WHATCOM COUNTY COUNCIL

SPECIAL COUNCIL MEETING
AS THE
HEALTH BOARD

10:00 a.m. Tuesday, March 29, 2022
Council Chambers, 311 Grand Avenue
(if virtual: www.whatcomcounty.us/joinvirtualcouncil)

A G E N D A

Meeting Topics	**Pages**	**Time**
1. Roll Call	no paper	10:00-10:05
2. Public Comment	no paper	10:05-10:15
3. Director/Health Officer Report	no paper	10:15-10:25
4. New Response Systems Division	pg 2-4	10:25-10:40
5. PHAB and Health Board Composition	pg 5-26	10:40-11:10
6. COVID Strategic Plan	pg 27-47	11:10-11:30

HEALTH BOARD
Discussion Form

March 29, 2022

AGENDA ITEM #4: *New Response Systems Division*

PRESENTERS: *Malora Christensen*

BOARD ACTION: Action Item Discussion ☑ FYI - Only

The Response Systems Division has successfully transitioned GRACE and LEAD staff from SeaMar into the new RS division. GRACE and LEAD staff had their first day at the County on Monday, March 14th.

The RS division includes:
RS Manager
RS Supervisor LEAD
RS Supervisor GRACE
LEAD Intensive Case Managers (5)
GRACE Intensive Case Manager (5)

Along similar lines, we received $2.2M in state funding via Rep. Alicia Rule, to remove and repurpose the old triage facility and to start a co-responder pilot. With the support of the Executive and the Bellingham Mayor, this co-responder pilot (also called the Alternative Response Team or ART) will hopefully launch mid-Summer to early Fall. ART will provide a behavioral health response to 911 calls not needing police intervention. This team will be housed within the new division as complementary service to the work of GRACE and LEAD.

EQUITY CONSIDERATIONS

(include data or information about how topic impacts or could impact equity, including racial equity)

GRACE and LEAD both serve vulnerable populations in Whatcom County.

BOARD ROLE / ACTION REQUESTED

Update only

ATTACHMENT(S)

Slide presentation

IMPROVE LIVES
REDUCE POLICE CONTACT
OFFER SUPPORT SERVICES
KEEP EVERYONE SAFE

Building caring community health and safety responses in Whatcom County

GRACE
Ground-level Response and Coordinated Engagement

LEAD
WHATCOM COUNTY

Response Systems Division

GRACE

97% reduction in EMS contacts
62% reduction in ED visits
84% reduction in jail bookings

LEAD

97% reduction in jail bookings

*jail booking data possibly impacted by pandemic and legislative changes in 2021

www.respondwhatcom.org

ART: Alternative Response Team

1. ART deployed from What-Comm by Triage Specialists
2. Dedicated communications channel & work station for ART
3. Two teams of two, each with at least one Masters MHP, Bellingham-based, 10 hours/day, 7 day/wk coverage (phased)
4. BFD and BPD continued involvement in oversight & review, future collaboration
5. Monitoring & evaluation plan, decision on key data requirements (This is a PILOT, we will learn from the process)

HEALTH BOARD
Discussion Form

March 29, 2022

AGENDA ITEM #5: *PHAB and Health Board Composition*

PRESENTERS: *Steve Bennett*

BOARD ACTION: Action Item ☑ Discussion FYI - Only

In 2021, the Washington State Legislature took two significant actions regarding public health. They passed a policy bill that requires both non-charter and charter counties without a community advisory board to change their composition to include non-elected members. In counties like Whatcom, where there is a community advisory board (Public Health Advisory Board (PHAB)), the Health Board is not required to change its composition. There are, however, requirements for community advisory boards, so either the Health Board will need to change its composition or the PHAB will need to make changes in some of its operations.

EQUITY CONSIDERATIONS

(include data or information about how topic impacts or could impact equity, including racial equity)

The legislation for Health Boards includes a requirement that consumers be included on the board, which provides opportunities for people with lived experience to weigh in on health policy matters countywide. The legislation states that:

- *"It is strongly encouraged that individuals from historically marginalized and underrepresented communities are given preference."*

The legislation for Community Health Advisory Boards includes a specific requirement to use a health equity framework for identifying and addressing community health needs. The legislation also reinforces the importance of diversity on the advisory board, including the following requirement:

- *"The local health jurisdiction and local board of health* ***must actively recruit advisory board members in a manner that solicits broad diversity*** *to assure representation from marginalized communities including tribal, racial, ethnic, and other minorities."*

BOARD ROLE / ACTION REQUESTED

Review new requirements and identify next steps
Set timeline for decision-making

ATTACHMENT(S)

- Public Health Advisory Board Changes Pursuant to RCW 70.46.140 Slide Presentation
- Proposed Rule Making CR-102 (Implements RCW 34.05.320)
- Washington State Board of Health Rulemaking FAQs

Public Health Advisory Board changes pursuant to RCW 70.46.140

STEVE BENNETT

PHAB

A 'New' Board? Its pretty prescriptive

Balance between elected and non-elected members- equal numbers

"Nonelected member" or "nonelected position" means a person appointed to a local board of health who is not an elected official, and represents three categories:

Public health, health care facilities, and providers:

- Medical ethicists; Epidemiologists; Experienced in environmental public health; Community health workers; Holders of master's degrees or higher in public health; Doctors; Nurses, etc

Consumers of public health

- This category consists of county residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs, with a focus on marginalized communities

Other community stakeholders.

- Community-based organizations or nonprofits that work with populations experiencing health inequities in the county; Active, reserve, or retired armed services members; The business community; or The environmental public health regulated community.

Based on the current board

7 elected

7 non-elected

The non-elected would be comprised of 2 each of the previous categories

- 2 public health providers
- 2 consumers
- 2 stakeholders
- 7th member would be tribal representation as chosen by American Indian health commission.

- Non-elected membership would be chosen by elected
- Worth noting- Any decision by the board of health related to the setting or modification of permit, licensing, and application fees may only be determined by the city and county elected officials on the board.

At this point

Rules are being finalized in the process

PHAB, as part of its advisory role, supports the move to a 'new' board

But as the current Health Board goes through it's decision-making process PHAB must adapt to the new policies

What's NOT changing…

- Promote public participation in and identification of local public health needs
  - We do this at some level currently, but it is *not operationalized,* and because of that, has been one of our greatest challenges. There would need to be discussion again on what this looks like and how it could be supported by the health board and health department.
- Provide community forums and hearings as assigned by the local board of health
- Establish community task forces as assigned by the local board of health
- Review and make recommendations to the local health jurisdiction and local board of health for an annual budget and fees

What is changing…

Provide input to the local board of health in the recruitment and selection of an administrative officer, pursuant to RCW 70.05.045, and local health officer, pursuant to RCW 70.05.050

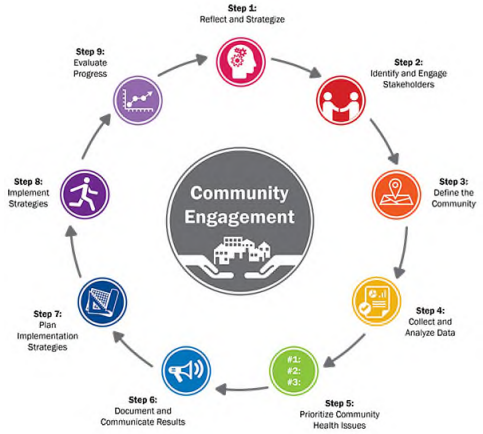
- This is a new official responsibility for PHAB, although would only come up as needed.
- This would need to be operationalized as to the process that would occur for PHAB to be adequately involved in both recruitment and selection.
- New PHAB by-laws will need to be in place

Use a health equity framework to conduct, assess, and identify the community health needs of the jurisdiction, and review and recommend public health policies and priorities for the local health jurisdiction and advisory board to address community health needs

- Currently our requirements simply state
  - 1. Recommend public health policies;
  - 2. Recommend public health priorities;
- "review and recommend"
- "conduct, assess, and identify the community health needs of the jurisdiction"
  - This is functionally new responsibility
  - identifies key health needs and issues through systematic, comprehensive data collection and analysis.

Community Health Assessment cont.

- Most assessment and planning frameworks include steps or phases that reflect the following actions, some of which may occur simultaneously:
  - Organize and plan
  - Engage the community
  - Develop a goal or vision
  - Conduct community health assessment(s)
  - Prioritize health issues
  - Develop community health improvement plan
  - Implement and monitor community health improvement plan
  - Evaluate process and outcomes



Evaluate the impact of proposed public health policies and programs, and assure identified health needs and concerns are being met

- Evaluation of Proposed policies and program
  - Require increased engagement with PHAB
  - PHAB need to review new proposed policies/programs before Health Board votes
- Impact Assessments
  - "practical approach used to judge the potential health effects of a policy, program or project on a population, particularly on vulnerable or disadvantaged groups. Recommendations are produced for decision-makers and stakeholders, with the aim of maximizing the proposal's positive health effects and minimizing its negative health effects."- WHO
- This is an in-depth process- takes time and engagement

Review and advise on local health jurisdiction progress in achieving performance measures and outcomes to ensure continuous quality improvement and accountability.

- Some discussion on what this would consist of
- Previous responsibilities would likely cover some of this but would need to formalize this review process.

