stanley Barone, Jr., and EPA Office of Water, Joyce Donohue. Experts such as head of the NTP Brian Berridge, Former Director of NIEHS and NTP Linda Birnbaum, and the best of the best scientists on fluoride are quoted.

This interview will give greater context and documentation for understanding current Federal inaction on protecting the public from fluoride's harm.

POLITICIANS QUASHED SCIENCE

Court Declaration by Dr. Linda Birnbaum, former Director of NIEHS and NTP

"As someone who believes deeply in NTP's science-based mission, I am concerned by the recent course of events with the fluoride monograph. The decision to set aside the results of an external peer review process based on concerns expressed by agencies with strong policy interests on fluoride suggests the presence of political interference in what should be a strictly scientific endeavor."

Dr. Wolf at NTP/NIH/NIEHS in April 28, 2022, emailed (FOI document) to CDC Casey Hannon and others that the scientists considered the analysis and conclusions were set, "We are sharing this document for your awareness. At this time the analysis and the conclusions are set."

NTP Monograph on the State of the Science Concerning Fluoride Exposure and Neurodevelopmental and Cognitive Health Effects: A Systematic Review. NTP Monograph 08, May 2022. "Seventy-two studies assessed association between fluoride exposure and IQ in children."

The Dental lobby (ASTDD a private company funded by CDC) took steps to change the conclusion from "presumed" to "moderate confidence" of fluoride's developmental neurotoxicity and like the tobacco lobby always claiming, "More studies are needed. . . ."

Rachel Levine quashes the report. However, Judge Chen in the Superior Court of Northern California ordered the release of the draft report, over 700 pages <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Foutlook.office.com%2Fmail%2FAA
.

Sincerely,

Bill Osmunson DDS MPH

_____
From: bill teachingsmiles.com
Sent: 5/21/2024 8:55:35 AM
To: DOH WSBOH
Cc:
Subject: New Research on Fluoride

External Email

Please provide this to the Board of Health Members.

Here is a new study confirming behavioral problems for children ingesting fluoride.

May 20, 2024
"Maternal Urinary Fluoride and Child Neurobehavior at Age 36 Months
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjamanetwork.com%2Fjournals%2
"
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjamanetwork.com%2Fjournals%2

Maternal Urinary Fluoride and Child Neurobehavior at Age 36 Months | Public Health | JAMA Network Open | JAMA Network
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fjamanetwork.com%2Fjournals%2

USC's Keck School of Medicine (https://medicalxpress.com/news/2024-05-fluoride-exposure-pregnancy-linked-childhood.html#google_vignette
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmedicalxpress.com%2Fnews%2F2
05-fluoride-exposure-pregnancy-linked-childhood.html%23google_vignette&data=05%7C02%7CWSBOH%40SBOH.WA.GOV%7Cc1b6805edcc64b9
) found that a 0.68 milligram per liter increase in fluoride levels in the urine of pregnant women almost doubled the chance of a child showing neurobehavioral problems. These problems included emotional reactivity, anxiety and physical complaints, such as headaches and stomach aches.

How big was this?

* It was the first fluoride neurotoxicity study using a U.S. cohort.

* It was published in JAMA Network Open, lending it significant credibility.

* It was the first study linking prenatal exposure to increases in behavioral problems associated with autism.

* It was funded by the National Institutes of Health, NIEHS, and EPA. This was the 10th consecutive study funded by NIH linking higher fluoride levels with neurotoxicity.

* It's already being covered by several mainstream news outlets, including Newsweek, LA Times, Healthnews.com, NBC, Daily Mail and others.

The study analyzed 229 mother-child pairs of mainly Hispanic families living in Los Angeles, following them from pregnancy. It tested children at age three using the highly-regarded Preschool Child Behavior Checklist to measure a child's social and emotional functioning. It's noteworthy that LULAC, (League of United Latin American Citizens), the nation's oldest and largest Hispanic advocacy group, has for years been opposed to fluoridation (https://fluoridealert.org/content/lulac_resolution/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Ffluoridealert.org%2Fcontent%2Flu).

The study controlled for possible confounding variables that could affect these behavioral and health outcomes, such as lead exposure, household income, education, maternal age, ethnicity and other health factors. None altered the study's conclusions.

One of the strongest articles came from Brenda Balotti at Children's Health Defense, at https://childrenshealthdefense.org/defender/pregnant-mothers-fluoridated-tap-water-children-higher-risk-neurobehavioral-problems/ <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fchildrenshealthdefense.org%2Fde mothers-fluoridated-tap-water-children-higher-risk-neurobehavioral-problems%2F&data=05%7C02%7CWSBOH%40SBOH.WA.GOV%7Cc1b6805edcc64b9b9e2908dc79ae71b5 . In it, co-author Howard Hu was quoted: "When you add this to all the other studies that have been done on this subject in the last few years," it creates a body of evidence, which — in conjunction with the basic science looking at how fluoride may be toxicologically active on the brain — suggests that the impact of fluoride on neurobehavioral development problems is causal. It's not just an epidemiological association."

Two quotes from USC's press release emphasize this study's relevance and importance:

"The researchers hope the new findings help convey the risks of fluoride consumption during pregnancy to policymakers, health care providers and the public."

"Our findings are noteworthy, given that the women in this study were exposed to pretty low levels of fluoride – levels that are typical of those living in fluoridated regions within North America, said (lead author) Ashley Malin, PhD. . ."

For a more detailed article, check out FAN's press release at https://www.einpresswire.com/article-print/713217866/first-us-study-of-fluoride-neurotoxicity-finds-significant-risk-to-developing-brain <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.einpresswire.com%2Farticle print%2F713217866%2Ffirst-us-study-of-fluoride-neurotoxicity-finds-significant-risk-to-developing-brain&data=05%7C02%7CWSBOH%40SBOH.WA.GOV%7Cc1b6805edcc64b9b9e2908dc79ae71b5%7C11d

Bill Osmunson DDS MPH

_____
From: Bob Runnells
Sent: 6/7/2024 10:29:34 AM
To: DOH WSBOH
Cc:
Subject: Comments to WA SBOH for 12-June-2024 meeting

attachments\E669BC6D25774613_BMJ excess deaths 2024 e000282.full.pdf

External Email

Dear Board Members of the Washington State Board of Health,

Please read the attached article from the British Medical Journal – Public Health, titled Excess mortality across countries in the Western World since the COVID-19 pandemic: 'Our World in Data' estimates of January 2020 to December 2022.

Summarized methods state:

"All-cause mortality reports were abstracted for countries using the 'Our World in Data' database. Excess mortality is assessed as a deviation between the reported number of deaths in a country during a certain week or month in 2020 until 2022 and the expected number of deaths in a country for that period under normal conditions. For the baseline of expected deaths, Karlinsky and Kobak's estimate model was used. This model uses historical death data in a country from 2015 until 2019 and accounts for seasonal variation and year-to-year trends in mortality.

Summarized Results:

"Excess mortality has remained high in the Western World for three consecutive years, despite the implementation of containment measures and COVID-19 vaccines. This raises serious concerns. Government leaders and policymakers need to thoroughly investigate underlying causes of persistent excess mortality."

The attached BMJ Public Health article is published after the New York Times published on May 4th https://archive.ph/nc4N8an
<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Farchive.ph%2Fnc4N8an&data=05
another article acknowledging that the vaccine injured have been ignored.

Many public health officials cite that deferred medical screenings are at fault for excess deaths coming home to roost. Yet, aren't our public health officials the ones who promoted lockdowns, restrictions and widespread fear to cause the deferred cancer screenings in the first place?

Departments of health, advising other officials, should learn from this and take a more comprehensive view of the pros and cons, risks and benefits, before so whole-heartedly endorsing untested masks, restrictions and shots.

Sincerely,

Bob Runnells

President, Informed Choice Washington

From: Testify Online Survey
Sent: 5/24/2024 3:15:57 PM
To: DOH WSBOH
Cc:
Subject: Survey Response: Testify Online *

The following survey response is submitted:

1.

State Board of Health Meeting Date:

June 12, 2024

2.

Agenda Item or Issue:

Amendment to the WAC 246-260-131 6.B (i & ii)

3.

Your Name:

_____

Dave Belanger

4.

Do you have a professional title?

1. Yes

_____

Aquatics Center Coordinator- City of Seattle

5.

Are you representing an organization?

2. No

6.

Address:

_____

12714 NE 118th St Apt 1 Kirkland, Wa 98034

7.

Email:

david.belanger@seattle.gov

8.

Phone Number (Include Area Code):

425-442-1096

9.

Do you have any special expertise relevant to this topic?

1. Yes

I've been in the aquatic industry for over 30 years and am an American Red Cross Lifeguard Instructor Trainer. I teach the best ways to lifeguard to younger generations and ensure all our sites have the best safety plans possible.

10.

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

1. Yes

The language under the Required Personnel in the WAC code 246-260-131 6.B (i & ii) to be amended.

11.

Are you Pro or Con on the proposal?

1. Pro

I would like to remove the option to substitute a qualified coach for an active lifeguard during swim programs not open to the public as described in these sections. My argument is that in my experience in aquatics, coaches do not lifeguard or supervise the same way that an active scanning lifeguard would. They mostly manage sets and have conversations with swimmers off to the side or their nose is in a clipboard writing. There are many examples of coaches not supervising adequately and a drowning or serious injury is the result. I have included a few in my original submission. Would it take for more of this to happen for this to be changed to a safer practice? I would hope that we would want the safest policy for our aquatic facilities as possible. We have trained lifeguards where scanning at max 30 seconds is their sole responsibility, so why not utilize them? Because the WAC code allows this as an option to substitute a lifeguard for a coach who has lifeguarding, facilities choose this to lower the competitive swim rental. In my more than 30 years experience, 99% of the time these coaches who rent the pools for their programs do not participate in the required lifeguard in-service trainings and have never actually practiced their skills outside of their lifeguard renewals every 2 years. This is not regulated by anyone since they are not an employee of the pool facility. The WAC code does not address this in the personnel section so it never gets enforced. The organization I work for is hesitant to make any changes here until the WAC code changes as well since many of the rentals we provide also rent at many other pools in the region. This has been the competitive swim culture for many years and will be a hard transition if approved, but even those who will complain, will acknowledge the improved safety it warrants. So in conclusion, I would like to see a requirement for all public swim pools who rent out to competitive swim teams be required to put qualified lifeguards in the LG chair actively scanning during their water time. Because the level of supervision/safety should not change from a public vs private program at the same location. Many times the pool doors are still open to allow the rental parents and spectators in so there is not always a clear designation that this is a private vs public program. All the public see's are no lifeguards on duty... Thank you for listening.

From: Christina Blocker
Sent: 4/29/2024 10:46:26 AM
To: DOH WSBOH
Cc:
Subject: Elevating Community Health through Targeted Collaboration

External Email

Dear Board of Directors,

I hope this email finds you well. As the Co-founder of Elevate Black Wellness <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.elevateblackwellness.com%2, I am reaching out to discuss an opportunity for collaboration that aligns with the Washington State Board of Health's mission to protect and improve the health of all people in Washington state.

Elevate Black Wellness has been making significant strides in promoting health equity and empowering communities in Washington state, as demonstrated by the success of our inaugural Black Wellness Week and our partnership with the Washington State Department of Health <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.abc27.com%2Fbusiness%2Freleases%2Faccesswire%2F855590%2Felevate-black-wellness-spearheads-transformative-movement-with-inaugural-black-wellness-week%2F&data=05%7C02%7Cwsboh%40sboh.wa.gov%7C7018464f1493475f878408dc687448a5%7C11d. Our work is rooted in the principle of targeted universalism, which recognizes that while universal strategies are important, targeted interventions are necessary to address the unique challenges faced by specific communities.

By focusing on the specific needs of Black communities, we aim to create a rising tide that lifts all boats. When we invest in the health and well-being of those most impacted by health disparities, we create a stronger, more resilient community for everyone. Our work addressing vaccine hesitancy and reducing stigma in Black communities is a model for how targeted interventions can lead to improved health outcomes for all.

I believe that by collaborating with the Washington State Board of Health, we can amplify our impact and create a more equitable and healthy Washington state. By combining our expertise in community engagement with your resources and influence, we can develop targeted strategies that address the root causes of health disparities while also promoting the overall health and well-being of all Washingtonians.

I would love to schedule a meeting with you to discuss how Elevate Black Wellness can support the Washington State Board of Health's goals and explore potential collaboration opportunities. Please let me know your availability for a 30-minute meeting in the coming weeks. I've included my calendar link here <https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fmeetings.hubspot.com%2Fchristinblocker%2Fpartnership-exploration&data=05%7C02%7Cwsboh%40sboh.wa.gov%7C7018464f1493475f878408dc687448a5%7C11 for your convenience.

Thank you for your time and consideration. I look forward to the possibility of working together to create a healthier, more equitable Washington state for each one of us.

Warmly,

Christina Blocker

Co-Founder of Elevate Black Wellness
www.ElevateBlackWellness.com
<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.elevateblackwellness.com%2

WASHINGTON STATE BOARD OF HEALTH

SBOH Active Rulemaking Projects, Estimated Milestones

Environmental Health Rules	CR-101	Board Update	Board Briefing	CR-102	Board Hearing	CR-103	Effective Date
On-Site Sewage Systems Chapter 246-272A WAC Board Sponsor: Kate Dean	March 2018	January 2023	October 2023	October 2023	January 2024	February 2024	April 2025
On-Site Sewage Systems – Rulemaking Delegation to DOH 246-272A-0110 WAC Table I Category 2	May 2024	TBD	TBD	TBD	TBD	TBD	TBD
Sanitary Control of Shellfish Chapter 246-282 WAC Board Sponsor: Patty Hayes	February 2022	June 2024	November 2024	September 2024	November 2024	February 2025	TBD
Water Recreation Chapters 246-260, 246-262 WAC Board Sponsor: Patty Hayes	December 2016	August 2024	TBD	TBD	TBD	TBD	TBD
School Environmental Health & Safety Chapters 246-366, 246-366A WAC, Proposed Chapter 246-370 WAC Board Sponsor: Patty Hayes	June 2024	Periodically	April/June 2025	TBD	TBD	TBD	TBD
Group A Public Water Supplies – PFAS	Est. 101&	Periodically	June 2024	TBD	TBD	TBD	TBD

Chapter 246-290 Board Sponsor: Kate Dean	103E, June 2024						
Group A Public Water Supplies – Consumer Confidence Reports	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Group A Public Water Supplies – Climate Resilience Planning (Rulemaking Delegation to DOH) Chapter 246-290 Board Sponsor – Patty Hayes		June 2024		February 2024	N/A	June 2024	July 2024
Handling of Human Remains – Response to SHB 1974 Chapter 246-500 Board Sponsor: Patty Hayes	N/A	April 2024	April 2024	May 2024	June 2024	June 2024	July 2024

Health Promotion Rules	CR-101	Board Update	Board Briefing	CR-102	Board Hearing	CR-103	Effective Date
Newborn Screening – OTCD Chapter 246-650 WAC Board Sponsor: Kelly Oshiro	February 2022	March 2024	August 2024	TBD	TBD	TBD	TBD
Newborn Screening – GAMT Deficiency and ARG1-D Chapter 246-650 WAC Board Sponsor: Kelly Oshiro	November 2023	March 2024	August 2024	TBD	TBD	TBD	TBD
Vital Statistics – Rulemaking Delegation to DOH Chapter 246-491 WAC Board Sponsor: Dr. Tao Kwan-Gett	January 2023	November 2024?	TBD	TBD	TBD	TBD	TBD

Auditory and Visual Standards – School Districts Chapter 246-760 WAC Board Sponsor: Kelly Oshiro	October 2023	November 2024	January 2025?	TBD	TBD	TBD	TBD

Updated June 2024

Please note: Estimated milestones are subject to change due to many factors. Staff will continue to monitor and periodically update project timelines.

Other SBOH Rule and Policy Projects

Project	Description	Status	Due Date	Comments
2024 State Health Report	A requirement under RCW 43.20.100 – biennial legislative report that the Board must submit to the Governor's Office in even-numbered years. Highlights suggestions for public health priorities and policy recommendations.	In progress	Due to the Governor's Office by July 1, 2024	
PEAR Plan	The Governor's Executive Order 22-04 implements the Washington State Pro-Equity Anti-Racism Plan and Playbook. All state agencies, including boards and commissions, must implement a PEAR Plan to bridge opportunity gaps. Every September, state agencies must	In progress	Board Adoption of PEAR strategic plan scheduled for October 2024.	

	provide data to the Office of Equity and submit updated plans. This year, the Board will complete its initial PEAR strategic plan.			
SB 6234 – Screening newborn infants for branched-chain ketoacid dehydrogenase kinase deficiency (BCKDKD)	SB 6234 tasks the State Board of Health to review BCKDKD for possible inclusion in the WA NBS panel following its process for reviewing candidate conditions. The Board must submit a report to the Governor and applicable legislative committees with findings and recommendations from this work.	Not started	Report due to the Governor's Office by June 30, 2025	The project start date is pending hiring an MA 5 NBS project position.
SB 5829 – Screening newborn infants for congenital cytomegalovirus (cCMV)	SB 5829 tasks the State Board of Health with reviewing cCMV for possible inclusion in the WA NBS panel following its process for reviewing candidate conditions. The Board must submit a report to the Governor and applicable legislative committees with findings and recommendations from this work.	Not started	Report due to the Governor's Office by January 31, 2025	The project start date is pending hiring an MA 5 NBS project position. The Board and Department initially reviewed cCMV in 2022. The TAC and Board recommended revisiting the condition in 2025. This work is aligned with our current agency work plans. The only addition is the required legislative report.

SBOH Rule Review Projects – Active and Pending

	Status	Start	Target Date	Comment
Camps Chapter 246-376 WAC	Rule Review	April 2024	August 2024	The rules have not been updated in a significant amount of time and are due for a review.
Outdoor Music Festivals Chapter 246-374 WAC	Rule Review	April 2024	August 2024	The rules have not been updated in a significant amount of time and are due for a review.

Health Impact Reviews (HIRs)

- Health Impact Reviews (HIRs) are completed by request of any Washington State Legislator or the Governor. A comprehensive and up-to-date list of all completed and active HIRs is available on the Board's website at: https://sboh.wa.gov/health-impact-reviews

ENVIRONMENTAL HEALTH COMMITTEE
SPECIAL MEETING SUMMARY NOTES

What: Environmental Health (EH) Committee

When: May 9, 2024

- **Attending:** Board of Health (Board) Members Kate Dean (Committee Chair), Patty Hayes (Board Chair), Mindy Flores, Paj Nandi, Steve Kutz; Board staff Michelle Davis (Executive Director), Andrew Kamali (Host), Molly Dinardo, Shay Bauman, Ashley Bell, Hannah Haag, Michelle Larson, Heather Carawan; Department of Health (Department) staff Brad Burnham, Dani Toepelt, Jocelyn Jones, Joe Laxon, Mike Means, Barbara Morrissey, Tami Thompson, Todd Phillips, Katitza Holthaus, Juan Gamez Briceno, Mike Dexel, Ali Boris, and approximately 12 members of the public also attended the meeting.

Summary Notes:

General Updates

EHD Updates

- Jen Garcelon, (Clallam County) Chair of Washington State Environmental Health Directors Association (WSEHD) provided an overview of WSEHD, its make-up, history, and goals. Board Members expressed appreciation for EHD participation in the meeting and the importance of their perspective.

Preview of June Board Meeting

- Michelle Davis, Board Executive Director, discussed the extension of WAC 246-366A effective date. Michelle D. described the School Environmental Health and Safety (EHS) project and discussed the recruitment, preliminary timeline, and foundational project work. Member Kutz expressed concern for adequacy of school funding, and challenges of assessing impacts.
- Shay Bauman, Board staff, discussed the rules hearing for the Handling of Human Remains. Shay is working on translating the proposed rule into Spanish so that rule alerts can go out before the hearing on June 12. Member Kutz expressed concern about unidentified remains. Shay noted the topic is outside of the Board's rule authority.
- Shay previewed rules update on Sanitary Control of Shellfish, which is separate from the Department's fee work. Shay updated the committee on draft language and the extension of the informal public comment period. Two areas of concern are seed size and inclusion of vibrio vulnificus. Members Nandi and Kutz asked for additional background before the June 12 Board meeting.

(Continued on the next page)

- Mike Means, Department Capacity Development and Policy Manager, provided an update on delegated rulemaking – introducing a new section into Climate Resilience in Water System Plans. The legislature requires group A plans to include a climate resiliency element (WAC 246-290-200). This is an abbreviated rulemaking process, and the hearing was held in April 2024. They received limited comments, four in support and others beyond the scope of the rulemaking. The department is working towards final adoption.
- Molly Dinardo, Board staff, discussed the 2024 State Health Report. Molly reflected on themes and status of past recommendations, as well as draft recommendations for the Board's consideration. Member Kutz requested a follow-up conversation with Molly. Member Hayes asked how the community groups we've connected with will have the opportunity to engage in the work. Hannah talked about revising our approach moving forward. Member Hayes mentioned the importance of thinking about community. Member Flores commended this work and looks forward to hearing more at the June 12 Board meeting.

Preview of August Board Meeting

- EH Committee Chair Dean referenced the School Environmental Health and Safety Project Update which was reviewed earlier in the meeting.
- Shay Bauman, Board staff, previewed a request for delegated rulemaking on the Lead and Copper rule which may come before the Board in August.
- Andrew Kamali, Board staff, provided an update on the Water Recreation Rules and progress since the petition from last August.
- Shay briefly presented information about the Camps rule review and will present recommendations at the August Board meeting.
- Andrew discussed the Outdoor Music Festival rule review (chapter 246-374 WAC). This rule hasn't been updated in many years, and Andrew is coordinating the review with local jurisdictions.
- Ashley Bell, Board staff, presented a Pro-Equity Anti-Racism (PEAR) Plan update. This is a strategic equity plan, identifying what we do well and where we can improve. The focus is on policy, access, and relationships. The Board will have an update on this work and some draft PEAR language to review at the August meeting. Member Nandi thanked Ashley and the team for this work.

Other Environmental Health (EH) Rulemaking Updates

- Department staff Mike Means, Capacity Development and Policy Manager, and Barbara Morrissey Toxicologist reviewed Per- and polyfluoroalkyl substances (PFAS). Mike and Barbara discussed what they are and Washington's efforts to address PFAS. Mike and Barbara also discussed the Environmental Protection Agency (EPA)'s new science on PFOA and PFOS and their 2024 MCL requirements.

- EH Committee Chair Dean asked about the Board's authority to adopt standards and asked Barbara about PFAS in fish. Barbara responded that the Department has a fish advisory program and that the contamination being reported is currently mostly in freshwater lakes.
- Todd Phillips, Department staff, Contamination Workgroup, spoke about finalizing an Interpretive Statement on Methamphetamine Contamination via personal use. This statement advises local health officers on how the Department of Health interprets chapter 64.44 RCW. The statement is focused on methamphetamine contamination by use in transient accommodations. Todd noted that these are interim steps to future policy.

Committee Member Comments, Questions, and Next Steps

- Andrew, Board staff and EH Committee Chair Dean are looking forward to seeing everyone in Vancouver in June.

HEALTH EQUITY
Governor's Interagency Council on Health Disparities

Esmael López
Council Engagement Lead

Esmael López joins the Governor's Interagency Council on Health Disparities on June 17, 2024. He leads community and Tribal engagement and outreach efforts, helping the Council build relationships with various partners and communities.

Esmael has spent most of his life organizing alongside youth, families, and communities of color to gain access to resources that improve community wellbeing. With a profound belief in the power of collective action, he is a dedicated community engagement specialist whose passion lies in supporting grassroots movements and community-based strategies.

Prior to joining the Council, Esmael worked as an Outreach Coordinator with the Northwest Justice Project. He engaged farmworkers and immigrant worker communities through legal support, employment rights education, and assistance in accessing personal protective equipment through the COVID-19 pandemic. Prior to that, Esmael supported the Washington State Office of Equity Task Force and the Environmental Justice Task Force as their Community Engagement Coordinator. He served as the liaison for community-based organizations and the public for both task forces by building relationships.

Grounded in the principles of equity and empowerment, Esmael brings a wealth of experience in mobilizing resources, facilitating dialogue, and implementing effective strategies for positive change. He hopes his commitment to movement building inspires others to join in the journey towards a more inclusive and empowered society.

HEALTH EQUITY
Governor's Interagency Council on Health Disparities

Gavin Rienne, MPH, PhD
Council Social Epidemiologist

Gavin Rienne joins the Governor's Interagency Council on Health Disparities on June 17, 2024. He designs and conducts research, epidemiological analyses, and evaluation to support the Council's policy development and decision making.

Prior to joining the Council, Dr. Rienne worked as a Postdoctoral Scholar at the Center for Innovation in Public Health at University of Kentucky, where he designed epidemiologic studies to investigate children's health needs and inequities in health services. He has designed studies examining the impact of disaster events on children and community health over time. Dr. Rienne has also provided consultation to state health officials on projects to improve health delivery outcomes. Dr. Rienne's other roles at University of Kentucky included serving as a teaching assistant and researcher. He also did public outreach presentations on the COVID-19 pandemic and health safety measures. Dr. Rienne has over 10 years of experience in translational research investigating environmental health, maternal and child health, and population health.

Dr. Rienne holds Bachelor of Science degrees in Psychology from the University of Maryland and Microbiology & Molecular Genetics from Michigan State University. He earned a Master of Public Health degree in Epidemiology from the University of Louisville as well as a Doctor of Philosophy (PhD) degree in Epidemiology & Biostatistics from the University of Kentucky.

Washington State Department of Health Update

Mike Ellsworth, JD, MPH

FEDERAL AND REGULATORY AFFAIRS DIRECTOR, WA-DOH

Kelly Cooper

POLICY & LEGISLATIVE RELATIONS DIRECTOR, WA-DOH

Washington State Board of Health
06/12/24 | Vancouver

Washington State Department of HEALTH

@WaDeptHealth
@WaHealthSec

Highly Pathogenic Avian Influenza (HPAI)

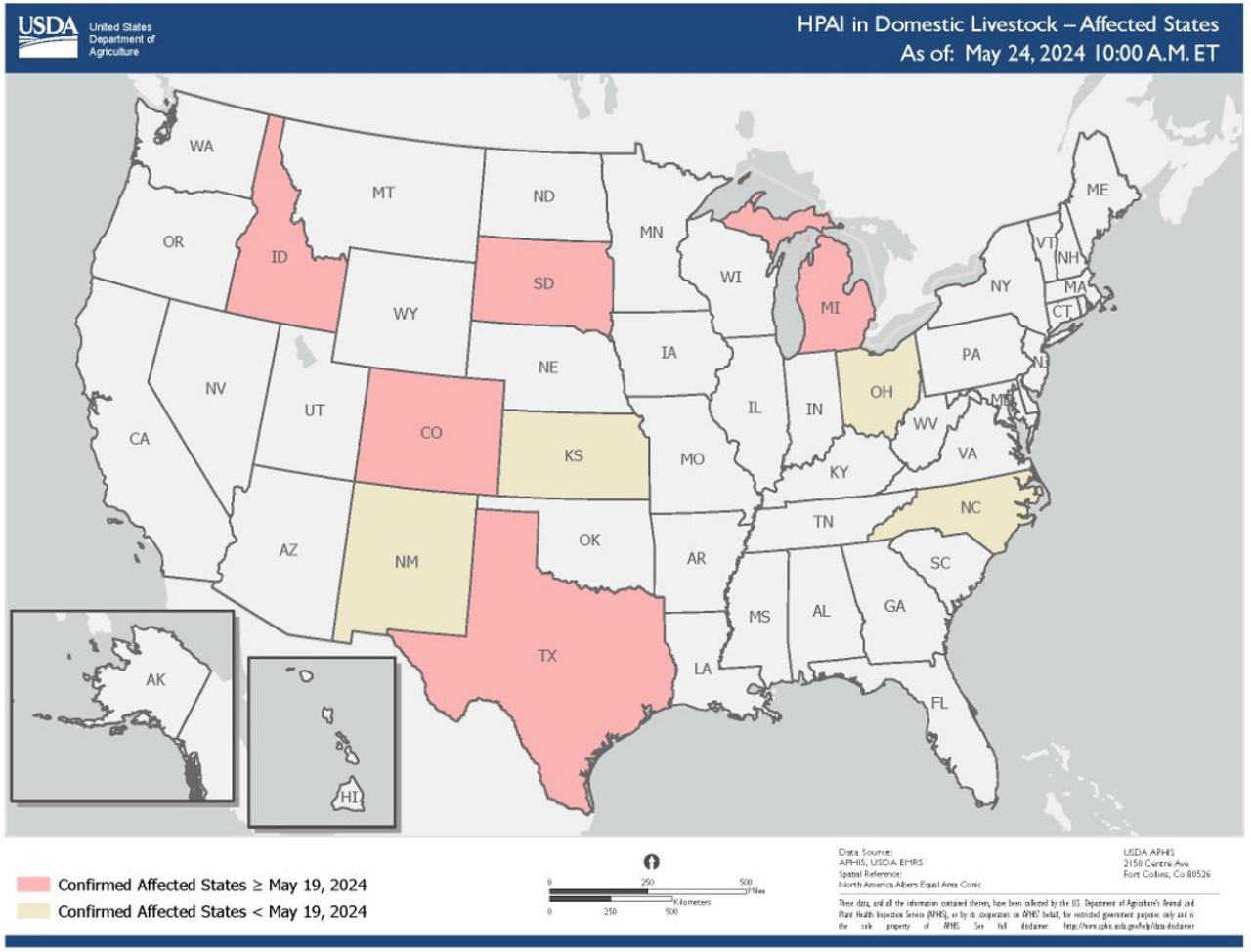
NATIONAL SUMMARY OVERVIEW OF HPAI H5N1 IN DOMESTIC LIVESTOCK

On March 25, 2024, the USDA National Veterinary Services Laboratory confirmed the first detection of HPAI H5N1 clade 2.3.4.4b in a Texas dairy herd. Phylogenetic analysis and epidemiology support a single introduction into this novel host followed by onward transmission.

The total confirmed detections for the domestic livestock incident includes:

- 63 premises in 9 states

State	# of Confirmed Detections
Colorado	4
Idaho	8
Kansas	4
Michigan	19
New Mexico	8
North Carolina	1
Ohio	1
South Dakota	4
Texas	14
Grand Total	63



Note: This map displays the affected States since Sunday.

Transformational Plan - Global & One Health

WA-DOH Chief of Global & One Health

April 11, 2024

Introducing DOH's First Chief of Global & One Health

Good afternoon DOH team!

It is my great pleasure to announce that Dr. Atousa Salehi will be joining DOH's Executive Leadership Team (ELT) in mid-April as our agency's inaugural Chief of Global & One Health (GOH).

In this capacity, Dr. Salehi will lead our first-ever Executive Office of Global One (OGO). This is an incredibly important milestone as DOH becomes the first state health agency in the nation to create such an office and to prioritize this work together. Her role will be to provide strategic leadership, foster ongoing connections, and enhance coordination of our work across the organization and externally, in line with our agency cornerstone values of Equity, Innovation, and Engagement (EIE).

"I am deeply honored to contribute my expertise to the Washington State Department of Health and am fervently committed to the organization's mission and to the innovations and One Health solutions that promise a more healthful future for all Washingtonians."

While the newly created OGO will start small, it will be mighty in its vision: to develop, curate, and implement the application of global and One Health learnings to improve the health and well-being of all Washingtonians. OGO will underscore the importance of a strong bidirectional global and domestic health ecosystem, while recognizing the important relationship of humans, animals, and the environment.

Dr. Salehi will help bring our agency vision for this work outlined in the DOH Transformational Plan to life. This includes incorporating best practices, leveraging collective strength and wisdom from Global and One Health innovators, seeking resources and funding to support this work, and working across DOH to support the health of immigrant, refugee, and migrant communities across Washington.

As background, Dr. Salehi is a board-certified emergency physician with a steadfast commitment to global health equity. She has over two decades of experience in clinical practice, health system management, and digital health innovations. During her career, she has served at the forefront of emergency response, led system-wide quality improvement initiatives that enhanced health outcomes and optimized healthcare delivery, and developed and implemented transformative digital health solutions.

Driven by a mission to close healthcare access and quality gaps through innovative technologies, Dr. Salehi has steadfastly designed and implemented evidence-based, scalable, and sustainable health initiatives through strong global collaborations and coordination. These endeavors have fostered robust health solutions to empower people to lead healthier lives. Her hands-on experience in emergency medicine, coupled with her own background and experience in under-resourced and emerging developing countries, have instilled in her a profound understanding of the unique challenges faced by underserved populations and the comprehensive strategies necessary to address them.

Global & One Health

Vision

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

Commitment

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

Key Strategies

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

Equity, Innovation, Engagement

WA-DOH Community Conversations

Equity, Innovation, Engagement

WA-DOH Opioid and Drug Use Data

Opioid and Drug Use Data

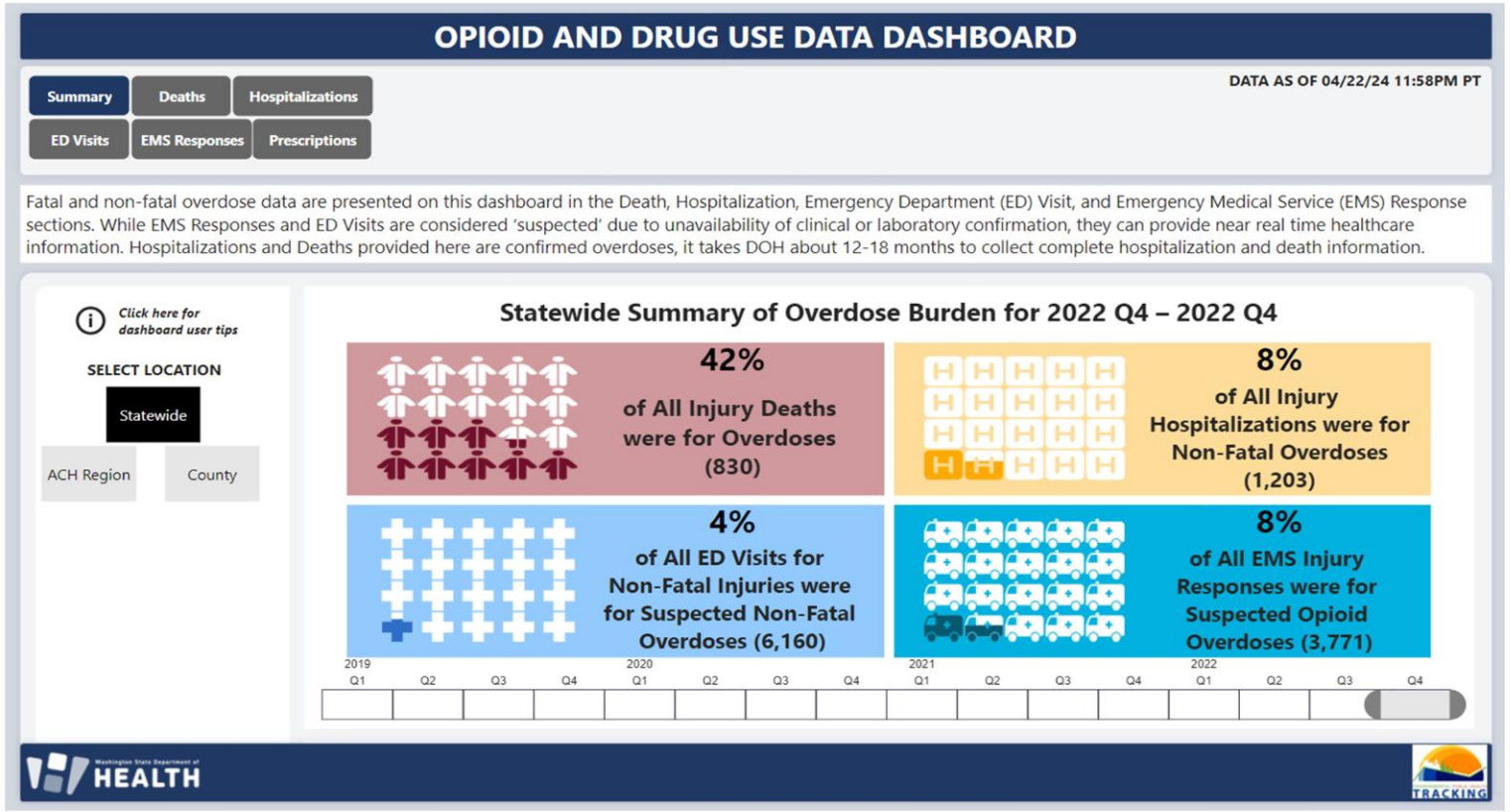
You are currently looking at the Opioid and Drug Use Data Dashboard. This dashboard contains data on *counts and rate trends* among Washington State residents.

If you are interested in seeing *circumstances surrounding* unintentional and undetermined drug overdose deaths in Washington, please refer to the SUDORS data dashboard

Jump to data downloads

Due to a data processing error, the number of non-fatal overdose ED visits is likely an undercount. For further questions, please contact the RHINO inbox at RHINO@doh.wa.gov.

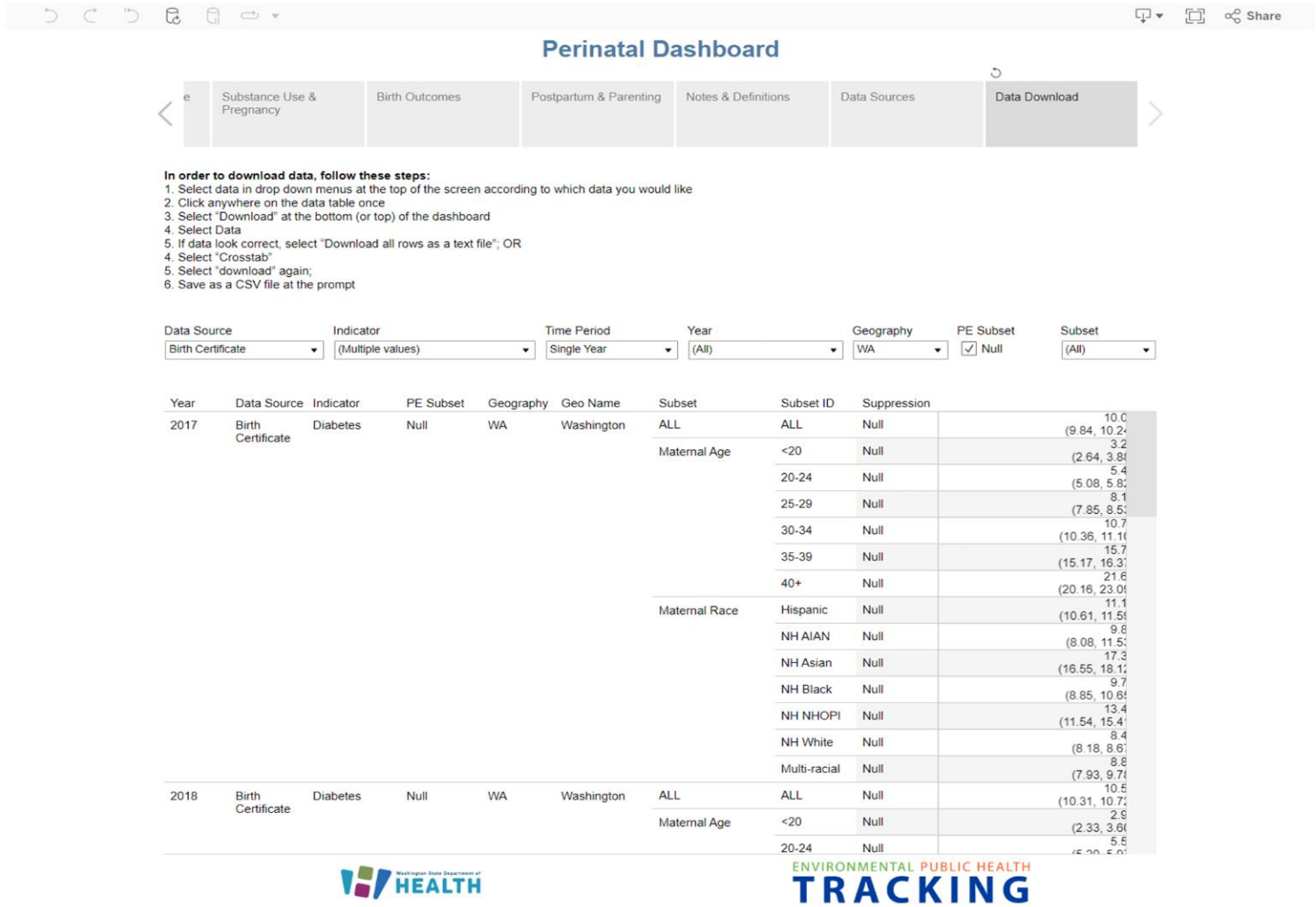
The monthly update of the EMS data on the dashboard is delayed due to a temporary system error. Please reach out to WEMSIS@doh.wa.gov if you have any questions.



WA-DOH Perinatal Data

Perinatal Dashboard

5/17/24 It has come to our attention that the data on birth outcomes in this dashboard differ from those produced in the Community Health Assessment Tool, and may not be accurate. We are working to address this issue and hope to publish an updated dashboard soon. No other data in this dashboard should be affected by this issue.



Equity, Innovation, Engagement

Public Health Connects

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Politics Law & Justice Watchdog Mental Health Project Homeless Education Traffic Lab Eastside Climate Lab Obituaries

Health | Local News | Mental Health | Nation | Wellness

We can all help combat loneliness, surgeon general says in Seattle

May 30, 2024 at 6:00 am | *Updated May 30, 2024 at 6:00 am*

2 of 2 | Washington State Health Secretary Umair Shah, left, and U.S. Surgeon General Vivek Murthy discuss loneliness and isolation in Seattle on Wednesday. (Washington State Department of Health)

By Taylor Blatchford

Seattle Times engagement reporter

Public Health Connects

A speaker series hosted by Secretary of Health, Dr. Umair A. Shah

Public Health Connects is a video series developed by the Washington State Department of Health to advance health equity, spotlight innovative ideas, and foster collaborative partner engagement throughout the health and wellness system — and beyond. Together, we can create a future where everyone can live their healthiest lives.

