Chapter 43.70 RCW
DEPARTMENT OF HEALTH

Sections

Comprehensive sexual health education, departmental duties: RCW 28A.300.475.

Health, board of: Chapter 43.20 RCW.

Immunization program, departmental participation: RCW 28A.210.060 through 28A.210.170.

Interagency agreement on prenatal substance exposure programs: RCW 71.24.610.

Visual and auditory screening of pupils, data transferred to secretary: RCW 28A.210.030.

RCW 43.70.005 Intent. The legislature finds and declares that it is of importance to the people of Washington state to live in a healthy environment and to expect a minimum standard of quality in health care. The legislature further finds that the social and economic vitality of the state depends on a healthy and productive population. The legislature further declares where it is a duty of the state to assure a healthy environment and minimum standards of quality in health care facilities and among health care professionals, the ultimate responsibility for a healthy society lies with the citizens themselves.

For these reasons, the legislature recognizes the need for a strong, clear focus on health issues in state government and among state health agencies to give expression to the needs of individual citizens and local communities as they seek to preserve the public health. It is the intent of the legislature to form such focus by creating a single department in state government with the primary

responsibilities for the preservation of public health, monitoring health care costs, the maintenance of minimal standards for quality in health care delivery, and the general oversight and planning for all the state's activities as they relate to the health of its citizenry.

Further, it is the intent of the legislature to improve illness and injury prevention and health promotion, and restore the confidence of the citizenry in the efficient and accountable expenditure of public funds on health activities that further the mission of the agency via grants and contracts, and to ensure that this new health agency delivers quality health services in an efficient, effective, and economical manner that is faithful and responsive to policies established by the legislature. [2005 c 32 § 1; 1989 1st ex.s. c 9 § 101.]

RCW 43.70.010 Definitions. As used in this chapter, unless the context indicates otherwise:

(1) "Assessment" means the regular collection, analysis, and sharing of information about health conditions, risks, and resources in a community. Assessment activities identify trends in illness, injury, and death and the factors that may cause these events. They also identify environmental risk factors, community concerns, community health resources, and the use of health services. Assessment includes gathering statistical data as well as conducting epidemiologic and other investigations and evaluations of health emergencies and specific ongoing health problems;

(2) "Board" means the state board of health;

(3) "Department" means the department of health;

(4) "Policy development" means the establishment of social norms, organizational guidelines, operational procedures, rules, ordinances, or statutes that promote health or prevent injury, illness, or death; and

(5) "Secretary" means the secretary of health. [1995 c 269 § 2201; 1994 sp.s. c 7 § 206; 1989 1st ex.s. c 9 § 102.]

Effective date—Part headings not law—Severability—1995 c 269: See notes following RCW 18.16.050.

Finding—Intent—Severability—1994 sp.s. c 7: See notes following RCW 43.70.540.

RCW 43.70.020 Department created. (1) There is hereby created a department of state government to be known as the department of health. The department shall be vested with all powers and duties transferred to it by chapter 9, Laws of 1989 1st ex. sess. and such other powers and duties as may be authorized by law. The main administrative office of the department shall be located in the city of Olympia. The secretary may establish administrative facilities in other locations, if deemed necessary for the efficient operation of the department, and if consistent with the principles set forth in subsection (2) of this section.

(2) The department of health shall be organized consistent with the goals of providing state government with a focus in health and serving the people of this state. The legislature recognizes that the secretary needs sufficient organizational flexibility to carry out the

department's various duties. To the extent practical, the secretary shall consider the following organizational principles:

(a) Clear lines of authority which avoid functional duplication within and between subelements of the department;

(b) A clear and simplified organizational design promoting accessibility, responsiveness, and accountability to the legislature, the consumer, and the general public;

(c) Maximum span of control without jeopardizing adequate supervision;

(d) A substate or regional organizational structure for the department's health service delivery programs and activities that encourages joint working agreements with local health departments and that is consistent between programs;

(e) Decentralized authority and responsibility, with clear accountability;

(f) A single point of access for persons receiving like services from the department which would limit the number of referrals between divisions.

(3) The department shall provide leadership and coordination in identifying and resolving threats to the public health by:

(a) Working with local health departments and local governments to strengthen the state and local governmental partnership in providing public protection;

(b) Developing intervention strategies;

(c) Providing expert advice to the executive and legislative branches of state government;

(d) Providing active and fair enforcement of rules;

(e) Working with other federal, state, and local agencies and facilitating their involvement in planning and implementing health preservation measures;

(f) Providing information to the public; and

(g) Carrying out such other related actions as may be appropriate to this purpose.

(4) In accordance with the administrative procedure act, chapter 34.05 RCW, the department shall ensure an opportunity for consultation, review, and comment by the department's clients before the adoption of standards, guidelines, and rules.

(5) Consistent with the principles set forth in subsection (2) of this section, the secretary may create such administrative divisions, offices, bureaus, and programs within the department as the secretary deems necessary. The secretary shall have complete charge of and supervisory powers over the department, except where the secretary's authority is specifically limited by law.

(6) The secretary shall appoint such personnel as are necessary to carry out the duties of the department in accordance with chapter 41.06 RCW.

(7) The secretary shall appoint the state health officer and such deputy secretaries, assistant secretaries, and other administrative positions as deemed necessary consistent with the principles set forth in subsection (2) of this section. All persons who administer the necessary divisions, offices, bureaus, and programs, and five additional employees shall be exempt from the provisions of chapter 41.06 RCW. The officers and employees appointed under this subsection shall be paid salaries to be fixed by the governor in accordance with the procedure established by law for the fixing of salaries for officers exempt from the state civil service law.