What PHAB would need to meet the new requirements

- The biggest immediate challenge is time, work and person-power
  - Our membership will likely need to increase towards 20 member
- Monthly full group meetings
  - Additional subgroup work meetings
  - Bi-monthly (every other month) joint meeting with Health board
- Increased communications, website, community engagement ability
  - For recruitment as well as mobilization required of new responsibilities
- Health department staff support
- Increased communication between all parties (PHAB, Health Board, Health Department)
- Need for rulemaking around abilities of chair and vice chair
- Likely budgetary request for Community Health Assessments

PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: February 25, 2022
TIME: 4:34 PM

WSR 22-06-063

Agency: State Board of Health

☒ **Original Notice**

☐ **Supplemental Notice to WSR**

☐ **Continuance of WSR**

☒ **Preproposal Statement of Inquiry was filed as WSR** 21-13-024 **; or**

☐ **Expedited Rule Making--Proposed notice was filed as WSR ; or**

☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☐ **Proposal is exempt under RCW .**

Title of rule and other identifying information: (describe subject) Chapter 246-90 WAC, Local board of health membership, the state board of health (board) is proposing adding a new chapter of rule to implement new requirements made by E2SHB 1152 (chapter 205, Laws of 2021) as it relates to the appointment of nonelected members of local boards of health.

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
04/13/2022	1:30 PM	In response to the coronavirus disease 2019 (COVID-19) public health emergency, the state board of health will not provide a physical location for this hearing. This helps provide social distancing and the safety of the citizens of Washington state. A virtual public hearing, without a physical meeting space will be held instead. Board members, presenters, and staff will all participate remotely. Register in advance for this hearing at: https://us02web.zoom.us/webinar/register/WN_fPNK3XjVT0uzyc12vSkdtQ After registering, you will receive a confirmation email containing information about joining the webinar/hearing.	

Date of intended adoption: 04/13/2022 (Note: This is **NOT** the **effective** date)

Submit written comments to:

Name: Samantha Pskowski
Address: P.O. Box 47990, Olympia, WA 98504-7990
Email: https://fortress.wa.gov/doh/policyreview

Fax: N/A
Other: None
By (date) 03/30/2022

Assistance for persons with disabilities:
Contact Melanie Hisaw
Phone: 360-236-4110
Fax: N/A
TTY: 711
Email: Melanie.Hisaw@sboh.wa.gov
Other:
By (date) 04/01/2022

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The proposed rule will establish the selection and appointment process for non-elected members of local boards of health. The purpose of the rule is to provide local governments a standard process for such recruitment and ultimate appointment of non-elected members of local boards of health. The rule will reduce uncertainty on how local boards of health need to conduct selection and provide the public an understanding of the process for how they may apply for local board of health positions.

Reasons supporting proposal: During the 2021 legislative session, the legislature passed E2SHB 1152. Among other changes, this bill made changes to the required composition of local boards of health by requiring an equal number of members who are nonelected officials. The statute specifies groups of individuals that must be represented on the local board of health. The legislation also requires the board to establish rules for the appointment process of these nonelected members of local boards of health in a manner that is fair and unbiased, and ensure to the extent possible a balanced representation of elected and nonelected persons with diversity of expertise and experience.

Statutory authority for adoption: E2SHB 1152 (chapter 205, Laws of 2021) codified as RCW 43.20.300

Statute being implemented: E2SHB 1152 (chapter 205, Laws of 2021) codified as RCW 43.20.300, RCW 70.05.030 (1)(a), 70.05.035 (1)(a), 70.46.020 (1)(a), and 70.46.031 (1)(a)

Is rule necessary because of a:

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

If yes, CITATION:

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

Name of proponent: (person or organization) Washington State Board of Health ☐Private ☐Public ☒Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Samantha Pskowski	101 Israel Road SE, Tumwater, WA 98504-7990	(360) 789-2358
Implementation:	Samantha Pskowski	101 Israel Road SE, Tumwater, WA 98504-7990	(360) 789-2358
Enforcement:	Samantha Pskowski	101 Israel Road SE, Tumwater, WA 98504-7990	(360) 789-2358

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No
If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:

Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:

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

☒ No: Please explain: The proposed rules are exempt from completing a cost-benefit analysis under RCW 34.05.328(5)(b)(ii) because they are only related to the internal operations of a governmental entity. The proposed rule sets the process and standards for the recruitment, selection, and appointment of non-elected members of local boards of health and is solely implemented by the governmental entity

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

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

Citation and description:

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

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

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

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

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

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

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

☐ No Briefly summarize the agency's analysis showing how costs were calculated.

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

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

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

Date: 02/25/2022	**Signature:** 
Name: Michelle A. Davis	
Title: Executive Director	

Chapter 246-90 WAC
LOCAL BOARD OF HEALTH MEMBERSHIP

NEW SECTION

WAC 246-90-005 Purpose, scope, and applicability of chapter. (1) The purpose of this chapter is to establish requirements for the recruitment, selection and appointment process of nonelected members of local boards of health. The processes established in this chapter are intended to be fair, unbiased, and ensure to the extent practicable that the membership of local boards of health include a balanced representation of elected officials and nonelected people with a diversity of expertise and lived experience.

(2) The provisions of this chapter apply to the following:

(a) A county without a home rule charter in which the jurisdiction of the local board of health is coextensive with the boundaries of the county as established in RCW 70.05.030;

(b) A county with a home rule charter in which the jurisdiction of the local board of health is coextensive with the boundaries of the county as established in RCW 70.05.035;

(c) A health district consisting of two or more counties in which the jurisdiction of the local board of health is coextensive with the combined boundaries of the counties as established in RCW 70.46.020; and

(d) A health district consisting of one county in which the jurisdiction of the board of health is coextensive with the boundary of the county as established in RCW 70.46.031.

(3) The provisions of this chapter apply only to the recruitment, selection and appointment of persons who are not elected officials who are identified in RCW 70.05.030 (1)(a), 70.05.035 (1)(a), 70.46.020 (1)(a), and 70.46.031 (1)(a).

NEW SECTION

WAC 246-90-010 Definitions. The following definitions apply throughout this chapter unless the context clearly requires otherwise:

(1) "Board" means the Washington state board of health.

(2) "Consumers of public health" means the category of persons consisting of county or health district residents who have self-identified as having faced significant health inequities or as having lived experiences with public health-related programs.

(3) "Elected official" means any person elected at a general or special election to public office representing a city or county, and any person appointed to fill a vacancy in any such office.

(4) "Health agency" means a private or public business or organization that renders or connects persons to health services, insurance, or other benefits.

(5) "Health facility" means a facility, clinic, or other setting licensed under Title 18, 70, or 71 RCW in which behavioral or medical diagnosis, care, treatment, or services are provided.

(6) "Local board of health" means the county or district board of health as established under chapter 70.05 RCW.

(7) "Local health jurisdiction" or "LHJ" means a county health department under chapter 70.05 RCW or health district under chapter 70.46 RCW.

(8) "Nonelected member" or "nonelected position" means a person appointed to a local board of health who is not an elected official, and represents:

(a) Public health, health care facilities, and providers;

(b) Consumers of public health; or

(c) Other community stakeholders.

(9) "Other community stakeholders" means the category of persons representing the following types of organizations located in the county or health district:

(a) Community-based organizations or nonprofits that work with populations experiencing health inequities in the county;

(b) Active, reserve, or retired armed services members;

(c) The business community; or

(d) The environmental public health regulated community.

(10) "Public health, health care facilities, and providers" means the category of persons practicing or employed in the county or health district who are:

(a) Medical ethicists;

(b) Epidemiologists;

(c) Experienced in environmental public health;

(d) Community health workers;

(e) Holders of master's degrees or higher in public health or another field with an emphasis or concentration in health care, public health, or health policy;

(f) Employees of a hospital located in the county; or

(g) Any of the following providers holding an active or retired license in good standing under Title 18 RCW:

(i) Physicians or osteopathic physicians;

(ii) Advanced registered nurse practitioners;

(iii) Physician assistants;

(iv) Registered nurses;

(v) Dentists;

(vi) Naturopaths; or

(vii) Pharmacists.

NEW SECTION

WAC 246-90-015 Local boards of health—Nonelected members. (1) The number of nonelected members, as defined in WAC 246-90-010, on a local board of health, including any tribal representatives as described in subsection (2) of this section, must equal the number of elected officials on a local board of health. Elected members of the local board of health may not constitute a majority.

(2) If a federally recognized Indian tribe holds reservation, trust lands, or has usual and accustomed areas within the county or health district, or if a 501(c)(3) organization registered in Washington that serves American Indian and Alaska Native people and provides services within the county or health district, the local board of

health must include a tribal representative selected by the American Indian health commission according to the selection process prescribed by the commission. A tribal representative as described in this subsection may serve in any of the three nonelected member categories as defined in this chapter if the representative meets the requirements of the category.

(3) Any changes to local board of health composition must meet the requirements of this chapter.

(4) If a board of county commissioners or a county legislative authority chooses to adopt a resolution or ordinance or otherwise act to change the size or composition of the local board of health, the resolution, ordinance, or other document used must:

(a) Include provisions, which are comparable to those of elected members, for the appointment, term, including initial term, and, if applicable, compensation or reimbursement of expenses for nonelected members as defined in this chapter;

(b) Ensure elected officials do not constitute a majority of the total membership of the local board of health;

(c) Ensure recruitment, selection, and appointment of nonelected members of the local board of health conform with the requirements of this chapter;

(d) Identify nonelected members as voting members of the local board of health except as it pertains to any decision related to the setting or modification of permit, licensing, and application fees; and

(e) Identify the process for how a local board of health will refer successful applicants to the board of county commissioners for approval and appointment. If a county does not have a board of county commissioners, the local board of health will refer successful applicants to the county legislative authority for consideration for approval and appointment.