Episode One: How to lead with heart during a time of crisis

Discussion with Abigail Echo-Hawk, M.A., Chief Research Officer, Seattle Indian Health Board

Episode Two: Fact or fiction? Navigating the social media rumor mill in an online world

Discussion with Dr. Kate Starbird, PhD, Co-Founder, Center for an Informed Public, University of Washington

Episode Three: How AI will transform healthcare and the healthcare ecosystem

Discussion with Vidhu Shekar, Government Strategy Leader, Microsoft

Episode Four: On the epidemic of loneliness and isolation in *Rx for a lonely nation*

Discussion with Dr. Vivek Murthy, U.S. Surgeon General

WA-DOH's Update on State Legislature

2024 Legislative Session Recap

2024 was a "short" session

- Even years are "short" 60-day sessions
- Odd years are "long" 105-day sessions

Democratic Majorities in the House and Senate

1,615 bills introduced, 379 bills passed the Legislature

74 DOH implementation plans in progress

- 27 bills
- 47 budget provisos

Supplemental budget - $2.1 Billion Overall

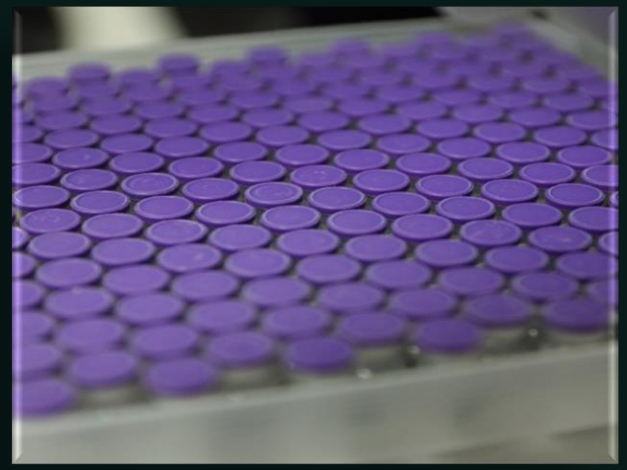
2024 Agency Request Legislation

Senate Bill 5271

DOH Facilities Enforcement

Senate Bill 6095

Standing Orders Authority



Senate Bill 5982

Updating the Vaccine Definition

Opioid and Fentanyl

DOH Outreach and Education Campaigns

- Statewide Drug Overdose Prevention campaign for youth and adults
- Higher Education – HB 2112
- OSPI Opioid Education Materials – Gov Requests (OSP/OPAE/PCH)

Guidelines

- High potency synthetic opioid guidance for courts - DCYF/Tight Timeline
- Breastfeeding SUD
- Car Decontamination

Naloxone Funding

- Expand access to K-12 schools, higher education, libraries, first responders

Pass-through funding to local health, CBOs, and Tribes

- Education & awareness opioid toolkits (Pierce County)
- Public awareness campaigns

DOH Opioid data dashboard & systems funding

Behavioral Health

Workforce

- WA Health Corp Scholarships
- Workforce Supports – HB 2247

Facilities

- Extending 23-hour crisis facilities to minors

Behavioral Crisis Coordination

- BH-Admin Services Designation (w/HCA)
- 988 Funding

Equity, Tribes, Environmental Health

- WSBOH School Rule: Advisory Group Review
- Native Youth Sports Program funding
- Shellfish program/fee review (and report)
- Fusion technology and clean energy policies workgroup
- Health Equity Zone Funding
- HEAL Act Funding
- *Food as Medicine* WIC Program
- Community Compensation Funding
- Oral Health Equity Workgroup

Health Systems Transformation

Certificate of Need Assessment and Report

- *CN exemption extended for psychiatric beds/hospitals*

New Models of Care

- Hospital at home services state law
- EMT Credential to Work in Hospitals

POLST Registry Feasibility Study

WA HEALTH Assessment

Workforce Transformation

New Interstate Licensing Compacts

Social Workers

Physician Assistants

Funding for a Community Organization to address health care workforce shortages amongst communities traditionally underserved

Telemedicine and AI Legislation

Telemedicine

Removes requirement that a patient and provider establish a relationship in-person to receive payment parity

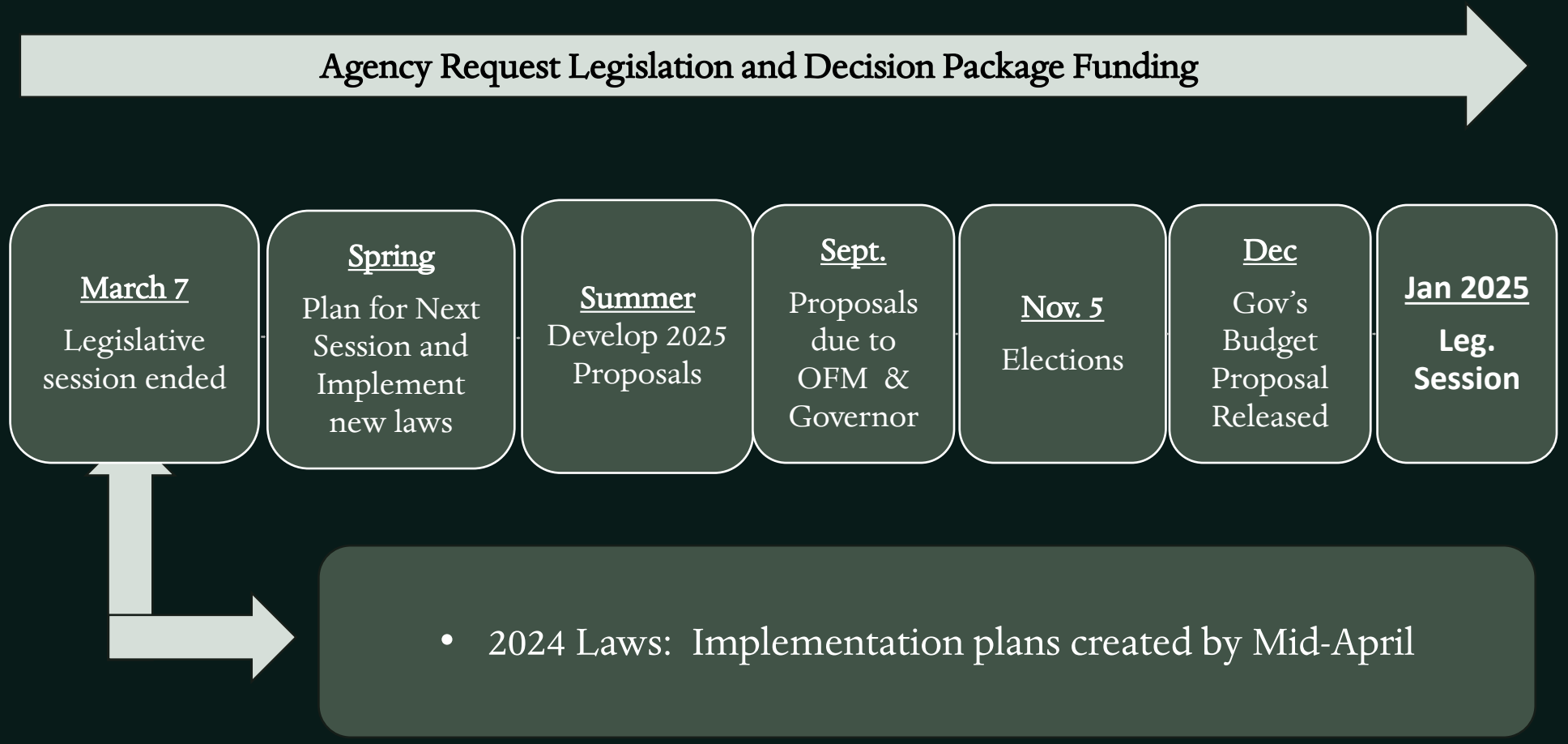
Uniform law commission's uniform telehealth act

- Provides circumstances in which out-of-state health care providers can provide telehealth services to patients in WA state.
- Allows a provider to establish a relationship with a patient via audio or video telehealth.

AI Task Force

Attorney General to convene to assess the use of AI, develop principles and make recommendations for its regulation. *(DOH not listed as a participant)*

Key Dates


Agency Request Legislation and Decision Package Funding
March 7
Legislative session ended
Spring
Plan for Next Session and Implement new laws
Summer
Develop 2025 Proposals
Sept.
Proposals due to OFM & Governor
Nov. 5
Elections
Dec
Gov's Budget Proposal Released
Jan 2025
Leg. Session
• 2024 Laws: Implementation plans created by Mid-April

Possible Agency Request Legislation for 2025

- Update Water Recreation Statute
- Pesticide Application Safety Committee
- Safe Drinking Water Act - EPA Compliance
- WIC Hemoglobin Testing Exemption
- Reduce Barriers to Data Sharing

KEY TAKE AWAYS

- U.S. Centers for Disease Control and Prevention believe current risk to public from HPAI is low, but certain people are at greater risk. Highlights need to implement application of global & One Health.
- WA-DOH is working with partners to better serve all Washingtonians, including (1) through Community Conversations & Urban Indian Initiative Listening Sessions; (2) expanded dashboards for opioid and drug use data, and new dashboard for perinatal data; and (3) Public Health Connects with U.S. Surgeon General to raise visibility on Epidemic of Social Isolation and Loneliness and the healing power of social connection.
- There is a lot of work going on to implement the many bills and provisos passed by the Washington State Legislature in 2024. WA-DOH looks forward to working with the State Board of Health and other partners as it develops proposed request legislation for 2025 to reenergize our commitment to health for all.

IN IT TOGETHER!

Umair A. Shah, MD, MPH
360-236-4030
Secretary@doh.wa.gov

Twitter:
@WaHealthSec
@WADeptHealth
@ushahmd

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Kate Dean, Board Member

Subject: Rules Briefing – Chapter 246-290 WAC, Group A Public Water Supplies, Implementing the EPA's Per and Polyfluoroalkyl Substances (PFAS) standards

Background and Summary:

RCW 43.20.030(2)(a) grants the State Board of Health (Board) authority to adopt rules for Group A public water systems that are necessary to assure safe and reliable drinking water and to protect public health.

In October 2021 the Board adopted drinking water state action levels (SALs) for per- and polyfluoroalkyl substances (PFAS) in chapter 246-290 WAC, Group A Public Water Supplies and related provisions in chapter 246-390 WAC, Drinking Water Laboratory Certification and Data Reporting. WAC 246-290-315 includes criteria for monitoring, reporting, follow-up actions, and public notification relevant to SALs. It also includes criteria that apply when the Environmental Protection Agency (EPA) adopts a federal MCL for a contaminant that has a state action level set in rule. WAC 246-290-315(8) says that a federal MCL will supersede a SAL, and the associated requirements, including for monitoring and public notice.

On April 26, 2024, the EPA published the first-ever national drinking water standard (federal standard) to protect communities from exposure to PFAS. The federal standard establishes federal MCLs, requirements for monitoring, reporting, public notification, treatment, and violations.

Across almost all the contaminants, the MCLs in the federal standard are more stringent than the SALs the Board adopted in 2021. The EPA also included a hazard index for certain chemicals to account for additive effects of some combinations of PFAS. To allow states and water system purveyors time to adapt to these changes, the EPA's effective dates for the MCLs, certain monitoring requirements, and public notification are delayed. This creates complexity and has implications the Board should consider.

Today, Mike Means from the Department of Health Office of Drinking Water will present to the Board an additional background on PFAS and a comparison of the Board's rule to the federal standards. Board staff will then present rulemaking options and recommendations for the Board to consider.

(continued on the next page)

Recommended Board Actions:

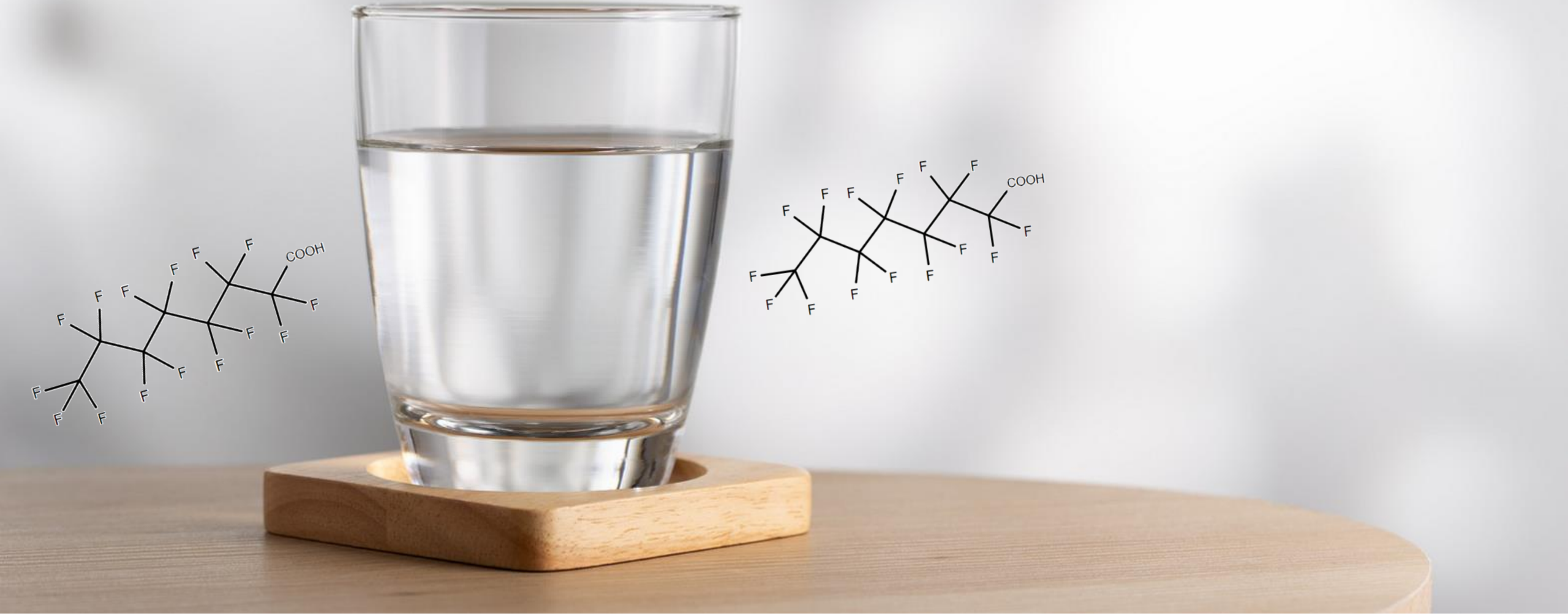
The Board may wish to consider and amend, if necessary, the following motions:

The Board directs staff to do the following:

- File a CR-103E to initiate rulemaking for WAC 246-290-315, to clearly maintain the SALs and associated requirements until the federal standards are effective;
- File a CR-102 to adopt the federal standards and associated effective dates into chapter 246-290 WAC through an exception rulemaking process;
- File a CR-101 to permanently fix the rule language in 246-290-315 and to explore adopting the MCLs as SALs until the MCLs become effective; and
- File a CR-102 to update references in chapter 246-390 WAC through an exception rulemaking process.

Staff

Shay Bauman, Policy Advisor



Washington State Department of HEALTH

WA STATE STANDARDS FOR PFAS IN DRINKING WATER

State Board of Health June 12, 2024

Speakers

Mike Means R.G., LHG

Capacity Development and Policy Manager

Office of Drinking Water

Mike.Means@doh.wa.gov

Barbara Morrissey

Toxicologist

Office of Environmental Public Health Sciences

Barbara.Morrissey@doh.wa.gov

Overview

- What are PFAS?
- State Action Levels (SAL)
- SAL Rule Implementation
- EPA Maximum Contaminant Levels (MCLs) and SAL Comparison

Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS)
Nonstick, Stain and Water Resistant, Heat Stable

Some PFAS are PBTs

Persistent in the environment

Bioaccumulate in humans

Toxic at low levels

Health Concerns

In Humans

- Increased serum cholesterol
- Altered liver enzymes
- Reduced immune response to vaccines
- Lower birth weight
- Blood pressure problems during pregnancy
- Increase risk of thyroid disease
- Increased risk of cancer (kidney and testicular)

In Laboratory Animals

- Liver toxicity
- Developmental toxicity
- Reproductive toxicity
- Immune toxicity
- Endocrine disruption
- Tumors in liver, pancreas, testes

WA State Action to Address PFAS

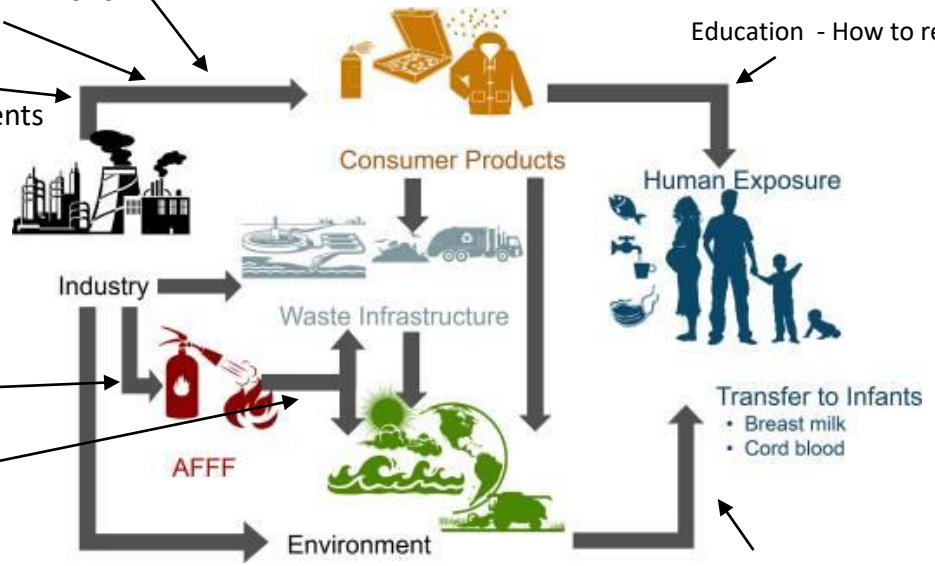
Cosmetics (HB 1047)

Ban on PFAS in food contact paper RCW 70A.222.070

Safer Products for Chapter 70A.350 RCW
- Aftermarket stain and water proofing treatments
- Leather and textile furnishings (indoor)
- Carpets and rugs

Ban on PFAS in firefighting foam RCW 70.75A

WA Dept of Ecology safe foam disposal program



Education - How to reduce PFAS exposure

- Drinking water standards
- Fish consumption advisories

Source: Sunderland EM et al. (2019) **A review of the pathways of human exposure to poly- and perfluoroalkyl substances (PFASs) and present understanding of health effects.** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6380916/

SALs set to be Health Protective

- A level in water expected to be without appreciable health effects over a lifetime of exposure, including in sensitive groups.

- Based on best available science at the time.

State Action Level (SAL) vs. Maximum Contaminant Level (MCL)

SAL

Set as close to Public Health Goal as possible…

Considering:

- Technical feasibility

MCL

Set as close to Public Health Goal as possible…

Limit is Enforced

Considering:

- Technical feasibility
- Cost-benefit

A SAL is a Bridge to an MCL

- SALs **require** testing, public notification and **guide** public health response to results.
- Testing helps define scope of problem and necessary funding and resources.
- Testing data is needed to develop state cost-benefit analyses for Maximum Contaminant Levels (MCL).

2021 State Action Levels (SALs)

Features:

- Sets action levels for 5 PFAS.
- Requires PFAS testing by most Group A water systems.
- Requires notification of customers.
- Requires follow-up monitoring.
- Effective date: Jan 1, 2022.
- Mitigation of water is not required, but systems are encouraged to follow public health advice and funding support is available.

WASHINGTON STATE BOARD OF HEALTH

Drinking water Contaminant	SAL (parts per trillion)
PFOA	10
PFOS	15
PFNA	9
PFHxS	65
PFBS	345

Implementation of the PFAS SALs

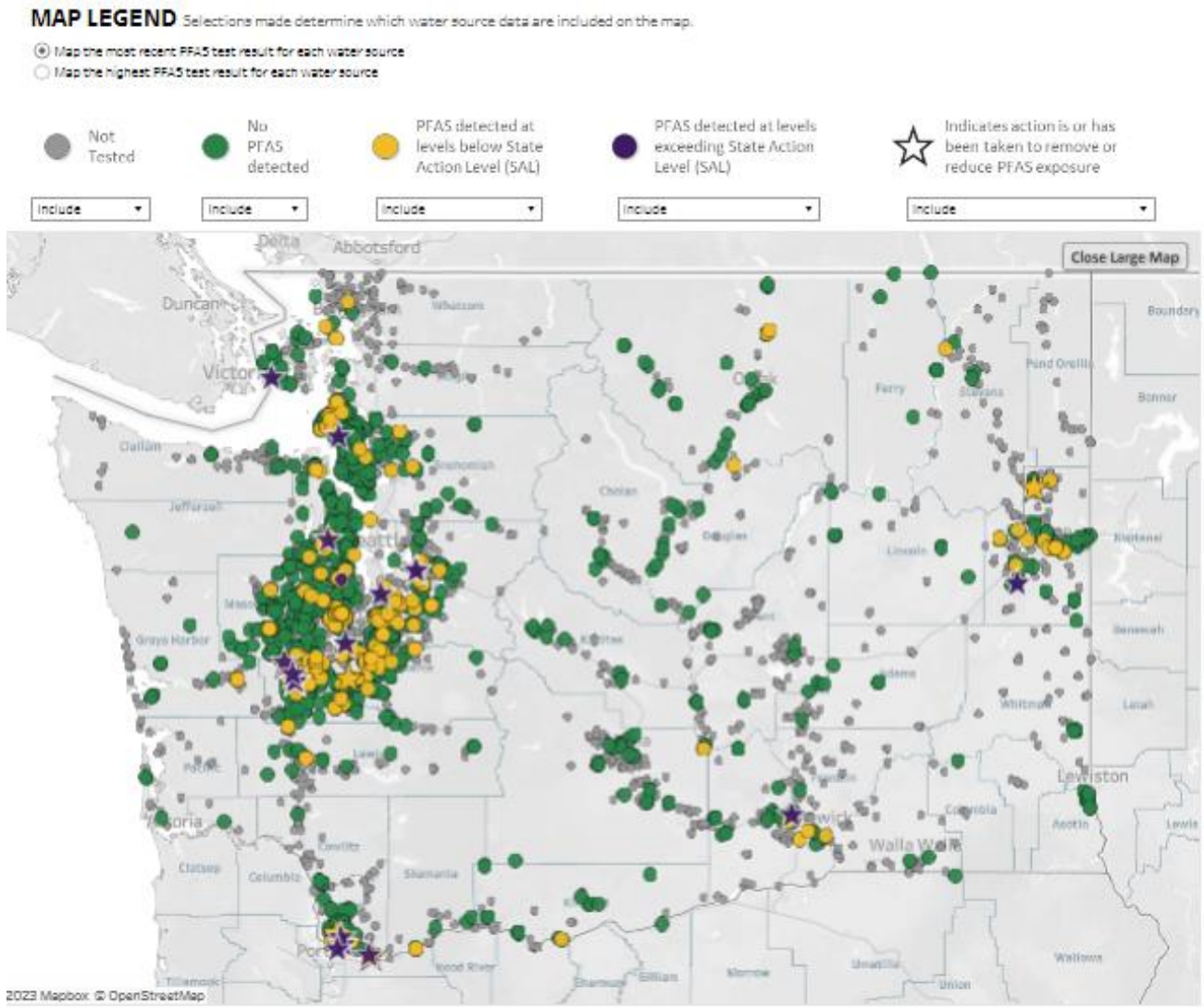
- Initial PFAS test required between Jan 2023 - Dec 2025 (EPA methods 533 or 537.1)
- SALs apply to Group A public Water Systems
  - 2,209 Community systems
  - 318 Nontransient, Noncommunity systems
  - ?/1,577 Transient Noncommunity (only asked to test if near a detection)
- Voluntary free testing program – 2022/23 reopening 2024/25

Map of PFAS Drinking Water Testing

Only includes samples for Group A water systems complying with new state rule.

- Doesn't include historical water testing results yet.
- Doesn't include military testing yet.
- Doesn't include private well results.

https://doh.wa.gov/data-and-statistical-reports/washington-tracking-network-wtn/pfas



U.S. Environmental Protection Agency (EPA) MCLs and SAL Comparisons

EPA's New Science

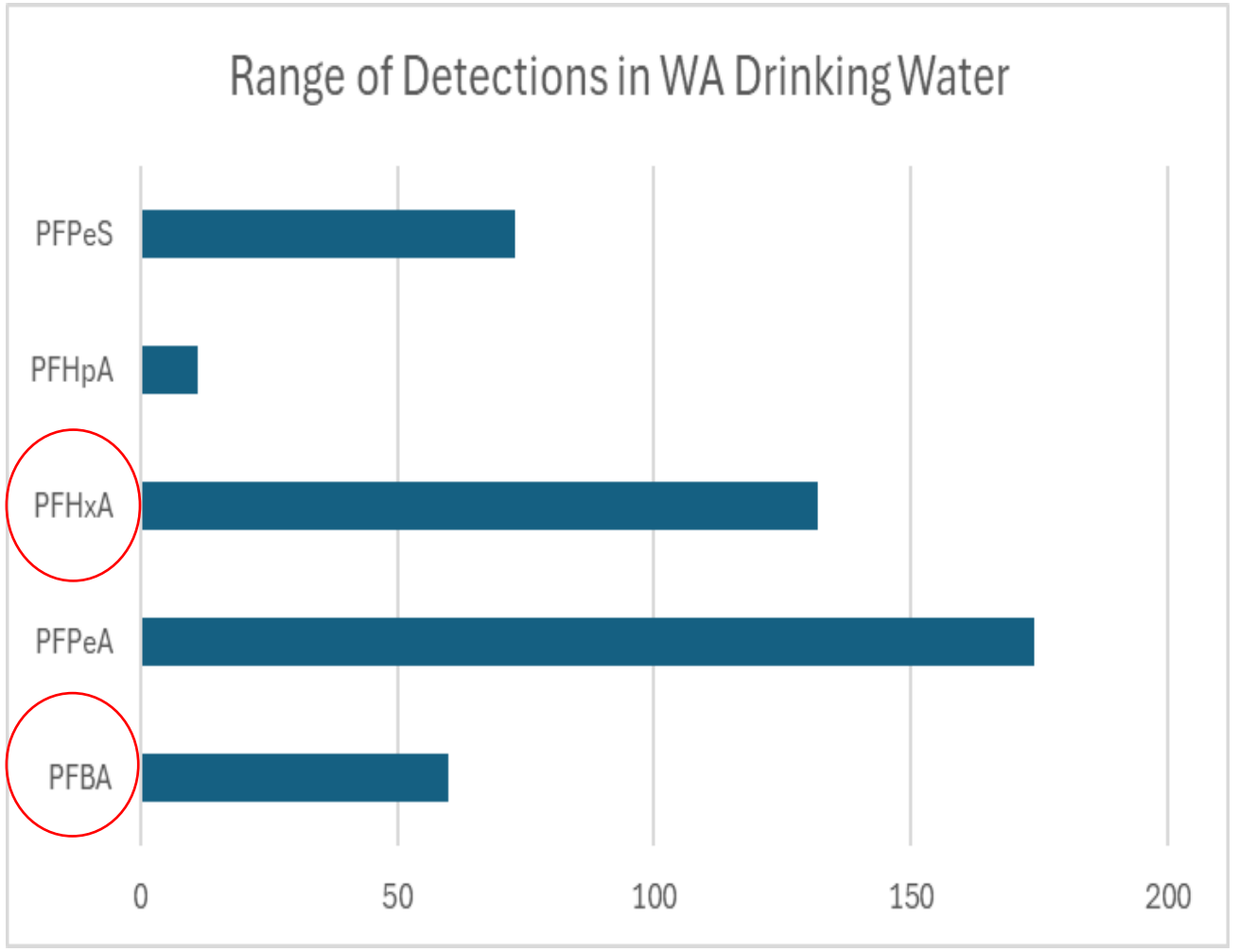
- PFOA, PFOS = Likely human carcinogens
- PFNA, PFHxS – based on Agency for Toxic Substances and Disease Registry (ASTDR) toxicity values
- GenX and PFBS – based on EPA toxicity values

- Group MCL- PFHxS, PFNA, PFBS, GenX
  - Assume effects are additive

- EPA has toxicity values for PFBA and PFHxA, did not include.

Other PFAS

- Five other PFAS frequently detected.
- No SAL to guide action.
- Develop state health recommendation?
- Adopt SAL?
- State MCL?



Note: Range shown doesn't include one water system with multiple PFAS at very high levels in San Juan County (outlier).

Evolving Health Guidelines for Drinking Water (ng/L or ppt)

EPA Health Advisories 2016

PFOA	70
PFOS	70

WA SALs 2021

PFOA	10
PFOS	15
PFNA	9
PFHxS	65
PFBS	345

Non-cancer endpoints sufficiently protective of cancer endpoint

EPA Health Advisories 2022

PFOA	*0.004*
PFOS	*0.02*
PFBS	2000
GenX	10

2024: EPA withdrew it's interim HALs for PFOA and PFOS

EPA Final MCLs 2024

PFOA	4
PFOS	4
PFHxS	10
PFNA	10
GenX	10

Grouped MCL for PFBS, GenX, PFNA & PFHxS

Impact of Federal MCLs

- Federal MCLs supersede SALs when MCL rule is adopted.
- WAC 246-290-315(8) states:

  "Upon federal adoption of an MCL, the federal MCL will supersede a SAL or a less stringent state MCL, and the associated requirements, including for monitoring and public notice. If the federally adopted MCL is less stringent than a SAL or state MCL, the board may take one of the following actions:

  (a) Adopt the federal MCL; or

  (b) Adopt a state MCL, at least as stringent as the federal MCL, using the process in subsections (6) and (7) of this section."

  (emphasis added)

State vs. EPA MCLs for PFAS in Drinking Water (ng/L or parts per trillion)

Individual PFAS	WA State Action Levels (2021)	EPA MCL (2024)
PFOA	10	4
PFOS	15	4
PFNA	9	10
PFHxS	65	10
GenX	-	10

Group MCL (Hazard Index*)		HBWC used in hazard index*
PFNA	9	10
PFHxS	65	10
PFBS	345	2,000
GenX	-	10

**Health-based water concentration (HBWC) are the "acceptable" values used to create a ratio of observed/acceptable for each of 4 PFAS. If the ratios add up to more than 1.0, the hazard index MCL is exceeded, and action must be taken to lower PFAS.*

Comparing SAL/MCL Requirements

Action	SAL	MCL
Sampling		
Initial	One sample unless detection then verification and quarterly	Two samples small groundwater – four large or surface water
Baseline	Quarterly for detections until reliably and consistently below MCL. Every 3 years for non-detect.	Quarterly starting June 2027 for detection, 3 years for non-detect starting June 2027
Public Notification		
Annual Consumer Confidence Report (CCR)	Any detection requires CCR notification currently	Any detection for initial or baseline starts June 2027
Tier 2 (30 day) notification	Required for any SAL exceedance	Required for MCL exceedance after June 2029
Treatment	Recommended, not required	Required for MCL exceedance after June 2029

Questions?

Implementing EPA's PFAS Standards

Rulemaking Recommendations

Shay Bauman, Policy Advisor

WASHINGTON STATE BOARD OF HEALTH

WAC 246-290-315(8)

Upon federal adoption of an MCL, the federal MCL will supersede a SAL or a less stringent state MCL, and the associated requirements, including for monitoring and public notice. If the federally adopted MCL is less stringent than a SAL or state MCL, the board may take one of the following actions:

(a) Adopt the federal MCL; or

(b) Adopt a state MCL, at least as stringent as the federal MCL, using the process in subsections (6) and (7) of this section.

EPA Effective Dates

Effective June 25, 2024

Analytical requirements*

Effective April 26, 2027

Consumer Confidence Reporting*

Ongoing compliance monitoring*

Reporting and recordkeeping*

Initial monitoring results reporting

Public notification for testing and procedure violations

Effective April 26, 2029

PFAS MCL Violations

MCL Compliance Requirements

30-day Public Notification for MCL violations*

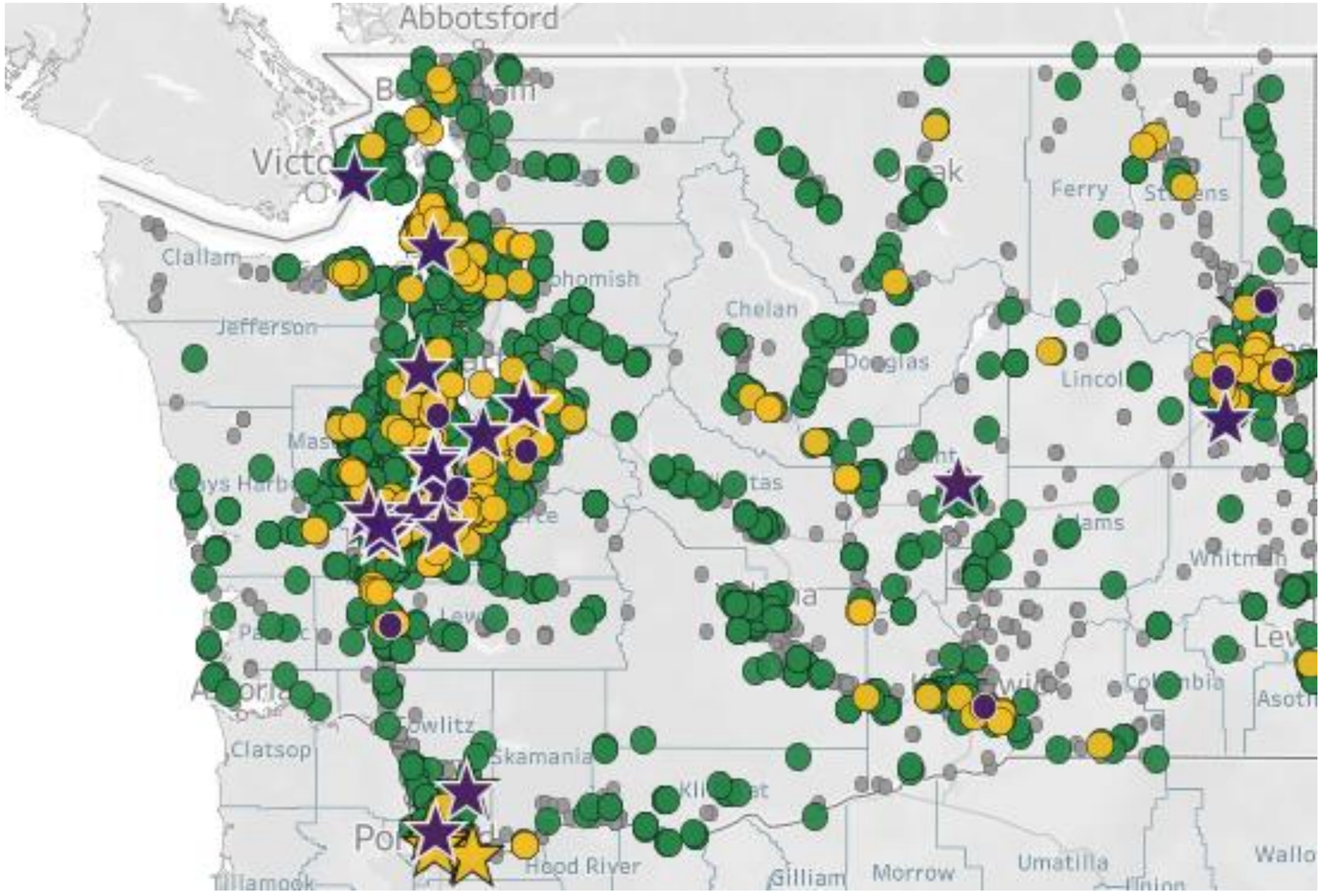
Not Tested

No PFAS detected

PFAS detected at levels below State Action Level (SAL)

PFAS detected at levels exceeding State Action Level (SAL)

Indicates action is or has been taken to remove or reduce PFAS exposure



Recommendation 1: Clearly define rule language to maintain current protections

~~Upon federal adoption of an MCL, the federal~~ When a federal MCL becomes effective, the MCL will supersede a SAL or a less stringent state MCL, and the associated requirements, including for monitoring and public notice. If the federally adopted MCL is less stringent than a SAL or state MCL, the board may take one of the following actions:

(a) Adopt the federal MCL; or

(b) Adopt a state MCL, at least as stringent as the federal MCL, using the process in subsections (6) and (7) of this section.

Options:

- Initiate an emergency rulemaking – *recommended, OR*
- Issue an interpretive statement
  - Delays timeline, issued due to emergency

Timeline:

- CR-103E filed after this meeting, every 120 days until permanent
- CR-101 to permanently fix rule language file along with 103E

Recommendation 2: Adopt the federal standards and effective dates into rule

- Necessary for the Department to maintain primacy, rule to comply with federal requirements
- SALs and associated requirements stay in effect until the federal effective dates supersede them. Customers are still notified of detections above the SALs within 30 days and systems continue frequency of monitoring for SALs

Options:

1. Initiate an exception rulemaking for each 246-290 and 246-390 – *recommended*
2. Adopt by reference
    - Tables with new MCLs would be located outside of WAC 246-290-310, creates inconsistency

Timeline:

- CR-102s filed after June 25
- Rules hearing in October or November 2024
- Effective 30 days after hearing

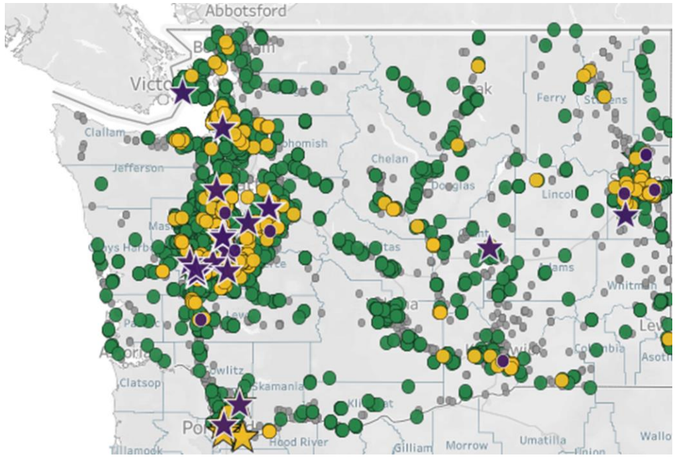
Recommendation 3: Explore adopting the MCL values as SALs until the federal effective date

Example

Contaminant	MCL Value (ng/L)	Detection Level (ng/L)	SAL (ng/L)
PFOA	4	6	10
PFOS	4	10	15

Provides 30-day notification to those served by systems with detections between the current SAL and MCL sooner than the EPA's effective date

- Current testing procedure can detect to the level of the MCLs
- Public Notification system is already active
- When the MCL effective date comes, these adopted SALs will turn into MCLs
- Procedure to adopt new SALs remains in rule to adapt as needed



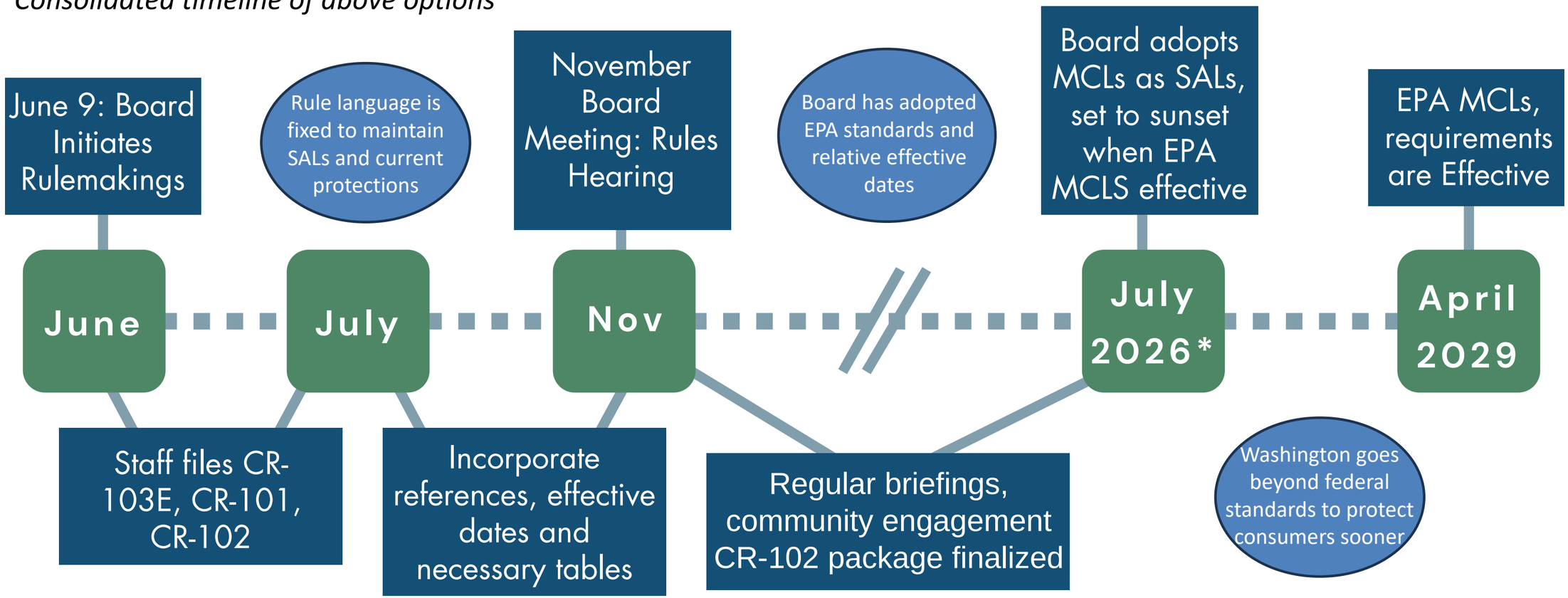
Timeline:

- Significant change according to the APA
- CR-101 filed after this meeting
- Interested party engagement, significant analysis, small business economic analysis, environmental justice assessment
  - Regular briefings

Tentative Effective Date	EPA Effective Date
July 2026	April 2029

1. Initiate an emergency rulemaking to fix rule language and maintain current standards
2. Initiate an exception rulemaking to adopt federal standards and effective dates into WAC 246-290
3. Initiate an exception rulemaking to update guidance references in WAC 246-390
4. Initiate permanent rulemaking to permanently fix rule language and adopt the MCL values as SALs

Consolidated timeline of above options



*Tentative

WASHINGTON STATE BOARD OF HEALTH

THANK YOU

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ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
- We are committed to providing access to all individuals visiting our agency website, including persons with disabilities. If you cannot access content on our website because of a disability, have questions about content accessibility or would like to report problems accessing information on our website, please call (360) 236-4110 or email wsboh@sboh.wa.gov and describe the following details in your message:
    - The nature of the accessibility needs
    - The URL (web address) of the content you would like to access
    - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.

PDF **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.]

NOTES:

Explanatory statement—2021 c 65: See note following RCW **53.54.030**.

Effective date—2009 c 495: "Except for section 9 of this act, this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 14, 2009]." [**2009 c 495 § 17**.]

Findings—1993 c 492: "The legislature finds that our health and financial security are jeopardized by our ever increasing demand for health care and by current health insurance and health system practices. Current health system practices encourage public demand for unneeded, ineffective, and sometimes dangerous health treatments. These practices often result in unaffordable cost increases that far exceed ordinary inflation for essential care. Current total health care expenditure rates should be sufficient to provide access to essential health care interventions to all within a reformed, efficient system.

The legislature finds that too many of our state's residents are without health insurance, that each year many individuals and families are forced into poverty because of serious illness, and that many must leave gainful employment to be eligible for publicly funded medical services. Additionally, thousands of citizens are at risk of losing adequate health insurance, have had insurance canceled recently, or cannot afford to renew existing coverage.

The legislature finds that businesses find it difficult to pay for health insurance and remain competitive in a global economy, and that individuals, the poor, and small businesses bear an inequitable health insurance burden.

The legislature finds that persons of color have significantly higher rates of mortality and poor health outcomes, and substantially lower numbers and percentages of persons covered by health insurance than the general population. It is intended that chapter 492, Laws of 1993 make provisions to address the special health care needs of these racial and ethnic populations in order to improve their health status.

The legislature finds that uncontrolled demand and expenditures for health care are eroding the ability of families, businesses, communities, and governments to invest in other enterprises that promote health, maintain independence, and ensure continued economic welfare. Housing, nutrition, education, and the environment are all diminished as we invest ever increasing shares of wealth in health care treatments.

The legislature finds that while immediate steps must be taken, a long-term plan of reform is also needed." [**1993 c 492 § 101**.]

Intent—1993 c 492: "(1) The legislature intends that state government policy stabilize health services costs, assure access to essential services for all residents, actively address the health care

needs of persons of color, improve the public's health, and reduce unwarranted health services costs to preserve the viability of nonhealth care businesses.

(2) The legislature intends that:

(a) Total health services costs be stabilized and kept within rates of increase similar to the rates of personal income growth within a publicly regulated, private marketplace that preserves personal choice;

(b) State residents be enrolled in the certified health plan of their choice that meets state standards regarding affordability, accessibility, cost-effectiveness, and clinical efficaciousness;

(c) State residents be able to choose health services from the full range of health care providers, as defined in RCW **43.72.010**(12), in a manner consistent with good health services management, quality assurance, and cost effectiveness;

(d) Individuals and businesses have the option to purchase any health services they may choose in addition to those included in the uniform benefits package or supplemental benefits;

(e) All state residents, businesses, employees, and government participate in payment for health services, with total costs to individuals on a sliding scale based on income to encourage efficient and appropriate utilization of services;

(f) These goals be accomplished within a reformed system using private service providers and facilities in a way that allows consumers to choose among competing plans operating within budget limits and other regulations that promote the public good; and

(g) A policy of coordinating the delivery, purchase, and provision of health services among the federal, state, local, and tribal governments be encouraged and accomplished by chapter 492, Laws of 1993.

(3) Accordingly, the legislature intends that chapter 492, Laws of 1993 provide both early implementation measures and a process for overall reform of the health services system." [**1993 c 492 § 102**.]

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW **43.72.910** through **43.72.915**.