(8) The secretary shall administer family services and programs to promote the state's policy as provided in RCW 74.14A.025. [1992 c 198 § 8; 1989 1st ex.s. c 9 § 103.]

RCW 43.70.030 Secretary of health. The executive head and appointing authority of the department shall be the secretary of health. The secretary shall be appointed by, and serve at the pleasure of, the governor in accordance with RCW 43.17.020. The secretary shall be paid a salary to be fixed by the governor in accordance with RCW 43.03.040. [1989 1st ex.s. c 9 § 104.]

RCW 43.70.040 Secretary's powers—Rule-making authority—Report to the legislature. In addition to any other powers granted the secretary, the secretary may:

(1) Adopt, in accordance with chapter 34.05 RCW, rules necessary to carry out the provisions of chapter 9, Laws of 1989 1st ex. sess.: PROVIDED, That for rules adopted after July 23, 1995, the secretary may not rely solely on a section of law stating a statute's intent or purpose, on the enabling provisions of the statute establishing the agency, or on any combination of such provisions, for statutory authority to adopt any rule;

(2) Appoint such advisory committees as may be necessary to carry out the provisions of chapter 9, Laws of 1989 1st ex. sess. Members of such advisory committees are authorized to receive travel expenses in accordance with RCW 43.03.050 and 43.03.060. The secretary and the board of health shall review each advisory committee within their jurisdiction and each statutory advisory committee on a biennial basis to determine if such advisory committee is needed;

(3) Undertake studies, research, and analysis necessary to carry out the provisions of chapter 9, Laws of 1989 1st ex. sess. in accordance with RCW 43.70.050;

(4) Delegate powers, duties, and functions of the department to employees of the department as the secretary deems necessary to carry out the provisions of chapter 9, Laws of 1989 1st ex. sess.;

(5) Enter into contracts and enter into and distribute grants on behalf of the department to carry out the purposes of chapter 9, Laws of 1989 1st ex. sess. The department must report to the legislature a summary of the grants distributed under this authority, for each year of the first biennium after the department receives authority to distribute grants under this section, and make it electronically available;

(6) Act for the state in the initiation of, or the participation in, any intergovernmental program to the purposes of chapter 9, Laws of 1989 1st ex. sess.; or

(7) Solicit and accept gifts, grants, bequests, devises, or other funds from public and private sources. [2005 c 32 § 2; 2001 c 80 § 2; 1995 c 403 § 105; 1989 1st ex.s. c 9 § 106.]

Findings—Intent—2001 c 80: "(1) The legislature finds that developing, creating, and maintaining partnerships between the public and private sectors can enhance and augment current public health services. The legislature further finds that the department of health should have the ability to establish such partnerships, and seek out

and accept gifts, grants, and other funding to advance worthy public health goals and programs.

(2) It is the intent of the legislature that gifts and other funds received by the department of health under the authority granted by RCW 43.70.040 may be used to expand or enhance program operations so long as program standards established by the department are maintained, but may not supplant or replace funds for federal, state, county, or city-supported programs." [2001 c 80 § 1.]

Findings—Short title—Intent—1995 c 403: See note following RCW 34.05.328.

RCW 43.70.041 Five-year formal review process of existing rules. The department of health must establish and perform, within existing funds, a formal review process of its existing rules every five years. The goal of the review is to decrease the numbers of, simplify the process, and decrease the time required for obtaining licenses, permits, and inspections, as applicable, in order to reduce the regulatory burden on businesses without compromising public health and safety. Benchmarks must be adopted to assess the effectiveness of streamlining efforts. The department must establish a process for effectively applying sunset provisions to rules when applicable. The department must report back to the applicable committees of the legislature with its review process and benchmarks by January 2014. [2013 2nd sp.s. c 30 § 4.]

Findings—Intent—2013 2nd sp.s. c 30: See note following RCW 43.21A.081.

RCW 43.70.045 Warren Featherstone Reid Award for Excellence in Health Care. There is created an award to honor and recognize cost-effective and quality health care services. This award shall be known as the "Warren Featherstone Reid Award for Excellence in Health Care." [1994 c 7 § 2.]

Finding—1994 c 7: "The legislature recognizes the critical importance of ensuring that all Washington residents have access to quality and affordable health care. The legislature further recognizes that substantial improvements can be made in health care delivery when providers, including health care facilities, are encouraged to continuously strive for excellence in quality management practices, value, and consumer satisfaction. The legislature finds that when centers of quality are highlighted and honored publicly they become examples for other health care providers to emulate, thereby further promoting the implementation of improved health care delivery processes." [1994 c 7 § 1.]

RCW 43.70.047 Warren Featherstone Reid Award for Excellence in Health Care. The governor, in conjunction with the secretary of health, shall identify and honor health care providers and facilities in Washington state who exhibit exceptional quality and value in the delivery of health services. The award shall be given annually consistent with the availability of qualified nominees. The secretary

may appoint an advisory committee to assist in the selection of nominees, if necessary. [1994 c 7 § 3.]

RCW 43.70.050 Collection, use, and accessibility of health-related data. (1) The legislature intends that the department and board promote and assess the quality, cost, and accessibility of health care throughout the state as their roles are specified in chapter 9, Laws of 1989 1st ex. sess. in accordance with the provisions of this chapter. In furtherance of this goal, the secretary shall create an ongoing program of data collection, storage, assessability, and review. The legislature does not intend that the department conduct or contract for the conduct of basic research activity. The secretary may request appropriations for studies according to this section from the legislature, the federal government, or private sources.