NEW SECTION

WAC 246-90-020 Local boards of health—Nonelected members—Recruitment. (1) A local board of health must actively recruit applicants for nonelected member positions of the local board of health in a manner that solicits a broad pool of applicants that represent a diversity of expertise and lived experience.

(2) A local board of health must:

(a) Provide reasonable advance notice for applicants to apply for vacancies for positions representing nonelected members on a local board of health;

(b) Post vacancy announcements in public places, including the newspaper of record, in the county or district;

(c) Make available vacancy announcements in any language upon request;

(d) Post vacancy announcements in all geographic regions represented by the local board of health;

(e) Work with local community organizations to distribute vacancy notices; and

(f) Comply with applicable provisions of the Americans with Disabilities Act, Public Law Number 101-336 and chapter 49.60 RCW.

(3) A local board of health may:

(a) Require nonelected members serving in the other community stakeholder or public health, health care facilities, and providers positions on the local board of health to reside within the county or local board of health's jurisdictional boundaries; and

(b) Work with local community organizations to identify potential applicants for nonelected positions.

(4) A local board of health may not require an applicant to provide their political affiliation or voting history.

(5) A local board of health may require an applicant to designate the specific category or categories they are applying for as identified in WAC 246-90-025(1) in their application materials. A local board of health may consider applicants for any position for which they are qualified.

(6) All applicants for nonelected positions shall be interviewed in a panel format by the local board of health subject to the following:

(a) All applicants shall be asked a standard set of questions;

(b) Follow up questions may be asked if necessary to understand the applicant's response to a standard question; and

(c) In the event of a substantial number of applicants, the local board of health may elect to interview a smaller number of applicants as long as the applicants interviewed include a diversity of expertise and lived experience.

(7) The recruitment process must be consistent with applicable provisions of chapter 42.30 RCW.

NEW SECTION

WAC 246-90-025 Local boards of health—Nonelected members—Selection. (1) Nonelected members of a local board of health must be selected from the following categories:

(a) Public health, health care facilities, and providers;

(b) Consumers of public health; and

(c) Other community stakeholders.

(2) If the total number of nonelected members of a local board of health is evenly divisible by three, there must be an equal number of members selected from each of the three categories.

(3) There may be no more than one member selected from each category with the same background or position except under the following circumstances:

(a) If there are one or two nonelected members over the nearest multiple of three, those nonelected members may be selected from any of the three categories; and

(b) If, in a health district consisting of one county, there are two nonelected members over the nearest multiple of three, each member over the nearest multiple of three must be selected from a different category.

(4) A local board of health shall assess the following when considering applicants for selection to a local board of health:

(a) Service, current or past, on other local boards or commissions;

(b) Whether the applicant's background meets the qualifications of the applicant's selected category or categories as defined in WAC 246-095-010;

(c) Potential conflict of interest;

(d) The applicant's demonstrated commitment to public health;

(e) Whether the applicant represents a diversity of expertise and lived experience; and

(f) Whether the applicant represents the geographic diversity of the community.

(5) A local board of health shall also assess whether the applicant identifies with a historically underrepresented community when being considered as a nonelected member representing consumers of public health.

(6) Local board of health membership must include a balanced representation of elected officials and nonelected people with a diversity of expertise and lived experience.

(7) Persons with a fiduciary obligation to a health facility or other health agency, or a material financial interest in the rendering of health services, may not be selected as a nonelected member of a local board of health representing consumers of public health.

(8) Applicants must disclose any potential conflict of interest.

(9) If a local board of health demonstrates that it attempted to recruit members from all three categories under subsection (1) of this section and was unable to do so, the local board of health may select members only from the other two categories.

(10) The selection process must be consistent with applicable provisions of chapter 42.30 RCW.

NEW SECTION

WAC 246-90-030 Local boards of health—Nonelected members—Appointment. (1) Nonelected members of a local board of health shall be approved and appointed by a majority vote of the board of county commissioners. If a county does not have a board of county commissioners, then the nonelected members of a local board of health shall be approved and appointed by a majority vote of the county legislative authority.

(2) The appointment process must be consistent with applicable provisions of chapter 42.30 RCW.

NEW SECTION

WAC 246-90-035 Local boards of health—Nonelected members—Exceptions. In accordance with RCW 70.05.030, 70.05.035, 70.46.020, and 70.46.031, the following exceptions apply to this chapter:

(1) For counties with a home rule charter, counties without a home rule charter, health districts consisting of two or more counties, and health districts consisting of one county. A local board of health comprised solely of elected officials may retain its composition if the local health jurisdiction had a public health advisory

committee or board with its own bylaws established on January 1, 2021. By January 1, 2022, the public health advisory committee or board must have met the requirements established in RCW 70.46.140 for community health advisory boards.

(2) For local boards of health made up of three counties east of the Cascade mountains:

(a) If a local board of health is comprised solely of elected officials, it may retain its current composition if the local health jurisdiction has a public health advisory committee or board that meets the requirements established in RCW 70.46.140 for community health advisory boards by July 1, 2022.

(b) If the local board of health does not establish the required community health advisory board by July 1, 2022, it must comply with the requirements of this chapter.

(3) For local boards of health established under RCW 70.46.031, "other community stakeholders" as defined in this chapter does not include active, reserve, or retired armed services members. Active, reserve, or retired armed services members are not precluded from representing other categories of nonelected members as defined in WAC 246-90-010.

WASHINGTON STATE BOARD OF HEALTH

Local Board of Health Membership Rulemaking Frequently Asked Questions

1. **Why is the State Board of Health engaging in this rulemaking?**
   During the 2021 legislative session, the legislature passed Engrossed Second Substitute House Bill 1152 (E2SHB 1152), Supporting measures to create comprehensive public health districts. This legislation requires the Board to adopt rules regarding the selection/appointment process for non-elected members of local boards of health.

2. **What did E2SHB 1152 do?**
   Among other changes, the legislation requires local boards of health to expand their membership to include non-elected persons representing the following groups, as further defined in the new law:
   a. Public health, health care facilities, and providers;
   b. Consumers of public health; and
   c. Other community stakeholders representing certain organizations within the jurisdiction.

   Local boards of health must also include a tribal representative selected by the American Indian Health Commission if a federally recognized tribe holds reservation, trust lands, or has usual and accustomed lands within the county or district, or if a non-profit organization serves American Indian and Alaska Native people within the county or district. The legislation allows for local boards of health comprised solely of elected officials to retain their composition in certain circumstances. Future changes to local board of health composition must meet the requirements of the legislation.

3. **What is the scope of the Board's rulemaking?**
   The State Board of Health (Board) must adopt rules establishing the selection/appointment process for members of local boards of health who are not elected officials. In accordance with E2SHB 1152, the selection process must be fair and unbiased, and to the extent practicable, ensure the membership of local boards of health include balanced representation of elected and non-elected persons with a diversity of expertise and lived experience.

4. **Will the Board's rules define who is an elected member and who is a non-elected member of local boards of health?**
   Yes. The Board's rules will include a definitions section defining these terms. Where applicable, the Board's rules will align with definitions used in the underlying statute.

5. **Will the Board's rulemaking address tribal representatives?**
   E2SHB 1152 gives the Board the authority to adopt rules establishing the selection/appointment process for members of local boards of health who are not elected officials. Board rules may include provisions related to tribal representatives. However, per the legislation, tribal representatives are selected by the American Indian Health Commission.

6. **Will the Board's rulemaking address voting abilities of non-elected members of local boards of health?**
   The Board does not have the authority to address the voting ability of non-elected members. E2SHB 1152 specifies that decisions by a local board of health related to the setting or modification of permit, licensing, and applications fees may only be determined by elected officials on the local board of health.

7. **Will the Board's rulemaking address how a local board of health should resolve votes resulting in a tie?**
   The Board does not have authority to address how local boards of health should resolve votes resulting in a tie.

8. **Are there exceptions to the new membership requirements for local boards of health?**
   E2SHB 1152 allows for local boards of health comprised solely of elected officials to retain its composition if the following conditions are met:
   a. For counties with a home rule charter, counties without a home rule charter, health districts consisting of two or more counties, and health districts consisting of one county:
      i. The local health jurisdiction must have had a public health advisory committee or board with its own bylaws established by January 1, 2021.
      ii. By January 1, 2022, the public health advisory committee or board must meet requirements established in RCW 70.46.140.
   b. For local boards of health made up of three counties east of the Cascade mountains:
      i. The local health jurisdiction has a public health advisory committee or board that meets the requirements established in RCW 70.46.140 by July 1, 2022.

9. **Who is required to comply with the Board's rules?**
   E2SHB 1152 revised several statutes related to local health boards, including those boards in: counties without a home rule charter (RCW 70.05.030), counties with a home rule charter (RCW 70.05.035), health districts of two or more counties (RCW 70.46.020), and health districts of one county (RCW 70.46.031). The Board recommends and encourages counties and districts impacted by the legislation to consult with their legal counsel to determine whether and how, they must comply with the Board's rules.