Severability—1992 c 34: See note following RCW **69.07.170**.

Effective date—Severability—1989 1st ex.s. c 9: See RCW **43.70.910** and **43.70.920**.

Savings—1985 c 213: "This act shall not be construed as affecting any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule, regulation, or order adopted under those sections, nor as affecting any proceeding instituted under those sections." [**1985 c 213 § 31**.]

Effective date—1985 c 213: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect June 30, 1985." [**1985 c 213 § 33**.]

Severability—1967 ex.s. c 102: See note following RCW **43.70.130**.

*Rules and regulations—Visual and auditory screening of pupils: RCW **28A.210.020**.*

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Kate Dean, Board Member

Subject: Update to WAC 246-290-100 – Delegated Rulemaking to Implement Climate Resilience in Water System Plans as required by Engrossed Second Substitute House Bill (E2SHB) 1181

Background and Summary:

In the 2023 legislative session, Washington's legislature passed Engrossed Second Substitute House Bill (E2SHB) 1181, codified as RCW 43.20.310. The intent of this bill is to improve the state's climate response planning framework. The comprehensive bill includes a section requiring Group A public water systems with 1,000 or more connections to include a climate resilience element in their water system plans.

On November 8, 2023, the State Board of Health (Board) granted delegated rulemaking authority to the Department of Health (Department) to update and align public water system planning requirements in WAC 246-290-100 with this new legislation.

On May 13, 2024, the Department adopted changes to WAC 246-290-100 in Washington State Register 24-11-057. The newly adopted rule becomes effective June 13, 2024.

Today, Mike Means with the Department of Health's Office of Drinking Water will provide a brief background on the bill, rulemaking process, and public comments received.

Staff

Shay Bauman, Policy Advisor

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

Washington State Department of HEALTH

UPDATE ON DELEGATED RULEMAKING FOR HOUSE BILL 1181

State Board of Health Meeting
June 12, 2024

Presenters

Mike Means

Capacity Development and Policy Manager

Office of Drinking Water
Division of Environmental Public Health

mike.means@doh.wa.gov

Brad Burnham

Policy and Planning Section Manager

Office of Drinking Water
Division of Environmental Public Health

brad.burnham@doh.wa.gov

www.doh.wa.gov

@WADeptHealth

House Bill 1181

- In 2023, the Legislature passed Engrossed Second Substitute House Bill (E2SHB) 1181 that added a new section to chapter 43.20 RCW.
- The new law, RCW 43.20.310, requires Group A community public water systems serving 1,000 or more connections to include a climate resilience element in water system plans initiated after June 30, 2025.

Delegated Rulemaking

SBOH delegated rulemaking to the Department at the November 2023 meeting:

- Add climate resilience element to WAC 246-290-100, Water system plan by direct reference RCW 43.20.310
- Non-substantive editorial changes to align with the 2023 Code Reviser's Bill Drafting Guide

Rulemaking

- Used an abbreviated rulemaking process
- Filed CR-102 on February 21, 2024
- Public Hearing on April 4, 2024
- Received 4 written comments
  - In support
  - Outside the scope - focused on updates to the Water System Planning Guidebook
- Received no comments at public hearing
- Filed CR-103 on May 13, 2024

Next Steps

- Update the Water System Planning Guidebook (PDF) (pub #331-068) before June 30, 2025
- Provide technical assistance to water systems as needed

Questions?

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

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Patty Hayes, Board Chair

Subject: Rules Hearing—Handling of Human Remains, Chapter 246-500 WAC

Background and Summary:
RCW 43.20.050(2)(f) grants the State Board of Health (Board) authority to adopt rules for the prevention and control of infectious and noninfectious diseases, including rules governing the receipt and conveyance of remains of deceased persons. These rules are established in chapter 246-500 WAC.

During the 2024 session, the Washington State Legislature passed Substitute House Bill 1974 (Chapter 57 Laws of 24), which amends RCW 68.50.230 to reduce the period during which a person or entity must be in lawful possession of human remains before disposal in the absence of direction from relatives or persons interested in the decedent from 90 days to 45 days and adds counties to the list of entities that can lawfully dispose of remains after 45 days.

The purpose of the holding period is to give family members and interested persons time to claim the body and direct the disposition. Sometimes relatives or other interested parties fail, neglect, or refuse to do so.

Chapter 246-500 WAC references the previous statutory 90 day holding period regarding remains reduced through cremation, alkaline hydrolysis, and natural organic reduction. In April, the Board directed that the rule be updated to reflect the changes in the statute. The Board filed the CR-102, Proposed Rules, on May 1, 2024, as WSR 24-10-094. Board staff alerted interested parties of the proposed changes on May 16, 2024. We received 3 comments supporting the change, which are included in your packets. We did not receive any opposing comments.

Today's agenda item includes a brief presentation on the proposed change, a summary of written public comments received, and recommendations for your consideration. The presentation will be followed by a public hearing allowing public testimony on the proposed rules and, finally, by Board discussion and action on the proposed rules.

(continued on the next page)

Recommended Board Actions:

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

The Board adopts the proposed amendments to chapter 246-500 WAC, Handling of Human Remains, as published in WSR 24-10-094, and directs staff to file a CR-103, Order of Adoption, and establish an effective date for the rules.

OR

The Board continues discussion of possible adoption of proposed amendments to chapter 246-500 WAC, Handling of Human Remains, as published in WSR 24-10-094, to its next meeting.

Staff

Shay Bauman, Policy Advisor

Changes to Chapter 246-500 WAC

Handling of Human Remains

June 12, 2024

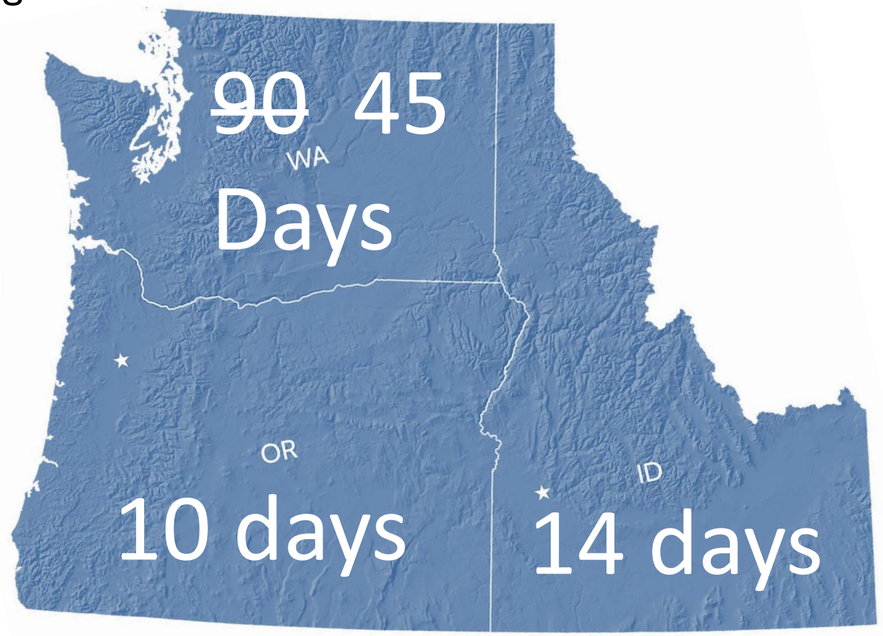
Shay Bauman – Policy Advisor

WASHINGTON STATE BOARD OF HEALTH

Substitute House Bill 1974

Signed by the Governor March 13

- Reduces holding period from 90 to 45 days
  - Improvements in technology used to identify next of kin
  - Industry feedback regarding the speed of decomposition
  - Capacity of small counties
- Adds Counties



Mandated holding period of Washington and neighboring states

Proposed Changes

The local registrar or the Department of Health may issue a burial-transit permit for the disposition of:

- human remains reduced through alkaline hydrolysis (050)
- cremated human remains (053)
- human remains reduced through natural organic reduction (055)

which have been in the lawful possession of any person, firm, corporation, **county,** or association for a period of **((~~ninety~~))** **45** days or more.

Public Comments

- 3 Supporting, 0 Opposing

- Casey Husseman
  Executive Director, People’s Memorial Association

- Hayley Thompson
  President, Washington Association of Coroners and Medical Examiners

- Timothy Grisham
  Deputy Director, Washington Association of County Officials

Recommendation

Adopt the proposed amendments to chapter 246-500 WAC, Handling of Human Remains, as published in WSR 24-10-094, and direct staff to file a CR-103, Order of Adoption, and establish an effective date for the rules.

WASHINGTON STATE BOARD OF HEALTH

THANK YOU

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ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

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    - The nature of the accessibility needs
    - The URL (web address) of the content you would like to access
    - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.

PROPOSED RULE MAKING

CR-102 (July 2022)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: April 30, 2024
TIME: 2:38 PM

WSR 24-10-094

Agency: State Board of Health

☒ **Original Notice**
☐ **Supplemental Notice to WSR**
☐ **Continuance of WSR**

☐ **Preproposal Statement of Inquiry was filed as WSR _____ ; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☒ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**
☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject) Chapter 246-500 WAC – Handling of Human Remains. The State Board of Health (Board) is proposing amending parts of the rule to align with the changes to RCW 68.50.230 prescribed in Substitute House Bill 1974, which passed during the 2024 legislative session.

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
June 12, 2024	1:30 P.M.	**Physical Location:** Heathman Lodge 7801 NE Greenwood Drive Vancouver, Washington 98662 **Virtual Link:** https://us02web.zoom.us/webinar/register/WN_vifXql9mSCGxcB06RcHl0Q	The State Board of Health will be holding a hybrid hearing with the option to attend and testify either via Zoom or in-person.

Date of intended adoption: 6/12/2024 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: Shay Bauman
Address: P.O. Box 47990
Olympia, WA
98504-7990
Email: shay.bauman@sboh.wa.gov
Fax: N/A
Other:
By (date) 5/31/2024

Assistance for persons with disabilities:
Contact Melanie Hisaw
Phone: 360-236-4104
Fax: N/A
TTY: 711
Email: melanie.hisaw@sboh.wa.gov
Other:
By (date) 06/05/2024

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The purpose of this proposal is to update WAC 245-500-050, WAC 246-500-053, and WAC 246-500-055 to align with changes in statute. These rules establish the requirements for remains reduced through cremation, alkaline hydrolysis, and natural organic reduction. Under these sections, the local registrar or the Department of Health may issue a burial-transfer permit for the disposition of cremated remains, remains reduced through alkaline hydrolysis, or remains reduced through natural organic reduction which have been in the lawful possession of any person, firm, corporation, or association for a period of 90 days or more. The 90 day holding period is established in RCW 68.50.230, which was recently amended to 45 days. The amendment also added counties to the list of entities that may lawfully dispose of human remains after the holding period. The purpose of the proposal is to align the rule with the changes in statute.

Reasons supporting proposal: This change is dictated by statute. The existing rules must be amended to align with the statute and to no be in conflict. The 90 day holding period is being amended to 45 days. The proposed rules also add counties to the list of entities that may lawfully dispose of human remains to be consistent with the language in the law.

Statutory authority for adoption: RCW 43.20.050(2)(f)

Statute being implemented: Substitute House Bill 1974 (Chapter 57, Laws of 2024), as codified in RCW 68.50.230

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Type of proponent: ☐ Private ☐ Public ☒ Governmental
Name of proponent: Washington State Board of Health

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Shay Bauman	101 Israel Road SE, Tumwater, WA, 98504	564-669-8929
Implementation:	Shay Bauman	101 Israel Road SE, Tumwater, WA, 98504	564-669-8929
Enforcement:	Funeral and Cemetary Board	405 Black Lake Blvd SW, Olympia, WA 98502	

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

☒ No: Please explain: The proposed rule is exempt under RCW 34.05.328(5)(b)(v) Rules explicitly and specifically dictated by statute

Regulatory Fairness Act and Small Business Economic Impact Statement
Note: The Governor's Office for Regulatory Innovation and Assistance (ORIA) provides support in completing this part.

(1) Identification of exemptions:
This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). For additional information on exemptions, consult the exemption guide published by ORIA. Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.
Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☒ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☒ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(4) (does not affect small businesses).

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of how the above exemption(s) applies to the proposed rule: All of the proposed changes are dictated by statute.

(2) Scope of exemptions: *Check one.*

☒ The rule proposal is fully exempt *(skip section 3)*. Exemptions identified above apply to all portions of the rule proposal.

☐ The rule proposal is partially exempt *(complete section 3)*. The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using this template from ORIA):

☐ The rule proposal is not exempt *(complete section 3)*. No exemptions were identified above.

(3) Small business economic impact statement: *Complete this section if any portion is not exempt.*

If any portion of the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☐ No Briefly summarize the agency's minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses and a small business economic impact statement is required. Insert the required small business economic impact statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

Date: April 30, 2024

Name: Michelle A. Davis

Title: Executive Director, State Board of Health

Signature:

AMENDATORY SECTION (Amending WSR 21-01-039, filed 12/7/20, effective 1/7/21)

WAC 246-500-050 Human remains reduced through cremation. (1) Other than the provisions in this section and WAC 246-500-010, this chapter does not apply to human remains after cremation.

(2) A local registrar, in cooperation with the Washington state funeral and cemetery board, may issue a burial-transit permit for disposition of cremated human remains. The permit for the disposition of cremated remains may be used in connection with the transportation of cremated remains by common carrier or other means.

(3) The local registrar or the department of health may issue a burial-transit permit for the disposition of cremated human remains which have been in the lawful possession of any person, firm, corporation, county, or association for a period of ((~~ninety~~)) 45 days or more. This permit will specify that the disposition of cremated remains must be consistent with Washington state laws and rules. [Statutory Authority: RCW 43.20.050 (2)(f). WSR 21-01-039, § 246-500-050, filed 12/7/20, effective 1/7/21. Statutory Authority: RCW

43.20.050 and 18.39.215. WSR 06-17-182, § 246-500-050, filed 8/23/06, effective 9/23/06.]

AMENDATORY SECTION (Amending WSR 21-01-039, filed 12/7/20, effective 1/7/21)

WAC 246-500-053 Human remains reduced through alkaline hydrolysis. (1) Other than the provisions in this section and WAC 246-500-010, this chapter does not apply to human remains after alkaline hydrolysis.

(2) A hydrolysis facility must:

(a) Operate a high-temperature purpose built vessel, that reaches a minimum temperature of ((~~two hundred fifty~~)) 250 degrees Fahrenheit for a minimum of ((~~thirty~~)) 30 minutes during the reduction process; or

(b) Operate a purpose built vessel, for which third-party validation testing is provided demonstrating the reduction process destroys prions, and achieves sterilization in both the water and airspace, according to the manufacturer's specifications. The testing criteria must include a matrix-assisted laser desorption/ionization time of flight (MALDI-TOF) mass spectrometry peptide sizing analysis

and a ((~~6~~)) six spore log reduction or greater in the level of *Bacillus* spores. An operator shall retain this documentation on-site and be able to provide it upon request to state or local health officials.

(3) A local registrar, in cooperation with the Washington state funeral and cemetery board, may issue a burial-transit permit for disposition of human remains reduced through alkaline hydrolysis. The permit for the disposition of remains reduced through alkaline hydrolysis may be used in connection with the transportation of remains reduced through alkaline hydrolysis by common carrier or other means.

(4) The local registrar or the department of health may issue a burial-transit permit for the disposition of human remains reduced through alkaline hydrolysis which have been in the lawful possession of any person, firm, corporation, county, or association for a period of ((~~ninety~~)) 45 days or more. This permit will specify that the disposition of remains reduced through alkaline hydrolysis must be consistent with Washington state laws and rules.

[Statutory Authority: RCW 43.20.050 (2)(f). WSR 21-01-039, § 246-500-053, filed 12/7/20, effective 1/7/21.]

AMENDATORY SECTION (Amending WSR 23-09-027, filed 4/12/23, effective 5/13/23)

WAC 246-500-055 Human remains reduced through natural organic reduction. (1) Other than the provisions of this section and WAC 246-500-010, this chapter does not apply to human remains after natural organic reduction.

(2) A natural organic reduction facility operator shall:

(a) Collect material samples for analysis that are representative of each instance of natural organic reduction using a sampling method such as described in the U.S. Composting Council 2002 Test Methods for the Examination of Composting and Compost, Method 02.01-A through E;

(b) Analyze each instance of reduced human remains for physical contaminants. Reduced remains must have less than 0.01 mg/kg dry weight of physical contaminants which include, but are not limited to, intact bone, dental fillings, and medical implants;

(c) Analyze, using a third-party laboratory, the reduction facility's reduced human remains according to the following schedule:

(i) The reduction facility's initial 20 instances of reduced human remains for the parameters identified in Table 500-A, and any

additional instances of human remains necessary to achieve 20 reductions meeting the limits identified in Table 500-A;

(ii) Following 20 reductions meeting limits outlined in Table 500-A, analyze, at minimum, 25 percent of a facility's monthly instances of reduced human remains for the parameters identified in Table 500-A until 80 total instances have met the requirements in Table 500-A;

(iii) The local health jurisdiction may require tests for additional parameters under (b) and (c) of this subsection;

(d) Not release any human remains that exceed the limits identified in Table 500-A;

(e) Prepare, maintain, and provide upon request by the local health jurisdiction, an annual report each calendar year. The annual report must detail the facility's activities during the previous calendar year and must include the following information:

(i) Name and address of the facility;

(ii) Calendar year covered by the report;

(iii) Annual quantity of reduced human remains;

(iv) Results of any laboratory analyses of reduced human remains; and

(v) Any additional information required by the local health jurisdiction; and

(f) Test for arsenic, cadmium, lead, mercury, and selenium, and either fecal coliform or salmonella in reduced human remains to meet the testing parameters and limits identified in Table 500-A.

Table 500-A

Testing Parameters

Metals and other testing parameters	**Limit (mg/kg dry weight), unless otherwise specified**
Fecal coliform	< 1,000 Most probable number per gram of total solids (dry weight)
or	
Salmonella	< 3 Most probable number per 4 grams of total solids (dry weight)
and	
Arsenic	≤ 20 ppm
Cadmium	≤ 10 ppm
Lead	≤ 150 ppm
Mercury	≤ 8 ppm
Selenium	≤ 18 ppm

(3) A local registrar, in cooperation with the Washington state funeral and cemetery board, may issue a burial-transit permit for disposition of human remains reduced through natural organic reduction. The permit for the disposition of remains reduced through natural organic reduction may be used in connection with the transportation of remains reduced through natural organic reduction by common carrier or other means.

(4) The local registrar or the department of health may issue a burial-transit permit for the disposition of human remains reduced through natural organic reduction which have been in the lawful possession of any person, firm, corporation, county, or association for a period of ((~~90~~)) 45 days or more. This permit will specify that the disposition of remains reduced through natural organic reduction must be consistent with Washington state laws and rules.

[Statutory Authority: RCW 43.20.050 (2)(f). WSR 23-09-027, § 246-500-055, filed 4/12/23, effective 5/13/23; WSR 21-01-039, § 246-500-055, filed 12/7/20, effective 1/7/21.]

Bauman, Shay (SBOH)

From: Casey Husseman <casey@peoplesmemorial.org>
Sent: Thursday, May 16, 2024 4:49 PM
To: Bauman, Shay (SBOH)
Subject: Opinion on WAC 246-500, HB 1974

External Email

I'm Casey Husseman, the Executive Director of People's Memorial Association, a Washington state nonprofit dedicated to education, advocacy, and promoting consumer choice in end of life matters.

Personally, I feel in support of this change. I think it will increase the availability of refrigeration space in county-owned facilities, and that decreases pressure on the end of life care industry overall for the limited resource that is refrigerators for bodies. And there is an ongoing crisis of increasing death rates and not enough refrigerators at care facilities for the deceased.

I don't see a sizable impact in the reduction of time for NOK to be found and notified. From my experience speaking with workers at the King County Medical Examiner's Office, the problem is not getting in touch with NOK. The problem is getting NOK to accept responsibility and PAY for disposition services.

Best,

Casey Husseman
Executive Director
People's Memorial Association
(Pronouns: they/them)

2011 1st Ave N, Seattle, WA 98109
Office: 206.325.0489
www.peoplesmemorial.org
Visit us on *Facebook*, *Instagram*, and *YouTube*

WASHINGTON ASSOCAITION OF CORONERS AND MEDICAL EXAMINERS

Letter of Support

May 17, 2024

Washington State Board of Health
P.O. Box 47990
Olympia, WA 98504-7990

RE: CR-102 Proposed Rule Alert: Handling of Human Remains, WAC 246/500

On behalf of the Washington Association of Coroners and Medical Examiners, I would like to submit this letter of support for the proposed changes related to the adoption of Substitute House Bill 1974, disposing of human remains.

Sincerely,

Hayley Thompson

Hayley Thompson, D-ABMDI
President
Washington Association of Coroners and Medical Examiners

Bauman, Shay (SBOH)

From: Timothy Grisham <tim@countyofficials.org>
Sent: Tuesday, June 4, 2024 3:59 PM
To: Bauman, Shay (SBOH)
Cc: Hayley Thompson
Subject: Public Comment - Handling of Human Remains – Response to SHB 1974

External Email

Chair Hayes and members of the Board:

For the record my name is Timothy Grisham, Deputy Director of the Washington Association of County Officials. Today I am writing in comment on proposed rules changes in Chapter 246-500 WAC in response to SHB 1974 on behalf of the Washington Association of County Officials. I am sorry I cannot be there to provide comment in person, however this meeting conflicts with another event I must attend.

The Washington Association of County Officials supports the alignment with SHB 1974; the bill was a 2024 legislative priority voted on by our membership (consisting of the elected county assessors, auditors, clerks, coroners, medical examiners, prosecutors, sheriffs, treasurers and their appointed counterparts in each county) to support the Coroner/Medical Examiner and funeral home efforts to reduce the unclaimed remains holding period.

Prior to this legislation it had been some time since the unclaimed remains holding period was last examined. In the years since tools to identify and locate next of kin have greatly reduced the search time. In many cases remains are held even after next of kin are notified due to refusal to take custody of the remains by family members. This, along with times of increased incidents of unattended deaths, has put some strain on storage capacity when held for 90 days.

This was most noticeable in the smaller counties where funeral homes are contracted as morgues. For example at the height of the pandemic many counties purchased cold storage units in case they faced storage overloads. The 90 day unclaimed remains period only complicated the matter more.

After careful review and consideration in the medical death community it was determined that 45 days would be sufficient to execute a well done and thorough search of next of kin, as well as transfer remains. Anecdotally I have been told, “If we don’t find them in under 45 days – we won’t find them by 90.”

I want to note that this holding period does not apply to remains that are part of an active investigation or criminal proceeding. These are the cases where an unattended death occurs, the case is closed (or no criminality is found), and is being prepared for interment.

I am available if you have any follow up questions. Thank you for your time.

Timothy Grisham
Deputy Director
Pronouns: He/Him/His
Tim@countyofficials.org
360-489-3044

The Washington Association of County Officials is a non-profit, nonpartisan organization providing legislative advocacy, education and training, and day-to-day support on a wide variety of issues of importance to counties. Our 260 members are the elected county assessors, auditors, clerks, coroners and medical examiners, prosecuting attorneys, sheriffs, treasurers and comparable appointed officials in charter counties.
countyofficials.org | Twitter | Facebook

From: shellies4@netzero.com
To: DOH WSBOH
Subject: Human remains rule. Public Comments
Date: Friday, May 17, 2024 7:04:18 PM

External Email

Good afternoon.
I would just like to say that I think ANY unclaimed human remains should be required to have a new tree planted and be put under the tree anywhere in our national forest!
Personally I would be honored to be put back to earth under a tree! We need more trees anyway so let's help the planet as much as we can for our children and grandchildren!
Thank you!
Have an amazing day!
Thank you for all your work and time!

CERTIFICATION OF ENROLLMENT

SUBSTITUTE HOUSE BILL 1974

Chapter 57, Laws of 2024

68th Legislature
2024 Regular Session

DISPOSITION OF HUMAN REMAINS—COUNTIES

EFFECTIVE DATE: June 6, 2024

Passed by the House February 9, 2024
Yeas 97 Nays 0

LAURIE JINKINS

Speaker of the House of Representatives

Passed by the Senate February 28, 2024
Yeas 49 Nays 0

DENNY HECK

President of the Senate

Approved March 13, 2024 1:57 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1974** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

FILED

March 14, 2024

Secretary of State
State of Washington

SUBSTITUTE HOUSE BILL 1974

Passed Legislature - 2024 Regular Session

State of Washington 68th Legislature 2024 Regular Session

By House Civil Rights & Judiciary (originally sponsored by Representatives Abbarno, Bronoske, and Doglio)

READ FIRST TIME 01/31/24.

AN ACT Relating to the disposition of human remains; and reenacting and amending RCW 68.50.230.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 68.50.230 and 2009 c 102 s 20 and 2009 c 56 s 1 are each reenacted and amended to read as follows:

(1) Whenever any human remains shall have been in the lawful possession of any person, firm, corporation, county, or association for a period of ((~~ninety~~)) 45 days or more, and the relatives of, or persons interested in, the deceased person shall fail, neglect, or refuse to direct the disposition, the human remains may be disposed of by the person, firm, corporation, county, or association having such lawful possession thereof, under and in accordance with rules adopted by the funeral and cemetery board, not inconsistent with any statute of the state of Washington or rule adopted by the state board of health.

(2)(a) The department of veterans affairs may certify that the deceased person to whom subsection (1) of this section applies was a veteran or the dependent of a veteran eligible for interment at a federal or state veterans' cemetery.

(b) Upon certification of eligible veteran or dependent of a veteran status under (a) of this subsection, the person, firm,

corporation, county, or association in possession of the veteran's or veteran's dependent's remains shall transfer the custody and control of the remains to the department of veterans affairs.

(c) The transfer of human remains under (b) of this subsection does not create:

(i) A private right of action against the state or its officers and employees or instrumentalities, or against any person, firm, corporation, county, or association transferring the remains; or

(ii) Liability on behalf of the state, the state's officers, employees, or instrumentalities; or on behalf of the person, firm, corporation, county, or association transferring the remains.

Passed by the House February 9, 2024.
Passed by the Senate February 28, 2024.
Approved by the Governor March 13, 2024.
Filed in Office of Secretary of State March 14, 2024.

--- END ---

PDF **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.]

NOTES:

Explanatory statement—2021 c 65: See note following RCW **53.54.030**.

Effective date—2009 c 495: "Except for section 9 of this act, this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 14, 2009]." [**2009 c 495 § 17**.]

Findings—1993 c 492: "The legislature finds that our health and financial security are jeopardized by our ever increasing demand for health care and by current health insurance and health system practices. Current health system practices encourage public demand for unneeded, ineffective, and sometimes dangerous health treatments. These practices often result in unaffordable cost increases that far exceed ordinary inflation for essential care. Current total health care expenditure rates should be sufficient to provide access to essential health care interventions to all within a reformed, efficient system.

The legislature finds that too many of our state's residents are without health insurance, that each year many individuals and families are forced into poverty because of serious illness, and that many must leave gainful employment to be eligible for publicly funded medical services. Additionally, thousands of citizens are at risk of losing adequate health insurance, have had insurance canceled recently, or cannot afford to renew existing coverage.

The legislature finds that businesses find it difficult to pay for health insurance and remain competitive in a global economy, and that individuals, the poor, and small businesses bear an inequitable health insurance burden.

The legislature finds that persons of color have significantly higher rates of mortality and poor health outcomes, and substantially lower numbers and percentages of persons covered by health insurance than the general population. It is intended that chapter 492, Laws of 1993 make provisions to address the special health care needs of these racial and ethnic populations in order to improve their health status.

The legislature finds that uncontrolled demand and expenditures for health care are eroding the ability of families, businesses, communities, and governments to invest in other enterprises that promote health, maintain independence, and ensure continued economic welfare. Housing, nutrition, education, and the environment are all diminished as we invest ever increasing shares of wealth in health care treatments.

The legislature finds that while immediate steps must be taken, a long-term plan of reform is also needed." [**1993 c 492 § 101**.]

Intent—1993 c 492: "(1) The legislature intends that state government policy stabilize health services costs, assure access to essential services for all residents, actively address the health care

needs of persons of color, improve the public's health, and reduce unwarranted health services costs to preserve the viability of nonhealth care businesses.

(2) The legislature intends that:

(a) Total health services costs be stabilized and kept within rates of increase similar to the rates of personal income growth within a publicly regulated, private marketplace that preserves personal choice;

(b) State residents be enrolled in the certified health plan of their choice that meets state standards regarding affordability, accessibility, cost-effectiveness, and clinical efficaciousness;

(c) State residents be able to choose health services from the full range of health care providers, as defined in RCW **43.72.010**(12), in a manner consistent with good health services management, quality assurance, and cost effectiveness;

(d) Individuals and businesses have the option to purchase any health services they may choose in addition to those included in the uniform benefits package or supplemental benefits;

(e) All state residents, businesses, employees, and government participate in payment for health services, with total costs to individuals on a sliding scale based on income to encourage efficient and appropriate utilization of services;

(f) These goals be accomplished within a reformed system using private service providers and facilities in a way that allows consumers to choose among competing plans operating within budget limits and other regulations that promote the public good; and

(g) A policy of coordinating the delivery, purchase, and provision of health services among the federal, state, local, and tribal governments be encouraged and accomplished by chapter 492, Laws of 1993.

(3) Accordingly, the legislature intends that chapter 492, Laws of 1993 provide both early implementation measures and a process for overall reform of the health services system." [**1993 c 492 § 102**.]

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW **43.72.910** through **43.72.915**.

Severability—1992 c 34: See note following RCW **69.07.170**.

Effective date—Severability—1989 1st ex.s. c 9: See RCW **43.70.910** and **43.70.920**.

Savings—1985 c 213: "This act shall not be construed as affecting any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule, regulation, or order adopted under those sections, nor as affecting any proceeding instituted under those sections." [**1985 c 213 § 31**.]

Effective date—1985 c 213: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect June 30, 1985." [**1985 c 213 § 33**.]

Severability—1967 ex.s. c 102: See note following RCW **43.70.130**.

*Rules and regulations—Visual and auditory screening of pupils: RCW **28A.210.020**.*

Date: June 12, 2024

To: Washington State Board of Health Members

From: Mindy Flores, Board Member

Subject: 2024 Draft State Health Report

Background and Summary:

RCW 43.20.100 requires the Washington State Board of Health (Board) to develop a State Health Report every two years, by July 1. The report includes “suggestions for public health priorities for the following biennium and such legislative action as [the Board] deems necessary.”

The State Health Report (SHR) doesn't aim to give a detailed overview of health in Washington State or list everything different groups are doing to improve health across the state. Instead, the report puts forward public health priorities and possible legislative actions for the upcoming legislative cycle for the Governor’s and Legislature’s consideration.

To prepare the 2024 report, staff collaborated with Board Members to decide what topics to include. Additionally, the Board organized two community panels to gather input on topics. Panelists representing communities from the west- and east-side of Washington State presented about current programs and strategies they’re using to address ongoing community needs. Staff also had one-on-one conversations with community representatives to collect additional input to include in the report.

Topics in the draft 2024 report include:

- Increase Data Disaggregation in Washington Through Data Reform to Promote Data Equity
- Remove Barriers to Health Care Insurance and Coverage for Culturally Appropriate Care
- Re-envision the Quality of Care in Washington by Increasing Access to Community-Driven, Culturally and Linguistically Relevant Services
- Advance School Environmental Health in Washington.
- Strengthen Investments in Washington’s Public Health System to Build a Modern and Responsive Public Health System
- Decrease Use of Commercial Tobacco Products, With Special Attention to Flavors

(continued on the next page)

- Support Public Health Improvements to Mitigate Environmental Hazards and Promote Environmental Justice

I have invited Hannah Haag and Molly Dinardo, Board Staff, to review how community voice was incorporated into the Report and discuss the recommendations in the 2024 State Health Report for the Board's consideration.

Recommended Board Actions:

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

The Board directs staff to finalize the 2024 State Health Report (SHR) based on the Board's input today, in consultation with the Chair and Board sponsor and to send the report to the Governor by July 1, 2024. Once the Governor's Office receives the SHR, staff are directed to send a copy to community representatives who contributed to it, the Legislature, and appropriate state agencies.

Staff

Molly Dinardo
Hannah Haag

2024 State Health Report (SHR)

June 12, 2024

Hannah Haag, Community Engagement Coordinator
Molly Dinardo, Health Policy Advisor

WASHINGTON STATE BOARD OF HEALTH

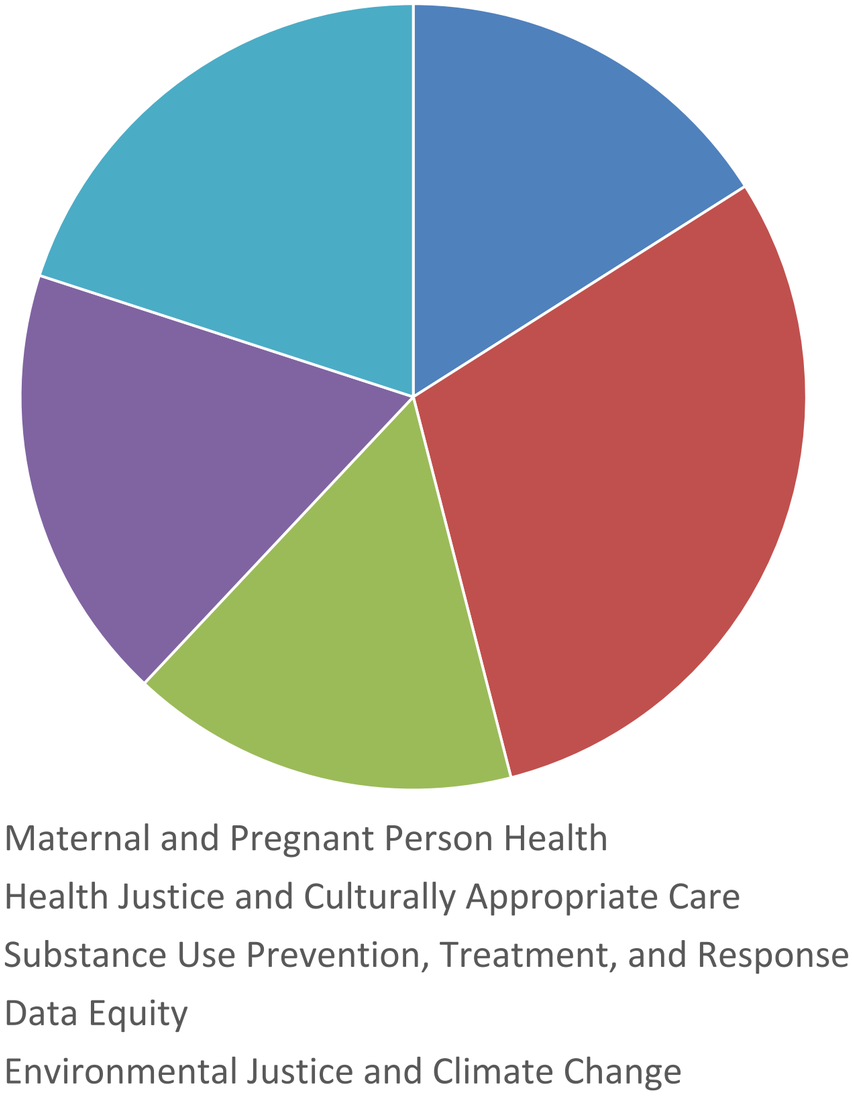
Overview

- SHR Community Engagement
- Brief Updates on 2022 SHR Recommendations
- 2024 Recommendations
- Timeline and Next Steps

SHR Community Engagement

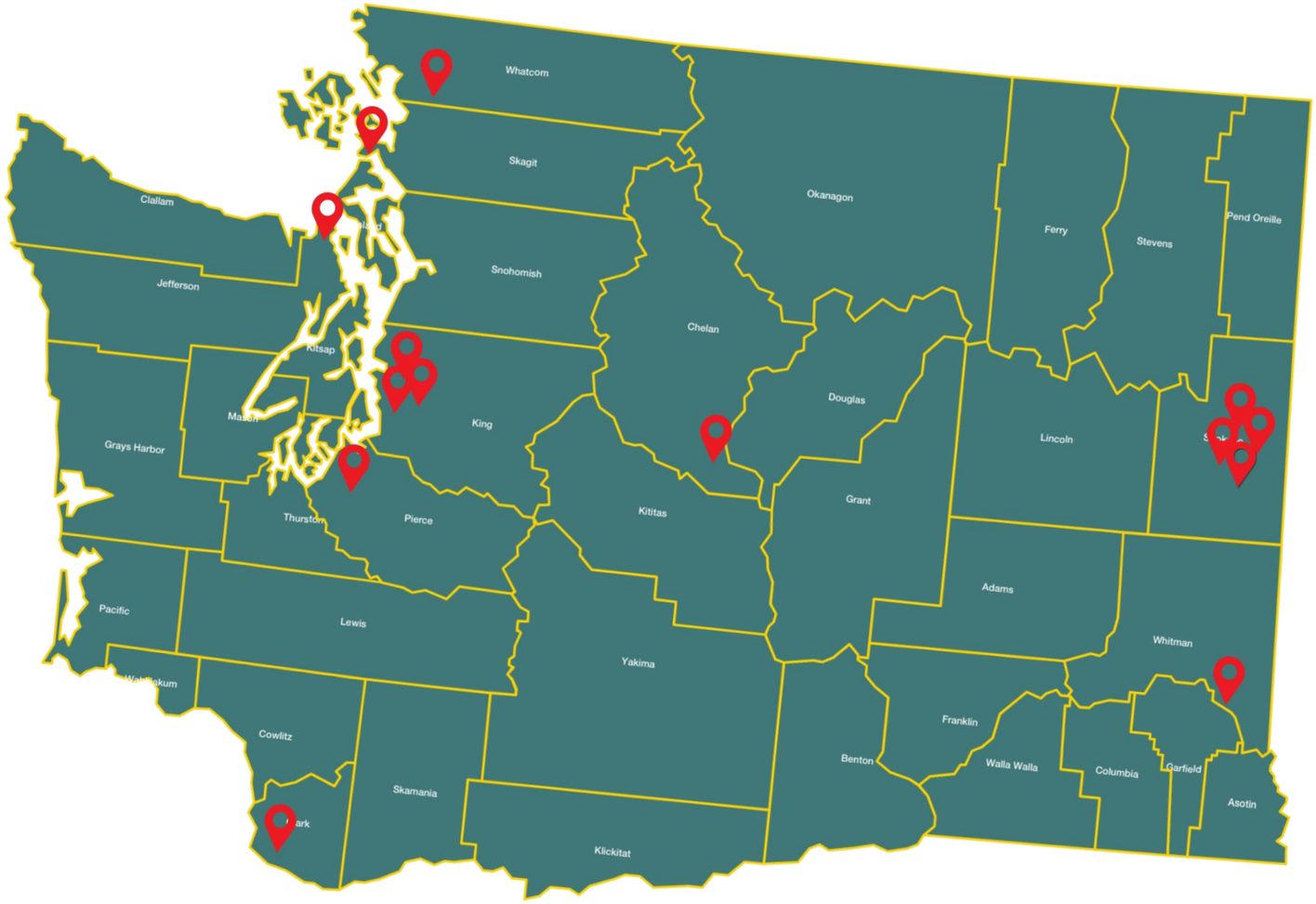
Community Engagement

- The Board held two community panels in March and April 2024, with 8 panelists from across the state.
- Staff met with each panelist at least once in preparation for the panels.
- Panelists represented Accountable Communities of Health, community-based organizations, and community health workers.
- After the panels, staff engaged in multiple follow-up activities, including evaluation conversations.



Community Engagement

Over the last five months, Board staff interacted with 26 community members, each with deep relationships with at least one community impacted by the topics focused on in the State Health Report.



Community Engagement

“Being a panelist was a great experience, but the most valuable part for me was the chance to network with Board Members and other panelists.”

“This work moves at the speed of trust.”

“We felt heard by the Board. Being listened to at this (state) level is so important.”

“I was honored to have the chance to represent the lived and living experience community. It helped me feel more confident in the value of my own lived experience.”

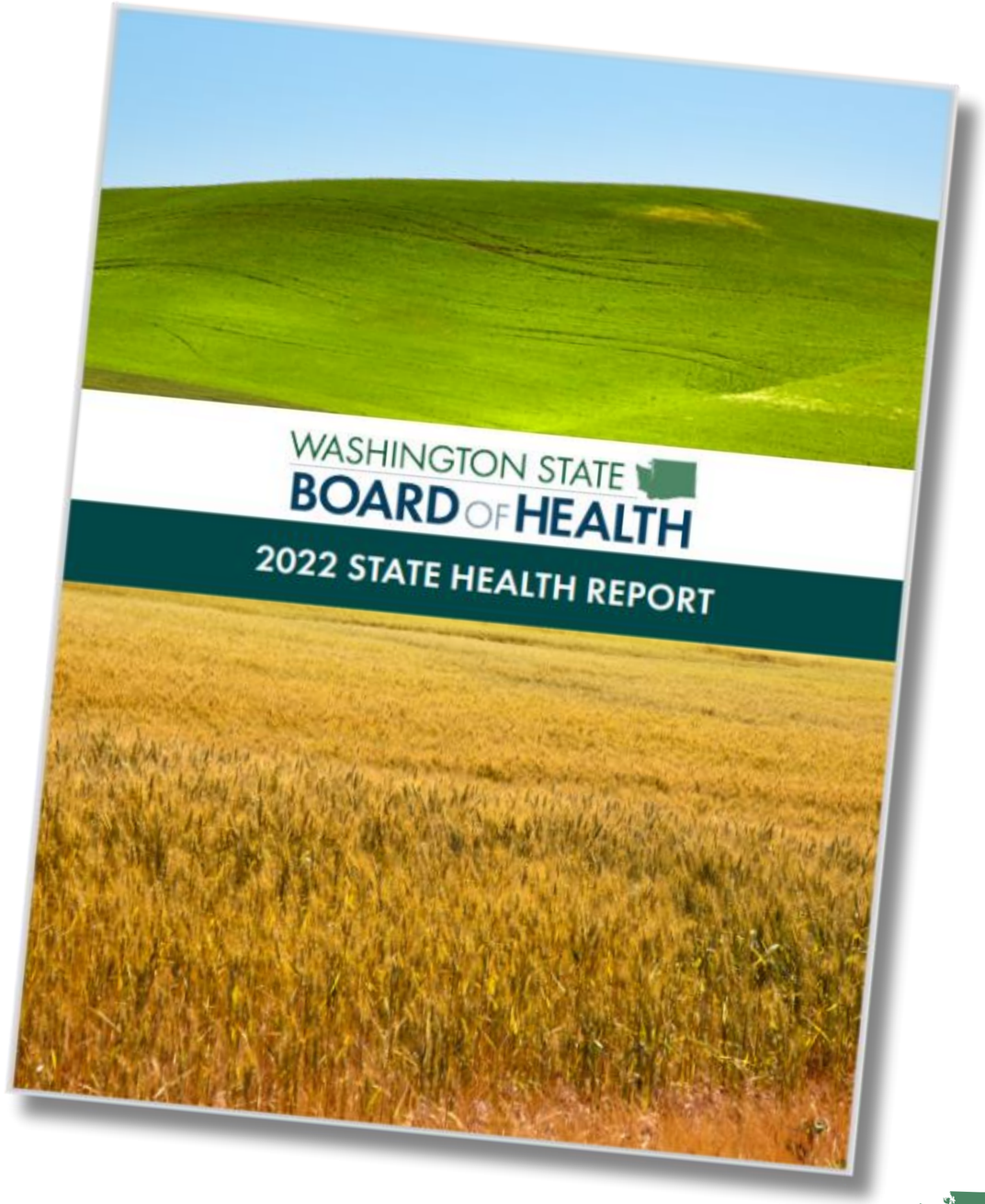
“Stepping into a Board meeting environment is challenging, but the preparation from staff made a big difference. ”

“Are the right folks being represented in the conversations, and from the beginning?”