(2) All state agencies which collect or have access to population-based, health-related data are directed to allow the secretary access to such data. This includes, but is not limited to, data on needed health services, facilities, and personnel; future health issues; emerging bioethical issues; health promotion; recommendations from state and national organizations and associations; and programmatic and statutory changes needed to address emerging health needs. Private entities, such as insurance companies, health maintenance organizations, and private purchasers are also encouraged to give the secretary access to such data in their possession. The secretary's access to and use of all data shall be in accordance with state and federal confidentiality laws and ethical guidelines. Such data in any form where the patient or provider of health care can be identified shall not be disclosed, subject to disclosure according to chapter 42.56 RCW, discoverable or admissible in judicial or administrative proceedings. Such data can be used in proceedings in which the use of the data is clearly relevant and necessary and both the department and the patient or provider are parties.

(3) The department shall serve as the clearinghouse for information concerning innovations in the delivery of health care services, the enhancement of competition in the health care marketplace, and federal and state information affecting health care costs.

(4) The secretary shall review any data collected, pursuant to this chapter, to:

(a) Identify high-priority health issues that require study or evaluation. Such issues may include, but are not limited to:

(i) Identification of variations of health practice which indicate a lack of consensus of appropriateness;

(ii) Evaluation of outcomes of health care interventions to assess their benefit to the people of the state;

(iii) Evaluation of specific population groups to identify needed changes in health practices and services;

(iv) Evaluation of the risks and benefits of various incentives aimed at individuals and providers for both preventing illnesses and improving health services;

(v) Identification and evaluation of bioethical issues affecting the people of the state; and

(vi) Other such objectives as may be appropriate;

(b) Further identify a list of high-priority health study issues for consideration by the board, within their authority, for inclusion in the state health report required by *RCW 43.20.050. The list shall specify the objectives of each study, a study timeline, the specific improvements in the health status of the citizens expected as a result of the study, and the estimated cost of the study; and

(c) Provide background for the state health report required by *RCW 43.20.050.

(5) Any data, research, or findings may also be made available to the general public, including health professions, health associations, the governor, professional boards and regulatory agencies and any person or group who has allowed the secretary access to data.

(6) Information submitted as part of the health professional licensing application and renewal process, excluding social security number and background check information, shall be available to the office of financial management consistent with RCW 43.370.020, whether the license is issued by the secretary of the department of health or a board or commission. The department shall replace any social security number with an alternative identifier capable of linking all licensing records of an individual. The office of financial management shall also have access to information submitted to the department of health as part of the medical or health facility licensing process.

(7) The secretary may charge a fee to persons requesting copies of any data, research, or findings. The fee shall be no more than necessary to cover the cost to the department of providing the copy. [2009 c 343 § 2; 2005 c 274 § 301; 1989 1st ex.s. c 9 § 107.]

***Reviser's note:** RCW 43.20.050 was amended by 2011 c 27 § 1, eliminating the "state health report."

RCW 43.70.052 Hospital financial and patient discharge data—Financial reports—Data retrieval—American Indian health data—Reporting—Patient discharge data—Confidentiality and protection. (1)(a) To promote the public interest consistent with the purposes of chapter 492, Laws of 1993 as amended by chapter 267, Laws of 1995, the department shall require hospitals to submit hospital financial and patient discharge information, including any applicable information reported pursuant to RCW 43.70.053, which shall be collected, maintained, analyzed, and disseminated by the department. The department shall, if deemed cost-effective and efficient, contract with a private entity for any or all parts of data collection. Data elements shall be reported in conformance with a uniform reporting system established by the department. This includes data elements identifying each hospital's revenues, expenses, contractual allowances, charity care, bad debt, other income, total units of inpatient and outpatient services, and other financial and employee compensation information reasonably necessary to fulfill the purposes of this section.

(b) Data elements relating to use of hospital services by patients shall be the same as those currently compiled by hospitals through inpatient discharge abstracts. The department shall encourage and permit reporting by electronic transmission or hard copy as is practical and economical to reporters.

(c) By January 1, 2023, the department must revise the uniform reporting system to further delineate hospital expenses reported in the other direct expense category in the statement of revenue and

expense. The department must include the following additional categories of expenses within the other direct expenses category:

(i) Blood supplies;

(ii) Contract staffing;

(iii) Information technology, including licenses and maintenance;

(iv) Insurance and professional liability;

(v) Laundry services;

(vi) Legal, audit, and tax professional services;

(vii) Purchased laboratory services;

(viii) Repairs and maintenance;

(ix) Shared services or system office allocation;

(x) Staff recruitment;

(xi) Training costs;

(xii) Taxes;

(xiii) Utilities; and

(xiv) Other noncategorized expenses.

(d) The department must revise the uniform reporting system to further delineate hospital revenues reported in the other operating revenue category in the statement of revenue and expense. The department must include the following additional categories of revenues within the other operating revenues category:

(i) Donations;

(ii) Grants;

(iii) Joint venture revenue;

(iv) Local taxes;

(v) Outpatient pharmacy;

(vi) Parking;

(vii) Quality incentive payments;

(viii) Reference laboratories;

(ix) Rental income;

(x) Retail cafeteria; and

(xi) Other noncategorized revenues.