10. **When will these rules go into effect?**
    E2SHB 1152 requires the Board's rules to be in effect no later than July 25, 2022. Board staff expect to present proposed rules to the Board for their consideration at the April 2022 meeting,

with a potential effective date of July 1, 2022. A more detailed rulemaking timeline can be found on the Board's rulemaking web page. Please note that all dates are estimates.

11. How can I receive updates and provide input on the rules?

a. You can subscribe to the Board's Local Board of Health Composition email distribution list. You will receive rule notices, opportunities for feedback on draft rules, and other updates as we proceed with the rulemaking process.
b. You may also attend a public meeting and provide your comments. The Board's meeting schedule is posted on online. Every meeting is open to the public and includes a dedicated public comment period.

12. Who can I contact for more information?

a. Email questions to lbohcomposition@sboh.wa.gov
b. Contact Board of Health policy advisors:
    i. Kaitlyn Donahoe, 360-584-6737
    ii. Samantha Pskowski, 360-789-2358

Please note: The Board cannot and does not provide legal advice.

HEALTH BOARD
Discussion Form

March 29, 2022

AGENDA ITEM #6: *COVID Strategic Plan*

PRESENTERS: *Kate Dabe*

BOARD ACTION: Action Item Discussion ☑ FYI - Only

Attached is the 2022 COVID-19 Strategic Plan. The plan describes how the Whatcom County Health Department will continue to provide leadership and protect public health as the COVID-19 pandemic transitions from an ongoing crisis to long-term, routine work.

Health Department staff who are currently involved in and leading the COVID-19 response collaborated to develop the plan. It addresses the vision and next steps for many different facets of COVID-19 response, including:

- The transition of case and contact investigations to the Washington State Department of Health
- The next step after the lease of the Byron isolation and quarantine facility ends in late March
- How the department tracks and supports testing capacity

The Health Department is committed to providing leadership and science-based decision-making. While COVID-19 still presents a threat to health and well-being, we are much further along in our knowledge of the disease and the response to it. Paying careful attention to local needs and disease trends, the Health Department is poised to transition to a sustainable, longer-term response over time.

EQUITY CONSIDERATIONS (include data or information about how topic impacts or could impact equity, including racial equity

The COVID-19 Strategic Plan should prioritize the needs of under-resourced populations who are disproportionately impacted, such as the Latinx population, those experiencing homeless, and more.

BOARD ROLE / ACTION REQUESTED

Feedback is requested on this document to maximize its usefulness for the Health Department and the community.

ATTACHMENT(S)

Strategic Plan – COVID 2022.pdf

2022 Strategic Plan: Ongoing COVID-19 Response

Introduction

The Whatcom County Health Department's mission is to lead the community in promoting health and preventing disease. To that end, we play a central role in community-wide planning around emergencies, such as natural disasters, pandemics, and bioterrorism.

In January 2020, Whatcom County Health Department initiated an incident response to the emerging novel coronavirus. Within two months, the department partnered with Whatcom County governments, Lummi Nation, the City of Bellingham and other agencies to stand up Whatcom Unified Command to respond to the COVID-19 pandemic. The core of the response was supported with guidance from our local, state, and federal public health authorities. Following the dissolution of Whatcom Unified Command in mid-2021, the Whatcom County Health Department has been the lead agency for the ongoing pandemic response.

This strategic plan describes how the Health Department will continue to provide leadership and protect public health as the COVID-19 pandemic continues. This document offers a sketch of the current response in Whatcom County and key priorities for the Department moving forward. Low- and high-intensity phases of the pandemic continue to alternate, and are difficult to predict. This plan will consider those possible swings, as well as the county's eventual move from ongoing crisis to long-term, routine COVID-19 response.

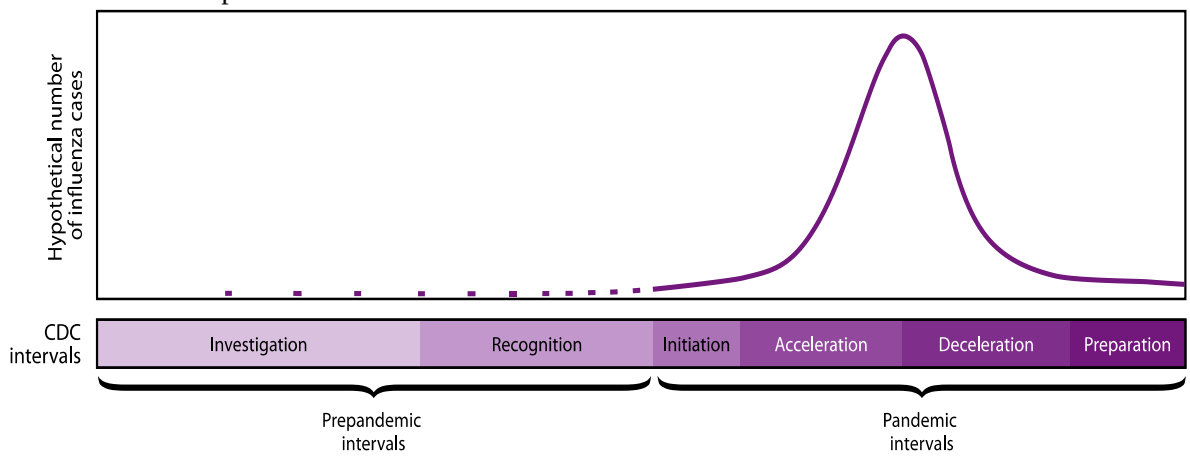
As we near the second anniversary of the pandemic, many Whatcom County families have faced diagnoses, hospitalizations or deaths of their loved ones from COVID-19. Many others have experienced hardships related to work exclusion for isolation or quarantine, lack of childcare, mitigation efforts, and more. We know that our most vulnerable populations are especially at risk both from the disease and from these effects.

However, Whatcom County is fortunate to have built and maintained a strong foundation of relationships with local governments, non-profits, medical providers, businesses, schools, faith-based organizations, foundations, and more, coming together to address problems and improve community health. The community has also learned a great deal about how to address COVID-19.

With our extraordinary public health staff, and the generous hearts and hands of the citizens of this community, we will continue to meet the challenges ahead.

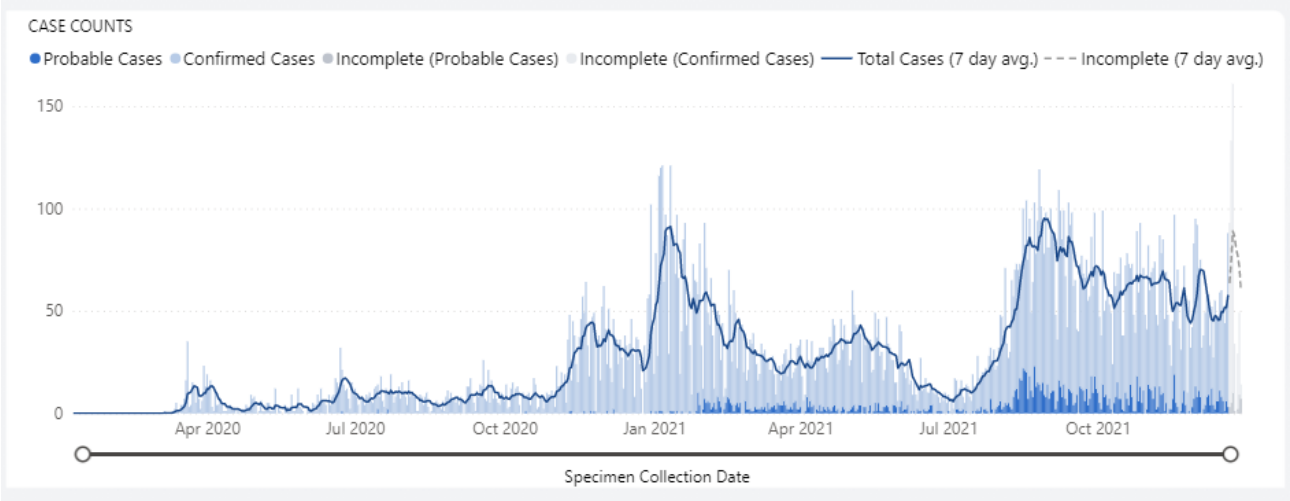
Background and Context

The Centers for Disease Control published *Updated Preparedness and Response Framework for Influenza Pandemics* in 2014[i] which offers a useful tool for COVID-19 response planning. In this framework, there are **six intervals** of a pandemic that should be considered.



Since March 2020, Whatcom County has experienced six Acceleration Intervals of varying intensity, beginning in March, June and November, 2020 and then again in April and August, 2021, and very late December, 2021 (the Omicron variant).

COVID-19 in Whatcom County: Cases by Specimen Collection Date as of 12/28/2021.[ii]



Future forecasting of the severity and frequency of Acceleration and Deceleration intervals is challenging. With the unpredictability of variants and their severity, modeling with accuracy has not yet been possible on a global, national or local scale. What we can expect is an unknown number of future Accelerations and Decelerations as we experience surges of COVID-19 infection. In addition, COVID-19 has become established and likely will be a permanent ongoing presence in our area. We will need to prepare for ongoing surveillance and management of the disease within the community, even when the pandemic ends and we enter the phase of Preparation (also called Recovery) for future waves of transmission.