Brief Updates on 2022 Recommendations

WASHINGTON STATE BOARD OF HEALTH

- Improving Public Health's Response to Health Inequities Through Data Reform
- Removing Barriers to Health Care Insurance and Care Coverage
- Improving Access to Culturally and Linguistically Appropriate Health Services
- Making School Environments Healthy and Safe
- Decreasing Youth Use of Tobacco, Nicotine, and Vapor Products
- Strengthening Washington's Public Health System Through Continued Investments



2024 Recommendations

Recommendation 1

Increase Data Disaggregation in Washington State Through Data Reform to Promote Data Equity.

- Continue to monitor and participate in opportunities to advocate for improvements in federal standards for interoperability and disaggregated demographic data collection. Ensure agencies can comply with updated federal standards within the appropriate timelines.
- Direct and provide funding to state agencies, boards, and commissions to enhance interoperability of data systems to facilitate the collection, analysis, storage, and protection of uniform, disaggregated demographic data.
- Provide 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/ethnicity data.

Feedback to date:

- This recommendation needs to be plain-talked. It also covers much more than data disaggregation. Consider changing the topic title to better represent the broader goal of using data to enhance health equity.
- Consider explaining how not breaking down data in Washington also worsens health disparities in rural areas.
- Include data or citations in this report section to support the discussion of increasing workforce diversity in Washington.

Recommendation 2

Remove Barriers to Healthcare Insurance and Coverage for Culturally Appropriate Care.

- Continue to provide funding to expand current programs that provide access to health insurance for people who are income-eligible and at least 19 years of age, regardless of their immigration status.
- Remove systemic barriers to care, such as cost and limited provider networks, so communities can access timely, culturally appropriate care.
- Actively monitor and participate in opportunities to advocate for coverage of complementary and alternative medicine (CAM) at the federal level.
- Require insurers to cover the cost of CAM, including for traditional healthcare practices provided by qualifying providers at Indian Health Service (IHS) and Tribal facilities.

Feedback to date:

- Consider expanding the topic title to reflect that the recommendations go beyond increasing access to health insurance. For example, it could be revised to “Improve healthcare access and increase the availability of culturally appropriate care.”
- Suggest discussing the intersection of rural health and race/ethnic health inequities, e.g., migrant worker health.

Recommendation 3

Re-envision the Quality of Care in Washington by Increasing Access to Community-Driven, Culturally and Linguistically Relevant Services.

- Follow the recommendations and feedback from the recent State Language Access Workgroup, including enhancing language accessibility in Washington by establishing a specialized Office of Language Access and a permanent public advisory body for interpreters at the state level.
- Expand culturally and linguistically appropriate healthcare services, including—but not limited to—implementing Culturally and Linguistically Appropriate (CLAS) standards and federal non-discrimination in healthcare standards, requiring medical information translation, and increasing access to interpretation services for appointments.
- Advocate for the growth of a community-based workforce in the state, encompassing roles such as community health workers, peer navigators, recovery navigators, and more. Explore diverse public policy strategies to enable reimbursement for the community-based workforce's services and ensure fair compensation. Ensure that community members in this workforce lead and direct this work.

Feedback to date:

- For the first dot point, does the recommendation cover just interpretation services, or would it also include translation?
- Initially, the second dot point only mentioned requiring prescription information translation. Should this be expanded to all medical information?

Recommendation 4

Advance School Environmental Health in Washington.

- Prioritize the School Rule Review Technical Advisory Committee's (TAC's) findings and recommendations for updating statewide minimum environmental health and safety standards for schools. Findings and recommendations will be available by July 2025.
- Allocate state funds towards essential upgrades for school facilities and to address remediation issues, following the recommendations of the School Rule Review Committee, with particular emphasis on overburdened and underserved communities.
- Upon completion of the School Rule Review in July 2025, support the implementation plan and remove the proviso preventing the Board from implementing modernized school environmental health and safety rules.
- Provide funding for localized school environmental health programs.
- Continue investing in the upkeep and modernization of HVAC systems in K-12 schools to mitigate the spread of contaminants and infectious diseases.

Feedback to date:

- Switch around the order of the recommendations (change incorporated).
- In the discussion of indoor air quality, consider mentioning the disproportionate impact of wildfire smoke on rural communities.
- Suggest including a discussion about other ways that schools serve as important community hubs.

Recommendation 5

Strengthen Investments in Washington's Public Health System to Build a Modern and Responsive Public Health System.

- Prioritize continued and expanded foundational public health investments in the 2025-2027 biennium and future biennia to build a modern and responsive governmental public health system in Washington State. These investments ensure that the system can prevent, identify, and control communicable diseases, enhance environmental public health services, improve services over the life course, improve system business competencies, and address inequities within the system.

Feedback to date:

- "Really important recommendation." Curious if we should make some connection with what we've learned from the pandemic and call out the importance of community engagement. See the "Chorus of COVID" report.

Recommendation 6

Decrease Use of Commercial Tobacco Products, With Special Attention to Flavored Vaping Products.

- Prohibit the sale of all flavored commercial tobacco products to the public to reduce the appeal and use of these products by youth and young adults and communities disproportionately impacted by tobacco industry marketing.

Feedback to date:

- Should we explicitly mention vaping as one of the products? These are given good air-time in the body of the report, but it might be good to either call out vaping in the topic title or the recommendations (change incorporated).

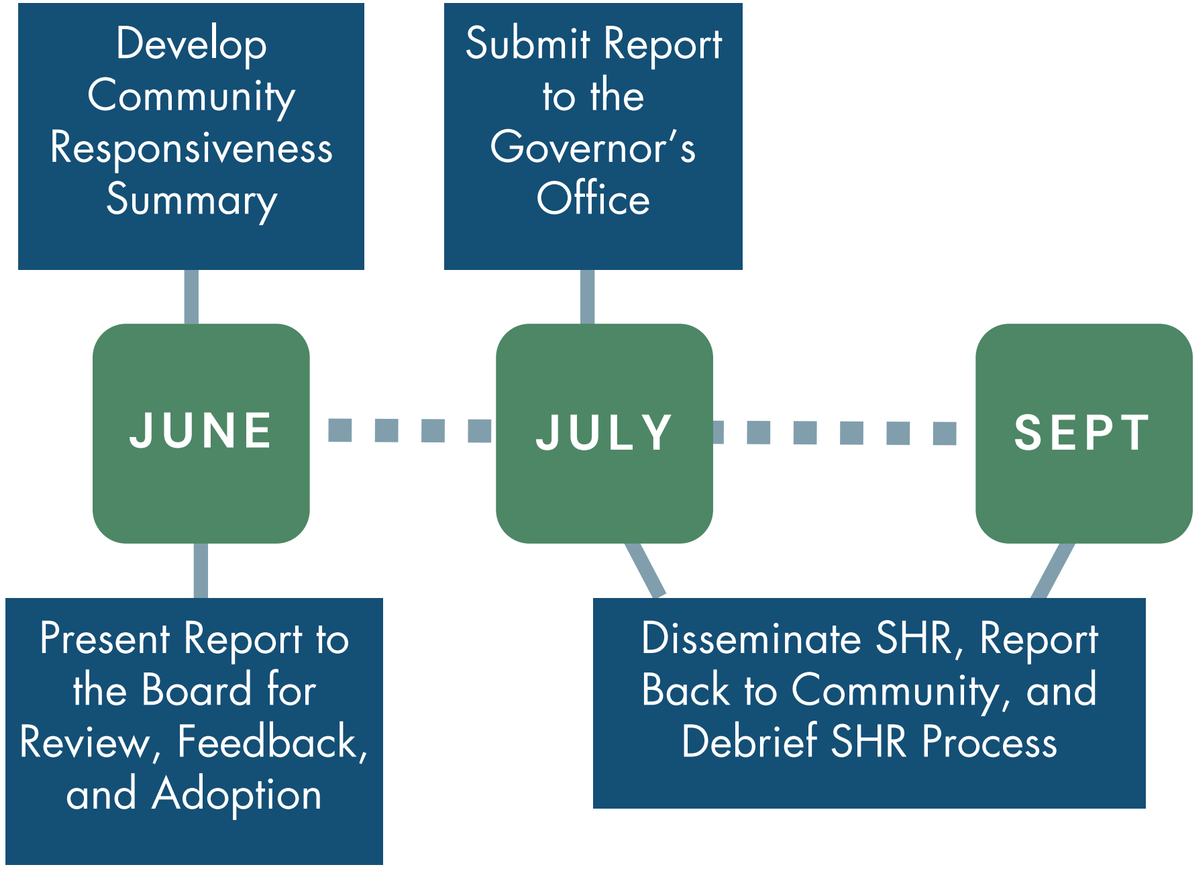
Recommendation 7

Support Public Health Improvements to Mitigate Environmental Hazards and Promote Environmental Justice.

- Provide adequate funding to increase the capacity of public health agencies to increase blood lead testing, reporting, and linkages to follow-up care, particularly for people on Medicaid.
- Expand public health safeguards, such as establishing sanitary controls for commercially harvested crab, to protect Washingtonians from environmental hazards.
- Continue to provide funding to support environmental justice assessments and ensure communities disproportionately impacted by environmental justice issues, such as environmental racism, are centered in this work.

No feedback to date.

Next Steps and Timeline



WASHINGTON STATE BOARD OF HEALTH

Questions?

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ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
- We are committed to providing access to all individuals visiting our agency website, including persons with disabilities. If you cannot access content on our website because of a disability, have questions about content accessibility or would like to report problems accessing information on our website, please call (360) 236-4110 or email wsboh@sboh.wa.gov and describe the following details in your message:
    - The nature of the accessibility needs
    - The URL (web address) of the content you would like to access
    - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.

2024 State Health Report – Working Draft

Contents Page

- To include a table of contents here.

Letter from Chair

- To insert a Letter from the Chair here.

Acknowledgments Page

- The Board would like to thank the community members who provided their expertise, feedback, and support for this report. Your contributions made this work possible.
- *Staff are contacting the people and organizations that helped contribute to this report. We will only list organizations with their consent.*

List of Acronyms/Abbreviations

Commented [DM(1]: Board Member Feedback: What are the possible ramifications for the report/organizations if we list the specific organizations?

Commented [DM(2]: Suggestion from SBOH Comms Team.

Executive Summary

The Washington State Board of Health (Board) was established by the Washington State Constitution in 1889. Since then, the Board has monitored the public's health and served as a public forum to inform health policy. One way the Board accomplishes this is by making policy recommendations to the Washington State Governor's Office and Legislature through its State Health Report.

The Board has produced a biennial State Health Report since 1977. RCW 43.20.100 requires the Board to create the report for the Governor's Office in even-numbered years. The report highlights suggestions for public health priorities and policy recommendations for the next biennium.

Despite its title, the State Health Report is not meant to describe or assess the state of health in Washington State. Instead, it highlights recommended policy directions for the Governor and Legislature's consideration.

The Board has included the following topics and recommendations for its 2024 report:

Increase Data Disaggregation in Washington State Through Data Reform to Promote Data Equity. Recommendations include:

- Continue to advocate for improvements in federal standards for interoperability and disaggregated demographic data collection. Ensure that agencies can comply with updated federal standards within the appropriate timelines.
- Direct and provide funding to state agencies, boards, and commissions to enhance interoperability of data systems to facilitate the collection, analysis, storage, and protection of uniform, disaggregated demographic data.
- Provide 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/ethnicity data.

Remove Barriers to Healthcare Insurance and Coverage for Culturally Appropriate Care. Recommendations include:

- Continue to provide funding to expand current programs that provide access to health insurance for people who are income-eligible and at least 19 years of age, regardless of their immigration status.
- Remove systemic barriers to care, such as cost and limited provider networks, so communities can access timely, culturally appropriate care.
- Actively monitor and participate in opportunities to advocate for coverage of complementary and alternative medicine (CAM) at the federal level.
- Require insurers to cover the cost of CAM, including for traditional healthcare practices provided by qualifying providers at Indian Health Service (IHS) and Tribal facilities.

Commented [DM(3]: Board Member: My "big picture" suggestions would be to (1) consider using some language around what we have learned from the pandemic to improve public health and (2) connect more of the content with rural health - I'm a member of the ASTHO population health and informatics policy committee, and rural health disparities will likely be one of their policy themes for the next year.

Commented [MD4]: Question for Michelle L and Team: In the HIR team's feedback, they added "State" anywhere I referenced Washington. They mentioned their team was advised by Comms to add this to assure no one thinks we're referring to WA DC. Do you want to keep this convention for this report as well?

Commented [DM(5]: Board Member: We highlight, but who is actually responsible for follow-up and updates?

Commented [DM(6]: Board Member: I think the recommendations here are great, but the topic title doesn't really capture all of what they are about. The recommendations are about so much more than data disaggregation. My suggestion would be to think of a new topic title that is more plain talk, encompasses all of the recommendations, and reflects the larger goal of using data to increase health equity.

Commented [DM(7]: Board Member: Consider broadening the topic title to reflect that the recommendations are more than just health insurance. Maybe, "Improve health care access and increase availability of culturally appropriate care."

Re-envision the Quality of Care in Washington by Increasing Access to Community-Driven, Culturally and Linguistically Relevant Services. Recommendations include:

- Follow the recommendations and feedback from the recent State Language Access Workgroup, including enhancing language accessibility in Washington by establishing a specialized Office of Language Access and a permanent public advisory body for interpreters at the state level.
- Expand culturally and linguistically appropriate healthcare services, including—but not limited to—implementing Culturally and Linguistically Appropriate (CLAS) standards and federal non-discrimination in healthcare standards, requiring medical information translation, and increasing access to interpretation services for appointments.
- Advocate for the growth of a community-based workforce in the state, encompassing roles such as community health workers, peer navigators, recovery navigators, and more. Explore diverse public policy strategies to enable reimbursement for the community-based workforce's services and ensure fair compensation. Ensure that community members in this workforce lead and direct this work.

Advance School Environmental Health in Washington. Recommendations include:

- Prioritize the School Rule Review Technical Advisory Committee's findings and recommendations for updating statewide minimum environmental health and safety standards for schools. These findings and recommendations will be available by July 2025.
- Allocate state funds towards essential upgrades for school facilities and to address remediation issues, following the recommendations of the School Rule Review Committee, with particular emphasis on overburdened and underserved communities.
- Upon completion of the School Rule Review in July 2025, support the implementation plan and remove the proviso preventing the Board from implementing modernized school environmental health and safety rules.
- Provide funding for localized school environmental health programs.
- Continue investing in the upkeep and modernization of HVAC systems in K-12 schools to mitigate the spread of contaminants and infectious diseases.

Strengthen Investments in Washington's Public Health System to Build a Modern and Responsive Public Health System. Recommendations include:

- Prioritize continued and expanded foundational public health investments in the 2025-2027 biennium and future biennia to build a modern and responsive governmental public health system in Washington State. These investments ensure that the system can prevent, assess, and control communicable diseases, enhance environmental public health services, improve services over the life course, improve system competencies, and address inequities within the system.

Decrease Use of Commercial Tobacco Products, With Special Attention to Flavored Vaping Products. Recommendations include:

Commented [DM(8]: Note to self: Need to reconfirm if the recommendation is specific to interpretation or would encompass both interpretation and translation.

Commented [DM(9]: Board Member Feedback: "The recommendations for the School EH rules: I suggest changing the first bullet/recommendation that asks the proviso to be lifted. Put it as the last bullet recommendation & reword to say something like "upon completion of the project to update the rules, support the implementation plan and remove the proviso preventing the Board from implementing the rule."

Commented [DM(10R9]: Recommendation incorporated

Commented [DM(11]: Board Member: Really important recommendation. Wondering if it would be good to make some connection with what we've learned from the pandemic and call out the importance of community engagement. See the "Chorus of COVID" report. This will also be a theme of the Public Health Advisory Board recommendations.

Commented [DM(12]: Board Member: Should we explicitly mention vaping as one of the products? They are given good air time in the main text, but it might be good to call out vaping in either the topic title or the recommendations as well.

Commented [DM(13R12]: Recommendation incorporated.

- Prohibit the sale of all flavored commercial tobacco products to the public to reduce the appeal and use of these products by youth and young adults and communities disproportionately impacted by tobacco industry marketing.

Support Public Health Improvements to Mitigate Environmental Hazards and Promote Environmental Justice. Recommendations include:

- Provide adequate funding to increase the capacity of public health agencies to increase blood lead testing, reporting, and linkages to follow-up care, particularly for people on Medicaid.
- Expand public health safeguards, such as establishing sanitary controls for commercially harvested crab, to protect Washingtonians from environmental hazards.
- Continue to provide funding to support environmental justice assessments and ensure communities disproportionately impacted by environmental justice issues, such as environmental racism, are centered in this work.

It's important to note that the 2024 State Health Report includes several topics and recommendations from past reports. While progress has been made in some areas, many issues have not been fully addressed in previous biennia. With the upcoming transition in the Governor's Office, leadership in state government, and the Legislature, the Board would like to highlight policies, initiatives, and investments enacted over the past biennia and areas of opportunity to advance the health of all Washingtonians into the next biennium and beyond. As such, this report will include updates on past report recommendations and identify policy initiatives and programs that should be retained, expanded, or established.

The Board would like to thank Governor Inslee for his leadership and support of critical public health policies and initiatives over the past decade. His commitment to addressing pressing public health challenges, particularly climate change, the COVID-19 pandemic response, the opioid and fentanyl crises, and threats to reproductive healthcare access, has been instrumental in shaping a healthier and more resilient Washington State. We look forward to continuing and expanding this work to promote health equity and address systemic inequities that impede communities' ability to thrive alongside a new administration.

While many topics deserve to be highlighted in this report, such as mis- and disinformation; eroded trust in the public health system; rising economic inequality; lack of available and affordable housing; and the impacts of structural racism, sexism, ableism, homophobia, transphobia, settler colonialism, and other forms of systemic oppression on the public's health; this 2024 report highlights actionable, statewide public health policy initiatives and recommendations anticipated over the next biennium.

The Board would like to thank all the community groups and public health entities who took the time to meet with us, share their expertise, and discuss public health priorities and barriers they see in their communities. For this report, we have included community input wherever possible. Staff have also compiled a summary of community feedback to outline the key themes we heard and how we have integrated community voice into the report. We still have a lot of work to do to incorporate community voice and feedback into this report in the future.

Commented [DM(14]: Board Member: This should be moved to the first part of the Executive Summary.

Commented [MD15]: This could be part of the Chair's letter at the front of the report.

Commented [MD16]: Board Staff Feedback: Could this be taken to suggest that the listed items are not actionable or that we just don't plan to address any of them in the next biennium? Maybe we can point to our PEAR planning here to show we are taking action, just through a different process?

Commented [MD17R16]: Note to self: Would love help from Ashley/Paj to include something about PEAR planning here.

Commented [DM(18]: Board Member: We should link to the community responsiveness summary here. This will help showcase outreach efforts for inclusive voices.

Commented [DM(19]: Board Staff Comment: I like this, but I do think it would be rewarding and cool for the individuals/groups to be specifically in the report for their contributions. I think this encourages further participation not only in Board work but government process in general. It makes steps up that Harvard catalyst engagement ladder to show we didn't just inform or consult but were truly involved.

Recommendation 1: Increase Data Disaggregation in Washington Through Data Reform to Promote Data Equity.

Commented [DM(20]: Board Member: Consider including some mention of the benefits of stronger health equity data to rural communities:

'Hidden' data exacerbates rural public health inequities | UW News (washington.edu)

Using Data to Identify Priorities and Health Inequities - RHIhub Health Equity Toolkit (ruralhealthinfo.org)

Data is an essential component of public health. Programs, funders, program managers, and community partners rely on data to allocate resources effectively. However, to be a useful tool, data must accurately reflect communities, incorporate considerations of personal privacy and data sovereignty, and prevent the misuse and misrepresentation of data that can harm communities and individuals. Data equity embodies social justice, inclusivity, and equity principles that guide data collection, interpretation, and distribution [1]. Data equity prompts reflection on how data can reinforce stereotypes and exacerbate inequities, and encourages critical thinking about intentional efforts to prevent harm.

> *"There is an intersection between data equity and language justice. [For example] data gathering tools often being available in certain languages limits how accurately collected 'data' can represent community needs."*
> *- Washington community-based provider*

Disaggregated data, which break down information among key demographic categories like race, ethnicity, sex, income, disability, and Veteran status, are indispensable for achieving health equity in Washington. Disaggregated data allows a more granular understanding of these key categories by providing detailed sub-categories. Such data exposes inequities within and across groups, particularly those most impacted by racism, ableism, and other forms of systemic oppression. These data illuminate community health outcomes, revealing who accesses public health programs and whether services reach institutionally underserved and underrepresented communities.

Lack of disaggregated data collection exacerbates and perpetuates harm against the communities most affected by inequities. Over the years, both the Board and the Governor's Interagency Council on Health Disparities (Council) have received feedback from communities expressing their frustration with erasure due to constraints in data collection and the biases, whether conscious or not, of those collecting data.

Health inequities persist when essential demographic factors like race, ethnicity, preferred language, disability status, and gender are misclassified, inaccurately reported, or left incomplete. This makes people invisible in data and perpetuates harm by obstructing access to culturally and linguistically appropriate care and related services, which impedes a person's ability to thrive. Furthermore, the lack of disaggregated data hinders communities' ability to apply for and receive grant funding to address inequities in their communities. To mitigate these issues, people should be able to self-report and select multiple demographic categories and sub-categories, promoting autonomy and accuracy. People should also have the choice of whether they share their personal information.

[1] Data.org. What is Data Equity, and Why Does it Matter? Data.org. No publication date. Accessed May 15, 2024. https://data.org/resources/what-is-data-equity-and-why-does-it-matter/

The Board recently learned from a community organization that talked about “genocide by data” [2] and how Indigenous people are often erased, undercounted, or not counted at all in Census and other population data. The organization emphasized that most data do not represent who Indigenous people are, especially Urban Indian communities, who account for roughly 70 percent of people who identify as American Indian and Alaska Native (AI/AN) in the U. S. [3]. Although not a new issue, the COVID-19 pandemic brought to light ongoing data genocide. Specifically how the lack of disaggregated data for AI/AN people impacted the ability of local, state, federal, and Tribal public health authorities in their pandemic response. It also limited decision-makers’ ability to make data-driven decisions for equitable policy and resource allocation [4].

Additionally, a recurring issue community members highlight is the tendency for agencies to lump diverse communities into a single, monolithic category during data collection efforts. For example, people from Filipino, Vietnamese, Indonesian, Japanese, Chinese, Lao, and other communities have been overlooked and marginalized when their experiences are homogenized under the broad data label of "Asian." While race and ethnicity are socio-political constructs created and manipulated when convenient to uphold the power of dominating cultures and systems of oppression, communities’ unique health challenges and experiences are overlooked when their data is lumped into a single category.

In addition, incorporating qualitative data—stories from impacted communities or information not able to be represented by numbers—into data collection methods whenever possible is essential to understanding the social and political determinants of health that impact communities. Data – both quantitative and qualitative – are crucial for uncovering and addressing longstanding inequities within the healthcare and public health systems, especially those affecting Black, Indigenous, and communities of color.

Communities have consistently asked agencies in Washington State to collect disaggregated data. Unfortunately, agencies are limited in the data they can collect. In many instances, governmental entities must follow federal statistical standards set by the Office of Management and Budget (OMB).

As an example, the Board recently adopted revisions to its notifiable conditions rule, chapter 246-101 of the Washington Administrative Code (WAC). This rule outlines the required information that healthcare providers, healthcare facilities, laboratories, and other entities must report to public health authorities with each case of a notifiable condition [5]. As part of recent revisions, the Board included the requirement for reporting patient-identified race, ethnicity, and preferred language based on significant community feedback. These new rules went into effect on January 1, 2023, and included 4 reporting categories for a patient's ethnicity, 72 for race, and 50 for a patient's preferred language.

Community members questioned the rationale behind having separate race and ethnicity questions and including ethnicities and nationalities under the race category reporting options within the Board's notifiable conditions rule. Board staff stated they were constrained by outdated federal standards.

The OMB established the minimum standards for collecting race and ethnicity data in 1997. This OMB standard consisted 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,

[2] Urban Indian Health Institute (UIHI). Data Genocide of American Indians and Alaska Natives in COVID-19 Data. February 15, 2021. Accessed May 15, 2024. https://www.uihi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/

[3] Urban Indian Health Institute (UIHI). Community Health profile, National Aggregate of Urban Indian Organization Service Areas. October 29, 2021. Accessed May 15, 2024. https://www.uihi.org/download/community-health-profile-national-aggregate-of-urban-indian-organization-service-areas/

[4] Urban Indian Health Institute (UIHI). Data Genocide of American Indians and Alaska Natives in COVID-19 Data. February 15, 2021. Accessed May 15, 2024. https://www.uihi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/

[5] Chapter 246-101 WAC. Accessed May 15, 2024. https://apps.leg.wa.gov/WAC/default.aspx?cite=246-101

and White). OMB only permitted additional granularity where it was supported by sample size and if the additional detail could be aggregated back to the minimum standard set of race and ethnicity categories.

In its 2022 State Health Report, the Board recommended that the Governor and Legislature actively monitor and advocate for enhancements in federal standards regarding interoperability and disaggregated demographic data collection. Subsequently, in April 2023, the Governor's Office, along with Washington State agencies such as the Board, Council, Department of Health, Health Benefit Exchange, and the Office of Financial Management (OFM), submitted comments on the OMB's Initial Proposals for Updating Federal Race and Ethnicity Standards, known as Statistical Policy Directive Number 15 (SPD 15)[6]. OMB allowed public feedback on its proposal from January to April 2023.

The proposal by OMB included various changes for public input, such as consolidating race and ethnicity into one combined question, encouraging individuals to select multiple options to reflect their identity, and introducing Middle Eastern or North African (MENA) as a new minimum category. Additionally, the proposal required collecting additional details beyond the minimum required categories in most situations to facilitate further disaggregation of data when applicable and appropriate.

In March 2024, OMB released its updated standards, largely reflecting the proposed changes from the original proposal and incorporating feedback from the public comment period [7]. The revisions included several updates to definitions, terminology, and agency guidance on data collection and presentation. Notably, the new minimum race and/or ethnicity categories encompass American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Middle Eastern or North African, Native Hawaiian or Pacific Islander, and white.

Agencies must adhere to the new data collection standards outlined by the OMB by March 2029, five years after the publication notice. While certain Washington State agencies are already collecting detailed disaggregated data, additional investments or direction from the Legislature may be required to accelerate this work and guarantee that agencies can align with the updated standards within the designated timeframe.

Disaggregated data are only as good as the public health and governmental system's ability to receive and analyze them for meaningful use. Prioritizing interoperability, which allows systems to seamlessly share and exchange data across public health and governmental agency systems, is crucial. It is imperative to standardize the type of data collected and how it's utilized and shared among various public health agencies and programs.

The Board acknowledges the importance of simultaneously evaluating all health-related data systems at the agency level. Collaborating with community partners, other state agencies, federal counterparts, and Tribal entities is essential to determine the necessary steps toward harmonizing the collection and safeguarding of disaggregated demographic data across multiple sources. Agencies need to ensure they are collecting disaggregated data in the same way. The scale and complexity of this long-term, systemic endeavor underscores the need for data collection reform. Addressing systemic issues calls for systemic solutions.

The Board also recommended in 2022 that the Governor and Legislature act to:

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[6] Office of Management and Budget (OMB). Initial Proposals For Updating OMB's Race and Ethnicity Statistical Standards. Federal Register. Published January 27, 2023. Accessed May 29, 2024. https://www.federalregister.gov/documents/2023/01/27/2023-01635/initial-proposals-for-updating-ombs-race-and-ethnicity-statistical-standards

[7] Office of Management and Budget (OMB). Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Federal Register. Published March 29, 2024. Accessed May 15, 2024. https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and

- Provide adequate funding to the Office of Equity to lead a community-centered process to develop enterprise-wide standards for collecting, analyzing, storing, and protecting disaggregated demographic data, starting with race/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.

Despite ongoing discussions among the Office of Equity and other state agencies regarding disaggregated data collection, the Legislature has not provided funding for these purposes. Additionally, while several state agencies have undertaken initiatives related to data disaggregation, the level of investment remains insufficient. Further investments are imperative to advance these efforts effectively and ensure uniformity across agencies.

Disaggregated data represents a crucial stride towards achieving data equity in Washington. Further, democratizing data and allowing communities to use their 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 who allow it to exist. For instance, during a recent community interaction, a member expressed, "It's not that there's a lack of data; there's a lack of understanding of how to access this data."

Commented [DM(21]: Board Member: Make into a "quote header" to drive this point.

Accessing data can be challenging, particularly for smaller, community-based organizations. Several organizations and people that the Board recently connected with have voiced frustration over agencies often excluding them from data collection projects. Some of these projects have moved forward without community input or consultation. Agencies must ensure that communities can readily access their data and assist in cultivating community capacity to steer research and other programmatic initiatives.

Disaggregated data and data equity also create transparency and help us evaluate the progress of equity initiatives. A community member recently emphasized to Board staff, "without measurement, there's no understanding or accountability for diversity or equity efforts." For example, in recent years, several efforts have been made in Washington to assess and improve the diversity of the healthcare provider workforce. Research consistently highlights the importance of a diverse healthcare provider workforce [8,9]. With diverse providers, including those serving their own communities, healthcare services can be tailored to meet the unique needs of patients from diverse backgrounds. This not only enhances cultural humility. It increases access to care by expanding access for underserved communities and improving patient-provider communication.

[8] Rotenstein Lisa S., Reede Joan Y., Jena Anupam B. Addressing Workforce Diversity — A Quality-Improvement Framework. New England Journal of Medicine. 2021;384(12):1083-1086. doi:10.1056/NEJMp2032224

[9] Stanford FC. The Importance of Diversity and Inclusion in the Healthcare Workforce. J Natl Med Assoc. 2020;112(3):247-249. doi:10.1016/j.jnma.2020.03.014

However, recruiting, supporting, and healthcare providers from underrepresented communities poses significant challenges due to longstanding racial and economic inequities in healthcare workforce development. Disaggregated data from the healthcare workforce can be crucial in establishing a baseline assessment of the current workforce landscape and measuring progress toward enhancing equity in the healthcare workforce.

Commented [DM(22]: Board Member: What are stats to support this? For example, in 2022, XX number of diverse providers were active in the workforce in WA [based off active licenses?]
In 2024, XX number of licenses...
Is this data available? Does it support claim?

The Board recommends the Governor and Legislature act to:

- Continue to advocate for improvements in federal standards for interoperability and disaggregated demographic data collection. Ensure that agencies can comply with updated federal standards within the appropriate timelines.
- Direct and provide funding to state agencies, boards, and commissions to enhance interoperability of data systems to facilitate the collection, analysis, storage, and protection of uniform, disaggregated demographic data.
- Provide 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/ethnicity data.

Recommendation 2: Remove Barriers to Healthcare Insurance and Coverage for Culturally Appropriate Care.

Despite the strides made in health insurance coverage due to the Affordable Care Act (ACA) and Medicaid expansion in 41 states, roughly 8 percent of people in the U.S. still lack access to health insurance [10,11]. While the number of insured people has increased in recent years, surveys conducted by health policy research groups highlight that healthcare affordability and coverage remain major concerns for many people [12,13]. Approximately 1 in 4 adults reported skipping or postponing necessary care due to financial constraints in the past year, and 6 in 10 uninsured adults stated they went without essential care because of costs[13].

Access to healthcare is a key social determinant of health. Inequities persist due to racism, geographic location, age, and social determinants of health like employment and income level [14]. Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Additionally, dental services are the most common preventive care service adults report delaying due to cost. 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.

While insurance doesn't guarantee affordable, high-quality healthcare, studies show that health insurance enhances access to vital services such as primary care, recommended screenings, and prescription medications. These are essential services for maintaining and enhancing positive health outcomes [15]. Additionally, access to health insurance coverage promotes financial stability by reducing unexpected medical expenses for people and their loved ones.

> *"Community members receiving services thought they were covered for all types of healthcare, only to find out they weren't. The system is confusing."*
> *-Washington community-based provider*

Washington State has consistently maintained one of the lowest uninsured rates nationwide, reaching a record low of 4.7 percent in 2022 [16]. However, coverage varies significantly by county, and rising healthcare costs pose an ongoing challenge for many Washingtonians [16,17]. Furthermore, inequities due to racism persist. For example, while the uninsured rate for people who identified as Hispanic decreased from

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[10]Bureau UC. Health Insurance Coverage in the United States: 2022. Census.gov. Accessed May 15, 2024. https://www.census.gov/library/publications/2023/demo/p60-281.html

[11] Kaiser Family Foundation (KFF). Status of State Medicaid Expansion Decisions: Interactive Map. KFF. Published May 8, 2024. Accessed May 15, 2024. https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/

[12] Nadeem R. Inflation, Health Costs, Partisan Cooperation Among the Nation's Top Problems. Pew Research Center. Published June 21, 2023. Accessed May 15, 2024. https://www.pewresearch.org/politics/2023/06/21/inflation-health-costs-partisan-cooperation-among-the-nations-top-problems

[13] Lopes L, Montero A, Presiado M, Published LH. Americans' Challenges with Health Care Costs. KFF. Published March 1, 2024. Accessed May 29, 2024. https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/

[14] Agency for Healthcare Research and Quality. 2023 National Healthcare Quality and Disparities Report. AHRQ; 2023. Accessed May 15, 2024. https://www.ahrq.gov/sites/default/files/wysiwyg/research/findings/nhqrdr/2023-nhqdr-rev.pdf

[15] Sommers Benjamin D., Gawande Atul A., Baicker Katherine. Health Insurance Coverage and Health — What the Recent Evidence Tells Us. New England Journal of Medicine. 2017;377(6):586-593. doi:10.1056/NEJMsb1706645

[16] Yen W. Medicaid increase created all-time low for Washington's uninsured rate, but a reversal is emerging. Washington Office of Financial Management (OFM) (Research Brief No.114). February 2024. Accessed May 15, 2024. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief114.pdf

[17] Prepared by Health Management Associates. Washington Office of the Insurance Commissioner (OIC) Preliminary Report on Health Care Affordability. Published online November 29, 2023. Accessed May 15, 2024. https://www.insurance.wa.gov/sites/default/files/documents/oic-prelim-report-1201123-final_1.pdf

2021 to 2022, the uninsured rate for Hispanics was approximately three times higher than people who identified as non-Hispanic [16].

According to a recent survey on consumer healthcare experiences, 62 percent of respondents in Washington State reported facing at least one affordability issue in the past year, with over 80 percent expressing concerns about affording healthcare in the future [18].[18] Moreover, with the end of the COVID-19 public health emergency (PHE) and Medicaid continuous coverage in 2023, the long-term impact on enrollees and the uninsured rate in Washington State remains uncertain. Based on Washington Health Care Authority (HCA) data from January 2024, over 600,000 people were removed from Medicaid between June and December 2023 [19] . While HCA, the Health Benefit Exchange (Exchange), and other partners worked to help people find affordable access to health insurance, further strategies to increase insurance affordability and coverage rates are critical to ensure more people can access preventive care and care for chronic and acute illnesses.

In the 2022 State Health Report, the Board recommended the Governor and Legislature expand health insurance for people who are income eligible and aged 19 years or older, regardless of immigration status. In 2022, a budget proviso directed the Exchange to submit an ACA waiver (section 1332) to the federal government [20]. Approximately one-third of Washington residents receive health and dental insurance through the Exchange [21]. The federal government approved the waiver in December 2022, allowing people to purchase insurance on the Exchange regardless of immigration status. In November 2023, the Exchange launched an open enrollment period with expanded access to health and dental plans. Under this expanded access, 23 percent of Washington's uninsured population is newly eligible to purchase a health plan on the Exchange [22].

Additionally, in 2023, the Legislature allocated funding to the HCA to explore a Medicaid look-alike program for people with low incomes aged 19 or older, regardless of immigration status, who lacked access to other federally subsidized health coverage. This expansion of Washington Apple Health is set to begin in July 2024. While these developments are promising, and the Board commends these recent expansion efforts, further expansion is necessary. For instance, the Medicaid look-alike program will only cover enrollment for 13,000 individuals, meeting roughly 13 percent of the needed coverage for eligible individuals [23].

Making healthcare more affordable in Washington State is essential for breaking down access barriers. However, systemic issues like medical racism and discrimination, a lack of understanding or respect for cultural beliefs, and care coverage that does not meet unique individual health needs continue to prevent access to care.

[18] Healthcare Value Hub. Consumer Healthcare Experience State Survey (CHESS). Data Brief No 1. Published April 2018, Updated July 2019. Accessed May 15, 2024. https://www.healthcarevaluehub.org/advocate-resources/consumer-healthcare-experience-state-survey

[19] Yen W. Medicaid increase created all-time low for Washington's uninsured rate, but a reversal is emerging. Washington Office of Financial Management (OFM) (Research Brief No.114). February 2024. Accessed May 15, 2024. https://ofm.wa.gov/sites/default/files/public/dataresearch/researchbriefs/brief114.pdf

[20] Washington Health Benefit Exchange. Washington Section 1332 Waiver Application. Submitted May 13, 2022. Revised on June 1, 2022. https://www.wahbexchange.org/content/dam/wahbe-assets/legislation/WA%20Section%201332%20Waiver%20Application-updated%206-8.pdf

[21] Washington Health Benefit Exchange. Health insurance enrollment sees strong growth for 2024 through Washington Healthplanfinder. April 25, 2024. Accessed May 15, 2024. https://www.wahbexchange.org/health-insurance-enrollment-sees-strong-growth-for-2024-through-/

[22] Washington Health Benefit Exchange | Immigrant Health Coverage. No date. Accessed May 15, 2024. https://www.wahbexchange.org/about-the-exchange/what-is-the-exchange/immigrant-health-expansion/

[23] Northwest Health Law Advocates. 2024 Legislative Session Review. March 20, 2024. Accessed May 15, 2024. https://nohla.org/wordpress/wp-content/uploads/2024/03/2024-Legislative-Session-Wrap-Up-3-20-24.pdf

For example, most standard insurance plans either do not cover or offer only limited coverage for complementary and alternative medicine (CAM) services like acupuncture, massage therapy, herbal medicine, and traditional or Indigenous healing practices. Between 2002 and 2012, rates of people who used acupuncture, chiropractic, and massage services increased, with the increase being most significant among people who are uninsured [24]. People with one or more chronic conditions and people who have had negative experiences with conventional medicine have also been found to have a higher prevalence of CAM use [25, 26].

"Culture is part of the cure for what ails us."
- Urban Indian Health Organization Leader

Additionally, among Black adults, CAM use was higher among people who reported experiencing racism in healthcare settings [27]. Research has revealed that more than one-third of Black and Latinx adults have reported experiencing discrimination in healthcare settings within the past year, either personally or through their family members [28]. Research has also shown that people who experience discrimination in healthcare settings, such as unfair treatment by providers or discrimination based on factors like ability to pay, insurance type, language proficiency, race, ethnicity, or gender, are more likely to use herbal medicines[29].

Several community-based organizations in Washington have stressed the significance of coverage for CAM during recent discussions with the Board. They also pointed out the existing gap in coverage and emphasized the critical need for more patient-centered and directed care.

In the 2022 State Health Report, the Board recommended that the Governor and Legislature require insurers to cover the cost of healthcare services used by Washington State communities, especially people impacted by racism and other forms of systemic oppression. These recommendations were based on recent studies conducted by the Tubman Center for Health and Freedom (TCHF). Below are examples of progress in these areas over the past biennium (note that this list is not exhaustive).

Require insurers to cover the cost of healthcare services utilized by Washington communities, including CAM.

- Some medical plans in Washington State currently offer coverage for CAM, but the extent of this coverage varies significantly. While certain insurance plans cover specific services such as acupuncture, chiropractic care, or massage therapies, others may reimburse a broader range of CAM therapies or none at all [30,31].

[24] National Center for Complementary and Integrative Health (NCCIH). Paying for Complementary and Integrative Health Approaches. Last Updated May 2016. Accessed May 15, 2024. https://www.nccih.nih.gov/health/paying-for-complementary-and-integrative-health-approaches
[25] Falci L. Multiple Chronic Conditions and Use of Complementary and Alternative Medicine Among US Adults: Results From the 2012 National Health Interview Survey. Prev Chronic Dis. 2016;13. doi:10.5888/pcd13.150501
[26] Tangkiatkumjai M, Boardman H, Walker DM. Potential factors that influence usage of complementary and alternative medicine worldwide: a systematic review. BMC Complementary Medicine and Therapies. 2020;20(1):363. doi:10.1186/s12906-020-03157-2
[27] Shippee TP, Schafer MH, Ferraro KF. Beyond the barriers: Racial discrimination and use of complementary and alternative medicine among Black Americans. Social Science & Medicine. 2012;74(8):1155-1162. doi:10.1016/j.socscimed.2012.01.003
[28] Bleich SN, Zephyrin L, Blendon RJ. Addressing Racial Discrimination in US Health Care Today. JAMA Health Forum. 2021;2(3):e210192. doi:10.1001/jamahealthforum.2021.0192
[29] 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;19(6):577-581. doi:10.1089/acm.2012.0586
[30] Tubman Center for Health & Freedom. Washington State Health Insurance Plans. Published January 25, 2023. Accessed May 29, 2024. https://tubmanhealth.org/washington-state-health-insurance-plans/
[31] Washington State Health Care Authority (HCA). Personal Communication. April 2024.

- To date, one Managed Care Organization (MCO) in Washington State offers traditional Indian medicine as a value-added benefit [31]. However, the Centers for Medicaid and Medicare Services (CMS) has not worked out a reimbursement methodology for traditional healing services. This means each state approaches coverage in its own way while waiting for CMS to identify reimbursement mechanisms.
- CMS recently hosted a webinar in April 2024 to obtain advice and input on pending section 1115(a) demonstration proposals for Medicaid coverage and reimbursement for traditional healthcare practices provided by qualifying providers at Indian Health Service (IHS) and Tribal facilities. The webinar also provided an overview of four pending proposals from the states of Arizona, California, Oregon, and New Mexico, to cover traditional healthcare practices.

Employ healthcare providers from the communities they serve,

- In the 2023-2025 budget, $1 million of the workforce education investment account was provided for the Center for Indigenous Health to increase the number of American Indian and Alaska Native physicians practicing in Washington State.

Remove systemic barriers to care, such as cost and insufficient provider networks, so communities can access timely, culturally appropriate care.

- During the 2023-2024 Legislative Sessions, a handful of bills were passed to address healthcare affordability. Some of these included:
    - Substitute Senate Bill 5986, which made it illegal for ground ambulance services to send surprise bills. The bill set up rules to protect people from getting unexpectedly high bills from ground ambulances. It also says that health insurance companies must cover the cost of taking someone to a behavioral health emergency service if they have a medical emergency.
    - Second Engrossed Substitute House Bill 1508, which directs the Health Care Cost Transparency Board (HCCTB) to conduct an annual survey of underinsurance among Washingtonians and a survey of insurance trends among employers and employees. It also requires the HCCTB to hold an annual public hearing to discuss and assess Washington State's healthcare costs.
    - Engrossed Substitute Senate Bill 5481 (also known as the Uniform Telehealth Act) aims to make it easier for people to access healthcare by increasing the use of telehealth. Among the bill's many provisions, it created fewer restrictions for providers and allows them to use telehealth with their patients as long as they maintain the standard level of care. It also allows more types of providers to treat patients using telehealth.
    - Second Engrossed Second Substitute Senate Bill 5580 will expand the income eligibility for Apple Health pregnancy and postpartum coverage to 210% of the federal poverty level (FPL) and improve supportive prenatal and perinatal services, with special attention to people with substance use disorders at the time of delivery.
    - Second Substitute Senate Bill 5581, which directs the Office of the Insurance Commissioner (OIC) to propose strategies for decreasing out-of-pocket expenses for maternity care services within privately regulated health plans in the state. OIC must submit a report to the Legislature by July 2024 detailing these strategies.
- The Legislature also allocated funding to agencies to remove systemic barriers to care and to improve timely and culturally appropriate care. Examples include providing funding for:
    - The HCA to support distressed hospitals or birthing centers in financial distress or at risk of limiting access to labor and delivery services due to a low volume of deliveries at the hospital through "one-time bridge grants." To apply for this grant funding, facilities must meet certain

criteria, including providing services to people enrolled in state or federal medical assistance programs.