(e)(i) A hospital, other than a hospital designated by medicare as a critical access hospital or sole community hospital, must report line items and amounts for any expenses or revenues in the other noncategorized expenses category in (c)(xiv) of this subsection or the other noncategorized revenues category in (d)(xi) of this subsection that either have a value: (A) Of $1,000,000 or more; or (B) representing one percent or more of the total expenses or total revenues; or

(ii) A hospital designated by medicare as a critical access hospital or sole community hospital must report line items and amounts for any expenses or revenues in the other noncategorized expenses category in (c)(xiv) of this subsection or the other noncategorized revenues category in (d)(xi) of this subsection that represent the greater of: (A) $1,000,000; or (B) one percent or more of the total expenses or total revenues.

(f) A hospital must report any money, including loans, received by the hospital or a health system to which it belongs from a federal, state, or local government entity in response to a national or state-declared emergency, including a pandemic. Hospitals must report this information as it relates to federal, state, or local money received after January 1, 2020, in association with the COVID-19 pandemic. The department shall provide guidance on reporting pursuant to this subsection.

(2) In identifying financial reporting requirements, the department may require both annual reports and condensed quarterly

reports from hospitals, so as to achieve both accuracy and timeliness in reporting, but shall craft such requirements with due regard of the data reporting burdens of hospitals.

(3)(a) Beginning with compensation information for 2012, unless a hospital is operated on a for-profit basis, the department shall require a hospital licensed under chapter 70.41 RCW to annually submit employee compensation information. To satisfy employee compensation reporting requirements to the department, a hospital shall submit information as directed in (a)(i) or (ii) of this subsection. A hospital may determine whether to report under (a)(i) or (ii) of this subsection for purposes of reporting.

(i) Within one hundred thirty-five days following the end of each hospital's fiscal year, a nonprofit hospital shall file the appropriate schedule of the federal internal revenue service form 990 that identifies the employee compensation information with the department. If the lead administrator responsible for the hospital or the lead administrator's compensation is not identified on the schedule of form 990 that identifies the employee compensation information, the hospital shall also submit the compensation information for the lead administrator as directed by the department's form required in (b) of this subsection.

(ii) Within one hundred thirty-five days following the end of each hospital's calendar year, a hospital shall submit the names and compensation of the five highest compensated employees of the hospital who do not have any direct patient responsibilities. Compensation information shall be reported on a calendar year basis for the calendar year immediately preceding the reporting date. If those five highest compensated employees do not include the lead administrator for the hospital, compensation information for the lead administrator shall also be submitted. Compensation information shall include base compensation, bonus and incentive compensation, other payments that qualify as reportable compensation, retirement and other deferred compensation, and nontaxable benefits.

(b) To satisfy the reporting requirements of this subsection (3), the department shall create a form and make it available no later than August 1, 2012. To the greatest extent possible, the form shall follow the format and reporting requirements of the portion of the internal revenue service form 990 schedule relating to compensation information. If the internal revenue service substantially revises its schedule, the department shall update its form.

(4) The health care data collected, maintained, and studied by the department shall only be available for retrieval in original or processed form to public and private requestors pursuant to subsection (9) of this section and shall be available within a reasonable period of time after the date of request. The cost of retrieving data for state officials and agencies shall be funded through the state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule developed by the department that reflects the direct cost of retrieving the data or study in the requested form.

(5) The department shall, in consultation and collaboration with tribes, urban or other Indian health service organizations, and the federal area Indian health service, design, develop, and maintain an American Indian-specific health data, statistics information system.

(6)(a) Except as provided in subsection (c) of this section, beginning January 1, 2023, patient discharge information reported by

hospitals to the department must identify patients by race, ethnicity, gender identity, sexual orientation, preferred language, any disability, and zip code of primary residence. The department shall provide guidance on reporting pursuant to this subsection. When requesting demographic information under this subsection, a hospital must inform patients that providing the information is voluntary. If a hospital fails to report demographic information under this subsection because a patient refused to provide the information, the department may not take any action against the hospital for failure to comply with reporting requirements or other licensing standards on that basis.

(b) The department must develop a waiver process for the requirements of (a) of this subsection for a hospital that is certified by the centers for medicare and medicaid services as a critical access hospital, is certified by the centers of medicare and medicaid services as a sole community hospital, or qualifies as a medicare dependent hospital due to economic hardship, technological limitations that are not reasonably in the control of the hospital, or other exceptional circumstance demonstrated by the hospital. The waiver must be limited to one year or less, or for any other specified time frame set by the department. Hospitals may apply for waiver extensions.

(c) Subject to funding appropriated specifically for this purpose, the department shall establish a process no later than October 1, 2022, for any hospital that is certified by the centers for medicare and medicaid services as a critical access hospital, is certified by the centers for medicare and medicaid services as a sole community hospital, or qualifies as a medicare dependent hospital, to apply for a grant to support updating the hospital's electronic health records system to comply with the requirements of this subsection, subject to the following:

(i) A hospital owned or operated by a health system that owns or operates two or more hospitals is not eligible to apply for a grant under this subsection;

(ii) In considering a hospital application, the department may consider information about the hospital's need for financial support to alter the hospital's electronic health records system, including, but not limited to, demonstrated costs necessary to update the hospital's current electronic health record system to comply with the requirements in this section and evidence of need for financial assistance. The department may provide grant amounts of varying sizes depending on the need of the applicant hospital;

(iii) A hospital that receives a grant under this section must update the hospital's electronic health records system to comply with the requirements of this section before the hospital may make other changes to its electronic health records system, except for changes that are required for security, compliance, or privacy purposes; and

(iv) A hospital that receives a grant under this section must comply with subsection (a) of this section no later than July 1, 2023.