The Current Situation

Whatcom County and Washington State's response to COVID-19 has had a positive impact on COVID-19 outcomes. When compared to other states, Washington has the fifth-lowest mortality rate of all U.S. States

and the District of Columbia.[iii] Within Washington State, Whatcom County has the seventh lowest mortality rate of 39 counties (113 COVID-19 deaths per 100,000).[iv]

States Ranked by Age-Adjusted COVID Deaths as of January 19, 2022.[iii]

Age-Adjusted COVID Deaths Ranking	State	COVID-19 Deaths per 100,000	Age-Adjusted COVID-19 Deaths per 100,000
1	Mississippi	375	384
2	Texas	284	338
3	Oklahoma	327	334
4	Alabama	335	330
5	Tennessee	317	320
		US Average is 259	
47	Washington	130	137
48	Oregon	136	131
49	Maine	145	122
50	Hawaii	77	70
51	Vermont	72	63

After two years of the COVID-19 pandemic, the situation has changed greatly. In the U.S., access to immunization for ages five and older are widespread. A large proportion of the population has some form of immunity, either through vaccination or prior infection. In addition, medical systems have increasing access to anti-viral treatments including monoclonal antibodies and other therapies. Hospitals and medical providers now have extensive experience treating COVID-19, including at its most severe. Our community has extensive community awareness and many more tools to respond to COVID-19. Despite the understandable fatigue resulting from such a long-standing crisis, the county is well-positioned to enter a new phase of COVID-19 response.

Goals and Role

As referenced in the Whatcom County Health Department's most recent strategic plan[v], the priorities of the department are to provide critical infrastructure, to engage the community and to drive policy changes. In the context of a pandemic, our role is to build community capacity and safeguard the community's ability to provide care. The Whatcom County Health Department's role is to be convener, strategist, and advocate, advising on or setting policies that are backed by public health science, only providing direct care when gaps exist between provider capacity and community need that cannot be addressed quickly enough to prevent serious health impacts.

In any crisis situation, leaders may be required to prioritize actions and allocation of resources. For the Whatcom County Health Department, our highest priorities will be:

- Decreasing the chance of infection for those most at risk for severe disease.
- Supporting hospitals and the health care system in their ability to retain capacity to treat those with critical needs.
- Retaining capacity within the Department to address essential functions critical to maintaining public health and safety.

Key Strategies

To accomplish these goals, we will focus on **nine key strategies** that must be considered during each phase of a pandemic.

	STRATEGY	PURPOSE
1	Incident Management	Ensure effective management of the public health emergency
2	Surveillance and Epidemiology	Increase understanding of disease behavior and spread, to support containment and mitigation
3	Medical Care & Countermeasures	Maintain adequate capacity within the health care system to respond to virus spread in the community
4	Community Mitigation	Slow the spread of the virus within the community and reduce impact on health care infrastructure
5	Testing	Provide information about who has the virus to contain spread and prevent infection
6	Vaccine	Decrease infections, hospitalizations and deaths, slowing the spread of the disease through vaccination
7	Risk Communication	Ensure that the public has accurate and timely information about the evolving situation, risks, and appropriate and necessary actions
8	State/Local Coordination	Ensure effective use of limited resources and coordinate action across jurisdictions
9	Essential Services	Ensure that the public has access to essential services, infrastructure, and support

Priority Actions

As we plan for the future of the pandemic, we will prepare for continuing Accelerations and Decelerations as well as the Preparation phase. Federal and state agencies such as the Centers for Disease Control and the Washington State Department of Health will identify the Preparation phase, both nationally and for local health jurisdictions. The Initiation and initial Acceleration and Deceleration phases were originally shared in the 2020 Strategic Plan for COVID-19 Response.[vi]

Strategy	Initiation and initial Acceleration and Deceleration phases	Continuing Acceleration and Deceleration Phases	Preparation/Recovery Phase
1. Incident Management	• Dedicate staffing to support WUC and ensure coordination of government and community partners during each interval of the pandemic. • Provide regular updates to Whatcom County Health Board on current pandemic data, useful information, and progress towards Incident Objectives. • Provide regular financial reports and budget and staffing recommendations to County Council and County Executive, to sustain necessary staffing support.	• Continue actions described in previous interval as appropriate. • Deactivate the Incident Command Structure and transition to internal COVID-19 operating structure within the Whatcom County Health Department, including coordination with government and community partners. (See Appendix III.)	• Integrate COVID-19 programming into WCHD's Communicable Disease & Epidemiology division. • Continue cross-divisional coordination on data reporting, communications and other functions. • Prepare for subsequent waves. • Create an after-action report to document lessons learned.
2. Surveillance and Epidemiology	• Continuously monitor and synthesize emerging science and guidance from global, national, and state public health authorities to inform local policy. • Conduct case and contact investigations for individuals with confirmed COVID-19; synthesize information about local and regional cases and close contacts to identify outbreaks, clusters, and populations disproportionately impacted. • Develop and use simulation and forecasting tools to guide planning and surge needs.	• Continue actions described in previous interval as appropriate, including monitoring the level of disease in the community. • Transition general case and contact investigation to the Washington State Department of Health.	• Continue to partner and align strategies with Washington State Department of Health for case and contact investigation. • Begin conducting routine interpandemic surveillance.
3. Medical Care and Countermeasures	• Coordinate with (and create a forum for communication between) hospital, emergency medical services, health care facilities, and congregate care facilities to ensure providers have the resources needed for infection control and response, including adequate testing supplies and information on isolation and quarantine following a patient diagnosis. • Coordinate community medical surge plans to respond to anticipated increases in patients requiring varying levels of care, including critical care. • Review and determine when to deploy sustained fatality plan.	• Continue actions described in previous interval as appropriate. • Continue to host the Health Care Coalition to support sharing best practices and identifying gaps and opportunities for capacity building, with and among providers. • Increase capacity of community to provide treatments, including both oral antiviral and monoclonal antibodies.	• Monitor medical surge trends. • Replenish stockpiles or caches as indicated.

Strategy	Initiation and initial Acceleration and Deceleration phases	Continuing Acceleration and Deceleration Phases	Preparation/Recovery Phase
4. Community Mitigation	• Monitor needs and barriers among Community Health Assessment-identified vulnerable populations and work with partners and WUC to address. • Work with businesses to create, and monitor effectiveness of re-opening safety measures implemented locally to reduce transmission (e.g. social/physical distancing, wearing face coverings, limiting capacity, increasing hygiene measures) • Ensure understanding of and adherence to isolation and quarantine through rigorous case and contact investigations, effective communication and support for successful home isolation and quarantine, and triage, refer and monitor individuals in the county's isolation and quarantine facility.	• Continue actions described in previous interval as appropriate. • Transition to an Isolation Facility. See Appendix I. • Resource and support mitigation response teams which focus on safety measures and outbreaks in healthcare, business, and school settings.	• Deactivate Isolation Facility. • Integrate mitigation response teams into WCHD Communicable Disease & Epidemiology division. • Continue to promote community mitigation preparedness activities on standby for a subsequent wave. Staff are trained and ready.
5. Testing	• Work with partners to increase clinical testing, share current testing guidance, and add testing facilities. • Track and adjust testing strategies and clinical criteria to maximize local testing availability and data collection. • Utilize a public health testing approach to support surveillance functions and containment/mitigation within and for the benefit of priority groups; increase capacity and provide surge testing if needed.	• Continue actions described in previous interval as appropriate. • Support access to testing by underserved groups such as East Whatcom and the Latinx community. • Continue to partner with NW Labs in support of our community testing site, until community has adequate access to testing through other means. (See Appendix II.)	• Begin routine interpandemic virologic surveillance.
6. Vaccine	*Note: as the previous COVID-19 Strategic Plan was written in July 2020, before any COVID-19 vaccine was available, no action items related to vaccine were included.*	• Support community capacity to vaccinate, particularly for newly eligible populations such as pediatric age groups and boosters. • Support access to vaccine by acting as an informal vaccine depot for smaller providers with limited storage capacity. • Monitor vaccination rates and focus outreach efforts to underserved populations, such as East Whatcom and the Latinx community. • Maintain situational awareness of providers' vaccine administration capacity and identify gaps in access. • Promote equitable vaccine access by focusing outreach efforts on hard-to-reach populations.	• Continue to advocate for community capacity to vaccinate. • Continue to focus outreach efforts on hard-to-reach populations.

Strategy	Initiation and initial Acceleration and Deceleration phases	Continuing Acceleration and Deceleration Phases	Preparation/Recovery Phase
7. Risk Communication	• Continue to provide accurate and reliable updates and guidance to the public in a variety of formats and for populations identified that are hesitant or unwilling to adopt personal mitigation measures. • Review/audit current public health pandemic guidelines and other information resources intended for the community at large and industry sectors to ensure that they are complete and readily available to the public in appropriate languages and formats. • Increase public awareness of the Health Department and WUC as reliable and trusted sources for information.	• Continue actions described in previous interval as appropriate, focusing on sharing changes to recommendations or risk. • Plan for communications around cessation of state-level community mitigation requirements.	• Disseminate updated risk messages, including information on measures to prepare for and respond to possible additional pandemic waves.
8. State/Local Coordination	• Maintain regular communications with state and federal public health and emergency management authorities to coordinate incident management. • Monitor increased health risks related to community mitigation measures and economic stressors and propose strategies to address risks. • Provide information and support so that partners can apply public health principles when responding to this unique type of a crisis.	• Continue actions described in previous interval as appropriate. • Continue to provide information and support so that partners can apply public health principles, particularly schools, businesses and congregate settings.	• Continue to coordinate with all partners as needed.
9. Essential Services	• Maintain staffing necessary to continue providing essential Health Department services, in addition to a robust COVID-19 response. • Provide tailored guidance for community service providers to reduce risk of transmission. • Create contingency plans for emergency leadership succession and staffing shortages.	• Continue actions described in previous interval as appropriate. • Balance staffing so that all critical public health services can effectively and fully serve community need. • Structure COVID-19-related systems to require minimal loaned staff, who are aware of their roles and in what circumstances they may be activated.	• Incorporate ongoing COVID-19 work into regular Communicable Disease & Epidemiology work, similar to influenza, tuberculosis, and other monitored diseases. • Continue to have robust contingency plans on an on-going basis.