- Reimbursement of services provided by doulas for Apple Health clients, in alignment with HCA's report to the Legislature from 2020. Before implementing this policy, CMS needs to approve a state plan amendment to reimburse for doula services. HCA was also provided funding to contract with an external organization for participatory and equity-focused engagement with doulas and doula partners across Washington State.
- Funding to continue an HCA grant program that reimburses services for patients up to 18 years old who receive services from community health workers (CHWs) in primary care clinics. This program reimburses CHWs who provide services to patients 18 years or younger in primary care clinics. These clinics mainly serve pediatric patients enrolled in medical assistance under Chapter 74.09 RCW, and this grant program will run until June 30, 2025. With this funding, CHWs may also receive merit increases.
- Authorization for the HCA to establish a CHW benefit, pending federal approval and appropriated funds. This benefit would be part of the medical assistance program and the state Children's Health Insurance Program (CHIP). The HCA would need approval from CMS to implement this benefit, and it would be contingent upon the availability of federal funding.

Expanding insurance coverage and ensuring that coverage meets the unique needs of Washington State'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 act to:

- Continue to provide funding to expand current programs that provide access to health insurance for people who are income-eligible and at least 19 years of age, regardless of their immigration status.
- Remove systemic barriers to care, such as cost and limited provider networks, so communities can access timely, culturally appropriate care.
- Actively monitor and participate in opportunities to advocate for coverage of CAM at the federal level.
- Require insurers to cover the cost of CAM, including for traditional healthcare practices provided by qualifying providers at Indian Health Service (IHS) and Tribal facilities.

Recommendation 3: Re-envision the Quality of Care in Washington State by Improving Access to Community-Driven, Culturally and Linguistically Relevant Services.

"In the community we serve, we see a movement away from the health system overall due to distrust and fear. The health system does nothing to address their concerns. Their experiences often push them further away from the system due to lack of culturally appropriate care."
- Washington community-based provider

Adequate health insurance coverage alone cannot remove barriers to accessing healthcare and addressing health inequities in Washington State. Many social, economic, geographical, and cultural factors prevent people from accessing the care they need to maintain their health and improve their overall well-being. Examples include barriers to accessing care that is culturally and linguistically appropriate, experiencing racism and discrimination within the healthcare system and related systems of care, and limited access to health facilities in local communities.

Based on recent U.S. Census data, approximately 22 percent of the population (or 68 million people) speak a language other than English (LOTE) [32] at home, marking an increase from previous years. About 8 percent of individuals also report speaking English less than "very well." Census data also highlight that the U.S. population is more racially and ethnically diverse than a decade ago [33-35]. The population demographics of the U.S. are changing and are expected to continue to change, with similar trends evident in Washington State. In our state, roughly 1 in 5 residents over age 5 report speaking a LOTE at home [36].

Language and cultural understanding are crucial to a person's ability to access healthcare and receive quality care. Research has consistently demonstrated the persistent gap in providing culturally and linguistically appropriate care and its impact on equity and health outcomes.

For example, people who speak a LOTE often encounter hurdles in accessing high-quality healthcare services. These obstacles can lead to delays in care, medical mistakes, which can lead to serious physical and emotional harm, and difficulties in comprehending and following provider instructions, among other issues [37-39]. Compared to English speakers, people who speak a LOTE are less likely to have a regular healthcare provider, visit a physician, and undergo screenings for blood pressure or cancer. It's also important to note that these

[32] Terminology note: The U.S. Census and other population data and reports frequently use the terms people with "Limited English Proficiency (LEP)" and "non-English speaking." These terms are deficit-oriented and promote the notion that there is a language hierarchy – that English is assumed to be the "primary" or "dominant" language and that people who don't speak English are less than. A recent Washington Language Access Work Group substituted these terms with "primary language other than English" or "PLOTE." This report will use "language other than English (LOTE)."
[33] Bureau UC. Nearly 68 Million People Spoke a Language Other Than English at Home in 2019. Census.gov. Published December 6, 2022. Accessed May 15, 2024. https://www.census.gov/library/stories/2022/12/languages-we-speak-in-united-states.html
[34] Bureau UC. 2020 U.S. Population More Racially Diverse Than Measured in 2010. Census.gov. Published August 12, 2021. Accessed May 15, 2024. https://www.census.gov/library/stories/2021/08/2020-united-states-population-more-racially-ethnically-diverse-than-2010.html
[35] Bureau UC. American Community Survey (ACS), Language Spoken at Home. Census.gov. Page Last Reviewed May 2, 2024. Accessed May 15, 2024. https://www.census.gov/programs-surveys/acs/
[36] Migration Policy Institute. Washington State Language Data. No Date. Accessed May 15, 2024. https://www.migrationpolicy.org/data/state-profiles/state/language/WA
[37]Twersky SE, Jefferson R, Garcia-Ortiz L, Williams E, Pina C. The Impact of Limited English Proficiency on Healthcare Access and Outcomes in the U.S.: A Scoping Review. Healthcare (Basel). 2024;12(3):364. doi:10.3390/healthcare12030364
[38] Foiles Sifuentes AM, Robledo Cornejo M, Li NC, Castaneda-Avila MA, Tjia J, Lapane KL. The Role of Limited English Proficiency and Access to Health Insurance and Health Care in the Affordable Care Act Era. Health Equity. 2020;4(1):509-517. doi:10.1089/heq.2020.0057
[39] Al Shamsi H, Almutairi AG, Al Mashrafi S, Al Kalbani T. Implications of Language Barriers for Healthcare: A Systematic Review. Oman Med J. 2020;35(2):e122. doi:10.5001/omj.2020.40

barriers extend to people who use sign languages. Deaf people often encounter obstacles in accessing care because most providers cannot offer communication access in American Sign Language (ASL) or other sign languages through qualified interpreters [40].

The Board believes communicating in one's preferred language is a fundamental human right. When people cannot communicate or access information or can only access poor-quality translations and interpretations, it harms their well-being. As such, federal and state law requires meaningful access to language assistance for people, ensuring accurate, timely, and effective communication at no cost to the person [41, 42]. However, the availability of such services within the Washington State healthcare system and beyond is limited. Although there is a growing demand for interpretation services in Washington State, there is an insufficient supply of qualified and certified interpreters, including those proficient in spoken languages and American Sign Language (ASL).

During the 2023 legislative session, the Legislature directed the Department of Social and Human Services (DSHS) to convene a language access workgroup. This workgroup examined interpretive service certification policies and programs for individuals who speak a LOTE and provided recommendations to the Legislature.

The workgroup submitted its report to the Legislature at the end of 2023 [43]. One of their top recommendations was for Washington to form a new state-centralized office to oversee all types of Language Access Professionals (LAPs). Additionally, the workgroup highlighted the existence of the Administrative Office of the Courts (AOC) Language Access and Interpreter Commission, which advises its court interpreter certification program. Proposing a similar permanent commission alongside a centralized language access office could offer another avenue to address interpreter access and availability challenges.

The language access workgroup report underscores the necessity for change to enhance language access for all Washingtonians. It urges the Governor and Legislature to carefully consider the workgroup's recommendations and insights to chart a course forward.

In its 2022 State Health Report, the Board proposed several recommendations to enhance culturally and linguistically appropriate health services, including:

- Allocating funding to establish a task force comprising public health, healthcare, community-based organizations, and relevant state agencies to assess and develop a baseline report on delivering culturally and linguistically appropriate healthcare services (CLAS) for communities served. It would also provide recommendations for improvement as needed.
- Expand culturally and linguistically appropriate healthcare services, including but not limited to prescription information translation and increased access to interpretation services for medical appointments and emergency room visits.

The Board is unaware of funding for these purposes over the last biennium from the Legislature. While CLAS training is accessible to state agencies and health-related organizations, there is no standardized method for

[40] National Association of the Deaf (NAD). Position Statement on Health Care Access For Deaf Patients. No date. Accessed May 15, 2024. https://www.nad.org/about-us/position-statements/position-statement-on-health-care-access-for-deaf-patients/

[41] U.S. Department of Health and Human Services (HHS). Limited English Proficiency (LEP). Published August 13, 2007. Content last reviewed April 15, 2024. Accessed May 15, 2024. https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html

[42] United States Department of Justice Civil Rights Division | Section V – Defining Title VI. Published December 11, 2015. Accessed May 29, 2024. https://www.justice.gov/crt/fcs/T6manual5

[43] Department of Social and Health Services (DSHS). Language Access Work Group Report to the Legislature.; 2023:253. Accessed May 16, 2024. https://www.dshs.wa.gov/sites/default/files/ltc/documents/report%20Language%20Access%20Work%20Group%202023%20final.pdf

evaluating CLAS implementation in Washington State. The Board wants to continue to underscore the importance of assessing CLAS provision across the state's major healthcare systems, independent healthcare providers, public health clinics, community-based organizations, and others to enhance patient experience, improve health outcomes, and address health inequities. Additionally, more work must be done to ensure prescription information is translated and interpretation services are available to all individuals needing it.

Additionally, in April 2024, the U.S. Department of Health and Human Services issued a final rule under Section 1557 of the Affordable Care Act (ACA) to strengthen non-discrimination protections and advance civil rights in healthcare [44]. The updated provisions are set to take effect gradually, beginning in July 2024. Section 1557 is the non-discrimination clause within the ACA. It prevents discrimination based on race, color, national origin, sex, age, or disability in designated health programs or activities ("covered entities"), including those receiving Federal funds [45].

Under the final rule, all covered entities must provide and display notices outlining a person's civil rights under Section 1557. Additionally, entities subject to the rule must issue notices informing people of the availability of free language assistance services and auxiliary aids and services for those who speak a LOTE and people with disabilities. These notices must be provided in the top 15 languages spoken by people who speak a LOTE in the relevant state or states where the entity operates. The Legislature should invest in efforts to promote these enhanced protections for patients and ensure compliance with these updated requirements.

The Board also learned about the quality of care and barriers to accessing care in recent panels and conversations with community representatives. Some of the key takeaways and feedback included:

- Washington State needs comprehensive, person-centered care models from infancy to end-of-life, emphasizing multi-generational wellness.
- There's a pressing need for sustainable funding structures in healthcare and social support systems to ensure long-term stability.
- Maternal and pregnant person healthcare in our state and nation faces significant challenges, particularly concerning access, quality, and affordability. These challenges are particularly acute in rural areas, where the viability of labor and delivery services is uncertain. One expert noted that a community's absence of maternity services or birthing centers can signal its decline.
- Building trust is essential to encourage people to seek necessary healthcare, emphasizing the importance of establishing strong patient-provider relationships.
- We need to recognize the unique needs of diverse communities. A tailored, adaptable approach to healthcare delivery is necessary, moving away from a one-size-fits-all approach.
- Washington State must strive for a racially and culturally diverse healthcare workforce that mirrors the communities it serves, promoting cultural competence and understanding. This workforce must also receive equitable compensation and have a reasonable caseload to ensure effective patient care.
- Community health workers (CHWs), often referred to as "cultural brokers," frequently belong to the communities they serve. While they play a vital role in bridging gaps in access to care, there is currently no statewide reimbursement or sustainable payment method for their services.

[44] U.S. Health and Human Services (HHS). HHS Issues New Rule to Strengthen Nondiscrimination Protections and Advance Civil Rights in Health Care | HHS.gov. Published April 26, 2024. Accessed May 15, 2024. https://www.hhs.gov/about/news/2024/04/26/hhs-issues-new-rule-strengthen-nondiscrimination-protections-advance-civil-rights-health-care.html

[45] U.S. Health and Human Services (HHS). Section 1557 Final Rule: Frequently Asked Questions. HHS.gov. Last Reviewed May 20, 2024. Accessed May 15, 2024. https://www.hhs.gov/civil-rights/for-individuals/section-1557/faqs/index.html

- Cultural practices and access to culturally relevant food are pivotal in promoting overall health and well-being.
- We must "heal our healers and nourish the strengths that already exist in communities."
- Generational trauma significantly impacts the physical and mental health of communities, which requires tailored interventions and support services.
- Providing services and support for people, whether through referrals or direct services, should be continued as long as someone needs it, especially during big life transitions (pregnancy and postpartum, substance recovery, etc.).
- People need advocates, especially in a medical setting, to ensure they receive the care they need.
- Systemic racism, discrimination, stigma, and biases contribute to widespread mistrust in the healthcare system, often resulting in patients feeling unheard and discouraged from seeking care due to past negative experiences.
- Community-based providers encounter challenges as people they serve navigate between various resources and referrals, highlighting the need for improved coordination and strategic planning among care systems and community organizations.
- The U.S. is grappling with an economic crisis and racism embedded in its systems, which contribute to poor health outcomes. Many individuals and families struggle to meet their basic needs, highlighting the urgency of addressing underlying causes to accurately assess and meet people's needs.

Throughout these discussions, the Board and staff also learned about community bright spots and heard examples of innovative projects and initiatives undertaken by various communities to deliver care and services that better meet their community's needs. One prominent theme highlighted in these discussions is the necessity for people to have an advocate—an individual they trust who reflects their values, culture, community, and language. This advocate can play a vital role in providing extra support, guaranteeing the provision of quality care, and facilitating access to culturally and linguistically aligned healthcare services. This could take various forms, such as a doula providing support during pregnancy and postpartum, a community health worker delivering health education at a community gathering, or a recovery navigator with lived experience assisting people in overcoming substance use or reentering society after incarceration.

Studies have shown that such community-centered professions effectively boost healthcare screening rates, enhance access to primary care services, and lower healthcare costs, among additional advantages [46-48]. They also contribute to preventing adverse health outcomes during pregnancy and postpartum and improving behavioral health outcomes for people in recovery [49-51].

Many positions or programs with community health workers, navigators, and similar roles rely on grants or are piloted on a small scale, posing challenges for sustainable funding, equitable compensation, and professional development opportunities. However, ensuring sustainable funding and fair compensation for these roles is

[46] Covert H, Sherman M, Miner K, Lichtveld M. Core Competencies and a Workforce Framework for Community Health Workers: A Model for Advancing the Profession. Am J Public Health. 2019;109(2):320-327. doi:10.2105/AJPH.2018.304737
[47] NIHCM Foundation. Community Health Workers: Their Important Role in Public Health. Published April 7, 2021. Accessed May 15, 2024. https://nihcm.org/publications/community-health-workers-infographic?token=KerpDcCUePwwD_0qW25Yd6Obd4XRKz-B
[48] Phillips E, Kaalund K, Farrar B, et al. Advancing Community Health Worker Models In Health System Reforms: Policy Recommendations From The RADx-UP Initiative. Health Affairs Forefront. doi:10.1377/forefront.20231208.803492
[49]Sobczak A, Taylor L, Solomon S, et al. The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus. 15(5):e39451. doi:10.7759/cureus.39451
[50] Scannell C. Voices of Hope: Substance Use Peer Support in a System of Care. Subst Abuse. 2021;15:11782218211050360. doi:10.1177/11782218211050360
[51] Kokorelias KM, Shiers-Hanley JE, Rios J, Knoepfli A, Hitzig SL. Factors Influencing the Implementation of Patient Navigation Programs for Adults with Complex Needs: A Scoping Review of the Literature. Health Serv Insights. 2021;14:11786329211033267. doi:10.1177/11786329211033267

complex and requires careful and deliberate consideration to avoid inadvertently creating additional barriers for this community-based workforce to function effectively. Additionally, this work must be informed and directed by the community members on the ground doing this work.

In Washington State, significant progress has been made in improving pregnant person care and outcomes, largely due to the advocacy and leadership of the doula workforce, along with support and investments from the Legislature. This advancement includes the integration of birth doula services into maternal care. In 2020, the Legislature tasked the Health Care Authority (HCA) with identifying strategies to reimburse doula services through Medicaid, collaborating with the Department of Health (Department) and other partners, and issuing recommendations to the Legislature.

Doulas and other interested parties strongly advocated for the creation of a voluntary credentialing program for doulas by the Department of Health in 2022 and Medicaid reimbursement in 2024. These new laws enable doulas to bill Apple Health for their services directly, and the voluntary certification process will eventually allow doulas who want to be reimbursed for their services to receive Medicaid reimbursement. [52].

Washington State's healthcare system and care structures have the opportunity to re-envision its service delivery to better suit diverse community needs. Through proactive measures and ample support, it can also improve the well-being of providers, creating a stronger workforce. To genuinely enhance access to care, Washington State must commit to reimagining service delivery, emphasizing language accessibility, community-driven approaches, culturally appropriate care, and providing adequate support and compensation for the workforce.

The Board recommends the Governor and Legislature act to:

- Follow the recommendations and feedback from the State Language Access Workgroup, including enhancing language accessibility in Washington by establishing a specialized Office of Language Access and a permanent public advisory body for interpreters at the state level.
- Expand culturally and linguistically appropriate healthcare services, including—but not limited to—implementing Culturally and Linguistically Appropriate Services (CLAS) standards and federal non-discrimination in healthcare standards, requiring medical information translation, and increasing access to interpretation services for appointments.
- Advocate for the growth of a community-based workforce in the state, encompassing roles such as community health workers, peer navigators, recovery coaches, and more. Explore diverse public policy strategies to enable reimbursement for their services and ensure fair compensation. Ensure that community members in this workforce lead and direct this work.

Recommendation 4: Advance School Environmental Health and Safety in Washington

[52] Washington State Health Care Authority (HCA). Methods to Secure Doula Reimbursement Approval from CMS, Report to the Legislature.; 2020:63. Accessed May 16, 2024. https://www.hca.wa.gov/assets/program/doula-reimbursement-approval-CMS-20201123.pdf

RCW 43.20.050 (2) (d) requires the Board to adopt environmental health and safety rules for K-12 schools in Washington State. These rules have existed since the 1960s and were last updated between 2004 and 2009. These revisions were initiated in response to significant public comments highlighting concerns that the rules, chapter 246-366 WAC, Primary and Secondary Schools, were outdated. Recognizing the need to align with contemporary scientific understanding and safety standards, revisions were undertaken to address critical areas such as indoor air quality, clean drinking water standards, and the safety of facilities like playgrounds and laboratories. 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. These amended rules ensure schools across the state have the same safety standards to protect students from getting sick or injured.

Before the Board could implement these updated rules, that same year, the Legislature put a budget proviso in place to suspend chapter 246-366A WAC due to concerns about the costs of implementing these revised standards. The proviso reads:

"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."

Since the 2009-2011 biennium, every state operating budget has included this proviso preventing the implementation of chapter 246-366A WAC. However, during the 2024 legislative session, the Legislature introduced an additional proviso (Section 222, subsection 159, page 492) within the supplemental operating budget [53]. This proviso directs the Board to initiate a comprehensive review and formulate new proposed rules to establish minimum standards for environmental health and safety in schools by June 30, 2025.

The proviso also directs collaboration between the Board, the Department of Health (Department), and a multi-disciplinary advisory committee to complete this work. Additionally, the Board must conduct a fiscal analysis in partnership with the Office of the Superintendent of Public Instruction (OSPI) regarding the draft proposed language recommendations, implementation recommendations, and an environmental justice assessment with the Department. The Board must work with partners to develop and provide a report with recommendations on sections or subject areas of the proposed rules with the greatest health and safety benefits for students and the order in which they should be implemented. The Board will receive funding to do this work starting July 1, 2024.

Updating the Board's School Environmental Health and Safety Rules is essential for schools to ensure safe conditions for all students and staff. The 2024 proviso provides an opportunity for the Board and key partners to review these rules thoroughly to address vital environmental considerations, such as indoor air quality and the impacts of climate change on school facilities. Once the updated proposed rules and implementation recommendations become available, it will be imperative for the Legislature to prioritize the removal of the original budget proviso, commit to fulfilling the recommendations outlined in the report, and allocate sufficient funding to support these efforts.

[53] Engrossed Substitute Senate Bill 5950. Chapter 376, Laws of 2024. 68th Legislature, 2024 Regular Session. Operating Budget, 2023-2025 Supplemental. https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5950-S.SL.pdf?q=20240416134323

Every student deserves to attend a school built, maintained, and operated to guarantee a healthy and safe learning environment. Studies consistently show that the physical environment where students learn and play is crucial to their health and development. When a school's physical environment is healthy and safe, students miss fewer days of school and do better in class, and they're less likely to get sick from contagious respiratory illnesses or asthma attacks [54-56]. Unfortunately, not all students in Washington State have equal access to maintained and updated learning facilities.

During the 2023-2024 school year, 295 public school districts served 1,098,997 students, and approximately 546 private schools served 81,962 students in Washington State [57-59]. Students spend about 1,300 hours in school yearly, not including after-school activities [60]. With so much time spent in schools, students should be protected from exposure to allergens, pollutants, chemicals, and other suboptimal classroom conditions, like poor ventilation, lighting, and temperature control. Children and youth are particularly vulnerable to contaminants and changes in the environment in school facilities compared to adults, as they are still growing and developing[61]. Students bear the disproportionate impact of unhealthy school environments, and these impacts are amplified by racial and economic inequities, which further drive health inequities [62]

Environmental public health professionals play a critical role in recognizing risks, anticipating issues, and devising solutions to enhance school 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. Only seventeen of Washington State's thirty-five local health jurisdictions (LHJs) have established or are in the process of initiating environmental health and safety programs [63]. However, school environmental health and safety represent foundational public health services that should be accessible in every community. Local health jurisdictions must be adequately resourced and equipped to conduct thorough school environmental health and safety inspections to ensure that all students in the state receive essential health and safety safeguards.

Indoor air quality (IAQ) has a profound influence on student health and academic performance. Ventilation rates in most schools fall below recommended standards. A 2020 study by the U.S. Government Accountability Office (GAO) revealed that 41 percent of school districts nationwide require updates or replacements for their heating, ventilation, and air condition (HVAC) systems in at least half of their school buildings [64]. If left

[54] The 21st Century School Fund, Inc., the International WELL Building Institute pbc, and the National Council on School Facilities. 2021 State of Our Schools, America's PK-12 Public School Facilities.; 2021:84. Accessed May 16, 2024. https://www.21csf.org/uploads/pub/SOOS-IWBI2021-2_21CSF+print_final.pdf
[55] Sadrizadeh S, Yao R, Yuan F, et al. Indoor air quality and health in schools: A critical review for developing the roadmap for the future school environment. Journal of Building Engineering. 2022;57:104908. doi:10.1016/j.jobe.2022.104908
[56] US Environmental Protection Agency (EPA). Evidence from Scientific Literature about Improved Academic Performance. Published October 20, 2014. Accessed May 15, 2024. https://www.epa.gov/iaq-schools/evidence-scientific-literature-about-improved-academic-performance
[57] Office of the Superintendent of Public Instruction (OSPI). About School Districts. No Publication Date. Accessed May 16, 2024. https://ospi.k12.wa.us/about-ospi/about-school-districts
[58] Office of the Superintendent of Public Instruction (OSPI). Report Card - Washington State Report Card. No Publication Date. Accessed May 16, 2024. https://washingtonstatereportcard.ospi.k12.wa.us/ReportCard/ViewSchoolOrDistrict/103300
[59] Washington State Board of Education (SBE). Private Schools. No Publication Date. Accessed May 16, 2024. https://www.sbe.wa.gov/our-work/private-schools
[60] Washington State Board of Education (SBE). Instructional Hours. No Publication Date. Accessed May 16, 2024. https://www.sbe.wa.gov/faqs/instructional_hours
[61] Ferguson A, Penney R, Solo-Gabriele H. A Review of the Field on Children's Exposure to Environmental Contaminants: A Risk Assessment Approach. International Journal of Environmental Research and Public Health. 2017;14(3):265. doi:10.3390/ijerph14030265
[62] Center on Budget and Policy Priorities. America's School Infrastructure Needs a Major Investment of Federal Funds to Advance an Equitable Recovery. Published May 17, 2021. Accessed May 16, 2024. https://www.cbpp.org/research/state-budget-and-tax/americas-school-infrastructure-needs-a-major-investment-of-federal
[63] Gamez Briceno, Juan C. University of Washington Report, Environmental Health and Safety Study: K-12 Schools. Presented at: Washington State Board of Health March 2023 Meeting; March 8, 2023; Hybrid. Accessed May 15, 2024. https://sboh.wa.gov/sites/default/files/2023-03/Tab06b-DOHPowerPoint-UWSchoolReport-March2023_0.pdf
[64] United States Government Accountability Office (GAO). K-12 Education, School Districts Frequently Identified Multiple Building Systems Needing Updates or Replacements, Report to Congressional Addresses.; 2020:130. Accessed May 15, 2024. https://www.gao.gov/assets/710/707517.pdf

unaddressed, these issues can lead to IAQ problems, such as mold, building material degradation, and uncomfortable or dangerous temperatures. Such IAQ issues in school settings can worsen asthma, cause sleepiness, nausea, headaches, eye, nose, throat, and skin irritation, and ultimately hinder students' focus and learning ability [55].

The COVID-19 pandemic and climate change have only reinforced the importance of school environmental health and safety, especially the need for good IAQ and proper ventilation.

In January 2024, Board staff convened an expert technical panel of IAQ specialists representing local, state, and national organizations. Panelists provided education on IAQ, how IAQ has evolved over time, and plans or efforts their organization is engaged in to help improve IAQ. Some key takeaways included [65]:

- Improving IAQ is vital for community health and requires a comprehensive approach beyond ventilation. Key principles include minimizing indoor emissions, controlling moisture to prevent issues such as mold, ensuring proper ventilation, and protecting against outdoor pollutants.
- Recent shifts in focus on IAQ stem from factors like COVID-19, climate-related issues such as extreme heat and wildfires, and the push for energy-efficient buildings to reduce carbon emissions. While outdoor air quality is regulated, standardized IAQ standards are lacking, especially for public buildings.
- Buildings, especially school facilities, need adequate filtration and cooling systems. Many schools and buildings in the Pacific Northwest were not originally constructed with air conditioning. People traditionally relied on natural ventilation. Climate change is increasing the need for cooling systems in schools.
- Proper design and maintenance of HVAC systems are crucial for IAQ, and filters rated MERV-13 or higher are recommended to remove airborne germs effectively.
- Efforts to enhance IAQ should prioritize tackling challenges in vulnerable and underserved communities, including children in educational settings, older adults, and individuals impacted by systemic issues such as environmental racism.

Climate change and respiratory illnesses impact every student in Washington State. Many communities struggle to pass bonds or levies needed for school facility remediation, maintenance, and updates. Students learning in these communities lack guaranteed access to clean air quality in their classrooms. These inequities disproportionately affect low-income students and students of color, worsening existing environmental injustices.

Commented [DM(25]: Board Member: Consider mentioning disproportionate impact of wildfire smoke on rural communities

While enhancing IAQ in Washington State requires a multifaceted approach, investing in HVAC systems in K-12 schools is paramount. In the 2022 State Health Report, the Board recommended that the Governor and Legislature take action to prioritize funding for K-12 school HVAC system maintenance and necessary upgrades to minimize the transmission of contaminants and communicable diseases. In the 2024 capital budget, the Legislature allocated about $40 million to OSPI for projects to improve IAQ and ensure equitable clean air access in classrooms. This funding will particularly benefit districts facing financial constraints, assisting them in repairing and replacing HVAC and air delivery systems.

It is crucial to recognize that a significant portion—around $30 million—of this allocation is made possible by the Climate Commitment Act (CCA). The CCA is one of several voter-approved ballot initiatives that will appear

[65] Bernard, N., Kemperman, B., McTigue, E., Omura, B., Vander May, E. Indoor Air Quality (IAQ) Panel. Presented at: Washington State Board of Health January 2024 Meeting; January 10, 2024; Tumwater, Washington. Accessed May 15, 2024. https://sboh.wa.gov/meetings/meeting-information/meeting-information/materials/2024-01-10

on the ballot during the 2024 elections in Washington State. If the CCA is repealed in November, these funds will expire before their intended implementation on January 1, 2025. Losing this financial support would leave many schools, especially those unable to pass capital bonds and levies, without resources to address IAQ issues. Given the escalating impacts of wildfires, extreme weather, and rising temperatures in Washington State, retaining the funding of the Climate Commitment Act is essential for school health and safety.

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

Commented [DM(26]: Board Member: Really important point. Consider mentioning other ways that schools serve as important community hubs.

The Board recommends the Governor and Legislature act to:

- Prioritize the School Rule Review Technical Advisory Committee's findings and recommendations for updating statewide minimum environmental health and safety standards for schools. These findings and recommendations will be available by July 2025.
- Allocate state funds towards essential upgrades for school facilities and to address remediation issues, following the recommendations of the School Rule Review Committee, with particular emphasis on overburdened and underserved communities.
- Upon completion of the School Rule Review in July 2025, support the implementation plan and remove the proviso preventing the Board from implementing modernized school environmental health and safety rules.
- Provide funding for localized school environmental health programs.
- Continue investing in the upkeep and modernization of HVAC systems in K-12 schools to mitigate the spread of contaminants and infectious diseases.

Recommendation 5: Strengthen Investments in Washington's Public Health System to Build a Modern and Responsive Public Health System.

Washington State has a fundamental responsibility to protect the public's health [66]. The governmental public health system, comprised of the Board, Department of Health, local health jurisdictions (LHJs), and sovereign Tribal governments, has a critical and unique public safety role 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 are improved.

Washington's governmental public health system provides unique services to communities across the state. The public relies on and expects this system to promptly detect and contain disease outbreaks, safeguard our food and water supplies, support pregnant person and child health, prevent injuries, and collaborate with community partners to strategize, prioritize, and execute services that address local needs effectively and efficiently. The state must continue to endorse and allocate funds for Foundational Public Health Services (FPHS) to establish a fully functioning and modernized public health system that can provide these services in every community.

What are Foundational Public Health Services (FPHS)?	
FPHS are a specific set of essential public health services. The governmental public health system provides these community health focused services. Most importantly, FPHS should be available to everyone, regardless of where they live in Washington State. These services fit into six core program areas and foundational capabilities that are necessary to support these programs.	
Foundational Program Areas - Access to and Linkage with Care - Communicable Disease Control - Chronic Disease and Injury Prevention - Environmental Public Health - Maternal, Child, and Family Health - Vital Records	Foundational Capabilities - Assessment - Emergency Preparedness and Response - Communications - Policy Development - Community Partnerships - Business Competencies

In 2018, representatives from the governmental public health system conducted a statewide baseline FPHS assessment report to evaluate the current implementation and functionality of FPHS, project the costs and funding required for complete implementation, and identify services that could benefit from possible new service delivery models [67]. The baseline assessment used 2016 calendar data and determined that no foundational program or capability was fully or significantly implemented across the system. The report also identified a gap of $225 million annually needed to implement FPHS in Washington State fully [68]. Notably, Tribes were not included in the baseline assessment as they were engaged in a Tribally driven process to define the FPHS delivery framework, costs, and gap analysis.

Sustained, regular investment in FPHS since 2018 has generally increased the availability of these services across the Washington State governmental public health system over the six years it has received funding [68]. In recent biennia, the Legislature has allocated funds toward FPHS infrastructure with historic investments during the 2023-2025 biennium. Even with these increasing investments, a funding gap still exists. Current appropriations only meet 72 percent of the funding required to fully implement public health services across

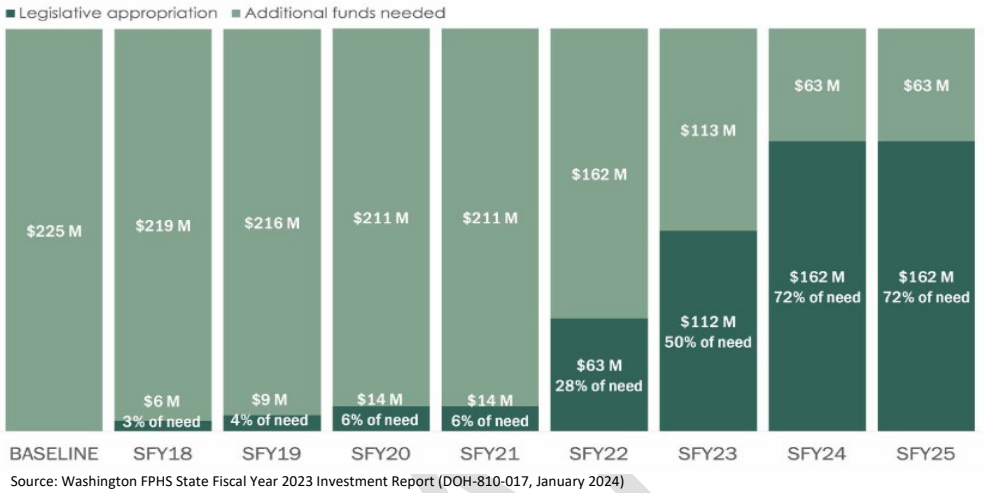
[66] RCW 43.70.512, Public health system—Foundational public health services—Intent. Accessed May 16, 2024. https://app.leg.wa.gov/RCW/default.aspx?cite=43.70.512

[67] Berk Consulting. Washington State Public Health Transformation Assessment Report.; 2018:91. Accessed May 15, 2024. https://wsalpho.app.box.com/s/j5d2xon6w25oj31q0gwr1qy6xqn2io4o

[68] Rede Group. Foundational Public Health Services in Washington, State Fiscal Year 2023 (SFY 2023) Investment Report.; 2024:99. Accessed May 15, 2024. https://wsalpho.app.box.com/s/u6yf26ckjbvthktfcckph9ldkpqrcwst

Washington State.

FPHS State Fiscal Year (SFY) Investments and Gaps in Funding (in millions)



Source: Washington FPHS State Fiscal Year 2023 Investment Report (DOH-810-017, January 2024)

As part of the 2017-2019 biennial budget, the Legislature initially invested $15 million to modernize and stabilize the system. A portion of the funds appropriated by the Legislature were invested in new service delivery models by funding four shared service demonstration projects [69]. These projects focused on sharing staff, expertise, and technology across LHJs to deliver specific FPHS in communicable disease and assessment.

In the 2019-2021 biennial budget, the Legislature allocated an additional $28 million for FPHS [70]. “Fund first” FPHS services were prioritized, including communicable disease, environmental public health, assessment (e.g., epidemiology, disease surveillance, and community health assessment), and their corresponding capabilities. These investments strengthened the governmental public health system, which allowed the system to pivot and rapidly respond to the COVID-19 pandemic. The COVID-19 pandemic illustrated the importance of a fully funded, functional, and nimble public health system. While investments funded critical improvements that helped the public health system respond to COVID-19, chronic underfunding of FPHS resulted in the system continuing to play catch-up in response to the global pandemic.

In the 2021-2023 biennial budget, the Legislature appropriated $175 million for FPHS, marking a substantial increase compared to previous biennia. This investment expanded the capacity and services provided by the governmental public health system. Examples included environmental public health data, planning, land use, and inspections; cross-cutting capabilities such as information technology, emergency preparedness, surveillance, and community partnership building; communicable disease data, planning, and investigations;

[69] Berk Consulting for the Washington State Association of Local Health Officials (WSALPHO) and the Washington State Department of Health. Service Delivery Demonstration Projects Year 1 Evaluation, Case Studies and Lessons Learned.; 2019:48. Accessed May 15, 2024. https://www.phf.org/resourcestools/FPHS%20%20WA%20Documents/2019_FPHS_Shared_Services_Demonstration_Projects_Year_1_Evaluation.pdf

[70] Rede Group. Foundational Public Health Services in Washington, State Fiscal Year 2021 (SFY 2021) Investment Report.; 2023:49. Accessed May 15, 2024. https://wsalpho.app.box.com/s/52cvz4k0tvqaotvare33mmiglmnbw5wv

public health lab investments; and promoting immunizations. First-time FPHS funds were also provided to Tribes and Urban Indian Health programs ($4.2 million). These resources were channeled into key areas, including pandemic response initiatives, community health assessments, policy formulation and planning, and the establishment of a Tribal Public Health Training Program.

During the current biennium, the governmental public health system has directed investments from the Legislature across all FPHS program areas and capabilities, with notable advancements in areas with longer investment histories, such as communicable disease [71]. The allocation of most FPHS funds to "any definition" has notably enabled agencies to use allocated funds within their chosen FPHS domains. This adaptable funding model fosters innovation and allows agencies to tailor services to better meet the specific needs of their communities.

This stable and flexible funding also allows agencies to make long-term plans for programs and staffing and to focus on public health prevention and response efforts. Additionally, the public health system has leveraged these resources to advance equity initiatives. This includes collaborative assessments with communities to identify inequities, forging genuine partnerships, and crafting culturally and linguistically appropriate communication materials to enhance outreach efforts.

Investments in FPHS, initially through one-time funding and later through sustained support, represent significant progress. Ensuring stable and reliable funding for FPHS is paramount for the governmental public health system to swiftly respond to emerging public health crises like the COVID-19 pandemic, measles outbreaks, and the ongoing opioid and fentanyl epidemics. However, even with historic investments by the Legislature, more is needed to fund FPHS, modernize the system, and fully safeguard the public's health.

The Board recommends the Governor and Legislature act to:

- Prioritize continued and expanded foundational public health investments in the 2025-2027 biennium and future biennia to build a modern and responsive governmental public health system in Washington State. These investments ensure that the system can prevent, assess, and control communicable diseases; enhance environmental public health services; improve services over the life-course; improve system competencies; and address inequities within the system.

Recommendation 6: Decrease Use of Commercial Tobacco Products, With Special Attention to Flavored Vaping Products.

[71] Rede Group. Foundational Public Health Services in Washington, State Fiscal Year 2023 (SFY 2023) Investment Report.; 2024:99. Accessed May 15, 2024. https://wsalpho.app.box.com/s/u6yf26ckjbvthktfcckph9ldkpqrcwst

Commercial tobacco [72] products remain the primary cause of preventable diseases, disabilities, and deaths in the United States, with 1 in 5 deaths attributed to tobacco-related illnesses annually [73]. In Washington State, approximately 8,300 people will lose their lives to smoking this year, excluding deaths from secondhand smoke exposure. Additionally, 1,800 young people in Washington State will start smoking, perpetuating the public health problem of nicotine use and dependence in our communities [74].

Beyond the profound health consequences, commercial tobacco use also has striking economic costs. Smoking costs the U.S. billions of dollars in direct medical expenses and lost productivity due to smoking-related illnesses, secondhand smoke exposure, and preventable deaths [74,75]. In Washington State alone, healthcare costs associated with smoking add up to $2.8 billion each year. The Board recognizes that all forms of commercial tobacco products, including combustible tobacco products, vaporized nicotine products with electronic devices, and smokeless tobacco, harm people's health, and effects only worsen with long-term use.

While overall smoking rates have declined over the past decade in Washington State, an uptick in e-cigarette use among youth and young adults threatens to reverse progress in declining rates of commercial tobacco use. Further, smoking rates remain high in certain communities due to aggressive marketing by the tobacco industry.

Youth and young adults younger than age 18 years are far more likely to start using tobacco than adults. Nearly 9 out of 10 adults who smoke started before the age of 18 [76]. 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 also prime young brains for tobacco use and dependence on other drugs [77]. Preventing youth initiation of tobacco and other nicotine use is critical to stem the tide of tobacco-related mortality, morbidity, and economic costs.

Although the overall use of commercial tobacco products among middle and high school students has declined in recent years, the popularity of e-cigarettes, especially flavored ones, has increased. Between 2011 and 2015, e-cigarette use among middle and high school students in the U.S. increased by a staggering 900 percent [78]. By 2014, with the rise of products like JUUL, e-cigarettes began to gain popularity, surpassing traditional combustible cigarettes as the most used tobacco product among youth [76]. Over the past decade, e-cigarettes have consistently been the preferred commercial tobacco product among middle and high school students [79].

Data from the Washington Healthy Youth Survey (HYS), conducted biennially in schools statewide, revealed significant increases in e-cigarette use among 8th, 10th, and 12th graders from 2016 to 2018. Usage rose from

[72] A note terminology: "Commercial tobacco" includes any products containing tobacco and/or nicotine produced and marketed by the tobacco industry. This includes cigarettes, electronic cigarettes (e-cigarettes), cigars, hookah, smokeless tobacco, and other oral nicotine products. It's important to note that commercial tobacco does not include traditional tobacco, which holds cultural and ceremonial significance for certain Indigenous communities. It's crucial to recognize and respect the distinction between commercial tobacco and traditional tobacco, and to honor the use of traditional tobacco in its cultural context.

[73] Centers for Disease Control (CDC) and Prevention. Tobacco Free. Health Effects of Cigarette Smoking. Published August 19, 2022. Accessed May 16, 2024. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm

[74] Washington State Department of Health. Tobacco and Vapor Products Data and Reports. No Publication Date. Accessed May 16, 2024. https://doh.wa.gov/data-statistical-reports/health-behaviors/tobacco

[75] Centers for Disease Control (CDC) and Prevention. Tobacco Costs and Expenditures. Published May 16, 2024. Accessed May 29, 2024. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/cost-and-expenditures.html

[76] Centers for Disease Control (CDC) and Prevention. Tobacco Free. Youth and Tobacco Use. Centers for Disease Control and Prevention. Published November 2, 2023. Accessed May 29, 2024. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm

[77] Centers for Disease Control (CDC) and Prevention. E-Cigarette Use Among Youth. Smoking and Tobacco Use. Published May 17, 2024. Accessed May 29, 2024. https://www.cdc.gov/tobacco/e-cigarettes/youth.html

[78] King BA, Jones CM, Baldwin GT, Briss PA. The EVALI and Youth Vaping Epidemics — Implications for Public Health. N Engl J Med. 2020;382(8):689-691. doi:10.1056/NEJMp1916171

[79] Birdsey J. Tobacco Product Use Among U.S. Middle and High School Students — National Youth Tobacco Survey, 2023. MMWR Morb Mortal Wkly Rep. 2023;72. doi:10.15585/mmwr.mm7244a1

6 to 10 percent among 8th graders, 13 to 21 percent among 10th graders, and 20 to 30 percent among 12th graders during this period [80].

Findings from the 2021 and 2023 HYS data indicate that e-cigarette use rates have declined since 2018. However, rates remain high among middle and high school students, with variations observed across different communities. HYS findings underscore that communities reporting the highest rates of youth tobacco use often mirror those disproportionately affected by tobacco-related health issues later in life, indicating ongoing inequities in commercial tobacco use trends [80, 81].

Recent national data reveals alarming trends in e-cigarette use among youth. Approximately 1 in 22 middle school students and 1 in 10 high school students reported using e-cigarettes in the past month [82]. Of those who reported e-cigarette use, nearly 90 percent preferred flavored varieties, with 61 percent choosing disposable e-cigarette products [83]. In recent years, disposable e-cigarettes have increased in popularity, claiming almost half the industry market share [84] . Their affordability, high nicotine content, and availability in enticing flavors like fruit and candy drive their popularity among youth. The lack of comprehensive regulations at both state and federal levels has allowed companies to rapidly evolve these products, making them more affordable, addictive, and appealing to young consumers.

In January 2020, the Food and Drug Administration (FDA) announced it would prioritize enforcement against pre-filled e-cigarette flavored products, including fruit and mint-flavored products [85]. Concurrently, the agency is reviewing thousands of vapor products through its Premarket Tobacco Product Application (PMTA) process [86]. However, due to the high volume of applications and legal challenges from tobacco companies, the FDA has encountered delays in issuing PMTA approvals. The FDA originally planned to complete its review of all applications by September 2021, but many products are still pending review, allowing them to remain on the market.

The FDA has granted marketing authorization to only 45 products, including 23 tobacco-flavored e-cigarette products and devices [87]. However, FDA marketing authorization does not signify the safety of these products; it simply permits their sale. Additionally, authorized products have not been tested for consumer safety, and the FDA has not certified any vapor products as safe.