(d) The department shall adopt rules to implement this subsection (6) no later than July 1, 2022.

(7) Beginning January 1, 2023, each hospital must report to the department, on a quarterly basis, the number of submitted and completed charity care applications that the hospital received in the prior quarter and the number of charity care applications approved in the prior quarter pursuant to the hospital's charity care policy, consistent with chapter 70.170 RCW. The department shall develop a

standard form for hospitals to use in submitting information pursuant to this subsection.

(8) All persons subject to the data collection requirements of this section shall comply with departmental requirements established by rule in the acquisition of data.

(9) The department must maintain the confidentiality of patient discharge data it collects under subsections (1) and (6) of this section. Patient discharge data that includes direct and indirect identifiers is not subject to public inspection and the department may only release such data as allowed for in this section. Any agency that receives patient discharge data under (a) or (b) of this subsection must also maintain the confidentiality of the data and may not release the data except as consistent with subsection (10)(b) of this section. The department may release the data as follows:

(a) Data that includes direct and indirect patient identifiers, as specifically defined in rule, may be released to:

(i) Federal, state, and local government agencies upon receipt of a signed data use agreement with the department; and

(ii) Researchers with approval of the Washington state institutional review board upon receipt of a signed confidentiality agreement with the department.

(b) Data that does not contain direct patient identifiers but may contain indirect patient identifiers may be released to agencies, researchers, and other persons upon receipt of a signed data use agreement with the department.

(c) Data that does not contain direct or indirect patient identifiers may be released on request.

(10) Recipients of data under subsection (9)(a) and (b) of this section must agree in a written data use agreement, at a minimum, to:

(a) Take steps to protect direct and indirect patient identifying information as described in the data use agreement; and

(b) Not redisclose the data except as authorized in their data use agreement consistent with the purpose of the agreement.

(11) Recipients of data under subsection (9)(b) and (c) of this section must not attempt to determine the identity of persons whose information is included in the data set or use the data in any manner that identifies individuals or their families.

(12) For the purposes of this section:

(a) "Direct patient identifier" means information that identifies a patient; and

(b) "Indirect patient identifier" means information that may identify a patient when combined with other information.

(13) The department must adopt rules necessary to carry out its responsibilities under this section. The department must consider national standards when adopting rules. [2021 c 162 § 1; 2014 c 220 § 2; 2012 c 98 § 1; 1995 c 267 § 1.]

Effective date—2014 c 220: See note following RCW 70.02.290.

Captions not law—1995 c 267: "Captions as used in this act constitute no part of the law." [1995 c 267 § 16.]

Severability—1995 c 267: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1995 c 267 § 17.]

Effective dates—1995 c 267: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1995, except sections 8 through 11 of this act which shall take effect immediately [May 8, 1995]." [1995 c 267 § 18.]

RCW 43.70.053 Hospital consolidated annual income—Reporting. (1)(a) Beginning July 1, 2022, for a health system operating a hospital licensed under chapter 70.41 RCW, the health system must annually submit to the department a consolidated annual income statement and balance sheet, including hospitals, ambulatory surgical facilities, health clinics, urgent care clinics, physician groups, health-related laboratories, long-term care facilities, home health agencies, dialysis facilities, ambulance services, behavioral health settings, and virtual care entities that are operated in Washington.

(b) The state auditor's office shall provide the department with audited financial statements for all hospitals owned or operated by a public hospital district under chapter 70.44 RCW. Public hospital districts are not required to submit additional information to the department under this subsection.

(2) The department must make information submitted under this section available in the same manner as hospital financial data. [2021 c 162 § 2.]

RCW 43.70.054 Health care data standards—Submittal of standards to legislature. (1) To promote the public interest consistent with chapter 267, Laws of 1995, the department of health, in cooperation with the director of the consolidated technology services agency established in RCW 43.105.025, shall develop health care data standards to be used by, and developed in collaboration with, consumers, purchasers, health carriers, providers, and state government as consistent with the intent of chapter 492, Laws of 1993 as amended by chapter 267, Laws of 1995, to promote the delivery of quality health services that improve health outcomes for state residents. The data standards shall include content, coding, confidentiality, and transmission standards for all health care data elements necessary to support the intent of this section, and to improve administrative efficiency and reduce cost. Purchasers, as allowed by federal law, health carriers, health facilities and providers as defined in chapter 48.43 RCW, and state government shall utilize the data standards. The information and data elements shall be reported as the department of health directs by rule in accordance with data standards developed under this section.

(2) The health care data collected, maintained, and studied by the department under this section or any other entity: (a) Shall include a method of associating all information on health care costs and services with discrete cases; (b) shall not contain any means of determining the personal identity of any enrollee, provider, or facility; (c) shall only be available for retrieval in original or processed form to public and private requesters; (d) shall be available within a reasonable period of time after the date of request; and (e) shall give strong consideration to data standards that achieve national uniformity.

(3) The cost of retrieving data for state officials and agencies shall be funded through state general appropriation. The cost of retrieving data for individuals and organizations engaged in research or private use of data or studies shall be funded by a fee schedule developed by the department that reflects the direct cost of retrieving the data or study in the requested form.

(4) All persons subject to this section shall comply with departmental requirements established by rule in the acquisition of data, however, the department shall adopt no rule or effect no policy implementing the provisions of this section without an act of law.

