2024 State Health Report – Working Draft

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Letter from Chair

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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.

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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."

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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:

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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.

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

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.

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)

[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/

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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

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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

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- 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.

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[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.

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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

Commented [DM(23]: Board Member: Excellent point - and rural communities suffer the lowest rates of insurance coverage (as well as the shortest life expectancies).

Commented [DM(24]: Board Member: Consider mentioning the intersection of rural health and ethnic health disparities, e.g. migrant worker health.

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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

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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.

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[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

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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].

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[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

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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

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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.

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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.

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[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

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[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

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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

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[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

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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

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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

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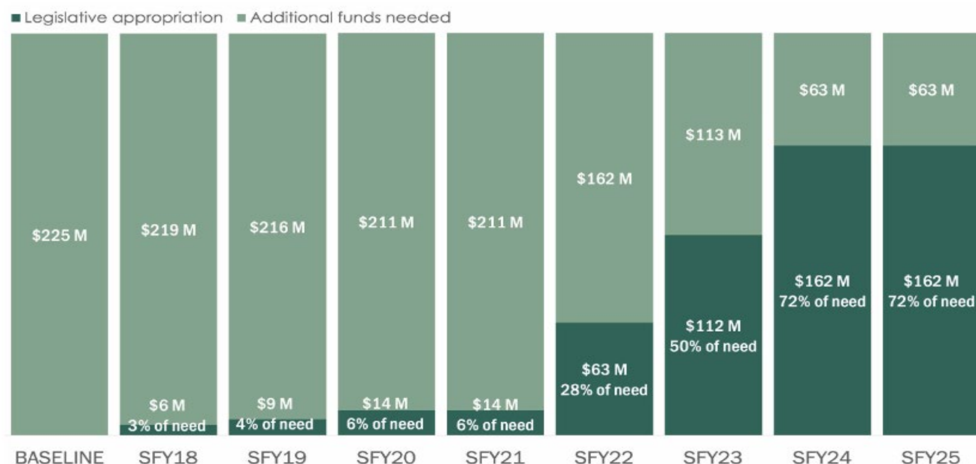
FPHS State Fiscal Year (SFY) Investments and Gaps in Funding (in millions)



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;

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[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.

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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

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[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.

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[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,

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[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.

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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

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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.

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[98] American Public Health Association. Environmental Health. No Publication Date. Accessed May 15, 2024. https://www.apha.org/topics-and-issues/environmental-health
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[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
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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

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[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.

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[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
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[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/
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[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

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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.

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