[80] Washington State. Washington State Healthy Youth Survey (HYS) Commercial Tobacco Product Use Fact Sheet, 2023 Data, Grades 6-12. Published online February 2024. Accessed May 15, 2024. https://www.askhys.net/SurveyResults/FactSheets

[81] Centers for Disease Control (CDC) and Prevention. Health Disparities Related to Commercial Tobacco and Advancing Health Equity: An Overview. Tobacco - Health Equity. Published May 2, 2024. Accessed May 30, 2024. https://www.cdc.gov/tobacco-health-equity/about/index.html

[82] Centers for Disease Control (CDC) and Prevention. Tobacco Free. Youth and Tobacco Use. Centers for Disease Control and Prevention. Published November 2, 2023. Accessed May 30, 2024. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm

[83] Birdsey J. Tobacco Product Use Among U.S. Middle and High School Students — National Youth Tobacco Survey, 2023. MMWR Morb Mortal Wkly Rep. 2023;72. doi:10.15585/mmwr.mm7244a1

[84] Diaz MC, Silver NA, Bertrand A, Schillo BA. Bigger, stronger and cheaper: growth in e-cigarette market driven by disposable devices with more e-liquid, higher nicotine concentration and declining prices. Tobacco Control. Published online August 3, 2023. doi:10.1136/tc-2023-058033

[85] Food and Drug Administration (FDA). FDA finalizes enforcement policy on unauthorized flavored cartridge-based e-cigarettes that appeal to children, including fruit and mint. Published March 24, 2020. Accessed May 30, 2024. https://www.fda.gov/news-events/press-announcements/fda-finalizes-enforcement-policy-unauthorized-flavored-cartridge-based-e-cigarettes-appeal-children

[86] Food and Drug Administration (FDA). FDA issues proposed rule for premarket tobacco product applications as part of commitment to continuing strong oversight of e-cigarettes and other tobacco products. Published March 24, 2020. Accessed May 30, 2024. https://www.fda.gov/news-events/press-announcements/fda-issues-proposed-rule-premarket-tobacco-product-applications-part-commitment-continuing-strong

[87] Food and Drug Administration (FDA). Products C for T. Premarket Tobacco Product Marketing Granted Orders. FDA. Published online May 2, 2024. Accessed May 30, 2024. https://www.fda.gov/tobacco-products/premarket-tobacco-product-applications/premarket-tobacco-product-marketing-granted-orders

There is a global consensus on the most effective and evidence-based strategies to prevent tobacco use and reduce tobacco-related health inequities [88, 89]. Some of these strategies include limiting the sale and marketing of commercial tobacco products to youth (especially flavored products), taxing commercial tobacco products (or increasing the unit price), implementing anti-tobacco mass media or health education campaigns, and increasing access to behavioral health services and tobacco cessation medications.

These strategies are inconsistently implemented across the U.S. The tobacco industry aggressively invests resources to keep its products on the market and opposes strict commercial tobacco control measures at the federal and state levels. Tobacco companies spend over $8 billion annually to market their products, nearly $1 million every hour [90]. This means that for every $1 states spend to mitigate the effects of commercial tobacco use in their communities, the industry spends over $11 to keep people dependent on their products. Research consistently highlights that flavored commercial tobacco products and companies' advertising of these products contribute to the appeal, initiation, and use of commercial tobacco products, especially among young people.

In response to requests from Legislators, Board staff have conducted several Health Impact Reviews (HIRs) over time on bills that would increase regulations for commercial tobacco products, including flavored products. Findings from these reviews have consistently shown evidence suggesting that prohibiting the sale of flavored vapor products will likely reduce the initiation and use of these products among youth and young adults.

In recent years, there has been a promising movement to limit or prohibit youth use of tobacco, nicotine, and vapor products. In 2019, the Washington State Legislature passed Engrossed House Bill 1074 (Chapter 15, Laws of 2019), raising the minimum purchase age for tobacco and vapor products to 21 years. This law went into effect on January 1, 2020. Although this law has prevented some youth access, youth can still access these products from older friends and classmates.

Furthermore, some flavored products, such as menthol cigarettes, remain on the market despite efforts by the U.S. Congress and others to prevent their sale. The Board supports the FDA's proposal to prohibit menthol as a characterizing cigarette flavor as described in Docket No. FDA-2021-N-1349, Tobacco Product Standard for Menthol in Cigarettes. As stated in the proposed rule, research indicates that limiting the availability of flavored tobacco products prevents youth tobacco use [91]. In 2009, Congress banned the use of characterizing flavors (excluding tobacco and menthol) in cigarettes due to their appeal to young people. While overall smoking rates declined after the passage of the law, the use of menthol cigarettes increased. This suggests that the remaining flavor still attracts youth and adults [92].

Although the FDA initially announced its intention to prohibit menthol in cigarettes in April 2022, the agency has faced delays in acting. In October 2023, the FDA sent the final rules to the OMB for review [93]. However,

[88] World Health Organization (WHO). World Health Organization (WHO) Report on the Global Tobacco Epidemic, Addressing New and Emerging Products.; 2021:212. Accessed May 15, 2024. https://iris.who.int/bitstream/handle/10665/343287/9789240032095-eng.pdf?sequence=1

[89] Centers for Disease Control and Prevention (CDC). Tobacco Control Interventions | Health Impact in 5 Years | OPPE. Published February 26, 2024. Accessed May 30, 2024. https://archive.cdc.gov/www_cdc_gov/policy/hi5/tobaccointerventions/index.html

[90] Centers for Disease Control and Prevention (CDC). Tobacco Free. Tobacco Industry Marketing. Centers for Disease Control and Prevention. Published October 20, 2023. Accessed May 30, 2024. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/tobacco_industry/marketing/index.htm

[91] Federal Register. Tobacco Product Standard for Menthol in Cigarettes. Published May 4, 2022. Accessed May 30, 2024. https://www.federalregister.gov/documents/2022/05/04/2022-08994/tobacco-product-standard-for-menthol-in-cigarettes

[92] Courtemanche CJ, Palmer MK, Pesko MF. Influence of the Flavored Cigarette Ban on Adolescent Tobacco Use. American Journal of Preventive Medicine. 2017;52(5):e139-e146. doi:10.1016/j.amepre.2016.11.019

[93] U.S. General Services Administration (GSA). Office of Information and Regulatory Affairs. Office of Management and Budget. Tobacco Product Standard for Characterizing Flavors in Cigars. Final Rule. Reginfo.gov. RIN 0910-AI28. Published October 13, 2023. Accessed May 15, 2024. https://www.reginfo.gov/public/do/eoDetails?rrid=341267

as of May 2024, no action has been taken. In response to this inaction, a coalition of civil rights and medical organizations filed a lawsuit against the FDA in April 2024 [94].

The tobacco industry aggressively targets its marketing to certain communities. There are clear connections between commercial tobacco use and a person's stress levels, experiences with racism and discrimination, mental health status, economic stability, and a range of other factors that affect the social determinants of health. The tobacco industry capitalizes on this, as they are more concerned with profits over public health and take advantage of people and communities based on these factors. For example, while menthol products account for about a third of U.S. tobacco sales, they are disproportionately marketed in Black communities, as well as marketed to youth, women, and LGBTQ+ communities [95, 96].

For decades, commercial tobacco companies have strategically and aggressively targeted the Black community with menthol cigarettes, including increased advertising in predominantly Black neighborhoods and publications and appropriating cultural elements in their marketing. Additionally, they have also intentionally marketed their products to LGBTQ+ communities by sponsoring Pride and other community events and contributing funding to local and national LGBTQ+ and HIV/AIDS organizations [97].

The widespread availability of flavored tobacco products and the tobacco industry's targeted marketing practices raise significant health equity and social justice concerns. Therefore, the Board believes that prohibiting the sale of flavored commercial tobacco products is essential to protect the health and well-being of people in Washington State, particularly those disproportionately impacted by tobacco industry marketing. Local governments are constrained by preemption from implementing flavor bans in their jurisdictions. Therefore, the Legislature needs to take action to protect future generations from a lifetime of nicotine dependence.

The Board recommends the Governor and Legislature act to:

- Prohibit the sale of all flavored commercial tobacco products to reduce the appeal and use of these products by youth and young adults and other communities disproportionately impacted by tobacco industry marketing.

Recommendation 7: Support Public Health Improvements to Mitigate Environmental Hazards and Promote Environmental Justice

[94] African American Tobacco Control Leadership Council, Action on Smoking and Health (ASH), and National Medical Association v. U.S. Department of Health and Human Services, Food and Drug Administration, and Center for Tobacco Products. Complaint. U.S. District Court, Northern District of California. Filed April 2, 2024. Accessed May 15, 2024. https://ash.org/wp-content/uploads/2024/04/2024.04.02-1-Complaint.pdf

[95] Centers for Disease Control and Pervention. Improving Tobacco-Related Health Disparities. Smoking and Tobacco Use. Published May 8, 2024. Accessed May 15, 2024. https://www.cdc.gov/tobacco/tobacco-features/health-equity.html

[96] Centers for Disease Control and Prevention. Menthol Tobacco Products. Smoking and Tobacco Use. Published May 7, 2024. Accessed May 15, 2024. https://www.cdc.gov/tobacco/menthol-tobacco/index.html

[97] Centers for Disease Control and Prevention. Pride Month. Smoking and Tobacco Use. Published May 20, 2024. Accessed May 30, 2024. https://www.cdc.gov/tobacco/tobacco-features/pride-month.html

The Board understands that opportunities for better health begin where we live, learn, work, and play. Environmental public health plays a pivotal role in protecting the well-being of communities by addressing the complex interactions between human health and the environment [98, 99]. Environmental factors profoundly influence health outcomes; from the air we breathe to the water we drink and the spaces we inhabit. Understanding and mitigating environmental hazards are essential for preventing disease, promoting health equity, and ensuring sustainable development.

Today, awareness of the importance of environmental public health only grows as we confront escalating challenges such as climate change, pollution, aging and degrading infrastructure, and other emerging issues. Moreover, the environmental health field actively works to rectify and prevent further environmental injustices. There's growing momentum in the field to address and raise awareness about the environmental harms that have disproportionately affected communities of color across the U.S.— a long-standing concern these communities have voiced for decades [100]. These issues underscore the interconnectedness of human health and the environment, emphasizing the need for proactive measures to mitigate risks and protect public health.

The Board has consistently prioritized promoting healthy and safe environments, both in the built and natural environment. In its most recent Strategic Plan, the Board outlined objectives to foster environmental health across diverse settings—urban, suburban, rural, and recreational. This encompassed initiatives to ensure access to safe and dependable drinking water systems and supporting efforts to minimize exposure to environmental hazards and tackle environmental health challenges. Additionally, the Board set an objective to closely monitor the health impacts of climate change on communities in Washington State.

Lead exposure remains a critical environmental health concern and an environmental justice issue, particularly within the built environment, where it remains a prevalent environmental contaminant. Sources of lead exposure include chipping paint, contaminated soil, and contaminated drinking water at homes, schools, and outdoor areas [101]. While anyone can be affected by prolonged exposure to lead, young children, especially those six years old and younger, are particularly vulnerable to its effects [102]. The Centers for Disease Control (CDC) acknowledges that there is no safe, detectable level of lead for children [103].

Even minimal exposure to lead can cause serious harm to a child's health and long-term development, as their bodies absorb more lead than adults, and their brains and nervous systems are more susceptible to its damaging effects. Other effects may include impaired growth and development, learning and behavioral difficulties, hearing and speech problems, and, in extreme cases, death.

[98] American Public Health Association. Environmental Health. No Publication Date. Accessed May 15, 2024. https://www.apha.org/topics-and-issues/environmental-health

[99] Centers for Disease Control and Prevention. National Center for Environmental Health. Agency for Toxic Substances and Disease Registry. What is Environmental Public Health? Published April 22, 2014. Accessed May 15, 2024. https://blogs.cdc.gov/yourhealthyourenvironment/2014/04/22/what-is-environmental-public-health/

[100] U.S. Environmental Protection Agency. Environmental Justice. Published November 3, 2014. Accessed May 15, 2024. https://www.epa.gov/environmentaljustice

[101] Washington State Department of Health. Community and Environment, Contaminants; Lead. No Publication Date. Accessed May 15, 2024. https://doh.wa.gov/community-and-environment/contaminants/lead

[102] Centers for Disease Control and Prevention. Lead (Pb) Toxicity: What Are Possible Health Effects from Lead Exposure? | Environmental Medicine | ATSDR. Published May 25, 2023. Accessed May 30, 2024. https://www.atsdr.cdc.gov/csem/leadtoxicity/physiological_effects.html

[103] Centers for Disease Control and Prevention (CDC). CDC Updates Blood Lead Reference Value. Childhood Lead Poisoning Prevention. Published May 28, 2024. Accessed May 30, 2024. https://www.cdc.gov/lead-prevention/php/news-features/updates-blood-lead-reference-value.html

The risk of lead exposure is not the same for all children, largely due to the enduring effects of systemic racism in the U.S., such as redlining policies [104]. Research indicates that elevated blood lead levels are more common among children from low-income neighborhoods, immigrant and refugee families, and Black and Latino communities. Children living in housing built before 1978 are also more at risk for lead exposure. Most children with elevated blood lead levels do not look or act sick. A blood test is the only way to tell if a child has been exposed to lead [105].

In December 2023, the Office of the Washington State Auditor presented its findings from a performance audit on lead testing for children enrolled in Medicaid [106]. The audit revealed that Washington State tested a smaller proportion of children compared to other western states. Specifically, only 26 percent of eligible children aged 1 to 6 received at least one of the federally required tests. The Auditor's report also outlines recommendations for the Department of Health (Department) and the Health Care Authority (HCA) to improve testing rates in Washington.

During a recent presentation to the Board, the Department emphasized the necessity of various measures to enhance lead prevention efforts in Washington State [107]. These include increasing lead testing promotion, improving engagement among healthcare providers and communities, and increasing educational initiatives. Targeted case management and swift responses upon identifying children with elevated blood lead levels are also crucial. Moreover, increased funding is vital to improving education and case management efforts at the local public health level.

Currently, each local health jurisdiction (LHJ) operates based on available resources, resulting in inequities in follow-up services and support for children with elevated blood lead levels, depending on their geographical location in Washington. While the Department offers guidance and fills gaps upon LHJ requests, a uniform, statewide approach is needed to eliminate such inequities. Identifying sources of lead exposure can inform prevention actions. Notably, no funds have been allocated to LHJs to address elevated blood lead levels at this time.

In 2016, Governor Inslee issued Directive 16-06 to address lead remediation in the built environment, focusing on schools [108]. The directive aimed to assist local communities with lead testing and reduce and prevent children's exposure to lead. The Board supports this directive and encourages the incoming Governor to continue and expand these important investments. Such actions are necessary to prevent further lead exposure and ensure that all children in Washington State have every opportunity to achieve the best health possible.

Climate change is profoundly reshaping the natural environment, introducing new environmental health hazards, and intensifying existing challenges. A recent United Nations (UN) International Panel on Climate Change report highlights that rising temperatures, heightened CO2 levels, shifting rainfall patterns, and more

[104] Child Trends. Redlining has left many communities of color exposed to lead. Published February 13, 2018. Accessed May 15, 2024. https://www.childtrends.org/publications/redlining-left-many-communities-color-exposed-lead
[105] Washington State Department of Health. Community and Environment, Contaminants; Lead. No Publication Date. Accessed May 15, 2024. https://doh.wa.gov/community-and-environment/contaminants/lead
[106] Office of the Washington State Auditor, Pat McCarthy. Lead Testing for Children Enrolled in Medicaid, Performance Audit.; 2023:70. Accessed May 15, 2024. https://sao.wa.gov/sites/default/files/audit_reports/PA_Lead_Testing_for_Children_Enrolled_in_Medicaid_ar-1033619_1.pdf
[107] Department of Health Office of Environmental Public Health Sciences, Healthy Homes and Communities. Childhood Lead Poisoning Prevention Programs. Presented at: Washington State Board of Health Meeting August 2023; August 9, 2023. Accessed May 15, 2024. https://sboh.wa.gov/sites/default/files/2023-08/Tab07a-SBOH%20Lead%20Program_7.20.2023_pFinal_0.pdf
[108] State of Washington Office of the Governor. Directive of the Governor 16-06. Assisting Community Agency Responses to Lead in Water Systems. Published May 2, 2016. Accessed May 15, 2024. https://governor.wa.gov/sites/default/files/directive/dir_16-06.pdf

frequent extreme weather events will create conditions that will support the increase and spread of diseases, pollutants, invasive species, and biotoxins in water ecosystems [109].

Warming surface water temperatures in the Pacific Northwest create optimal conditions for harmful algal blooms (HABs) and other biotoxins to thrive, creating significant food safety concerns and endangering the health and availability of shellfish, and threatening the livelihood of fishing communities. In recent years, the algae that produce Diarrhetic Shellfish Poisoning toxins has been detected at unsafe levels in Washington State's marine waters, and people have become sick after eating shellfish contaminated with these toxins [110].

This poses a disproportionate risk for communities reliant on shellfish, especially those for whom shellfish are dietary staples deeply ingrained in cultural and traditional practices and for fishing communities. Shellfish constitute First Foods for some Tribes in Washington, serving as vital components of their heritage and sustenance [111, 112]. Additionally, shellfish are crucial in supporting Tribal livelihoods, ensuring food security and sovereignty, providing essential dietary nutrients, and contributing to the broader marine ecosystem, which also has cultural significance [113].

In 2023, at the Legislature's request, Board staff completed a Health Impact Review (HIR) on Substitute House Bill (SHB) 1010, Concerning the sanitary control of shellfish. The bill's intent was to address a gap in state law by allowing the regulation of commercial crab fisheries in Washington State to strengthen public health protections against marine biotoxins. The bill would have directed the Board to adopt rules regulating commercial crab harvesting, tracking, and recalls for biotoxin contamination. Additionally, it would have granted the Department of Health authority to regulate commercially harvested crab for biotoxin contamination.

The HIR highlighted evidence that SHB 1010 may increase monitoring, flexibility of management actions, coordination, and compliance related to biotoxin contamination in commercially harvested crab [114]. It may also increase opportunities for commercial Dungeness crab fisheries to remain open during biotoxin contamination events, which would likely improve economic, social, cultural, mental, and emotional outcomes and reduce inequities for commercial crabbers and fishing communities. The bill would also improve public health safeguards related to biotoxin contamination in commercially harvested Dungeness crab, which would likely prevent negative health outcomes and reduce inequities for people who consume Dungeness crab commercially harvested in Washington State.

[109] Duchenne-Moutien RA, Neetoo H. Climate Change and Emerging Food Safety Issues: A Review. Journal of Food Protection. 2021;84(11):1884-1897. doi:10.4315/JFP-21-141

[110] Washington State Department of Health. Diarrhetic Shellfish Poisoning (DSP). No Publication Date. Accessed May 15, 2024. https://doh.wa.gov/community-and-environment/shellfish/recreational-shellfish/illnesses/biotoxins/diarrhetic-shellfish-poisoning

[111] Frohne L. First Foods: How Native people are preserving the natural nourishment of the Pacific Northwest. The Seattle Times. Published July 10, 2022. Accessed May 15, 2024. https://projects.seattletimes.com/2022/first-foods-native-people-pacific-northwest-preserving/

[112] NASA Jet Propulsion Laboratory, California Institute of Technology. How is climate change impacting shellfish in the ocean? – JPL Earth Science. Published May 16, 2022. Accessed May 15, 2024. https://earth.jpl.nasa.gov/news/28/how-is-climate-change-impacting-shellfish-in-the-ocean/

[113] Lee MJ, Henderson SB, Clermont H, Turna NS, McIntyre L. The health risks of marine biotoxins associated with high seafood consumption: Looking beyond the single dose, single outcome paradigm with a view towards addressing the needs of coastal Indigenous populations in British Columbia. Heliyon. 2024;10(5):e27146. doi:10.1016/j.heliyon.2024.e27146

[114] Washington State Board of Health. Health Impact Review (HIR) on Substitute House Bill (SHB) 1010. Published November 17, 2023. Accessed May 15, 2024. https://sboh.wa.gov/sites/default/files/2023-11/HIR-2024-03-SHB%201010_0.pdf

The impacts of climate change on marine ecosystems and the consequential health risks underscore the urgent need for proactive measures to safeguard the public's health and protect coastal communities' livelihoods. These concerns also extend beyond marine ecosystems; climate change will impact every part and everyone in Washington State in some way. Mitigating the impacts of climate change remains a high priority for the Board, and the Board supports efforts for the Legislature to explore ways further to protect communities from the effects of climate change.

"Racism and classism [intersect] within environmental justice and climate change. Often, interstate highways, large development projects, airports, locations for landfills, factories, etc. disproportionately impacts neighborhoods that have been historically communities of color. And when new apartment buildings, light rail stations, and 'infrastructure improvements' come to neighborhoods these communities are not consulted."
- Washington community-based provider

The passage of the Healthy Environment for All (HEAL) Act in 2021 marked a monumental step toward addressing environmental and health inequities among communities of color and low-income households in Washington State [115]. It was the first law of its kind in the state to create a coordinated state agency approach to environmental justice. The HEAL Act created the Environmental Justice Council and created obligations for seven state agencies to integrate environmental justice into agency decision-making, policy, and practice, as well as specific provisions to update and maintain the Washington Tracking Network's Environmental Health Disparities Map. Other agencies may opt-in to the obligations. Three agencies, including the Board, have opted to join in a "Listen and Learn" capacity and are participating in meetings of the Environmental Justice Council and implementing HEAL Act requirements as resources allow.

The Board supports ongoing and increased funding to implement the HEAL Act and support additional environmental justice efforts across state agencies. Such actions are necessary to prevent further environmental injustices and ensure communities live in safe, healthy environments. The Environmental Justice Task Force stated, "Washington cannot achieve equity without [environmental justice]" and "[t]he pathway to reaching an equitable Washington is only possible through ongoing anti-racism, environmental conservation, public health, and community engagement work."

[115] Washington State Department of Health. Environmental Justice. No Publication Date. Accessed May 15, 2024. https://doh.wa.gov/community-and-environment/health-equity/environmental-justice

The Board recommends the Governor and Legislature act to:

- Provide adequate funding to increase the capacity of public health agencies to improve education efforts for blood lead testing, reporting, and linkages to follow-up care, particularly for people on Medicaid.
- Expand public health safeguards, such as establishing sanitary controls for commercial crabbing, to protect Washingtonians from environmental hazards.
- Continue to provide funding for environmental justice efforts in Washington, such as state agency environmental justice assessments, and ensure those disproportionately impacted by environmental justice issues, such as environmental racism, are centered in this work.

2024 State Health Report Community Responsiveness Summary – Working Draft

What is a community responsiveness summary? The Washington State Board of Health staff created this document. It highlights what we learned from talking to community members while creating the 2024 State Health Report. The summary also explains how we used community input in the final report.

What is the State Health Report? The Board must create the State Health Report for the Governor's Office every two years (it is required by Washington law). The report includes ideas for public health priorities and possible laws for the Governor to consider for the next legislative cycle.

Why did staff connect with the community for the report? The Board's mission is to support policies that make sure everyone in Washington stays healthy, safe, and able to thrive. To do this right, state agencies must listen and work with the people most affected by these policies. Disability justice and other community advocates often remind agencies: "Nothing about us, without us."

How did staff connect with community? To create the 2024 report, staff worked with Board members to decide what topics and issues to focus on. Board staff then set up two community panels to get input on the list of topics. Panelists from the west and east sides of Washington State talked about programs and strategies they are using to meet community needs in these areas. Staff also had one-on-one talks with community members to gather more ideas for the report.

What were the topics community was asked about? Board staff asked community members to share their knowledge, experience, and stories of how current public health policies impact their community and community health priorities. The Board had a special interest in hearing about:

- Maternal and Pregnant Person Health
- Health Justice and Culturally Appropriate Care
- Substance Use
- Data Equity
- Climate Change and Environmental Justice

What did the Board and staff learn, and how did we incorporate it into the final report? Some of the key things that Board staff learned from the community included:

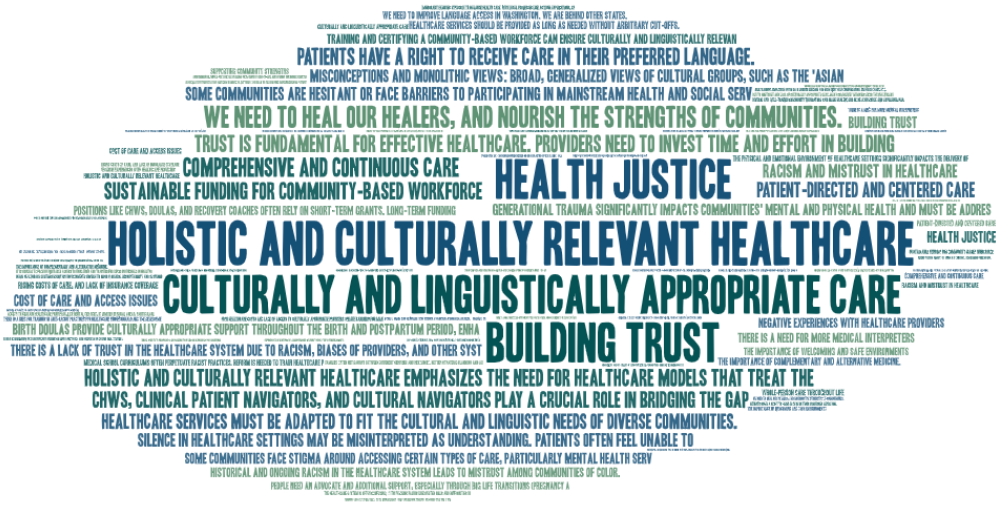
(Option 1) – Word Clouds, with key points listed underneath.

Commented [MD1]: Note: This is a draft of the State Health Report's community responsiveness summary. Some of the information outlined is incomplete and doesn't reflect all community feedback. The purpose of this version is to outline options for how staff can convey what we learned from the community and how it was incorporated into the final report.

Commented [DM(2]: We will need to work with Comms and Community Engagement to discuss the best format for outlining this information. We don't want this summary to be longer than 2-3 pages. I've outlined 3 possible options below.

- **Substance Use Disorder in Pregnancy:**
  - Many pregnant people with substance use disorders lack advocacy and support during delivery. Babies are sometimes given treatments like methadone without the parents' knowledge or consent. More education about supportive care models, like the "eat, sleep, console" method, is needed.
- **Key Factors in Maternal Care:**
  - For pregnant people, three critical aspects are essential: easy access to care, high-quality care, and affordable care.
- **Importance of Birth Doulas:**
  - Doulas provide crucial physical and mental support during and after childbirth. They help empower families to advocate for their health needs.
- **Medicaid Reimbursement for Doulas and Community Health Workers (CHWs):**
  - Medicaid should cover services doulas and CHWs provide to support maternal health. This is in progress but needs to happen sooner.
- **Challenges in Postpartum Lactation Support:**
  - Many families struggle to find adequate lactation support after birth.
- **Essential Resources for Families:**
  - Families often need tangible resources like diapers, food, and housing. Addressing these basic needs is crucial to help them effectively.
- **Core Needs in Maternal Care:**
  - Three main areas are vital: lactation support, financial resources, and culturally competent care from doulas and other providers.
- **Non-Medical Support in Healthcare Settings:**
  - People benefit from having non-medical supporters, like doulas, in medical spaces to help them voice their needs and navigate care.
- **Lead Poisoning Screening for Infants:**
  - There's a need to ensure lead poisoning screening is part of regular check-ups for infants and young children.

- **Culturally Sensitive Healthcare:**
    - Healthcare providers must understand and respect different cultural beliefs and practices. This builds trust and leads to better health outcomes.



- **Holistic and Multi-Generational Care:**
    - Emphasizes the need for healthcare models that treat the whole person and support multiple generations within a family, recognizing the interconnectedness of mental, physical, emotional, and spiritual health.
- **Building Trust Between Providers and Patients:**
    - Trust is fundamental for effective healthcare. Providers need to invest time and effort in building trust with their patients to improve health outcomes.
- **Role of Community Health Workers (CHWs) and Navigators:**
    - CHWs, clinical patient navigators, and cultural navigators play a crucial role in bridging the gap between communities and healthcare systems. Sustainable reimbursement and funding for these roles are necessary to support their work.
- **Culturally Relevant Care:**
    - Healthcare services must be adapted to fit the cultural and linguistic needs of diverse communities. This includes avoiding a one-size-fits-all approach and acknowledging the unique needs and barriers different communities face....

(Option 2) – Dot point lists, with "recommendations" under each bullet.

Access to Healthcare and Support Services

- Communities need better access to healthcare and related services. The high costs of care, and lack of care coverage is a major concern.
    - *Recommendation:* Included throughout recommendation 2 in the State Health Report.
- Issues of racism, historical and ongoing harm, and distrust in the healthcare system, especially among Black, Indigenous, People of Color (BIPOC) are ongoing issues and remain major barriers to accessing care.
    - *Recommendation*:
- Pregnant and postpartum people need better access to care, especially those from communities that are marginalized. Pregnant people benefit from the advocacy of doulas – more people need to be able to access doulas. Doulas help fill a huge gap in providing breastfeeding support and culturally appropriate care.
    - *Recommendation:*
- People highlighted that Medicaid should pay for doulas and community health workers (CHWs) because the services they provide for communities are really important.
    - *Recommendation:*
- Many families have difficulty getting the help they need early on to support their children's development and other services.
    - *Recommendation:*

The Importance of Culturally Relevant Care

- Culturally relevant and appropriate care is essential to support diverse communities across Washington. Healthcare providers must understand and respect the different cultures and practices of the people they are helping.
- Providers must also find ways to have appointments in a patient's preferred language. Providers need training to provide this type of care, but more importantly, providers need to be from the community and/or share the same culture and language as their patients.

Economic and Systemic Barriers to Care

- Many families struggle to afford basic needs, like food and housing. This makes it hard for them to stay healthy and get out of a cycle of economic instability and poverty. When people can't meet their basic needs, it's hard for them to think about anything else. Also, if families don't have stable housing, it directly affects their health and ability to thrive.
- Medicaid doesn't cover all the services that people need.

Systemic Issues in Healthcare

- There is an urgent need for systemic changes in healthcare—such as longer appointment times so providers can give better and more personalized care, better connections from clinics to community-based services, and anti-racist training for providers and staff—to provide better patient care and culturally appropriate care.
- Our healthcare system must move towards whole-person, holistic care models that address physical, mental, emotional, and spiritual well-being. This care should also be multi-generational.

Commented [HH3]: If this was in the table below, would each dot point be one row? Or are you grouping them by bolded topic? Like will each dot point have an answer to each of these questions: **Recommendation:** How was this or wasn't incorporated into the Final State Health Report? **Next Steps:** What now? What do we plan to do with this information?

I was initially thinking that each dot point would have it's own answer to each of these questions, but maybe that gets too repetitive. Hmm, what if we actually grouped them by 'things that were directly incorporated into the report', 'things that will be used in future board work but aren't directly in the report', and 'things that we will pass on to another agency' rather than by topic? Hmm, maybe there's too much overlap where some will be in all three categories...

It may be worth consulting with Comms about the best way to visually present this data, but another option I can think of is to have those two questions answered just below each dot point. That may get too tricky/cluttered though. (not sure if I'm describing this well!)

- Providers and systems of care need to support individual and community healing. If we can't acknowledge past harms and help communities heal, we can't move forward and authentically build back trust.
- Culturally appropriate care needs to be addressed in the workforce development realm, where BIPOC providers have equitable access to education, training, and ongoing support to become healthcare professionals.

Data and Equity

- To move towards data equity, the community should lead and direct data collection efforts, or agencies should support community involvement at every stage. In any data collection and analysis process, it is essential to ensure that people's voices are heard, and their needs are addressed.
- There are calls from the community for transparency and accountability in data use, especially in addressing inequities.
- People also asked, "How can we turn data into action?"

Support for People with Substance Use Disorders (SUDs)

- Community members highlighted:
    - There is a call for more support and services for pregnant individuals with substance use disorders, including better prenatal and postnatal care.
    - The importance of addressing the roots of substance use, such as early childhood trauma.
    - The need for a public health approach to SUD instead of a criminal-legal approach was also highlighted.

Commented [HH4]: Why do you have this for SUDs and don't have it anywhere else?

Community and Environmental Health

- The health of a community is closely connected to the natural and built environment. For example, homes should be checked for things like mold and lead that can make people sick and have long-term impacts on health.
- Pollution from Airports and Traffic: Communities near airports are exposed to more pollution from planes and cars. This pollution can cause health problems like asthma and heart disease.
- Heat and Housing: Many homes lack cooling systems, making extreme heat dangerous for families.
- Lead Poisoning and Safe Homes: Community groups need to provide lead testing for children and check homes for lead to prevent exposure.
- Green Spaces for Communities of Color: It's crucial for communities, especially BIPOC communities, to have access to safe, outdoor green areas.
- Environmental Racism and Infrastructure Projects: Environmental issues like pollution from highways, factories, and airports often affect communities of color the most. Big projects like new apartments or railways sometimes ignore these communities' needs and input.
- Consulting BIPOC Communities on Environmental Justice: Agencies should consult with and hire people from BIPOC communities who can represent and make decisions for their neighborhoods.

- Tribal Land and Green Projects: Green energy projects like wind turbines and solar panels are sometimes built on Tribal lands without consulting the Tribes, risking harm to their cultural sites and knowledge.
- Climate Change Impacts on Tribes: Tribes have long noticed how climate change affects their lands and ways of life, such as changes to their traditional foods and the seasons.
- Effects of Climate Change: Climate change is already forcing people to move and affecting their health in Washington.
- Improving Air Quality: Improving air quality with filters and better HVAC systems is critical, especially after COVID-19.

Option 3, Table Format: Summary of what we learned from community members and how it was incorporated into the final report.

Summary: What did we learn?	**Recommendation:** How was this or wasn't incorporated into the Final State Health Report?	**Next Steps:** What now? What do we plan to do with this information?
Theme/general comment (de-identified).	Ex) Is this in the report?	Ex) In addition to including this as a recommendation, we connected panelists with X..., which we sent these comments to, etc. Ex) We will continue to monitor this. Ex) This will be feedback to incorporated into either the PEAR Plan or the next Board Strategic Plan.

RCW 43.20.100

Biennial report.

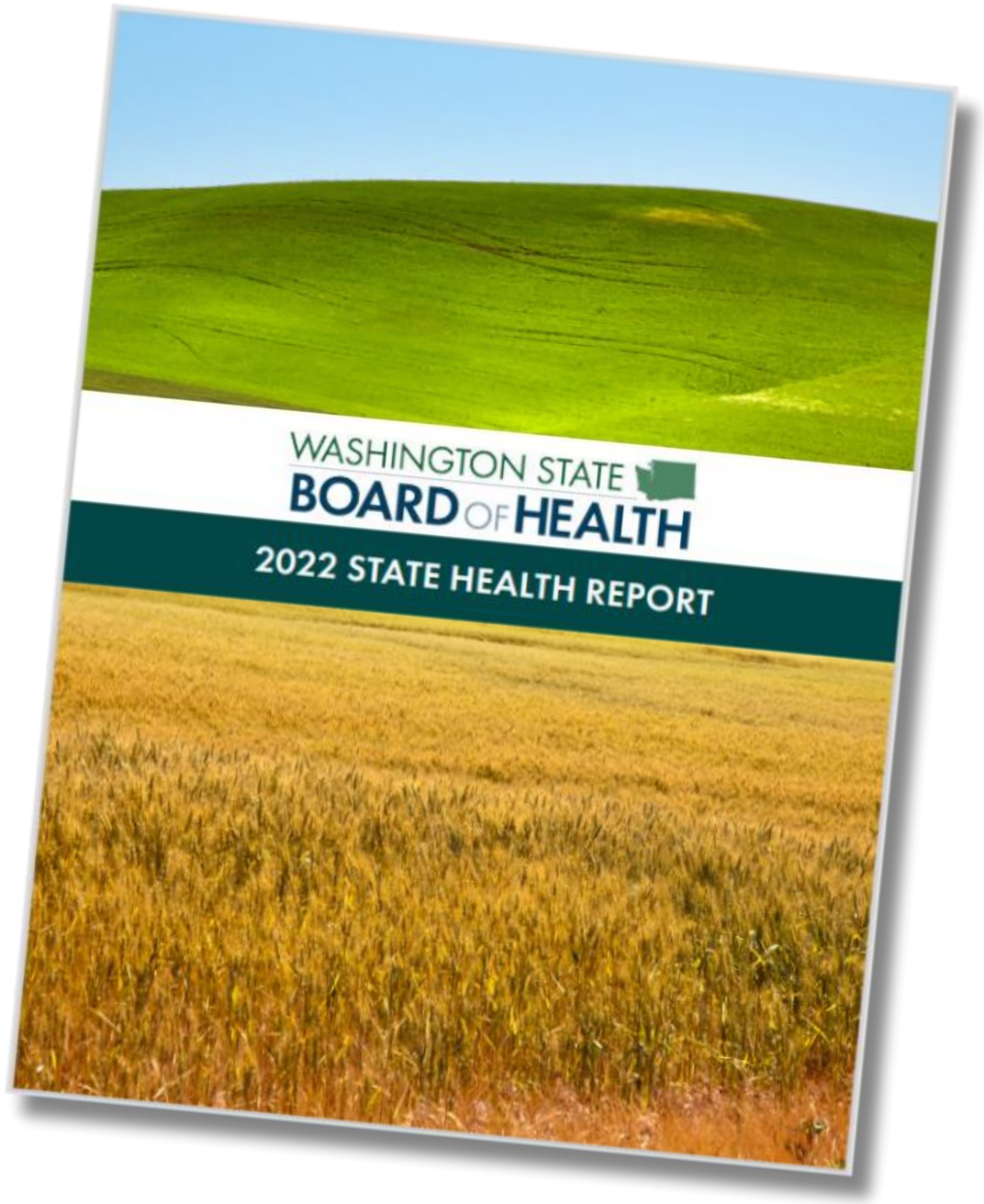
The state board of health shall report to the governor by July 1st of each even-numbered year including therein suggestions for public health priorities for the following biennium and such legislative action as it deems necessary.

[**2009 c 518 § 23**; **1977 c 75 § 44**; **1965 c 8 § 43.20.100**. Prior: **1891 c 98 § 11**; RRS § 6007.]

Updates on 2022 State Health Report Recommendations

WASHINGTON STATE BOARD OF HEALTH

- Improving Public Health's Response to Health Inequities Through Data Reform
- Removing Barriers to Health Care Insurance and Care Coverage
- Improving Access to Culturally and Linguistically Appropriate Health Services
- Making School Environments Healthy and Safe
- Decreasing Youth Use of Tobacco, Nicotine, and Vapor Products
- Strengthening Washington's Public Health System Through Continued Investments



Improving Public Health's Response to Health Inequities Through Data Reform

- 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.

  Status: Over the last biennium, the Legislature did not provide the Office of Equity funding for this purpose.

- Direct and provide funding to state agencies to enhance the interoperability of data systems to facilitate the collection, analysis, storage, and protection of uniform, disaggregated demographic data.

  Status: Many state agencies are engaged in efforts related to data disaggregation. The Legislature has provided some minor investments to enhance the interoperability of some data systems, but more investment is needed.

- Actively monitor and participate in opportunities to advocate for improvements in federal standards for interoperability and disaggregated demographic data collection.

  Status: In April 2023, the Board, Council, and other state agencies submitted comments on the OMB's Initial Proposals for Updating Race and Ethnicity Standards. OMB Released the revised SPD 15 in March 2024 (OMB-2023-001).

Removing Barriers to Health Care Insurance and Care Coverage

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

- Status: Over the past biennium, the Legislature provided funding to expand access to Apple Health and Exchange Plans for people who are income-eligible and at least 19 years of age, regardless of immigration status. Enrollment for the new Apple Health program will start in July 2024. Due to the available funding levels, the program will have a capped enrollment of 13,000 individuals. More funding is needed.

Employ strategies identified by the Tubman Center for Health and Freedom to ensure access to the type of healthcare services that members of marginalized communities most rely on, including but not limited to:

i. Requiring insurers to cover the cost of health care utilized by Washington communities, including CAM.
ii. Employ health care providers from the communities they are serving.
iii. Incentivize providers who use the health care that communities who have been historically or are currently marginalized prefer to use.
iv. Remove systemic barriers to care, such as cost and insufficient provider networks, so that communities can access timely, culturally-based care.

- Status: The Legislature has made some progress on these recommendations. Examples include legislation banning ground ambulance balance billing, increasing access to quality telehealth services, expanding income eligibility for Apple Health pregnancy/postpartum coverage, and directing agencies to study approaches to improving healthcare affordability. Funding was also provided for reimbursing services provided by doulas for Apple Health clients, continuing community health worker grant programs, and increasing the number of American Indian and Alaska Native physicians practicing in Washington.

Improving Access to Culturally and Linguistically Appropriate Health Services

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.

- Status: The Legislature didn’t pass legislation related to prescription information translation over the past biennium. However, the Pharmacy Commission and the Department of Health initiated rulemaking in June 2023 to consider amendments to WAC 246-945-015 and WAC 246-945-417 and possibly add new sections to chapter 246-945 WAC about prescription drug label accessibility. This work is ongoing. Several bills related to interpreters and translators were introduced over the biennium. One bill that passed, SB 5304, required DSHS to convene a language access workgroup to study and recommend language interpreter certification policies and programs to the Legislature. The workgroup’s report was sent to the Legislature in December 2023.

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.

- Status: The Legislature has not provided funding for this purpose.

Making School Environments Healthy and Safe

Remove the budget proviso that prevents revision and implementation of the Board's school environmental health and safety rules.

- Status: The budget proviso suspending the Board's rules was not removed. However, a new proviso that directs the Board to initiate a School Rule Review project with key partners was created. The Board will receive this funding starting July 2024.

Require the Department of Health, local health jurisdictions, OSPI, and the Board to collaborate to conduct a school environmental health and safety review and needs assessment to inform updates to the K-12 School Health and Safety Guide and future rulemaking.

- Status: The Board, Department, local health jurisdictions, OSPI and other partners will conduct a school environmental health and safety rule review as part of the 2024 School Rule Review budget proviso (see ESSB 5950, Section 222, subsection 159, page 492).

Prioritize funding for K-12 school HVAC system maintenance and necessary upgrades to minimize transmission of contaminants and communicable diseases.

- Status: The Legislature made a large investment (~$40 million) to OSPI to improve classroom air quality by allowing school districts to repair and replace HVAC and air delivery systems. Note that this funding (~$30 million) was possible because of the Climate Commitment Act (CCA). If the CCA is repealed on the ballot in the November 2024 election, funding for this work will lapse by the end of the year.

Actively monitor and participate in opportunities to advocate for federal indoor air quality standards in the built environment.

- Status: The Board is unaware of activities completed over the past biennium related to this recommendation.

Decreasing Youth Use of Tobacco, Nicotine, and Vapor Products

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.

- Status: While legislation prohibiting and regulating the sale of flavored vaping products was introduced over the last biennium, the Legislature did not take action.

Strengthening Washington’s Public Health System Through Continued Investments

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).

- Status: During the 2023 Legislative session, the Legislature invested an additional $50 million for Fiscal Years 24 and 25 for Foundational Public Health Services ($100 million total).

ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
- We are committed to providing access to all individuals visiting our agency website, including persons with disabilities. If you cannot access content on our website because of a disability, have questions about content accessibility or would like to report problems accessing information on our website, please call (360) 236-4110 or email wsboh@sboh.wa.gov and describe the following details in your message:
    - The nature of the accessibility needs
    - The URL (web address) of the content you would like to access
    - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Patty Hayes, Board Chair

Subject: Effective Date Extension – Primary and Secondary Schools, chapter 246-366 WAC, and Environmental Health and Safety Standards for Primary and Secondary Schools, chapter 246-366A WAC

Background and Summary:

Under the authority of RCW 43.20.050, the State Board of Health (Board) revised its environmental health and safety standards for primary and secondary schools on August 12, 2009. The adopted rules reflect the Board's intent to have chapter 246-366A WAC supersede chapter 246-366 WAC to promote safe and healthy school environments. The new rules have not been implemented due to restrictions enacted by the Legislature related to concerns with the financial impact of the new rules.

The 2009 – 2011 Washington State operating budget bill included a proviso prohibiting the Washington State Department of Health and the Board from implementing new or amended school rules until the Legislature takes action to fund implementation. Based on that directive, the Board filed a Rule-Making Order (CR-103) on December 22, 2009, specifying a July 1, 2010, effective date for the new rules. The Board agreed to review the actions of the Legislature at the end of each session to determine whether any portions of the rules could be implemented and to amend the CR-103 accordingly.