(5) The department shall submit developed health care data standards to the appropriate committees of the legislature by December 31, 1995. [2015 3rd sp.s. c 1 § 408; 1997 c 274 § 2; 1995 c 267 § 2.]

Effective date—2015 3rd sp.s. c 1 §§ 101-109, 201-224, 406-408, 410, 501-507, 601, and 602: See note following RCW 43.105.007.

Effective date—1997 c 274: See note following RCW 41.05.021.

Captions not law—Severability—Effective dates—1995 c 267: See notes following RCW 43.70.052.

RCW 43.70.056 Health care-associated infections—Data collection and reporting—Advisory committee—Rules. (1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Health care-associated infection" means a localized or systemic condition that results from adverse reaction to the presence of an infectious agent or its toxins and that was not present or incubating at the time of admission to the hospital.

(b) "Hospital" means a health care facility licensed under chapter 70.41 RCW.

(2)(a) A hospital shall collect data related to health care-associated infections as required under this subsection (2) on the following:

(i) Central line-associated bloodstream infection in all hospital inpatient areas where patients normally reside at least twenty-four hours;

(ii) Surgical site infection for colon and abdominal hysterectomy procedures.

(b) The department shall, by rule, delete, add, or modify categories of reporting when the department determines that doing so is necessary to align state reporting with the reporting categories of the centers for medicare and medicaid services. The department shall begin rule making forty-five calendar days, or as soon as practicable, after the centers for medicare and medicaid services adopts changes to reporting requirements.

(c) A hospital must routinely collect and submit the data required to be collected under (a) and (b) of this subsection to the national healthcare safety network of the United States centers for disease control and prevention in accordance with national healthcare safety network definitions, methods, requirements, and procedures.

If the centers for medicare and medicaid services changes reporting from the national healthcare safety network to another database or through another process, the department shall review the

new reporting database or process and consider whether it aligns with the purposes of this section.

(d) Data collection and submission required under this subsection (2) must be overseen by a qualified individual with the appropriate level of skill and knowledge to oversee data collection and submission.

(e)(i) A hospital must release to the department, or grant the department access to, its hospital-specific information contained in the reports submitted under this subsection (2), as requested by the department consistent with *RCW 70.02.050.

(ii) The hospital reports obtained by the department under this subsection (2), and any of the information contained in them, are not subject to discovery by subpoena or admissible as evidence in a civil proceeding, and are not subject to public disclosure as provided in RCW 42.56.360.

(3) The department shall:

(a) Provide oversight of the health care-associated infection reporting program established in this section;

(b) By November 1, 2013, and biennially thereafter, submit a report to the appropriate committees of the legislature that contains: (i) Categories of reporting currently required of hospitals under subsection (2)(a) of this section; (ii) categories of reporting the department plans to add, delete, or modify by rule; and (iii) a description of the evaluation process used under (d) of this subsection;

(c) By December 1, 2009, and by each December 1st thereafter, prepare and publish a report on the department's website that compares the health care-associated infection rates at individual hospitals in the state using the data reported in the previous calendar year pursuant to subsection (2) of this section. The department may update the reports quarterly. In developing a methodology for the report and determining its contents, the department shall consider the recommendations of the advisory committee established in subsection (5) of this section. The report is subject to the following:

(i) The report must disclose data in a format that does not release health information about any individual patient; and

(ii) The report must not include data if the department determines that a data set is too small or possesses other characteristics that make it otherwise unrepresentative of a hospital's particular ability to achieve a specific outcome;

(d) Evaluate, on a regular basis, the quality and accuracy of health care-associated infection reporting required under subsection (2) of this section and the data collection, analysis, and reporting methodologies; and

(e) Provide assistance to hospitals with the reporting requirements of this chapter including definitions of required reporting elements.

(4) The department may respond to requests for data and other information from the data required to be reported under subsection (2) of this section, at the requestor's expense, for special studies and analysis consistent with requirements for confidentiality of patient records.

(5)(a) The department shall establish an advisory committee which may include members representing infection control professionals and epidemiologists, licensed health care providers, nursing staff, organizations that represent health care providers and facilities, health maintenance organizations, health care payers and consumers,

and the department. The advisory committee shall make recommendations to assist the department in carrying out its responsibilities under this section, including making recommendations on allowing a hospital to review and verify data to be released in the report and on excluding from the report selected data from certified critical access hospitals.

(b) In developing its recommendations, the advisory committee shall consider methodologies and practices related to health care-associated infections of the United States centers for disease control and prevention, the centers for medicare and medicaid services, the joint commission, the national quality forum, the institute for healthcare improvement, and other relevant organizations.

(6) The department shall adopt rules as necessary to carry out its responsibilities under this section. [2013 c 319 § 2; 2013 c 319 § 1; 2010 c 113 § 1; 2009 c 244 § 2; 2007 c 261 § 2.]

***Reviser's note:** RCW 70.02.050 was amended by 2013 c 200 § 3, eliminating many of the provisions relating to disclosure of health care information without patient's authorization, effective July 1, 2014. See RCW 70.02.200 through 70.02.260.

Effective date—2013 c 319 § 2: "Section 2 of this act takes effect July 1, 2017." [2013 c 319 § 4.]

Effective date—2010 c 113: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [March 18, 2010]." [2010 c 113 § 2.]