Conclusion

The Whatcom County Health Department is committed to providing leadership and science-based decision-making throughout the COVID-19 pandemic. It is the role and responsibility of public health to prepare for and address public health emergencies. COVID-19 presented just such an emergency to public health systems worldwide over the past two years. And while it still presents a real and dangerous threat to health and well-being, we are much further along in our knowledge of the disease and the response to it. Paying careful attention to local needs and disease trends, the Health Department is poised to transition to a longer-term, more sustainable, less crisis-driven response over time. This will include tending to our community's recovery from secondary effects from the COVID-19 pandemic, such as those described in our COVID-19 Community Health Impact Assessment.[vii]

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[i] Rachel Holloway, Sonja A. Rasmussen, MD, Stephanie Zaza, MD, et al. Updated Preparedness and Response Framework for Influenza Pandemics. MMWR 2014;63(No. 6).

[ii] Washington State Department of Health. COVID-19 Data Dashboard. Olympia, WA: Washington State Department of Health; 2021. Available at https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard.

[iii] Ratley, Grace. "States Ranked by Age-Adjusted Covid Deaths." *Bioinformaticscro.com*, The Bioinformatics CRO, Inc., 18 Feb. 2022, https://www.bioinformaticscro.com/blog/states-ranked-by-age-adjusted-covid-deaths/.

[iv] "Washington Coronavirus Cases and Deaths." *USAFacts.org*, USAFacts, 18 Feb. 2022, https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/state/washington.

[v] Whatcom County Health Department. Whatcom County Health Department 2015-2019 Strategic Plan. Bellingham, WA: Whatcom County Health Department; 2015. Available at https://www.whatcomcounty.us/2347/Strategic-Planning.

[vi] Whatcom County Health Department. Strategic Plan for COVID-19 Response. Bellingham, WA: Whatcom County Health Department; 2020.

[vii] Whatcom County Health Department. COVID-19 Community Health Impact Assessment. Bellingham, WA: Whatcom County Health Department; 2021. Available at https://whatcomcounty.us/DocumentCenter/View/58373/COVID-19-Community-Health-Impact-Assessment-July-2021.

Appendix I. Isolation & Quarantine

The Isolation and Quarantine Facility (IQF) offered by the Whatcom County Health Department (WCHD) has been located at the facility on Byron Avenue in Bellingham since early in the pandemic. The majority of the population using the facility are those living in congregate settings such as homelessness shelters or migrant farmworker housing, who have no other safe place to isolate or quarantine when exposed or when experiencing a COVID-19 infection that does not require hospitalization.

This facility is needed not only to decrease the spread of COVID-19, but also to maintain or increase the capacity of hospitals and medical facilities during severe outbreaks. Patients infected with COVID-19 but experiencing mild symptoms are generally discharged to recuperate at home. Those experiencing homelessness, with no other space to go while sick, occupy hospital beds that could be used to serve those with urgent or life-threatening injuries or illnesses. With the Byron Avenue facility available, patients who have no other place to go can be discharged to the IQF.

The contract for the Byron Avenue facility will end on March 31, 2022. The purpose of this appendix is to plan for the future of this type of facility in Whatcom County through the next phase of the COVID-19 pandemic.

Byron Facility Usage

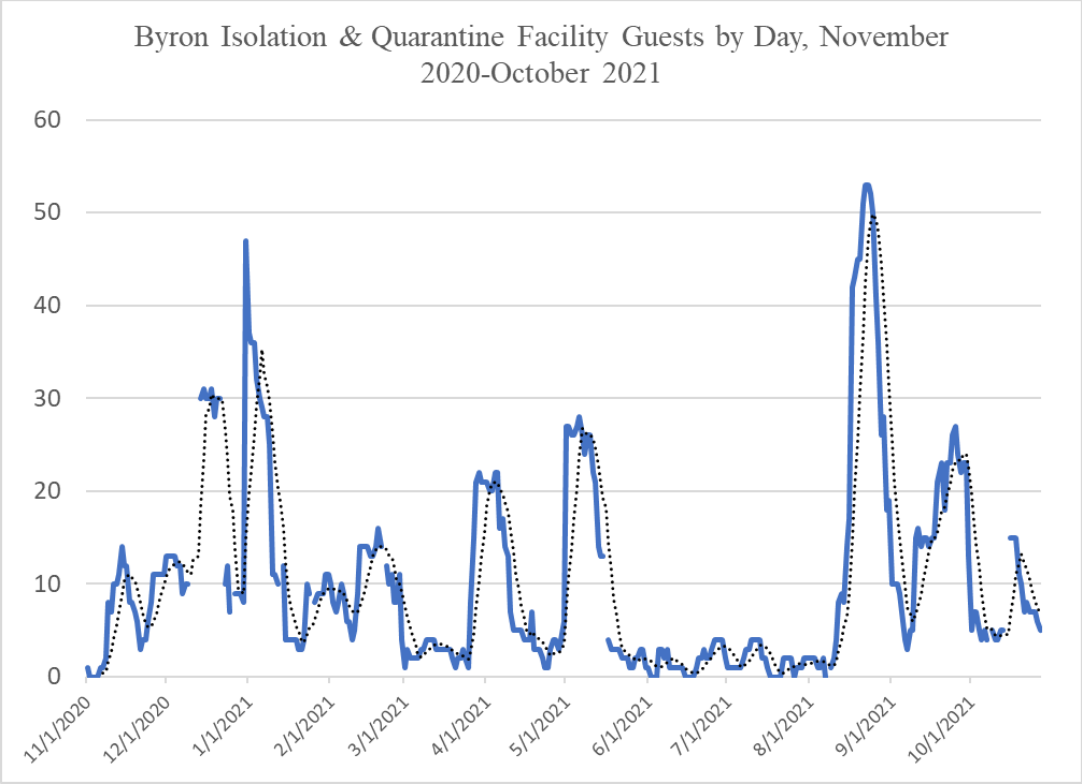
The Byron Avenue facility has been used for both isolation (for those infected with COVID-19) and quarantine, (for those exposed to COVID-19). Individual and double rooms are available, offering a non-congregate setting and a way to separate those isolating from those quarantining. The facility nominally has beds for 74; 15 double rooms and 41 single rooms and several cots. However, ongoing maintenance and repair needs, including the need to clean and restock between guests, would make it difficult to maximize this space.

When reviewing data from November 2020 to October 2021, the Isolation and Quarantine Facility has often been underutilized, with fewer than ten guests for 61% of 348 days tracked. However, when significant outbreaks occur, the need becomes urgent quickly. The existing facility has supported as many as 55 guests at a time.

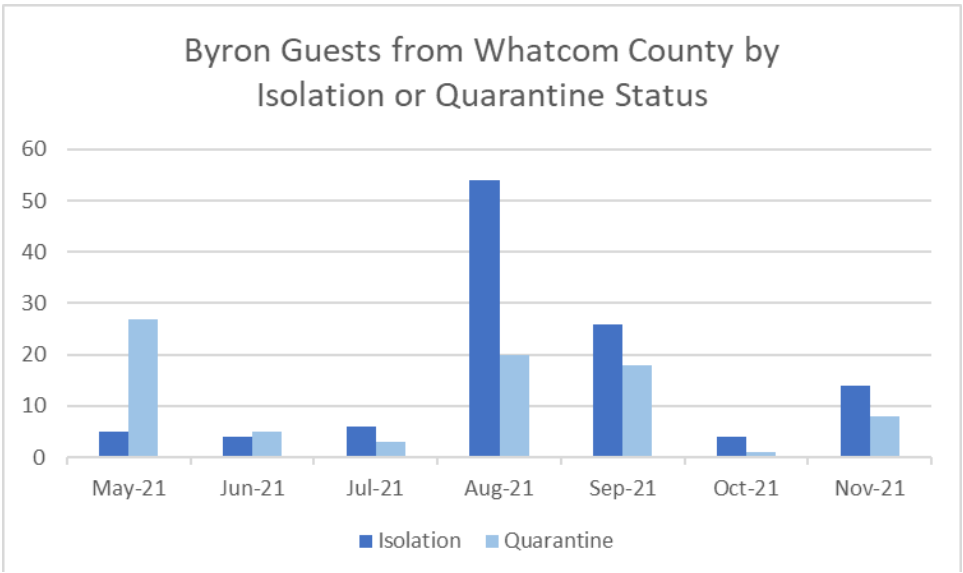
Guests	Days	%
<10	211	61%
10-20	75	22%
21-30	44	13%
>30	18	5%
Total	348	

Below is a graph of guests at the Byron facility over time. Surges of more than 20 guests occurred six times. Severe surges of more than 30 residents occurred in December 2020, January 2021, August 2021, and December 2021-January 2022. Less severe surges, between 20 and 30 residents, occurred in April, May and September 2021. These surges corresponded to outbreaks at congregate facilities such as Base Camp and Agape House, two Bellingham homeless shelters operated by Lighthouse Mission Ministries,

as well as work release programs for both the State Department of Corrections and Whatcom County Jail. These surges lasted an average of 11 days, with a range of 9-13 days. During severe surges, the true isolation and quarantine needs of the county may not be represented by this data, as isolation guests with COVID-19 were prioritized for available beds and any potential guests who had a private room at their current housing were requested to isolate in place.