Each subsequent biennial budget has included the proviso prohibiting implementation of the new rules and has provided no implementation funding. The Board voted to continue to delay the effective date at the following meetings:

- March 10, 2010 (filed as WSR 10-12-018 on May 21, 2010)
- April 13, 2011 (filed as WSR 11-10-080 on May 3, 2011)
- March 13, 2013 (filed as WSR 13-09-040 on April 11, 2013)
- March 11, 2015 (filed as WSR 15-09-070 on April 15, 2015)
- June 14, 2017 (filed as WSR 17-14-055 on June 28, 2017)
- June 12, 2019 (filed as WSR 19-14-107 on July 2, 2019)
- June 9, 2021 (filed as WSR 21-14-056 on July 1, 2021)
- June 8, 2022 (filed as WSR 22-14-021 on June 24, 2022)
- June 14, 2023 (filed as WSR 23-16-005 on July 19. 2023)

During the 2024 legislative session, Engrossed Substitute Senate Bill 5950 (Section 222, subsection 1 (page 457) retained the prohibition on implementation (while also adding a proviso directing the Board to review and update the school rules, as described in the related agenda item). For this reason, the Board must file a new CR-103 before August 2024 to further extend the effective date of the rules.

(continued on the next page)

Recommended Board Actions:

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

The Board directs staff to amend the effective date of new sections of chapter 246-366 WAC and new chapter 246-366A WAC, as filed in WSR 23-16-005, by filing a new CR-103, Order of Adoption, to delay the effective date of the new rules to September 1, 2025.

Staff

Andrew Kamali

To request this document in an alternate format or a different language, please contact the Washington State Board of Health, at 360-236-4110 or by email at wsboh@sboh.wa.gov TTY users can dial 711.

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Patty Hayes, Board Chair

Subject: School Environmental Health and Safety Rules Review Project

Background and Summary:

During the 2024 legislative session, the Legislature included a new budget proviso (2024 supplemental operating budget (Section 222, subsection 159 (page 491- 492)) that directs the State Board of Health (Board) to review and draft new proposed rules to set minimum health and safety standards for K-12 schools. The proviso also requires the Board to:

Conduct the rule review in collaboration with the Department of Health and a multi-disciplinary technical advisory committee (TAC). At a minimum, the TAC must consist of representatives from the:

- Office of Superintendent of Public Instruction (OSPI),
- Small and large school districts,
- Washington Association of School Administrators,
- Washington State School Directors Association,
- Washington Association of Maintenance and Operations Administrators, and,
- Washington Association of School Business Officials.

In developing the draft proposed rule, the Board must consider the size of school districts, regional cost differences, the age of schools, and any other variables that may affect rule implementation. The Board has also been tasked with developing a report in collaboration with OSPI, the Department of Health, the TAC, and local health jurisdictions. The report must prioritize the sections or subject areas that provide the greatest health and safety benefits for students, and any other implementation recommendations. This work must be completed and submitted to the Legislature and the Governor's office by June 30, 2025.

Staff will file a CR-101 to formally initiate the rule drafting process and notify interested parties of the work.

Recommended Board Actions:

This is an informational update, not requiring any Board action.

Staff

Andrew Kamali

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

ESSB 5950, Section 222, subsection 159

Proviso Language:

(a) $750,000 of the general fund—state appropriation for fiscal year 2025 is provided solely to review and update the rules for school environmental health and safety. The state board of health and the department shall conduct the review in collaboration with a multi-disciplinary technical advisory committee. The proposed new rules shall establish the minimum statewide health and safety standards for schools. The state board of health shall consider the size of school districts, regional cost differences, the age of the schools, the feasibility of implementing the proposed rules by section or subject area, and any other variables that may affect the implementation of the rules. In developing proposed rules, the state board of health shall:

(i) Convene and consult with an advisory committee consisting of, at minimum, representatives from:

(A) The office of the superintendent of public instruction;

(B) Small and large school districts;

(C) The Washington association of school administrators;

(D) The Washington state school directors' association;

(E) The Washington association of maintenance and operations administrators; and

(F) The Washington association of school business officials;

(ii) After the development of the draft rules, the state board of health shall meet at least one time with the advisory committee and provide the opportunity for the advisory committee to comment on the draft rules;

(iii) Collaborate with the office of the superintendent of public instruction and develop a fiscal analysis regarding proposed rules that considers the size of school districts, regional cost differences, the age of the schools, range of costs for implementing the proposed rules by section or subject area, and any other variables that may affect costs as identified by the advisory committee; and

(iv) Assist the department in completing environmental justice assessments on any proposed rules.

(b) The office of the superintendent of public instruction, the department, the state board of health, the advisory committee, and local health jurisdictions shall work collaboratively to develop and provide a report to the office of the governor and appropriate committees of the legislature by June 30, 2025, detailing prioritized sections or subject areas of the proposed rules that will provide the greatest health and safety benefits for students, the order in which they should be implemented, and any additional recommendations for implementation.

School Rules Review Project

Andrew Kamali, Board Staff

WASHINGTON STATE BOARD OF HEALTH

06/12/2024

Background


2010
Budget Proviso prohibiting implementation of Chapter 246-366A WAC
2015
JARRC review
2016
Governor's Directive 16-06
2023
EJC Recommendations
2024
Supplemental Operating Budget Proviso

Budget Proviso

- $750,000 of the general fund—state appropriation for fiscal year 2025 is provided solely to review and update the rules for school environmental health and safety.
- Collaborate with the Office of the Superintendent of Public Instruction and develop a fiscal analysis
- Assist the Department of Health in completing environmental justice assessments on any proposed rules.
- The Office of the Superintendent of Public Instruction, the Department of Health, the State Board of Health, the advisory committee, and local health jurisdictions shall work collaboratively to develop and provide a report to the Office of the Governor and appropriate committees of the Legislature by June 30, 2025

Deliverables

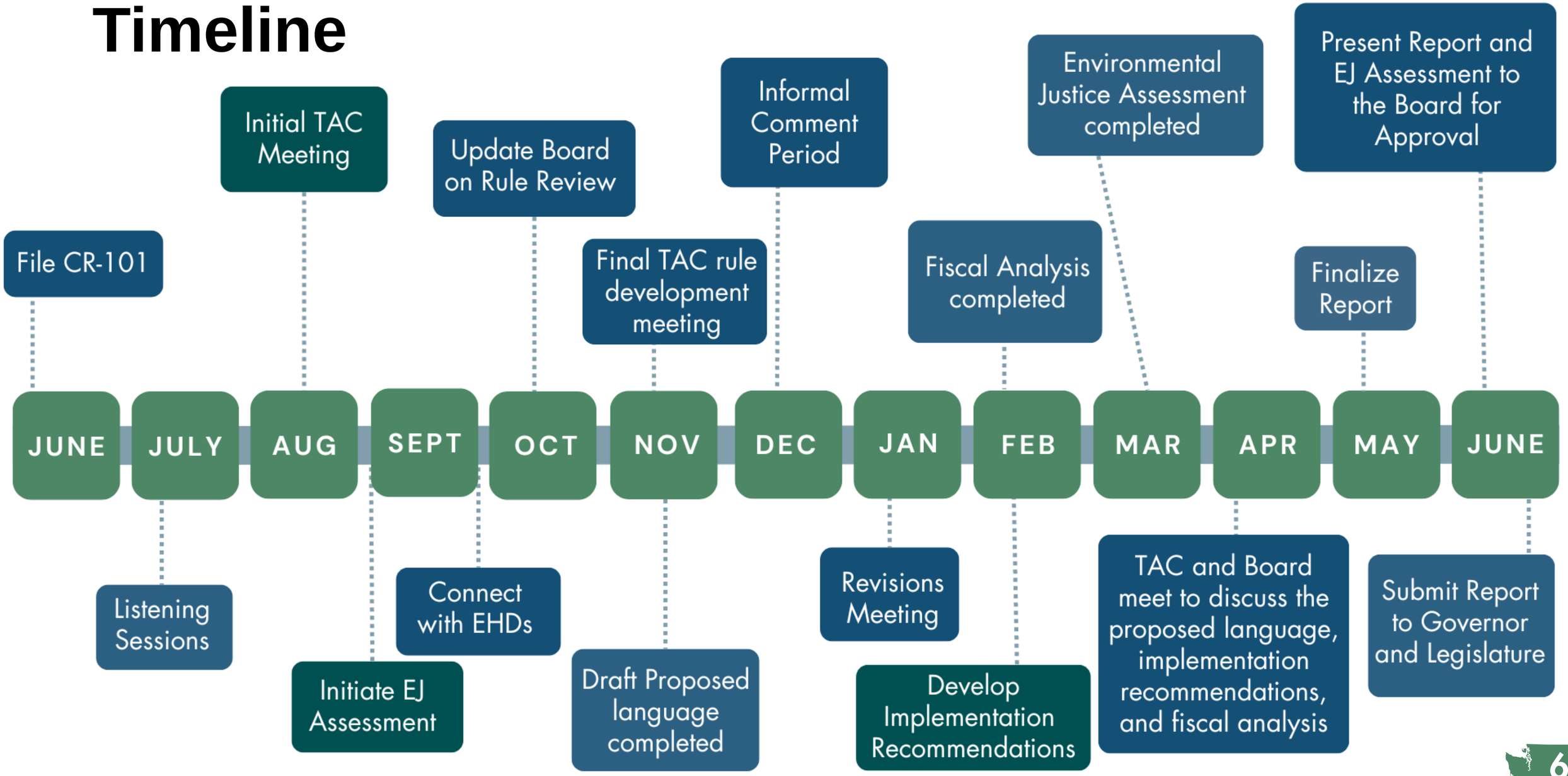
- Draft of proposed new rules
- Environmental Justice Assessment
- Fiscal Analysis
- Report prioritizing implementation recommendations to the Governor’s office and Legislature

Technical Advisory Committee

- Required Members
  - Office of Superintendent of Public Instruction
  - Small & Large School Districts
  - Washington Association of School Administrators
  - Washington State School Directors' Association
  - Washington Association of Maintenance and Operation Administrators
  - Washington Association of School Business Officials
- Additional Members
  - Washington Education Association
  - Small & Large Local Health Jurisdictions
  - Parent Teacher Association
  - Private Schools
  - Tribal-Compact Schools
  - Overburdened Communities
  - Washington Association of School Principals
  - Department of Health

Each organization will be asked to provide one representative and one alternate. Invitations have already been sent out and we are working to compile the names of the representatives and schedule the first Technical Advisory Committee (TAC) meeting.

Timeline


File CR-101
Initial TAC Meeting
Update Board on Rule Review
Final TAC rule development meeting
Informal Comment Period
Fiscal Analysis completed
Environmental Justice Assessment completed
Finalize Report
Present Report and EJ Assessment to the Board for Approval
JUNE
JULY
AUG
SEPT
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUNE
Listening Sessions
Initiate EJ Assessment
Connect with EHDs
Draft Proposed language completed
Revisions Meeting
Develop Implementation Recommendations
TAC and Board meet to discuss the proposed language, implementation recommendations, and fiscal analysis
Submit Report to Governor and Legislature

WASHINGTON STATE BOARD OF HEALTH

THANK YOU

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ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

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    - The nature of the accessibility needs
    - The URL (web address) of the content you would like to access
    - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Dimyana Abdelmalek, Board Member

Subject: Request for Delegated Rulemaking Authority – Minor Administrative Updates to Immunization Rules WAC 246-105-040 and 060

Background and Summary:

According to the Revised Code of Washington (RCW) 28A.210.140, the State Board of Health (Board) is responsible for creating rules that detail the steps and requirements for children to meet full immunization standards before attending school or child care centers in Washington. These rules are set forth in chapter 246-105 of the Washington Administrative Code (WAC), which includes the diseases children must be immunized against and the documentation options available to fulfill these requirements.

The Department of Health (Department) has asked the Board to delegate its rulemaking authority to make minor administrative changes to two sections of the rule, WAC 246-105-040 (Requirements based on national immunization guidelines) and WAC 246-105-060 (Duties of schools and child care centers). This request has been made for the following reasons:

- WAC 246-105-040 currently references the 2019 immunization schedule. However, updates between 2019 and 2024 change the recommended ages for administering some required vaccines for school and child care entry. As a result, the Department needs to update the schedule to the most recent version available (2024).
- WAC-246-105-060 requires schools to submit an annual immunization status report by November 1. The Department has determined that it's necessary to update this section of the rule to remove the school immunization status reporting date. Doing so would allow the Department to periodically determine the reporting date, consistent with RCW 28A.210.110(3), and better support schools and child care facilities in meeting the reporting deadlines.

Per RCW 43.20.050(4), the Board can delegate its authority to adopt rules to the Department under specific conditions. The Board has established Policy 2000-001, outlining its procedures for evaluating such requests from the Department. This policy includes criteria to help Board Members determine if requests meet the necessary conditions for rulemaking delegation.

(continued on the next page)

Each delegation by the Board is for a single rulemaking process unless otherwise specified in an approved motion. Once delegated, the Department will provide periodic progress reports to inform the Board about the rule-making progress. Additionally, the Board reserves the right to revoke its delegation at any time.

I have asked Meghan Cichy and Katherine Graff, Department Staff, to discuss the Department's request for delegated rulemaking authority for the Board's consideration.

Recommended Board Actions:

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

The Board delegates to the Washington Department of Health rulemaking authority to make minor changes to WAC 246-105-040 to update the immunization schedule to the most recent version and WAC 246-105-060 to remove the school immunization status reporting date.

Or

The Board does not delegate to the Washington Department of Health rulemaking authority to amend WAC 246-105-040 or WAC 246-105-060 for the reasons stated by the Board.

Staff

Molly Dinardo

STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47890 • Olympia, Washington 98504-7890
Tel: 360-236-4030 • 711 Washington Relay Service

June 12th, 2024

TO: Michelle Davis, Executive Director
Washington State Board of Health

FROM: Michele Roberts, Assistant Secretary
Division of Prevention and Community Health

SUBJECT: Request for Delegation of Rulemaking Authority for WAC 246-105-040 and WAC 246-105-060.

The Department of Health (department) requests the authority to propose and adopt changes to WAC 246-105-040 (Requirements based on national immunization guidelines) and WAC 246-105-060 (Duties of schools and child care centers).

Under WAC 246-105-040, the department develops and distributes implementation guidelines for schools and child care centers consistent with national immunization guidelines. Guidelines are determined by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) and are published annually in the Morbidity and Mortality Weekly Report as the Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger — United States.

WAC 246-105-040 references the 2019 immunization schedule. Changes to the immunization schedule between 2019 and 2024 impact the recommended ages of vaccine administration for required school and child care immunizations, requiring the WAC to be updated.

Under WAC 246-105-060, schools and child cares are required to submit an annual immunization status report. WAC 246-105-060 requires these reports to be submitted to the department by November 1st. The department, in collaboration with schools, has determined it is necessary to update WAC 246-105-060 to remove the school immunization status reporting date from the rule. This would enable the department to determine the reporting date as authorized by RCW 28A.210.110 and to better support schools and child cares in meeting the reporting deadline.

Purpose of Rulemaking

Regarding WAC 246-105-040, the department identified several changes in the CDC's immunization schedule from 2019 to 2024 that necessitate consideration for amending the rule. These include:

Disease	Vaccines	2019	2024	Year Changed
Tetanus, Diphtheria, and Pertussis	Tdap	Children ages 7–10 years who receive Tdap inadvertently or as part of the catch-up series should receive the routine Tdap dose at 11–12 years.	- Children ages 7–9 years who receive Tdap should receive the routine Tdap dose at age 11–12 years. - Children ages 10 years who receive Tdap do not need to receive the routine Tdap dose at age 11–12 years.	2020
Hepatitis B	Hepatitis B	Hepatitis B vaccine is not routinely recommended for all persons ages 19 and older.	People ages 19 through 59 should complete the Hepatitis B vaccine series.	2022
Pneumococcal	PCV13, PCV15, PCV20	PCV13 vaccine used in routine immunization schedule.	- PCV13 removed. - PCV15 and PCV20 are now used in the series. - Previous doses of PCV13 do not need to be repeated with PCV15 or PCV20.	2024
Polio	IPV	Not routinely recommended at ages 18 and older.	All persons unvaccinated or incompletely vaccinated should finish the polio series.	2024

Updating the reference to the 2024 guidelines would allow the rule to remain consistent with national consensus regulating clinical standards of care as recommended by the CDC's Advisory Committee on Immunization Practices.

RCW 28A.210.110, requires the Chief Administrator to file a written annual report with the Department of Health on the immunization status of students or children attending child care on a date and on forms prescribed by the department. Regarding WAC 246-105-060, the date is not needed in rule. The deadline that schools and child care centers must report is communicated in multiple ways and shown on the reporting form.

Potential Changes to the Rule

The department has identified the following changes that could occur during rulemaking:

- WAC 246-105-040: Update the ACIP recommendations reference to: ""*Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2024*"; as published in the *Morbidity and Mortality Weekly Report* (MMWR) 2024; 73(1):6-10."

- WAC 246-105-060: Remove the reporting date from the rule: "Submit an annual immunization status report under RCW 28A.210.110 at a time and in a manner approved by the department."

SBOH Delegation Considerations

This rulemaking delegation request is based on the following criteria established in the State Board of Health's Policy Number 2000-001, Considering Delegation of Rules to Department of Health:

The extent to which the proposed rule seeks to adopt federal requirements in which the state has little or no discretion.

WAC 246-105-040: Several changes have occurred to immunization recommendations since the 2019 CDC ACIP recommendations were published. The department wishes to align WAC 246-105-040 with the current national immunization schedule for children and adolescents.

The extent to which the substance and direction of the proposed rule is expected to have broad public and professional consensus.

WAC 246-105-040: The CDC ACIP immunization schedule provides guidance to assist health care providers in implementing current immunization recommendations. Continual realignment with the most current ACIP recommended immunization schedule aligns with expert consensus for children and adolescent immunizations. The potential rule change does **not** make any changes to the list of diseases for which full immunity is required for school or child care attendance.

WAC 246-105-060: The potential change is consistent with feedback from schools and child cares requesting additional time to complete reporting requirements.

The extent to which the proposed rule may make significant changes to a policy or regulatory program.

WAC 246-105-040: The potential rule change would not make significant changes. It would seek to bring guidance up to date with current immunization recommendations.

WAC 246-105-060: The proposed rule change would remove the reporting date requirement from the WAC and align with RCW 28A.210.110 which already explicitly and specifically dictates the reporting requirements.

The extent to which the rule revision process would benefit from the Board's role as a convener of interested parties.

The department will follow the requirements for exception rulemaking including holding a public hearing. The department will notify interested parties of rulemaking activity by email, provide the proposed rule language to interested parties, and post information about the rulemaking on the department's web page.

Collaboration with the SBOH

If delegation is granted, the department commits to work closely with the State Board of Health's policy staff to make certain that any proposed amendment maintains the integrity of the rule. For more information, please contact Meghan Cichy, PCH Senior Policy Analyst at (564) 669-3834 or meghan.cichy@doh.wa.gov.

Washington State Department of HEALTH

REQUEST FOR RULEMAKING AUTHORITY DELEGATION: WAC 246-105-040 AND 246-105-060

State Board of Health Meeting, June 2024

WAC 246-105-040 and 246-105-060

- **WAC 246-105-040 - Requirements based on national immunization guidelines.**
  - (1) Unless otherwise stated in this section, a child must be vaccinated against, or provide documentation of immunity against, each vaccine-preventable disease listed in WAC **246-105-030** at ages and intervals according to the national immunization guidelines in the "*Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2019*"; as published in the *Morbidity and Mortality Weekly Report* (MMWR) 2019; 68(5):112-114.
- **WAC 246-105-060 - Duties of schools and child care centers.**
  - 4(b) Submit an immunization status report under RCW **28A.210.110** in a manner approved by the department. The report must be submitted to the department by November 1 of each year. If a school opens after October 1, the report is due thirty calendar days from the first day of school.

Advisory Committee on Immunization Practices (ACIP)

ACIP is a committee of the Centers for Disease Control and Prevention (CDC).

- ACIP develops recommendations for United States immunizations, including ages when vaccines should be given, number of doses, time between doses, and precautions and contraindications.
- Recommendations are reviewed by the CDC's Director and adopted as official policy.
- Recommendations are published in the CDC's Morbidity and Mortality Weekly Report (MMWR).
- Immunization recommendations are updated at least annually.

Other state's school immunization rules include either:

- General reference to aligning with ACIP guidelines and a state developed schedule, or
- Reference a specific set of published recommendations with periodic updates to bring the reference up to date.

Rulemaking Considerations WAC 246-105-040

Washington Department of Health (WA-DOH) identified several changes in the CDC immunization schedule from 2019 to 2024 that necessitate consideration for amending the rule. Changes include:

Disease	Vaccines	2019	2024	Year Changed
Tetanus, Diphtheria, and Pertussis	Tdap	Children ages 7–10 years who receive Tdap inadvertently or as part of the catch-up series should receive the routine Tdap dose at 11–12 years.	- Children ages 7–9 years who receive Tdap should receive the routine Tdap dose at age 11–12 years. - Children ages 10 years who receive Tdap do not need to receive the routine Tdap dose at age 11–12 years.	2020
Hepatitis B	Hepatitis B	Hepatitis B vaccine is not routinely recommended for all persons age 19 and older.	People ages 19 through 59 should complete the Hepatitis B vaccine series.	2022
Pneumococcal	PCV13, PCV15, PCV20	PCV13 vaccine used in the routine immunization schedule.	- PCV13 removed. - PCV15 and PCV20 are now used in the series. - Previous doses of PCV13 do not need to be repeated with PCV15 or PCV20.	2024
Polio	IPV	Not routinely recommended at age 18 and older.	All persons unvaccinated or incompletely vaccinated should finish the polio series.	2024

Rulemaking Considerations WAC 246-105-060

RCW 28A.210.110 Immunization program—Administrator's duties upon receipt of proof of immunization or certification of exemption

…

(3) requires the chief administrator of a public or private school or day care center to file a written annual report with WA-DOH on the immunization status of students or children attending the day care center at a time and on forms prescribed by WA-DOH. (emphasis added)

Potential Changes to the Rule

- **WAC 246-105-040 - Update the ACIP recommendation reference to:**

(1) Unless otherwise stated in this section, a child must be vaccinated against, or provide documentation of immunity against, each vaccine-preventable disease listed in WAC 246-105-030 at ages and intervals according to the national immunization guidelines in the "*Advisory Committee on Immunization Practices (ACIP) Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States,* ((~~*2019*~~)) *2024*"; as published in the *Morbidity and Mortality Weekly Report* (MMWR) ((~~2019; 68(5):112-114~~)) 2024; 73(1):6-10.

Potential Changes to the Rule

- **WAC 246-105-060 - Remove the reporting date from the rule:**

(b) Submit an immunization status report under RCW 28A.210.110 at a time and in a manner approved by the department. ((~~The report must be submitted to the department by November 1 of each year. If a school opens after October 1, the report is due thirty calendar days from the first day of school.~~))

Rulemaking Exemptions

1. **Update WAC 246-105-040 to refer to the 2024 Advisory Committee on Immunization Practices (ACIP) guidance.**
    - Use exemption RCW 34.05.310 (4)(c) and RCW 34.05.328(5)(b)(iii) Rules adopting or incorporating by reference without material change…national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule;
2. **Update WAC 246-105-060 to remove the reporting deadline in rule and add the deadline to the form that schools must use to report.**
    - Use exemption RCW 34.05.310 (4)(e) and RCW 34.05.328(5)(b)(v) Rules the content of which is explicitly and specifically dictated by statute.
3. **For both sections regarding the Small Business Economic Impact Statement:**
    - Use exemption RCW 19.85.025(3) Does not apply to the adoption of a rule described in RCW 34.05.310(4).

SBOH Delegation Considerations

The extent to which the proposed rule seeks to adopt federal requirements in which the state has little or no discretion.

WAC 246-105-040: Several changes have occurred to immunization recommendations since the 2019 CDC ACIP recommendations were published. The department wishes to align WAC 246-105-040 with the current national immunization schedule for children and adolescents.

The extent to which the substance and direction of the proposed rule is expected to have broad public and professional consensus.

WAC 246-105-040: The CDC ACIP immunization schedule provides guidance to assist health care providers in implementing current immunization recommendations. Continual realignment with the most current ACIP recommended immunization schedule aligns with expert consensus for children and adolescent immunizations. The potential rule change does **not** make any changes to the list of diseases for which full immunity is required for school or child care attendance.

WAC 246-105-060: The potential change is consistent with feedback from schools or child care centers requesting additional time to complete reporting requirements.

SBOH Delegation Considerations

The extent to which the proposed rule may make significant changes to a policy or regulatory program.

WAC 246-105-040: The potential rule change would not make significant changes. It would seek to bring guidance up to date with current immunization recommendations.

WAC 246-105-060: The proposed rule change would remove the reporting date requirement from the WAC and align with RCW 28A.210.110 which already explicitly and specifically dictates the reporting requirements.

The extent to which the rule revision process would benefit from the Board's role as a convener of interested parties.

The department will follow the requirements for exception rulemaking including holding a public hearing. The department will notify interested parties of rulemaking activity by email, provide the proposed rule language to interested parties, and post information about the rulemaking on the department's web page.

Questions?

Meghan Cichy

Senior Policy Analyst

Prevention and Community Health

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@WADeptHealth

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RCW 28A.210.140

Immunization program—State board of health rules, contents.

The state board of health shall adopt and is hereby empowered to adopt rules pursuant to chapter 34.05 RCW which establish the procedural and substantive requirements for full immunization and the form and substance of the proof thereof, to be required pursuant to RCW 28A.210.060 through 28A.210.170. [1990 c 33 § 198; 1984 c 40 § 9; 1979 ex.s. c 118 § 9. Formerly RCW 28A.31.116.]

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.]

Washington State Board of Health
Policy & Procedure

Policy Number:	**2000-001**
Subject:	**Considering Delegation of Rules to Department of Health**
Approved Date:	**November 8, 2000 (Revised June 13, 2012)**

Policy Statement

In some instances, the Washington State Board of Health may determine it is appropriate to delegate its authority for rulemaking to the Department of Health (RCW 43.20.050). The Board and the Department recognize the need to balance both broad constituent participation and administrative efficiency when making decisions about any rule delegation. For this reason, the Board and the Department have agreed upon a set of criteria to assist Board members in their decisions related to rule delegation.

The Board's decision to delegate a specific rule will be made on a case-by-case basis. The Board will determine the breadth of the delegation, which may range from specific aspects of a single rule section to a broader body of regulatory authority, such as an entire chapter of rules. Each Board delegation is for a single rulemaking process unless specified in an approved motion to be a continuing delegation until rescinded. Once a rule has been delegated, the Department will keep the Board informed about the rule making process through periodic progress reports. The Board may rescind its delegation at any time.

When considering delegation of authority to modify or adopt a rule, the Board may consider the following criteria:

- The extent to which the proposed rule revision is expected to include editorial and/or grammatical changes that do not change the substance of the rule;
- The extent to which the proposed rule seeks to adopt federal requirements in which the state has little or no discretion;
- The extent to which the substance and direction of the proposed rule is expected to have broad public and professional consensus;
- The extent to which the proposed rule may make significant changes to a policy or regulatory program; and
- The extent to which the rule revision process would benefit from the Board's role as a convener of interested parties.

Procedure

When the Board receives a request from the Department to delegate authority for rulemaking, the Executive Director will review the request compared with the above policy criteria. The Executive Director will prepare or direct staff to prepare a recommendation for the Board to consider at its next most convenient meeting. The Executive Director will consult with the Board Chair and members of any appropriate policy committee to formulate the recommendation. The Board may take action to delegate authority to the Department as requested or may otherwise specify rulemaking authority it delegates.

If the Board is not scheduled to meet again within two months and the Department justifies a pressing need to begin rulemaking, the Board's Chair may delegate the Board's rulemaking authority to the Department without a vote of the Board. The Board's Chair will consider recent actions of the Board that inform the collective philosophy of the Board, along with recommendations from the Executive Director and an appropriate policy committee of the Board before deciding to delegate authority to the Department without a vote of the Board. The Chair will limit any such delegation to a single rulemaking process. The Chair or Executive Director shall notify Board members of the delegation.

WASHINGTON STATE BOARD OF HEALTH

Date: June 12, 2024

To: Washington State Board of Health Members

From: Patty Hayes, Board Chair

Subject: Rules Briefing—The Sanitary Control of Shellfish, chapter 246-282 WAC. This is not an action item.

Background and Summary:

The State Board of Health (Board) and the Washington Department of Health (Department) collaborate to regulate the sanitary control of molluscan shellfish. The Board serves as the rulemaking body and the Department serves as the regulatory agency. The Department also serves as the state shellfish authority administering the model ordinance of the National Shellfish Sanitation Program (NSSP).

RCW 69.30.030 authorizes the Board to adopt rules governing shellfish sanitation, shellfish growing areas, and shellfish operations to protect public health and safety. Further, RCW 43.20.050, establishes authority to adopt rules for the prevention and control of infectious and noninfectious disease, including food and vector borne illness.

On February 23, 2022, the Board filed a CR-101, Preproposal Statement of Inquiry, as WSR 22-06-034, to initiate rulemaking to update chapter 246-282 WAC, Sanitary Control of Shellfish. The rulemaking covers miscellaneous technical revisions along with updates to WAC 246-282-006, Vibrio parahaemolyticus (Vp) Control Plan and other parts of the rule.

Board staff coordinated with the Department's Office of Environmental Health and Safety to finalize draft proposed changes and gather feedback. An informal public comment period was open from April 12, 2024, to May 24, 2024.

Complementing this update to the chapter, on March 9, 2022, the Board delegated rulemaking authority to the Department to amend the Vp Control Plan in the event heat-wave conditions occurred early in the Vp control season and prior to completion of rulemaking on the chapter. The Department exercised this authority and adopted an emergency rule on May 17, 2023, filed as WSR 23-11-074, to allow enforcement of the strictest Vp time-to-cooling standards for commercial oyster harvesters and dealers.

The Board's shellfish rulemaking authority does not include fee authority. Separate from the Board's rulemaking on other sections of the chapter, the Department recently withdrew proposed updates to the fees section WAC 246-282-990, because the 2024 Legislature passed a budget proviso that gives the Department funding to contract with

(continued on the next page)

an independent third-party consultant to study the commercial shellfish regulatory program and make recommendations on fees.

Today, Danielle Toepelt from the Department's Office of Environmental Health and Safety will present the Board with additional background on the rule, updates to the draft proposed changes, feedback received, and next steps.

This is not an action item.

Staff
Shay Bauman, Policy Advisor

Chapter 246-282 WAC, Sanitary Control of Shellfish Rulemaking Update

Background

- *Vibrio parahaemolyticus* (Vp) is a naturally occurring bacteria found in marine waters. Molluscan bivalve shellfish acquire Vp through filter feeding. Humans who consume raw or undercooked shellfish containing Vp can develop an intestinal disease called Vibriosis. The majority of Vibriosis cases in Washington state occur during the summer months due to increased air and water temperatures, which allow the bacteria to thrive.
- WAC 246-282-006, Washington state *Vibrio parahaemolyticus* control plan, requires commercial shellfish operations that harvest and process oysters to follow additional requirements from May through September to prevent Vibriosis illnesses.
- In 2021, there were a high number of Vibriosis cases involving Washington shellfish, largely due to exceedingly high temperatures in June.
- The Washington State Department of Health (Department) expects the trend of high temperatures to continue. The 2021 event highlighted gaps in the current rule and demonstrated the need to review the rule to determine if the current controls are adequate to protect consumers.

Rulemaking Overview

- The Washington State Board of Health (Board) delegated emergency rulemaking authority to the Department if heat-wave conditions occur prior to July 1 until permanent rulemaking is complete.
- Revisions to the permanent rule could include a combination of requirements based on environmental factors to determine the safety of shellfish prior to harvest and consumption. The rule revision may also include updating definitions, seed size, and other technical and editorial changes as needed.

Rulemaking Timeline

- In February 2022, the CR-101 for permanent rulemaking was filed.
- In March 2022, the Board delegated emergency rulemaking authority. The Department enacted the emergency rule in May 2023 for 120 days due to hotter than normal weather and mid-day low tides.
- From October 2022 to April 2024, meetings were held with a Rulemaking Advisory Committee (RAC) and Tribal partners to work on rule updates and language.
- On August 9, 2023, the Department updated the Board.
- In April 2024, the proposed WAC changes were sent for informal review to the RAC and Tribal partners. These groups requested more time to review the changes, so the informal review was extended by two weeks.

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Washington State Department of HEALTH

SANITARY CONTROL OF SHELLFISH RULEMAKING UPDATE

June 12, 2024

Presenter

Dani Toepelt, R.S.

Manager

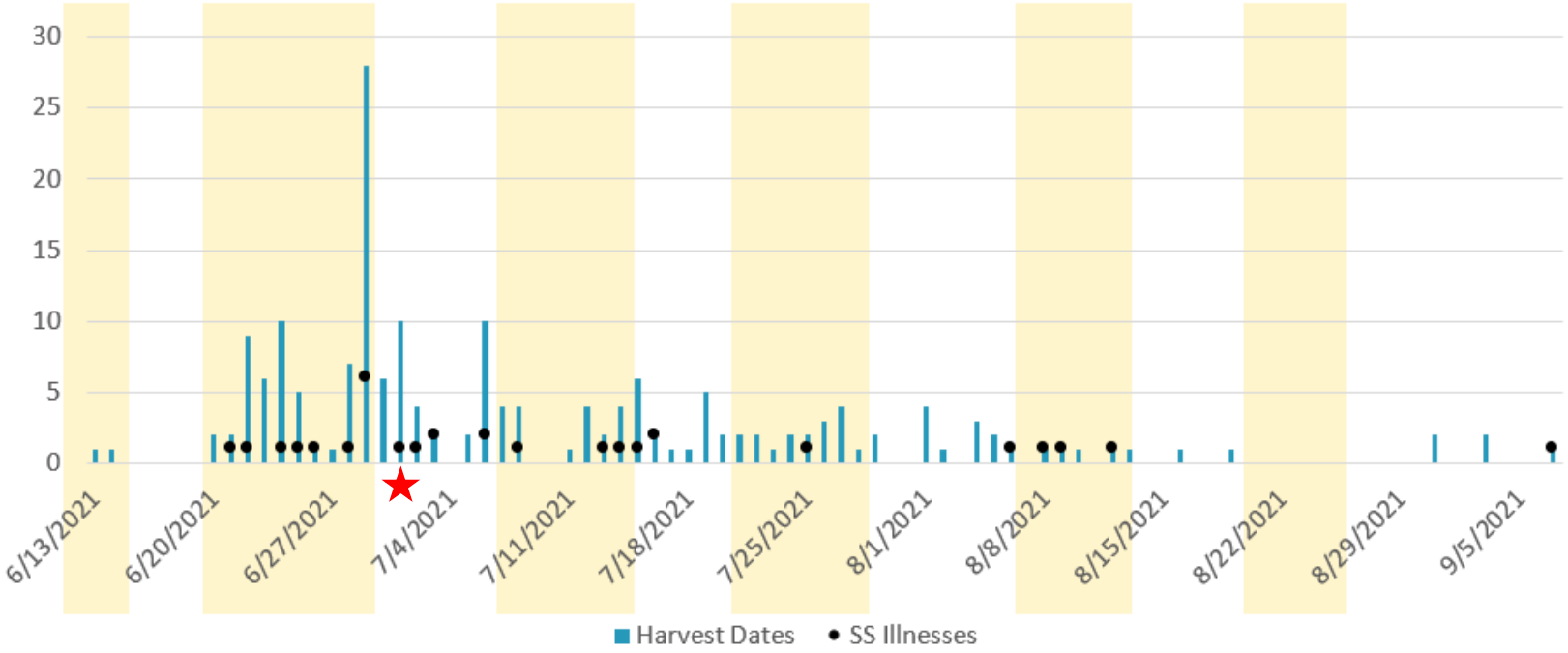
Shellfish Licensing & Certification

Chapter 246-282 WAC Rulemaking

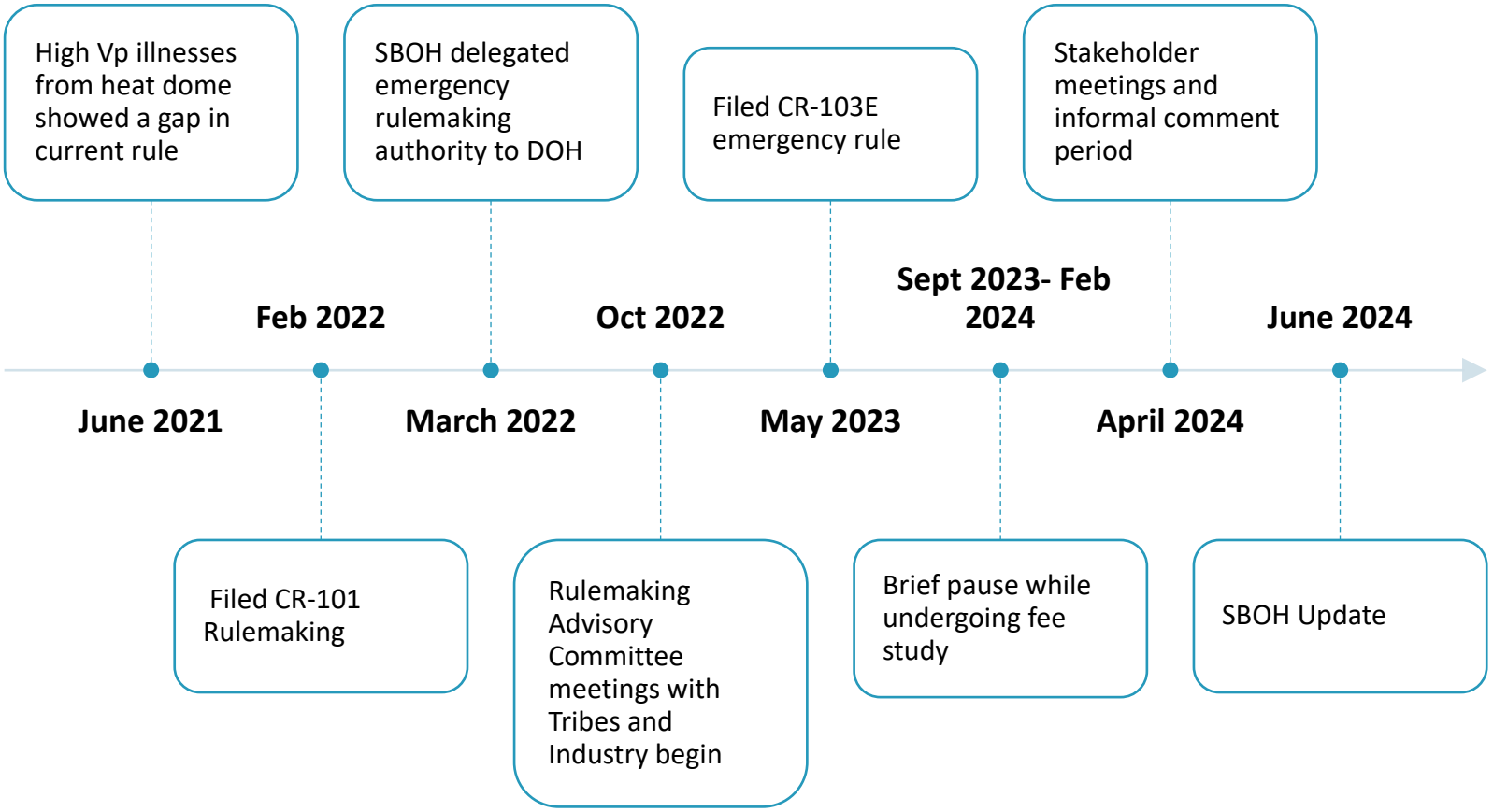
- Background
- Emergency Rule
- Recommended Changes
- Informal Comments Summary
- Next Steps

How did we get here?

- Vibrio is a naturally occurring bacteria, thrives in warm water.
- WAC 246-282-006 Vibrio *parahaemolyticus* control plan.
- 2021 Heat Dome showed gap in regulation.



Background


High Vp illnesses from heat dome showed a gap in current rule
SBOH delegated emergency rulemaking authority to DOH
Filed CR-103E emergency rule
Stakeholder meetings and informal comment period
June 2021
Feb 2022
March 2022
Oct 2022
May 2023
Sept 2023- Feb 2024
April 2024
June 2024
Filed CR-101 Rulemaking
Rulemaking Advisory Committee meetings with Tribes and Industry begin
Brief pause while undergoing fee study
SBOH Update

Emergency Rule – Vp Time to Cooling Requirements

- WAC 246-282-006 Vp Control Plan requirements
- Defines Vp season as May 1 to September 30
- Time to cooling is based on the risk category (1, 2, or 3) given to each growing area
  - Based on last 5 years of illnesses

- Emergency rule changed period for strictest controls:
  - High temperatures & mid-day low tide
  - Emergency rule effective for 120 days

Requirements:	Time to Cooling:
Except as noted below, time of harvest to cooling requirement from May 1st through September 30th is:	5 hours
When ambient air temperature at harvest is greater than 80°F, the time of harvest to cooling requirement is:	3 hours
When harvest temperature is between 64°F and 66°F from July 1st through August 31st, the time of harvest to cooling requirement is:	1 hour
Harvest Control: From July 1st through August 31st, harvest is not allowed for twenty-four hours when harvest temperature is above 66°F.	

Other Potential Changes

- Vibrio *parahaemolyticus* Control Plan Changes
  - Vibrio *vulnificus*, months, re-submergence time
- Seed size reduction for Pacific oysters
- Add definitions
- Update permitting requirements
- Add tagging requirements
- Add labeling requirements
- Align with 2023 Code Reviser Bill Drafting Guide (Example: grammatical & tense changes)

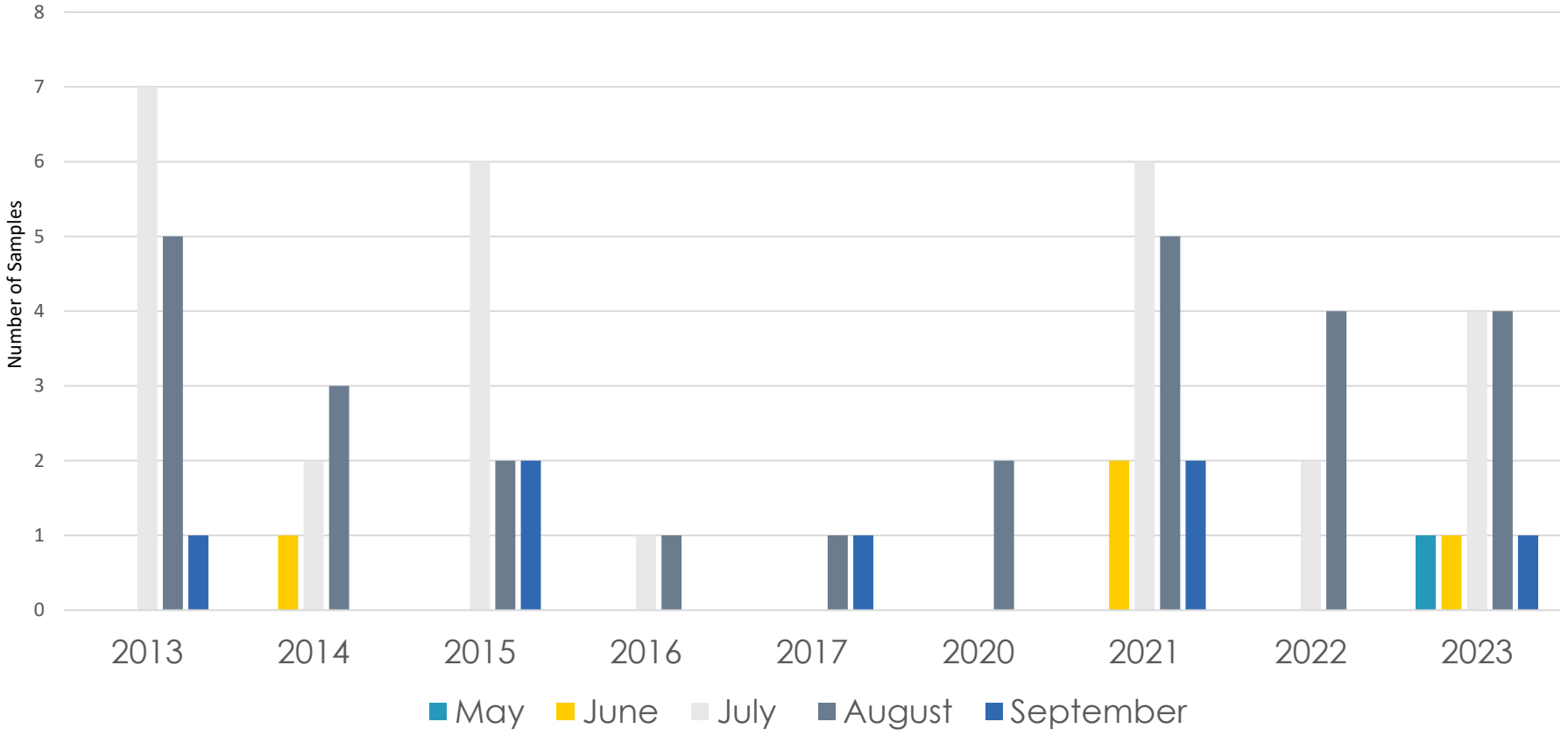
Informal Comments Summarized

Adding Vv

- Concerns about adding Vibrio *vulnificus* to the Vibrio *parahaemolyticus* control plan.