Findings—2007 c 261: "The legislature finds that each year health care-associated infections affect two million Americans. These infections result in the unnecessary death of ninety thousand patients and costs the health care system 4.5 billion dollars. Hospitals should be implementing evidence-based measures to reduce hospital-acquired infections. The legislature further finds the public should have access to data on outcome measures regarding hospital-acquired infections. Data reporting should be consistent with national hospital reporting standards." [2007 c 261 § 1.]

RCW 43.70.057 Hospital emergency room patient care information—Data collection, maintenance, analysis, and dissemination—Rules. (1) The legislature finds that public health data is critical to the department's ability to respond to emerging public health threats and chronic conditions affecting the public health and, therefore, intends that the department be fully informed about emerging public health threats and chronic conditions that may impact the health of Washington citizens.

(2) The department shall require hospitals with emergency departments to submit emergency department patient care information, which must be collected, maintained, analyzed, and disseminated by the department. The department shall also accept other data types submitted voluntarily as approved by the department. The data must be collected in a way that allows automated reporting by electronic transmission. Emergency departments submitting data must be able to obtain their data and aggregate regional and statewide data from the collection system within thirty minutes of submission of a query for

the data once the data is available in the system. The department may, if deemed cost-effective and efficient, contract with a private entity for any or all parts of data collection, maintenance, analysis, and dissemination. The department or contractor shall include the following elements:

(a) A demonstrated ability to collect the data required by this section in a way that allows automated reporting by electronic transmission;

(b) An established data submission arrangement with the majority of emergency departments required to submit data pursuant to this section;

(c) The demonstrated ability to allow emergency departments submitting data to immediately obtain their own data and aggregate regional and statewide data and the department to immediately obtain any data within thirty minutes of submission of a query for data once the data is available in the system; and

(d) The capacity to work with existing emergency department data systems to minimize administrative reporting burden and costs.

(3) Data elements must be reported in conformance with a uniform reporting system established by the department in collaboration with representatives from emergency departments required to submit data pursuant to this section and in conformance with current or emerging national standards for reporting similar data. Data elements to be initially collected include, but are not limited to, data elements identifying facility information, limited patient identifiers, patient demographics, and encounter, clinical, and laboratory information. In order to ensure meaningful public health surveillance, after consulting with emergency departments required to submit data pursuant to this section, the department shall adopt rules including, but not limited to, data element and format requirements and time frames for reporting and addressing errors in submission. The rules adopted shall support alignment with current or emerging national standards for reporting similar data and minimization of administrative burden and costs.

(4) The department may require additional information from data providers only for the purposes of validating data received, verifying data accuracy, conducting surveillance of potential public health threats, and addressing potential public health threats.

(5) The data collected, maintained, and analyzed by the department must only be available for retrieval in original or processed form to public and private requestors pursuant to subsection (6) of this section and must be available within a reasonable period of time after the date of request, except that emergency departments submitting data pursuant to this section must have the ability to immediately obtain their own data and aggregate regional and statewide data within thirty minutes of submission of a query for data once the data is available in the system. The cost of retrieving their own data and aggregate regional and statewide data in standardized reports for state, local, tribal, federal officials and agencies, and health care facilities, and health care providers associated with the emergency departments submitting data pursuant to this section, must be funded through the agency's resources. The cost of retrieving data for individuals and organizations engaged in research or private use of data or reports must be funded by a fee schedule developed by the department that reflects the direct cost of retrieving the data or report in the requested form.

(6) The department must maintain the confidentiality of patient data it collects under subsection (2) of this section. Patient data collected by the department is health care information under chapter 70.02 RCW. Patient data that includes direct and indirect identifiers is not subject to public inspection and copying and the department may only release that data as allowed for in this section. Any agency that receives patient data under (a) or (b) of this subsection must also maintain the confidentiality of the data and may not release the data except as consistent with subsection (7)(b) of this section. The department may release the data as follows:

(a) Data that includes direct and indirect patient identifiers, as specifically defined in rule, may be released to:

(i)(A) Federal, Washington state, tribal, and local government agencies upon receipt of a signed data use agreement with the department;

(B) In the case of an emergent public health threat, the signed data use agreement requirement must be waived for public health authorities. The department may disclose only the minimum amount of information necessary, to the fewest number of people, for the least amount of time required to address the threat;

(ii) Researchers with approval of an institutional review board upon receipt of a signed confidentiality agreement with the department;

(b) Data that does not contain direct patient identifiers but may contain indirect patient identifiers may be released to agencies, institutional review board-approved researchers, and other persons upon receipt of a signed data use agreement with the department;

(c) Data that does not contain direct or indirect patient identifiers may be released on request.

(7) Recipients of data under subsection (6)(a) and (b) of this section must agree in a data use agreement, as applicable, at a minimum, to:

(a) Take steps to protect direct and indirect patient identifiers as described in the data use agreement; and

(b) Not redisclose the data except as authorized in their data use agreement consistent with the purpose of the agreement.

(8) Recipients of data under subsection (6)(b) and (c) of this section must not attempt to determine the identity of persons whose information is included in the data set or use the data in any manner that identifies individuals or their families.

(9) For the purposes of this section:

(a) "Direct patient identifier" means information that identifies a patient; and

(b) "Indirect patient identifier" means information that may identify a patient when combined with other information.

(10) The department may adopt rules necessary to carry out its responsibilities under this section. The department must consider national standards when adopting rules. [2017 c 220 § 1.]