Information about guests' status – isolation or quarantine – is available by month. The below graph is a snapshot of seven months in mid- to late-2021. Quarantined guests ranged from just a few to more than 25. Isolated guests, those with a diagnosed COVID-19 infection, ranged from five to nearly 55.



Updates to the CDC's Isolation and Quarantine Guidance

In late December 2021, the CDC shared updated guidance on isolation and quarantine for the general public.[1] The most relevant changes include:

- Decreasing isolation to five days, regardless of vaccination status
- Eliminating quarantine for those vaccinated

However, the CDC maintained guidance of a 10-day isolation period for those living in congregate settings. While the IQF is a non-congregate setting with individual rooms, many guests were previously living in congregate spaces such as shelters. Due to capacity issues, WCHD has modified its IQF policy to align with the CDC guidance, allowing isolated guests to test after five days and be released if the results are negative.

Based on the new CDC guidelines and WCHD's modifications, WCHD will focus on identifying a new facility that will solely offer isolation for those diagnosed with COVID-19. For those who risk exposure, the health department will continue to support the medical system to vaccinate and test individuals in our community, and allocate our limited resources to vaccinating and ensuring testing is available for populations which lack access or are historically underserved. The health department will continue this work to decrease the spread of the disease, but also, in part, to decrease the need for a quarantine facility.

Narrowing the purpose of the next facility to isolation changes its requirements. Most significantly, since all guests will have a COVID-19 infection, a congregate setting is an appropriate option and individual rooms are not required. This decision will have limited impact on the size of the facility required, as the number of isolated guests tend to range greatly by month.

Size of Isolation Facility

Two scenarios are offered to maximize the flexibility of this plan:

- Priority: A facility with space to fit 30-35 well and 55 when crowded would serve 100% of previous need. An overflow option should be planned for but would likely be rarely needed.
- Alternative: Unless guidance or the pandemic changes greatly, a facility or facilities with space to fit 20-25 well and 30-35 when crowded would meet 95% of past need. An overflow option would likely be needed at least twice per year.

Previously, at the Byron facility, Whatcom County entered into agreements with Snohomish and Island counties to host their isolation and quarantine residents as space allowed. The size of the next facility will likely make continuing these agreements difficult. Due to this challenge, WCHD plans to not continue these collaborative agreements past March 31, 2022.

Options for a New Isolation Facility

To replace the current Byron facility, the WCHD has considered several models in use in Whatcom County and other local health jurisdictions:

- Motels and hotels

[1] "CDC Updates and Shortens Recommended Isolation and Quarantine Period for General Population." *Centers for Disease Control and Prevention,* Centers for Disease Control and Prevention, 27 December 2021, https://www.cdc.gov/media/releases/2021/s1227-isolation-quarantine-guidance.html.

- Adult family homes
- Commercial space
- Space owned by local human services organizations and churches
- Space owned by local city or county government

Motels and hotels. The Byron Avenue facility, a motel, follows this model. (This option requires direct access outside, rather than a lobby, to follow protocols.) Unfortunately, through previous request for proposal (RFP) processes, very few local businesses showed interest. In the last RFP round, no motel or hotel submitted a proposal. Two businesses, including the Byron facility, submitted a proposal during the previous round. After discussion, it became clear that management of the other facility had underestimated the potential impact of isolation guests on their business model.

Adult family homes. The Tacoma-Pierce County Health Department is using this model currently. They have partnered with a significant number of adult family homes that can house those who need isolation or quarantine. The primary challenge with this model is that only 23 adult family homes are currently licensed in Whatcom County. Generally, adult family homes house a maximum of six residents. Whatcom would need to partner with 4-6 homes in order to provide sufficient beds for our alternative scenario with 25-35 capacity. Operationally, having a different manager for each location is very challenging both logistically and for case management during a surge. Having potentially a quarter of adult family homes in the region devoted to isolation needs will have a significant impact in available services, while still requiring the county to have an overflow option available for surges throughout the year. This model would also require identifying ways to house current residents elsewhere in order to empty the facility for guests in isolation. Using adult family homes as isolation facilities will be very resource intensive, both more costly and requiring more staff and logistical support than other models.

Commercial space. Another option is to contract for commercial real estate that is currently unused, and stand up a site similar to a winter warming shelter. This option would require two large dorm spaces segregated by gender that could house 30-55 cots, and also offer bathrooms, kitchen facilities, and a separate space for staff. Adequate HVAC systems would also be needed to ensure safety of staff. Currently, the Bellingham commercial real estate market is very strong, and the asking price for leasing space is increasing[2].

Space owned by local human services organizations and churches. After discussion with local organizational leadership, no current space exists that could be used long-term for isolation. Options exist that may potentially be available seasonally, but not year-round. A potential long-term solution would be to partner with an organization with plans to build a facility, with an agreement to rent it through the end of the pandemic. However, the short time period until the Byron Avenue facility is no longer available and the uncertainty around the length of the pandemic and need for an isolation facility makes this option, while inexpensive, logistically challenging.

Space owned by local city or county government. Similar to human service organization properties, no local city or county facilities are unused year-round. Options exist for seasonal use, as evidenced by winter warming shelters, but those spaces are not consistently available.

After considering these options, the Whatcom County Health Department will focus the search for a new facility on finding a commercial space. Should none of these options prove viable, the options in the overflow section, below, may be considered.

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[2] Gallagher, Dave. "Demand for Bellingham retail space increases in third quarter." *Bellingham Herald*, Bellingham Herald, 6 October 2021, https://www.bellinghamherald.com/news/business/article254753202.html.

Options for Overflow during a Surge

Once a facility has been identified, options for potential overflow should also be identified based on expectations of that facility's capacity. A large isolation facility would likely mean less frequent need for overflow. Weather and season should be taken into account, as each option has variable availability, and potentially harmful temperatures must be addressed. Need for an overflow option during a surge will likely last one to two weeks, and will rarely be needed beyond that period.

Options to consider include:

- An (additional) commercial real estate location
- Seasonally underused county or city buildings or floors, such as the Civic Field locker rooms or the Civic Center Garden Room
- Temporary solutions, such as heated buses with bathrooms, tents with heaters, or portable trailers
- For an extremely large outbreak, consider partnering with Base Camp to invert their facility to isolation only, and offer the facility usually used for isolation to shelter the COVID-negative

Ideally, these overflow options would be aligned with severe weather shelters, and potentially both could be planned for simultaneously.

Transportation

Limited options for transportation to and from the IQF exist for guests leaving the hospital, shelters, or other locations. The sole private medical transport company available locally is not a good fit for ambulatory, sometimes asymptomatic, IQF guests. Instead, Whatcom County's Emergency Medical Services stood up a transport operation for IQF guests. This operation is funded through 2022, and WCHD plans to continue to use this service for the duration of the pandemic.

Closing the Isolation Facility

WCHD will follow the guidance of the CDC, Washington State Department of Health, and other health care authorities when considering when to stand down operation of the isolation facility. This decision will be considered once closing the facility will not significantly impact hospital capacity or community transmission. If needed, overflow options could be held in reserve for possible future needs.

Appendix II. COVID-19 Testing in Whatcom County

Summary

This appendix describes COVID-19 diagnostic testing capacity in Whatcom County and plans for the shifting testing landscape. As with most of the nation, during COVID-19 surges Whatcom has experiencing high demand for testing while experiencing both low supply of antigen tests and limited access to molecular (specifically PCR) testing. While the need for testing remains high, the Whatcom County Health Department will take advantage of every resource-effective opportunity to increase testing capacity in the county, particularly for vulnerable, high risk populations who have been traditionally underserved.

Molecular Testing

The most widely available form of COVID-19 molecular test is the polymerase chain reaction (PCR) test. They are more accurate than rapid antigen tests and are the gold standard for confirming and detecting even asymptomatic COVID-19 infections.[1]

Processing laboratories tend to have sufficient infrastructure to process a significant number of tests. Northwest Laboratory (NW Lab) manages the Community Testing Site at the Bellingham International Airport and processes many of the tests collected in Whatcom and across the state. In mid-December 2021, NW Lab shared that they were only processing 20%-25% of what their labs are capable of and what they were processing at their test processing peak in early 2021.

Sample collection is the point in the process when access for the general public becomes difficult and when demand outpaces supply. Documented staffing shortages nation-wide[2] have also affected the local healthcare system. These staffing shortages have led to limited opportunities for the general public to make appointments and access PCR testing.

In Whatcom, there are two main pathways to access PCR tests: the Airport Community Testing Site and through the medical system, either through pharmacies or medical providers. Both of these options are challenging for those with limited access to resources. For instance, those without a medical provider or for whom their remote location or lack of transportation options means that pharmacies and the airport are too far to access.