- Why is it important?
  - Deadly strain of Vibrio
  - Requirement in the Model Ordinance once a foodborne illness is documented
  - Detected Vv in our shellfish (Twanoh SP)
  - Matter of time (CA had a confirmed Vv illness two years ago)

Number of Samples with detectable *Vv* Levels in Oyster Tissue

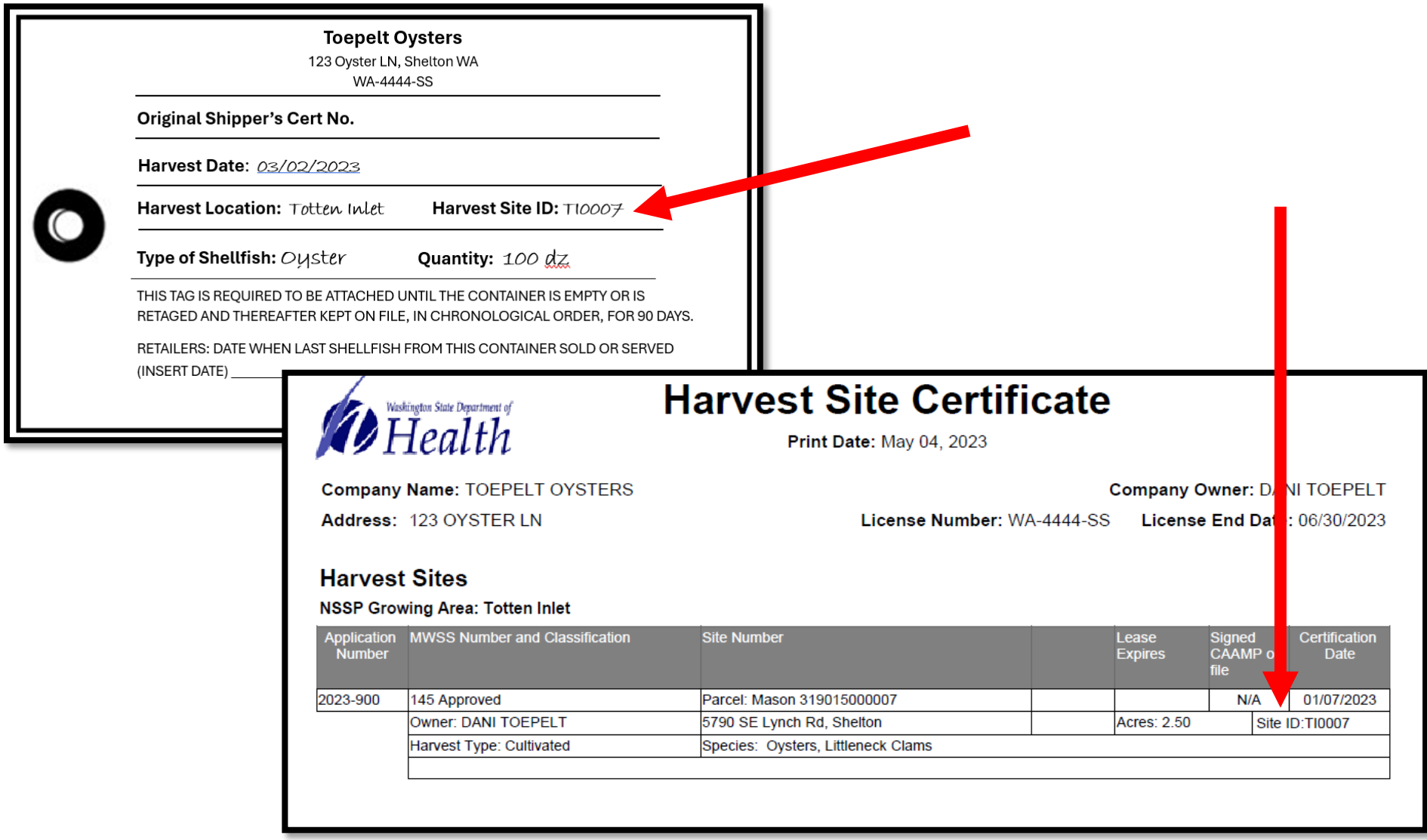


Additional Tagging Requirements

- Concerns about requiring a harvest site ID, parcel number, or other approved department methods to a tag.

- Why does this matter?
  - Obtain parcel information right away.
    - Currently, takes about 2 to 3 days to get parcel information from industry
  - Close parcels instead of entire growing areas
  - Prevent illnesses

Tag Example



Toepelt Oysters
123 Oyster LN, Shelton WA
WA-4444-SS

Original Shipper's Cert No.

Harvest Date: 03/02/2023

Harvest Location: Totten Inlet **Harvest Site ID:** TI0007

Type of Shellfish: Oyster **Quantity:** 100 dz

THIS TAG IS REQUIRED TO BE ATTACHED UNTIL THE CONTAINER IS EMPTY OR IS RETAGED AND THEREAFTER KEPT ON FILE, IN CHRONOLOGICAL ORDER, FOR 90 DAYS.

RETAILERS: DATE WHEN LAST SHELLFISH FROM THIS CONTAINER SOLD OR SERVED

(INSERT DATE) _____

Washington State Department of Health

Harvest Site Certificate

Print Date: May 04, 2023

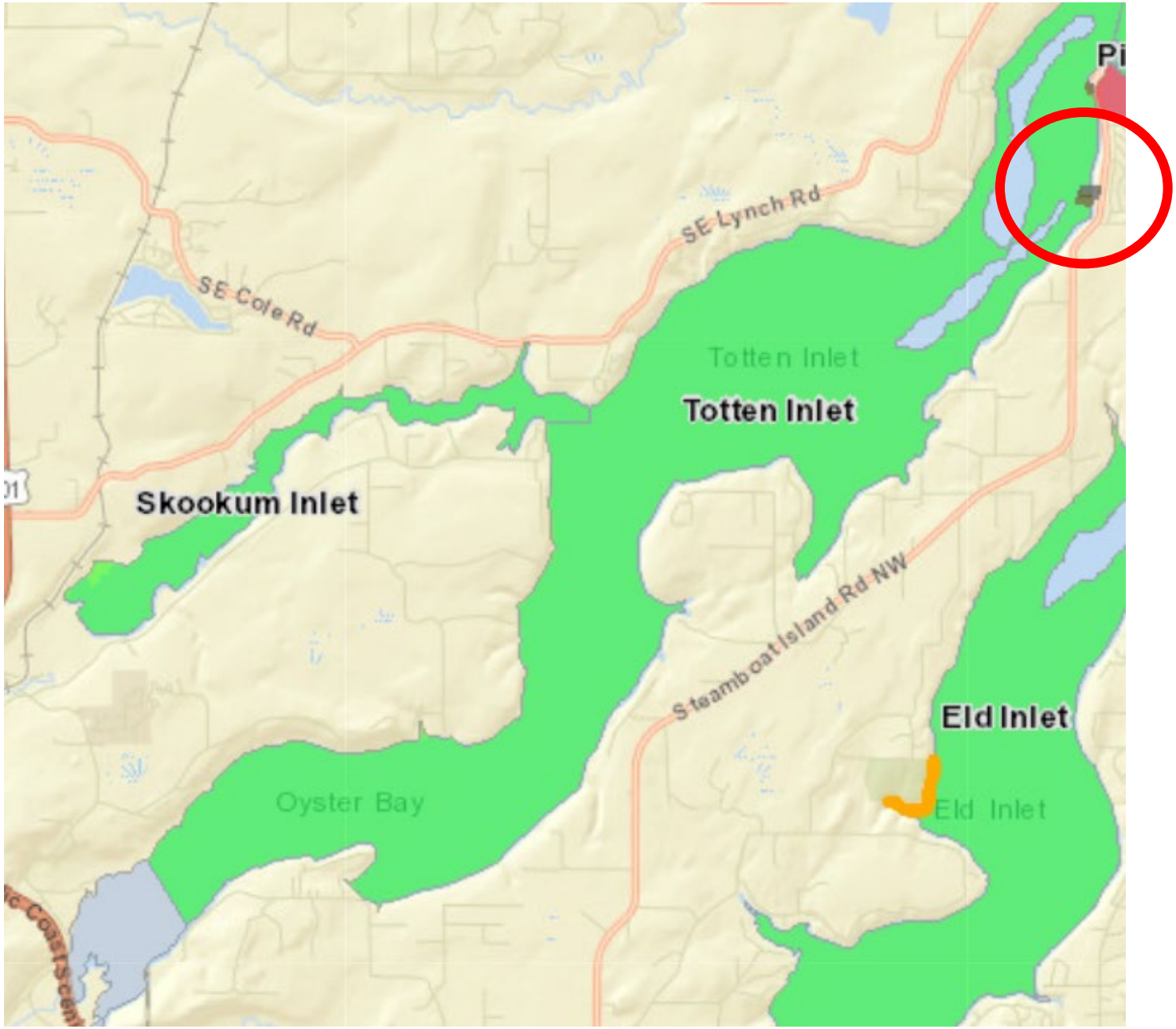
Company Name: TOEPELT OYSTERS **Company Owner:** DANI TOEPELT

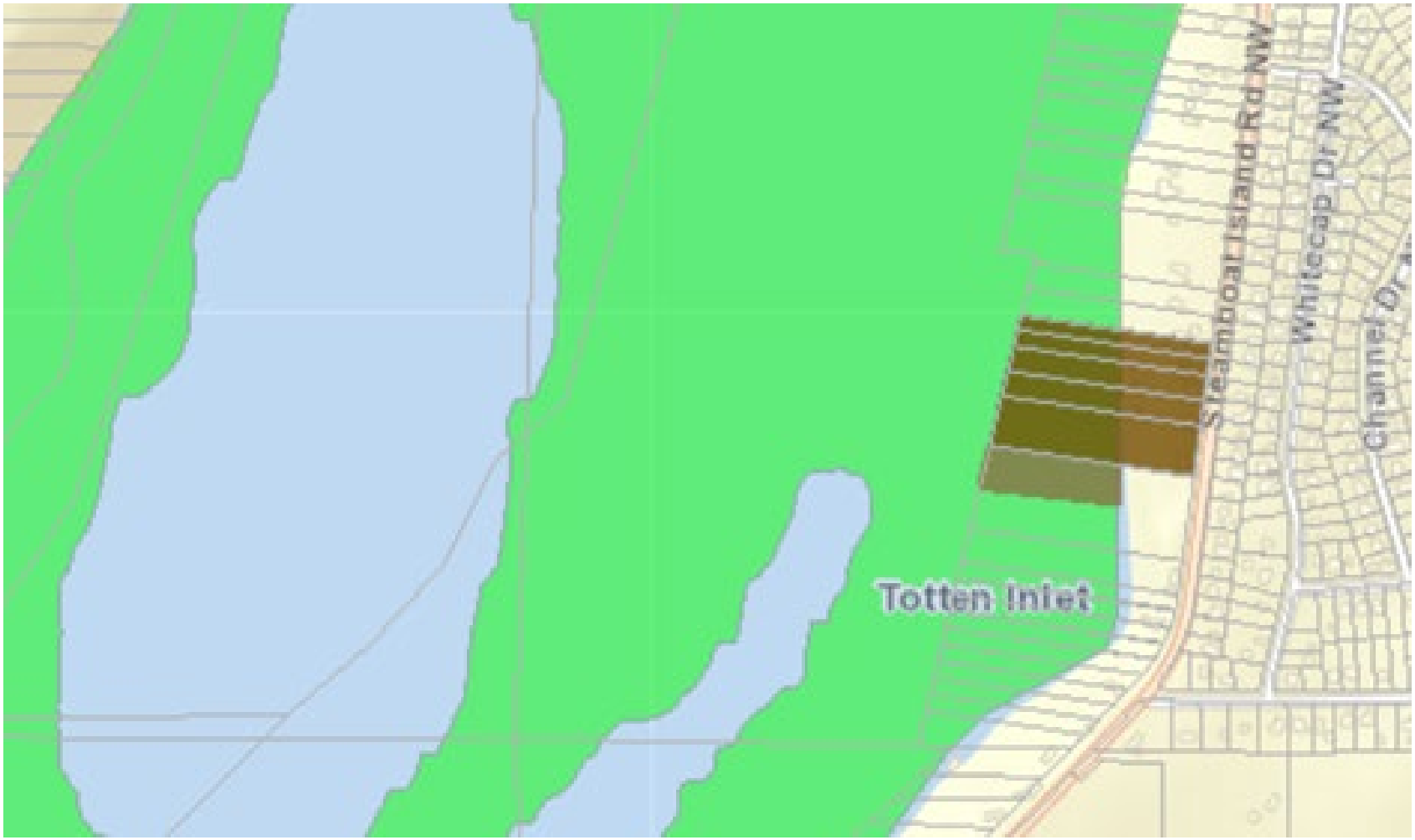
Address: 123 OYSTER LN **License Number:** WA-4444-SS **License End Date:** 06/30/2023

Harvest Sites

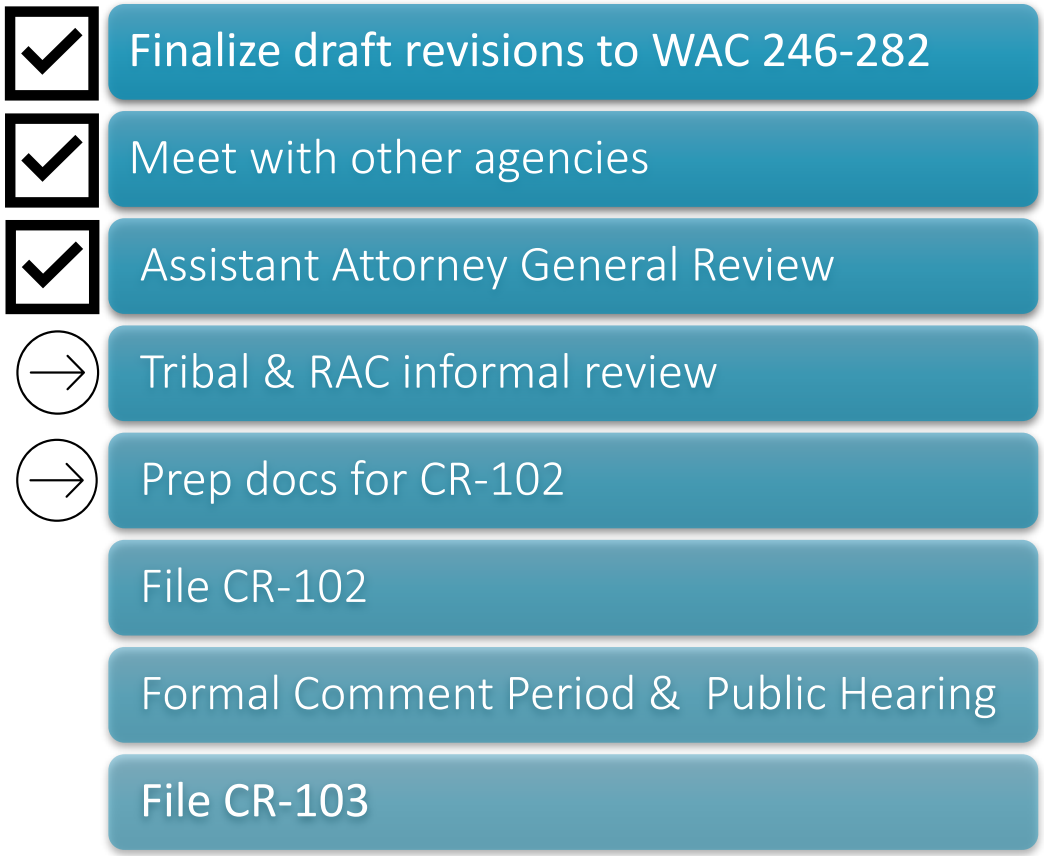
NSSP Growing Area: Totten Inlet

Application Number	MWSS Number and Classification	Site Number		Lease Expires	Signed CAAMP on file	Certification Date
2023-900	145 Approved	Parcel: Mason 319015000007			N/A	01/07/2023
	Owner: DANI TOEPELT	5790 SE Lynch Rd, Shelton		Acres: 2.50	Site ID:TI0007	
	Harvest Type: Cultivated	Species: Oysters, Littleneck Clams				


SE Lynch Rd
SE Cole Rd
Totten Inlet
Totten Inlet
Skookum Inlet
Steamboat Island Rd NW
Eld Inlet
Oyster Bay
Eld Inlet


Totten Inlet
Steamboat Island Rd NW
Whitecap Dr NW

Progress and Next Steps



Done

In process

Questions?

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PDF **RCW 69.30.030**

Rules and regulations—Duties of state board of health.

(1) The state board of health shall adopt rules governing the sanitation of shellfish, shellfish growing areas, and shellfish plant facilities and operations in order to protect public health and carry out the provisions of this chapter. Such rules and regulations may include reasonable sanitary requirements relative to the quality of shellfish growing waters and areas, boat and barge sanitation, building construction, water supply, sewage and wastewater disposal, lighting and ventilation, insect and rodent control, shell disposal, garbage and waste disposal, cleanliness of establishment, the handling, storage, construction and maintenance of equipment, the handling, storage and refrigeration of shellfish, the identification of containers, and the handling, maintenance, and storage of permits, certificates, and records regarding shellfish taken under this chapter. The state board of health shall adopt rules governing procedures for the disposition of seized shellfish.

(2) The state board of health shall consider the most recent version of the national shellfish sanitation program model ordinance, adopted by the interstate shellfish sanitation conference, when adopting rules.

[**2011 c 194 § 3**; **1995 c 147 § 2**; **1955 c 144 § 3**.]

PDF **RCW 43.20.050**

Powers and duties of state board of health—Rule making—Delegation of authority—Enforcement of rules.

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(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;

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(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.]

NOTES:

Explanatory statement—2021 c 65: See note following RCW **53.54.030**.

Effective date—2009 c 495: "Except for section 9 of this act, this act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [May 14, 2009]." [**2009 c 495 § 17**.]

Findings—1993 c 492: "The legislature finds that our health and financial security are jeopardized by our ever increasing demand for health care and by current health insurance and health system practices. Current health system practices encourage public demand for unneeded, ineffective, and sometimes dangerous health treatments. These practices often result in unaffordable cost increases that far exceed ordinary inflation for essential care. Current total health care expenditure rates should be sufficient to provide access to essential health care interventions to all within a reformed, efficient system.

The legislature finds that too many of our state's residents are without health insurance, that each year many individuals and families are forced into poverty because of serious illness, and that many must leave gainful employment to be eligible for publicly funded medical services. Additionally, thousands of citizens are at risk of losing adequate health insurance, have had insurance canceled recently, or cannot afford to renew existing coverage.

The legislature finds that businesses find it difficult to pay for health insurance and remain competitive in a global economy, and that individuals, the poor, and small businesses bear an inequitable health insurance burden.

The legislature finds that persons of color have significantly higher rates of mortality and poor health outcomes, and substantially lower numbers and percentages of persons covered by health insurance than the general population. It is intended that chapter 492, Laws of 1993 make provisions to address the special health care needs of these racial and ethnic populations in order to improve their health status.

The legislature finds that uncontrolled demand and expenditures for health care are eroding the ability of families, businesses, communities, and governments to invest in other enterprises that promote health, maintain independence, and ensure continued economic welfare. Housing, nutrition, education, and the environment are all diminished as we invest ever increasing shares of wealth in health care treatments.

The legislature finds that while immediate steps must be taken, a long-term plan of reform is also needed." [**1993 c 492 § 101**.]

Intent—1993 c 492: "(1) The legislature intends that state government policy stabilize health services costs, assure access to essential services for all residents, actively address the health care

needs of persons of color, improve the public's health, and reduce unwarranted health services costs to preserve the viability of nonhealth care businesses.

(2) The legislature intends that:

(a) Total health services costs be stabilized and kept within rates of increase similar to the rates of personal income growth within a publicly regulated, private marketplace that preserves personal choice;

(b) State residents be enrolled in the certified health plan of their choice that meets state standards regarding affordability, accessibility, cost-effectiveness, and clinical efficaciousness;

(c) State residents be able to choose health services from the full range of health care providers, as defined in RCW **43.72.010**(12), in a manner consistent with good health services management, quality assurance, and cost effectiveness;

(d) Individuals and businesses have the option to purchase any health services they may choose in addition to those included in the uniform benefits package or supplemental benefits;

(e) All state residents, businesses, employees, and government participate in payment for health services, with total costs to individuals on a sliding scale based on income to encourage efficient and appropriate utilization of services;

(f) These goals be accomplished within a reformed system using private service providers and facilities in a way that allows consumers to choose among competing plans operating within budget limits and other regulations that promote the public good; and

(g) A policy of coordinating the delivery, purchase, and provision of health services among the federal, state, local, and tribal governments be encouraged and accomplished by chapter 492, Laws of 1993.

(3) Accordingly, the legislature intends that chapter 492, Laws of 1993 provide both early implementation measures and a process for overall reform of the health services system." [**1993 c 492 § 102**.]

Short title—Savings—Reservation of legislative power—Effective dates—1993 c 492: See RCW **43.72.910** through **43.72.915**.

Severability—1992 c 34: See note following RCW **69.07.170**.

Effective date—Severability—1989 1st ex.s. c 9: See RCW **43.70.910** and **43.70.920**.

Savings—1985 c 213: "This act shall not be construed as affecting any existing right acquired or liability or obligation incurred under the sections amended or repealed in this act or under any rule, regulation, or order adopted under those sections, nor as affecting any proceeding instituted under those sections." [**1985 c 213 § 31**.]

Effective date—1985 c 213: "This act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect June 30, 1985." [**1985 c 213 § 33**.]

Severability—1967 ex.s. c 102: See note following RCW **43.70.130**.

*Rules and regulations—Visual and auditory screening of pupils: RCW **28A.210.020**.*

WASHINGTON STATE BOARD OF HEALTH

2024 Meeting Schedule

Approved by the Board November 8, 2023
Updates approved by the Board January 10, 2024 (to hold April meeting)
Location updates discussed January 10 and March 13, 2024
Updates proposed to the Board June 12, 2024

	Meeting Date	Location
Board	**Wednesday January 10, 2024**	**Hybrid:** • **Physical Location; Washington State Department of Health, 111 Israel Road S.E., Tumwater, WA 98501, Building: Town Center 2 (Rooms 166 & 167)** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.**
Board	**Wednesday March 13, 2024**	**Hybrid:** • **Physical Location; Swinomish Casino and Lodge, 12885 Casino Dr, Anacortes, WA 98221 (WA Walton Conference Room)** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.**
Board	**Wednesday April 10, 2024**	**Hybrid:** • **Physical Location; Spokane Public Library, 906 W. Main Ave, Spokane, WA, 99201 (Rooms: Central Events A & B)** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.**
Board	**Wednesday June 12, 2024**	**Hybrid:** • **Physical Location; Heathman Lodge, 7801 NE Greenwood Drive, Vancouver, WA 98662, Meeting (Chinook & Klickitat Rooms)** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.** *(note: WA State Association of Local Public Health Officials (WSALPHO) Annual meeting is in Spokane, June 4-6, 2024)*
Board	**Wednesday--cancel July 10, 2024**	**Hold date – meet only if necessary**

Board	**Wednesday** **August 14, 2024** **Change to:** **Wednesday** **August 7, 2024**	**Hybrid:** • **Physical Location; Pacific Tower, 1200 12th Avenue South, Seattle, WA 98144 (Panoramic Room)** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.**
Board	**Tuesday** **October 8, 2024**	**Hybrid:** • **Physical Location; Yakima, Meeting Space TBD** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.** *(note: WA State Public Health Association (WSPHA) Annual conference is in Yakima, October 9-11, 2024. The WSALPHO Environmental Public Health Directors meeting is Oct 1-4 in Leavenworth)*
Board	**Wednesday** **November 13, 2024**	**Hybrid:** • **Physical Location; Labor & Industries Auditorium, 7273 Linderson Way SW, Tumwater, WA 98501** • **Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees**

Start time is 9:30 a.m. unless otherwise specified. Time and locations subject to change as needed. See the Board of Health Web site and the Health Disparities Council Web site for the most current information.

Last updated 06/05/2024

Date: June 12, 2024

To: Washington State Board of Health Members

From: Patty Hayes, Board Chair

Subject: Rulemaking Petition – WAC 246-260-131 - Operation of Water Recreation Facilities

Background and Summary:

The Administrative Procedures Act (RCW 34.05.330) allows any person to petition a state agency for the adoption, amendment, or repeal of any rule. Upon receipt of a petition, the agency has sixty days to either (1) deny the petition in writing stating the reasons and, as appropriate, offer other means for addressing the concerns raised by the petitioner, or (2) accept the petition and initiate rulemaking.

On May 8, 2024, the State Board of Health (Board) received a petition for rulemaking from David Belanger requesting the amendment of WAC 246-260-131, Operation of Water Recreation Facilities, subsections (6)(b)(i) and(ii). The petition specifically requests that the Board amend the rule to remove an allowance for the substitution of a swim or dive coach or scuba diver instructor in place of a lifeguard. The petition notes that instructors are in place to teach, not supervise swimmer safety and are not trained in the same lifesaving skills as lifeguards.

The Board's authority under RCW 70.90.120 requires the Board to adopt rules governing safety, sanitation, and water quality for water recreation facilities. The rules include requirements for facility operation. Beginning in 2016, the Board initiated rulemaking for revision of Chapters 246-260 & 246-262 WAC (CR-101) and has now established a Technical Advisory Committee (TAC) in conjunction with the Department of Health (Department).

The CDC updated the Model Aquatic Health Code (MAHC) in 2023 and the advisory committee has begun reviewing the MAHC and will be developing recommendations for the Board to review. The TAC will be taking MAHC guidelines into consideration when offering recommendations to the Board.

I have invited Andrew Kamali, Board Staff, and Ashlie Laydon, Department Staff, to provide additional information on this topic.

Recommended Board Actions

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

The Board declines the petition to initiate rulemaking to amend WAC 246-260-131(6)(b)(i) and (ii), for the reasons articulated by the Board, and directs staff to notify the requestor of the Board's decision.

OR

The Board accepts the petition for rulemaking to amend WAC 246-260-131(6)(b)(i) and (ii) to be considered as part of the ongoing rulemaking for water recreation facilities and directs staff to notify the requestor of its decision. The Board further requests that the Department direct the TAC to brief the Board on the TAC's findings by November 2024.

Staff
Andrew Kamali

To request this document in an alternate format or a different language, please contact the Washington State Board of Health Communication Manager.
TTY users can dial 711.

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

PETITION FOR ADOPTION, AMENDMENT, OR REPEAL OF A STATE ADMINISTRATIVE RULE

Print Form

In accordance with RCW 34.05.330, the Office of Financial Management (OFM) created this form for individuals or groups who wish to petition a state agency or institution of higher education to adopt, amend, or repeal an administrative rule. You may use this form to submit your request. You also may contact agencies using other formats, such as a letter or email.

The agency or institution will give full consideration to your petition and will respond to you within 60 days of receiving your petition. For more information on the rule petition process, see Chapter 82-05 of the Washington Administrative Code (WAC) at http://apps.leg.wa.gov/wac/default.aspx?cite=82-05.

CONTACT INFORMATION *(please type or print)*

Petitioner's Name David Belanger

Name of Organization City of Seattle - Parks and Recreation - Aquatics

Mailing Address 10515 35th Ave NE

City Seattle State Wa Zip Code 98125

Telephone 206-233-7607 Email david.belanger@seattle.gov

COMPLETING AND SENDING PETITION FORM

- Check all of the boxes that apply.
- Provide relevant examples.
- Include suggested language for a rule, if possible.
- Attach additional pages, if needed.
- Send your petition to the agency with authority to adopt or administer the rule. Here is a list of agencies and their rules coordinators: http://www.leg.wa.gov/CodeReviser/Documents/RCIist.htm.

INFORMATION ON RULE PETITION

Agency responsible for adopting or administering the rule: _____

☐ **1. NEW RULE - I am requesting the agency to adopt a new rule.**

☐ The subject (or purpose) of this rule is: _____

☐ The rule is needed because: _____

☐ The new rule would affect the following people or groups: _____

☒ **2. AMEND RULE - I am requesting the agency to change an existing rule.**

List rule number (WAC), if known: 246-260-131 6.B (i and ii)

☒ I am requesting the following change: Remove "Substitution of Coach/Scuba for qualified lifeguard."

☒ This change is needed because: Coaches/Scuba do not supervise well. They do teach well. They ~~do not practice skills as lifeguards do.~~ No in service requirements.

☒ The effect of this rule change will be: Pools will use their own lifeguards for swim practices in addition ~~to coaches. Or Teams will have own lifeguards AND~~ Coaches.

☒ The rule is not clearly or simply stated: So much room for interpretation.

☐ **3. REPEAL RULE - I am requesting the agency to eliminate an existing rule.**

List rule number (WAC), if known: _____

(Check one or more boxes)

☐ It does not do what it was intended to do.

☐ It is no longer needed because: _____

☐ It imposes unreasonable costs: _____

☐ The agency has no authority to make this rule: _____

☐ It is applied differently to public and private parties: _____

☐ It conflicts with another federal, state, or local law or rule. List conflicting law or rule, if known: _____

☐ It duplicates another federal, state or local law or rule. List duplicate law or rule, if known: _____

☐ Other (please explain): _____

Washington State Board of Health
Policy & Procedure

Policy Number:	**2005-001**
Subject:	**Responding to Petitions for Rule-Making**
Approved Date:	**November 9, 2005 (revised August 13, 2014)**

Policy Statement

RCW 34.05.330 allows any person to petition a state agency to adopt, repeal, or amend any rule within its authority. Agencies have 60 days to respond. The agency can deny the request—explaining its reasons and, if appropriate, describing alternative steps it is prepared to take—or it must initiative rule-making. If a petition to repeal or amend a rule is denied, a petitioner can appeal the agency's decision to the Governor.

This policy defines who must be notified and consulted when the Board is petitioned, who may respond on behalf of the Board, and whether Board action is required.

- **Board Response**: When the Board receives a written petition for rule-making within its authority that clearly expresses the change or changes requested, the Board will respond within 60 days of receipt of the petition. The response will be made at the direction of the Board. The response will be in the form of a letter from the Chair denying the petition or informing the petitioner the Executive Director has been directed to initiate rule-making.

- **Consideration of the Petition:** The Chair may place a petition for rule-making on the agenda for a Board meeting scheduled to be held within 60 days of receipt of the petition. Alternatively, if the Board does not have a regular meeting scheduled within 60 days of receipt of the petition, or if hearing the petition at the next regular meeting would defer more pressing matters, the Chair shall call a special meeting of the Board to consider the petition for rulemaking.

Procedure

- **Notifications:** Board staff, in consultation with the Executive Director, will respond to the petitioner within three business days acknowledging receipt of the petition and informing the petitioner whether the request is clear. The Executive Director or staff will notify Board members that a petition for rule-making has been received and will be brought to the Board for consideration at the next regularly scheduled board meeting or will be considered at a special meeting. If

no regular meeting is scheduled before the 60-day response deadline, or if the agenda for the regular meeting cannot accommodate the petition, the Executive Director will notify the Chair of the need to schedule a special board meeting for the purposes of considering the petition. Upon Board action on the petition, the Executive Director shall assure Board members receive electronic copies of the final petition response.

- **Appeals:** If a petitioner appeals the Board's decision to deny a petition to the Governor, the Executive Director will inform the Board of the Governor's action on the appeal at the next scheduled Board meeting.

- **Consultation:** The Executive Director and Board staff will gather background information for the Board's use when it considers the petition. In this regard, the Executive Director will consult with the Board member who sponsored the most recent revisions to the rule being challenged or the appropriate policy committee. The Executive Director may also consult with appropriate representatives of the implementing agency or agencies, and may consult with stakeholders as appropriate.

WAC 246-260-131 Operation of water recreation facilities. (1) **Operation plan.** Owners shall ensure proper operation to protect the public health, safety, and water quality by establishing standard practices and developing a written operations manual addressing each of the following:

(a) Physical pool facility components and signage;

(b) Personnel;

(c) Users and spectators, including pool rules;

(d) Emergency response provisions;

(e) Diving during supervised swimming instruction into water depths recognized as adequate by the organization certifying the activity, such as ARC; and

(f) Environmental conditions.

(2) **Physical components.** Owners shall check each WRF's physical components routinely to ensure:

(a) Barrier protection, emergency equipment and structural facilities are properly maintained.

(b) Water does not pond on walking surfaces;

(c) Common articles provided for patrons, such as towels, bathing suits, bathing caps, etc., are sanitized before reuse;

(d) Sanitation items including toilet tissue, handwashing soap and single use towels or equivalent are maintained at facilities;

(e) Treatment of the water recreation pool facility occurs continuously at turnover rates required by this chapter twenty-four hours a day during periods of use;

(f) Swimming, spa, wading and spray pools shall be equipped with drain covers that are properly maintained, intact and secured to protect against entrapment.

(g) Extra filter cartridge provided for each cartridge filter.

(3) **Food service.** If food service is provided and allowed, the owner shall:

(a) Ensure food and beverage sale and consumption areas at general use pools are separated from pool and deck enclosure areas;

(b) Prohibit food and beverage in pool water at limited use pools and maintain a minimum four-foot clear area between pool edge and any tables and chairs provided for food service;

(c) Prohibit use of glass in pool facility and provide trash containers; and

(d) Prohibit the sale or consumption of alcohol at general use pools.

(4) **Spa and recirculating spray pool reservoir cleaning.** Owners shall routinely drain, clean and refill spa and recirculation spray pools at a minimum frequency specified by the following formula.

Spa or spray pool reservoir volume in gallons/3/average number of users per day = Number of days between draining, cleaning and refilling.

(5) **Signage for user rules.**

(a) Owners shall provide and maintain signage specifying user rules and safety information required by this section in a conspicuous place in the pool area with easily readable lettering at least three-eighths of an inch high. All swimming, spa and wading pool facilities must have signs stating pool rules:

(i) Prohibiting use by anyone running or participating in horseplay:

(ii) Prohibiting use by anyone under the influence of alcohol or drugs;

(iii) Prohibiting use by anyone with a communicable disease or anyone who has been ill with vomiting or diarrhea within the last two weeks;

(iv) Prohibiting anyone from bringing food or drink into the pool water;

(v) Requiring everyone to have a cleansing shower before entering the pool;

(vi) Requiring anyone in diapers to wear protective covering to prevent contamination;

(vii) Requiring diapers to be changed at designated diaper change areas;

(viii) Warning patrons that anyone refusing to obey the pool rules is subject to removal from the premises;

(ix) Directing patrons to the location of the nearest telephone and first-aid kit for emergency use;

(x) Advising patrons that anyone with seizure, heart, or circulatory problems should swim with a buddy; and

(xi) Where diving boards are used, provide signs for proper use.

(b) All swimming, spa, and wading pool facilities where lifeguards or attendants are not present shall have signs stating additional pool rules that:

(i) If a child twelve years of age or less is using the pool, a responsible adult eighteen years of age or older must accompany the child and be at the pool or pool deck at all times the child uses the facility; and

(ii) If an individual between thirteen years of age and seventeen years of age is using the pool, at least one other person must be at the pool facility.

(c) All spa pool facilities must have signs stating additional pool rules:

(i) Cautioning that children under the age of six should not use a spa pool;

(ii) Cautioning that persons suffering from heart disease, diabetes, or high blood pressure should consult a physician before using a spa pool;

(iii) Cautioning that women who are or might be pregnant seek physician's advice regarding using a spa pool;

(iv) Cautioning everyone to limit the stay in the spa pool to fifteen minutes at any one session; and

(v) Posting the maximum bather capacity of each spa pool.

(d) All spray pool facilities must have signs stating pool rules as specified in (a)(i), (ii), (iii), (iv), (v), (vi), and (viii) of this subsection.

(6) **Required personnel.**

(a) Owners shall ensure appropriate personnel specified in this subsection provide monitoring at pool facilities.

(b) General use swimming pool facilities shall have lifeguards present at all times pools are in use; except:

(i) If swim or dive teams are facility users, the owner may allow substitution of a qualified coach properly credentialed by the sponsoring organization furnishing the swim or dive coach; and

(ii) Owners may substitute persons with Master Scuba Diver Trainer or Master Scuba Diver Instructor certification through PADI or SCUBA instructor, assistant instructor or divemaster through NAUI or other department-approved training in lieu of lifeguards for SCUBA training.

(iii) PADI or NAUI certified scuba instructing staff shall maintain the following conditions:

(A) Limit number of persons training to ten persons per instructor.

(B) Ensure all persons being instructed are monitored at all times while in the pool to ensure thirty-second response time can be provided.

(iv) Private club swimming pool facilities must have lifeguards present at all times persons sixteen years of age and younger are using the pool facilities, except:

(A) Attendants or shallow water lifeguards may supervise persons thirteen through sixteen years of age when these users are restricted to a pool depth less than or equal to five feet; and

(B) Attendants or shallow water lifeguards may supervise all persons sixteen years of age and under if the entire pool depth is less than four and one-half feet.

(c) If a spa or wading pool is in same enclosure as a swimming pool, all pools are subject to the most stringent monitoring personnel requirements applicable for any pool in the enclosure unless barriers that conform to WAC 246-260-031(4) restrict access between pools.

(d) The use of spas or wading pools not requiring lifeguards or attendants is subject to the following conditions:

(i) If the pool is used by children twelve years of age or under, a responsible adult eighteen years of age or older must accompany the children and be at the pool or pool deck at all times the children use the facility;

(ii) If the pool is used by persons seventeen years of age or under, a minimum of two people must be at the pool facility at all times the pool is in use;

(iii) The owner shall post the requirements of this subsection to assure the responsible person is notified of conditions for use of the facility.

(e) Limited use pool facilities must have an equivalent or greater level of supervision as specified for private clubs in (b)(iv) of this subsection during any times when activities are provided that put the pools into the category of general use pools.

(f) At limited use pool facilities, if alcohol is sold within the pool facility, the owner must provide a lifeguard or attendant at the pool area.

(g) All pool facilities must have a water treatment operator.

(7) **Personnel duties and equipment.**

(a) Owners shall ensure personnel are present at each WRF who perform duties specified in this subsection.

(b) Lifeguards, shallow water lifeguards and swim coaches shall guard assigned pool users and provide a rescue response time of thirty seconds or less.

(c) Attendants, if provided at pools not requiring lifeguards, shall oversee pool use by the bathers and provide supervision and elementary rescues such as reaching assists to bathers in need. This does not mean the person is qualified or trained to make swimming rescues.

(d) Owners shall notify responsible persons on the conditions for facility use at pools not requiring lifeguards and for which no lifeguards or attendants are present. A responsible person means a person having responsibility for overseeing users seventeen years of age or under including, but not limited to, a person:

(i) Renting an apartment, hotel, motel, RV camp, etc.; or

(ii) Who is an owner or member of a condominium, homeowner's association, fraternity, equity ownership facility, mobile home park, sorority, or private club with a pool facility.

(e) Water treatment operators shall assure the water treatment components of each WRF are functioning to protect health, safety and water quality.

(f) Owners shall ensure that lifeguards, shallow water lifeguards, swim coaches, and attendants:

(i) Wear a distinguishing suit/uniform, or emblem; and

(ii) Carry a whistle or equivalent signaling device.

(8) **Personnel training.**

(a) Owners shall ensure that pool personnel required by subsection (6) of this section have skills necessary for their duties, obtained by training and certification specified in Table 131.1 in Appendix B, or equivalent.

(b) Owners shall keep a copy at the WRF of each currently valid certification required for pool personnel.

(c) Owners shall ensure safety-monitoring personnel obtain continuing education needed to maintain lifeguarding skills and maintain valid certifications required by this subsection.

(d) If SCUBA or kayaking lessons are conducted at a pool, owners shall ensure that personnel monitoring these activities are trained to recognize special hazards associated with these activities.

(9) **Emergency response plan.**

(a) Owners shall prepare and implement emergency response plans specified in this subsection.

(b) In pool facilities where lifeguards, shallow water lifeguards, or swimming coaches are required by subsections (6) and (7) of this section:

(i) Sufficient qualified personnel must be present and appropriately located to provide a rescue response time of thirty seconds or less for all pool users;

(ii) The number and qualifications of personnel present must be based on factors dealing with pool depth, line of sight, bather load, potential emergency procedures, and personnel rotation;

(iii) Emergency response drills must be held two or more times each year to test whether thirty-second response time can be met; and

(iv) A record of each response drill must be kept at the WRF for three or more years.

(c) In pool facilities where lifeguards are not present, in accordance with subsection (6)(c) and (e) of this section, owners shall adopt rules, provide enforcement of conditions for pool use and notify users when first using facility and at least annually thereafter that conditions for use include:

(i) If a child twelve years of age or less is using the pool, a responsible adult eighteen years of age or older shall accompany the child and be at the pool or pool deck at all times the child uses the facility; and

(ii) If anyone seventeen years of age or less is using the pool, a minimum of two people shall be at the pool facility.

(d) Emergency equipment specified in WAC 246-260-041, 246-260-051, and 246-260-071 must be readily available during WRF operating hours.

(e) In facilities where chlorine gas is used:

(i) WRF personnel shall conduct annual emergency drills; and

(ii) The plan shall identify the location of accessible chlorine cylinder repair kits.

(f) Operators shall ensure that lifeguards, shallow water lifeguards, and swim coaches receive ongoing training of emergency response skills.

(10) **Environmental conditions.** Owners shall monitor various environmental conditions affecting the facility or potentially affecting the health and safety of users. Owners shall close the WRF or take other appropriate action in response to adverse environmental factors, (e.g., electrical storms, fog, wind, and visibility problems) to ensure that the health and safety of users are protected.

(11) **Closure.** Owners shall close the facility when the facility presents an unhealthful, unsafe, or unsanitary condition. These conditions include lack of compliance with the water quality or an operation requirement in this section or in WAC 246-260-111.

[Statutory Authority: RCW 70.90.120. WSR 05-09-004, § 246-260-131, filed 4/7/05, effective 5/8/05. Statutory Authority: Chapters 70.90 and 43.20 RCW. WSR 04-18-096, § 246-260-131, filed 9/1/04, effective 10/31/04.]

PETITION FOR RULEMAKING: WAC 246-260-131

Washington State Department of HEALTH

State Board of Health, June 12, 2024
Water Recreation Program

Presenters

Ashlie Laydon

Rules Coordinator

EPH Rules Team

David DeLong

Program Lead

Water Recreation

WAC vs MAHC

Staff are working with a technical advisory committee (TAC) to adopt the U.S. Centers for Disease Control and Prevention Model Aquatic Health Code (MAHC) standards into rule.

WAC 246-260-131	MAHC 6.3.2.1
(6) Required personnel. (b) General use swimming pool facilities shall have lifeguards present at all times pools are in use; except: (i) If swim or dive teams are facility users, the owner may allow substitution of a qualified coach properly credentialed by the sponsoring organization furnishing the swim or dive coach; and (ii) Owners may substitute persons with Master Scuba Diver Trainer or Master Scuba Diver Instructor certification through PADI or SCUBA instructor, assistant instructor or divemaster through NAUI or other department-approved training in lieu of lifeguards for SCUBA training.	List of Aquatic Facilities Requiring Qualified Lifeguards 4) Any AQUATIC VENUE while it is being used for group training must have dedicated lifeguards on DECK for class surveillance, sufficient to meet the requirements of MAHC 6.3.3.1, including but not limited to competitive swimming and/or sports, lifeguard training, exercise programs, and swimming lessons;

Rulemaking Process

Questions?