Airport Community Testing Site (CTS). The CTS is run by Northwest Laboratory, in partnership with the Whatcom County Health Department and under the order of the Whatcom County Health Officers. The site operates daily, outside of holidays and severe weather events, and has the capacity to serve 600 per day with its current staffing and infrastructure. The daily demand for tests has been as high as nearly 800, and as low as the 300s. Severe weather events, surges, new variants, and holidays all impact demand.

The CTS offers two lanes for testing, and appointments are required. In the midst of a COVID surge, collection capacity could be increased, for instance by adding a third lane. That third lane requires five additional staff, however, and the CTS is already currently understaffed and finding it difficult to fill

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[1] Anthes, Emily. "How Accurate Are At-Home Covid Tests? Here's a Quick Guide." *The New York Times,* The New York Times, 3 January 2022, https://www.nytimes.com/article/at-home-covid-tests-accuracy.html.
[2] Ellyatt, Holly. "There Are Millions of Jobs, but a Shortage of Workers: Economists Explain Why That's Worrying." *CNBC*, CNBC, 20 October 2021, https://www.cnbc.com/2021/10/20/global-shortage-of-workers-whats-going-on-experts-explain.html.

positions. Volunteers are often essential for operations such as this, but volunteer interest has waned over the past few years of the pandemic. Volunteer staffing can also sometimes be less predictable than paid staffing, which can cause cascading challenges at a large testing site as those with appointments can't be seen at their appointed times.

Since the beginning of the Delta surge in August 2021, nearly two-thirds of appointments at the CTS have regularly been filled, and appointments have frequently been filled to capacity. At the time of this writing in early January 2022, the Omicron surge has meant that appointments are booked out to a week in advance, past the five day isolation guidelines for those vaccinated.

The Whatcom County Health Department and NW Lab will follow the guidance of the CDC, Washington State Department of Health, and other health care authorities when considering when to stand down operation of the CTS. This decision will be considered once closing the facility will not significantly impact community transmission, and sufficient options for testing are available.

Pharmacies and Medical Providers. The general public can also access PCR tests through their medical provider and through neighborhood pharmacies, including rapid PCR test options that are available the same day.

In December 2021, Lara Welker Consulting conducted a scan of testing capacity in Whatcom County from these providers. Except for NW Lab and one pharmacy, every other provider and pharmacy shared that they had no or very limited capacity for additional PCR test collection. This is a clear indicator that the COVID-19 testing infrastructure in Whatcom County is stretched and could not accommodate an additional surge in cases. This is being borne out through the current Omicron surge in mid-January 2022, as test appointments become extremely scarce and only available in one to two weeks.

Antigen Testing

Rapid antigen tests are less accurate than PCRs, particularly for those who are asymptomatic.[3] However, they offer much quicker results and the potential of being readily available if production increases sufficiently and supply becomes stable. These benefits and the limited availability of PCR access makes them a powerful public health tool.

CLIA-Waived COVID-19 Testing. A CLIA waiver, or Clinical Laboratory Improvement Amendment Certificate of Waiver, offers a way for facilities to administer rapid antigen tests to their employees or clients. CLIA-waived tests "must be simple and have a low risk for erroneous results. To decrease the risk of erroneous results, the test needs to be performed correctly, by trained personnel and in an environment where good laboratory practices are followed."[4] Facilities with a CLIA waiver are expected to have a training plan and report test results.

The Whatcom County Health Department's role is primarily to educate interested organizations about how to get a CLIA waiver and how to order antigen test kits from the Washington State Department of Health. WCHD also maintains a supply of test kits to offer CLIA-waived agencies when they are experiencing an outbreak or have depleted supply but haven't yet received additional shipments.

Examples of facilities that have CLIA waivers in Whatcom County include:

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[3] Anthes, Emily. "How Accurate Are At-Home Covid Tests? Here's a Quick Guide." *The New York Times,* The New York Times, 3 January 2022, https://www.nytimes.com/article/at-home-covid-tests-accuracy.html.
[4] "Waived Tests." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 3 September 2021, https://www.cdc.gov/labquality/waived-tests.html.

- Long-term care facilities
- Base Camp, a shelter for those experiencing homelessess
- Whatcom Transportation Authority
- School districts
- North Sound Accountable Communities of Health

The Washington State Department of Health (DOH) maintains a fairly consistent supply of tests for CLIA-waived facilities. However, during previous COVID-19 surges, demand has exceeded supply and test kit availability has been limited. Also, the number of facilities who have requested a CLIA-waiver is increasing.

Local Supply of Over-the-Counter Test Kits. Rapid antigen test kits are also available at pharmacies, both online and in person. While widely known and available through a diverse range of vendors, anecdotally, rapid antigen test kits have been difficult to find and purchase since they first became available in mid-2020. During surges, rapid antigen tests are in particularly short supply. The tests have also been expensive historically , at $10 to $20 per test or even more during high demand. In late 2021, the federal government and the Washington State DOH shared that they would soon offer a limited number of free tests upon individual request on a first-come, first-served basis in early 2022.

Opportunities to Increase Access

Whatcom County Health Department will take advantage of every resource-effective opportunity to increase testing capacity in the county, particularly for vulnerable, high risk populations who have been traditionally underserved. Below are several new strategies the WCHD is currently exploring:

Cue. Cue tests are a molecular option requiring a CLIA waiver. Results take 20 minutes to produce, and are more accurate than rapid antigen tests.[5] The DOH offered several kits to the WCHD, which has loaned them on a trial basis to facilities with high-risk patients who may most benefit from a rapid molecular test option, such as Signature Home Health, which serves homebound individuals.

Operation Expanded Testing. Operation Expanded Testing (OpET) is a federally funded project that requires very limited support from local health jurisdictions or community organizations. They offer either CLIA-waived rapid antigen testing or PCR collection. WCHD has connected them with several local organizations and agencies that are interested in and have a need for regular testing.

Federal Supply for Local Distribution. The U.S. Department of Health & Human Services is offering a large number of rapid antigen home-test kits to local organizations, providers and health jurisdictions who can best distribute them locally.

WCHD has partnered with Unity Care NW, a Federally Qualified Community Health Center, which is able to receive free at-home, FDA-authorized COVID-19 testing supplies as part of the Biden Administration's Path Out of the Pandemic COVID-19 Action Plan, through a partnership between the U.S. Department of Health and Human Services and the U.S. Department of Defense for distribution to their communities. When the national supply permits, Unity Care NW is able to order test kits to share with the wider community, and hopes to receive more by the end of February.

[5] "Cue COVID-19 Test for Home and Over The Counter (OTC) Use - Fact Sheet for Individuals." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 5 March 2021, https://www.fda.gov/media/138094/download.

When distributing at-home test kits in collaboration with our community partners, Whatcom County Health Department will prioritize vulnerable, at risk and under-resourced populations and those who work with them.

Our community partners include:

- Human services organizations providing direct service to those experiencing homelessness and disability
- Food banks
- Community centers such as the East Whatcom Regional Resource Center
- Locations hosting vaccine clinics coordinated by WCHD
- Fire stations
- Libraries
- Childcare centers
- Businesses whose employees have direct interaction with the public or must work in a congregate setting such as a warehouse or factory. All businesses are highly encouraged to have their employees work remotely if possible.

WCHD will reserve 500 to 1,000 test kits to share with businesses experiencing outbreaks. Other frequently-cited locations that serve our target populations use CLIA-waived tests, including long-term care facilities, adult family homes, Base Camp (a Bellingham shelter), and schools.

Strategies to Decrease Demand

During surges, access to testing can be extremely limited. Clear communication with the public can help reduce demand in these instances. Examples of key messages that the WCHD Communications Team and partners share during these periods include;

- If test appointments are not available within a few days of symptom onset, symptomatic residents should assume they have COVID and isolate at home.
- Clearly sharing when PCRs are needed. For instance, a PCR is not required in order to return to work if the appropriate isolation guidance has been followed.

The Shifting COVID-19 Testing Landscape

As access to at-home testing increases, public health situational awareness of disease in the community will change. Since early in the pandemic, epidemiologists have relied on PCR testing to inform data reporting and public health understanding of the disease. Once diagnostic testing shifts to home settings, which rely on self-reporting, methods for creating situational awareness will need to change as well.

Several methods inform awareness and understanding of other diseases in the community. For influenza, public health entities rely on facility-based notification. A pattern of facilities reporting high absenteeism rates indicates a possible outbreak. As COVID-19 cases decrease, outbreaks will be easier to identify through this type of facility notification.

Nationally, communities are using PCR testing of wastewater as a leading indicator of COVID-19. methods to use wastewater PCR testing to detect COVID-19 levels in wastewater which tends to tick upward about 4 days prior to clinically detectable increases in COVID cases in the community. In the past, one of our Whatcom communities, Lynden, has done this with a commercial lab in Ferndale.

A statewide effort is ongoing to support this shift in the testing landscape. An array of strategies are being considered, such as:

- Strengthening the current tools for self-reporting and monitoring.

- Waste water surveillance to identify trends and areas of concern.
- Transitioning to facility notification.

WCHD will collaborate with and follow the guidance of the CDC, Washington State Department of Health, and other health care authorities when considering how to address monitoring and surveillance of COVID-19 within the community.