RCW 43.70.060 Duties of department—Promotion of health care cost-effectiveness. It is the intent of the legislature to promote appropriate use of health care resources to maximize access to adequate health care services. The legislature understands that the rapidly increasing costs of health care are limiting access to care. To promote health care cost-effectiveness, the department shall:

(1) Implement the certificate of need program;
(2) Monitor and evaluate health care costs;
(3) Evaluate health services and the utilization of services for outcome and effectiveness; and
(4) Recommend strategies to encourage adequate and cost-effective services and discourage ineffective services. [1989 1st ex.s. c 9 § 108.]

RCW 43.70.064 Health care quality—Findings and intent—Requirements for conducting study under RCW 43.70.066. The legislature finds that it is difficult for consumers of health care services to determine the quality of health care prior to purchase or utilization of medical care. The legislature also finds that accountability is a key component in promoting quality assurance and quality improvement throughout the health care delivery system, including public programs. Quality assurance and improvement standards are necessary to promote the public interest, contribute to cost efficiencies, and improve the ability of consumers to ascertain quality health care purchases.

The legislature intends to have consumers, health carriers, health care providers and facilities, and public agencies participate in the development of quality assurance and improvement standards that can be used to develop a uniform quality assurance program for use by all public and private health plans, providers, and facilities. To that end, in conducting the study required under RCW 43.70.066, the department of health shall:

(1) Consider the needs of consumers, employers, health care providers and facilities, and public and private health plans;
(2) Take full advantage of existing national standards of quality assurance to extend to middle-income populations the protections required for state management of health programs for low-income populations;
(3) Consider the appropriate minimum level of quality assurance standards that should be disclosed to consumers and employers by health care providers and facilities, and public and private health plans; and
(4) Consider standards that permit health care providers and facilities to share responsibility for participation in a uniform quality assurance program. [1995 c 267 § 3.]

Captions not law—Severability—Effective dates—1995 c 267: See notes following RCW 43.70.052.

RCW 43.70.066 Study—Uniform quality assurance and improvement program—Reports to legislature—Limitation on rule making. (1) The department of health shall study the feasibility of a uniform quality assurance and improvement program for use by all public and private health plans and health care providers and facilities. In this study, the department shall consult with:
(a) Public and private purchasers of health care services;
(b) Health carriers;
(c) Health care providers and facilities; and
(d) Consumers of health services.

(2) In conducting the study, the department shall propose standards that meet the needs of affected persons and organizations, whether public or private, without creation of differing levels of quality assurance. All consumers of health services should be afforded the same level of quality assurance.

(3) At a minimum, the study shall include but not be limited to the following program components and indicators appropriate for consumer disclosure:

(a) Health care provider training, credentialing, and licensure standards;

(b) Health care facility credentialing and recredentialing;

(c) Staff ratios in health care facilities;

(d) Annual mortality and morbidity rates of cases based on a defined set of procedures performed or diagnoses treated in health care facilities, adjusted to fairly consider variable factors such as patient demographics and case severity;

(e) The average total cost and average length of hospital stay for a defined set of procedures and diagnoses;

(f) The total number of the defined set of procedures, by specialty, performed by each physician at a health care facility within the previous twelve months;

(g) Utilization performance profiles by provider, both primary care and specialty care, that have been adjusted to fairly consider variable factors such as patient demographics and severity of case;

(h) Health plan fiscal performance standards;

(i) Health care provider and facility recordkeeping and reporting standards;

(j) Health care utilization management that monitors trends in health service underutilization, as well as overutilization of services;

(k) Health monitoring that is responsive to consumer, purchaser, and public health assessment needs; and

(l) Assessment of consumer satisfaction and disclosure of consumer survey results.

(4) In conducting the study, the department shall develop standards that permit each health care facility, provider group, or health carrier to assume responsibility for and determine the physical method of collection, storage, and assimilation of quality indicators for consumer disclosure. The study may define the forms, frequency, and posting requirements for disclosure of information.

In developing proposed standards under this subsection, the department shall identify options that would minimize provider burden and administrative cost resulting from duplicative private sector data submission requirements.

(5) The department shall submit a preliminary report to the legislature by December 31, 1995, including recommendations for initial legislation pursuant to subsection (6) of this section, and may submit supplementary reports and recommendations as completed, consistent with appropriated funds and staffing.

(6) The department shall not adopt any rule implementing the uniform quality assurance program or consumer disclosure provisions unless expressly directed to do so by an act of law. [1998 c 245 § 72; 1997 c 274 § 3; 1995 c 267 § 4.]

Effective date—1997 c 274: See note following RCW 41.05.021.

Captions not law—Severability—Effective dates—1995 c 267: See notes following RCW 43.70.052.

RCW 43.70.068 Quality assurance—Interagency cooperation. The department of health, the health care authority, the department of social and health services, the office of the insurance commissioner, and the department of labor and industries shall form an interagency group for coordination and consultation on quality assurance activities and collaboration on final recommendations for the study required under RCW 43.70.066. [1997 c 274 § 4; 1995 c 267 § 5.]

Effective date—1997 c 274: See note following RCW 41.05.021.

Captions not law—Severability—Effective dates—1995 c 267: See notes following RCW 43.70.052.

RCW 43.70.070 Duties of department—Analysis of health services. The department shall evaluate and analyze readily available data and information to determine the outcome and effectiveness of health services, utilization of services, and payment methods. This section should not be construed as allowing the department access to proprietary information.

(1) The department shall make its evaluations available to the board for use in preparation of the state health report required by *RCW 43.20.050, and to consumers, purchasers, and providers of health care.

(2) The department shall use the information to:

(a) Develop guidelines which may be used by consumers, purchasers, and providers of health care to encourage necessary and cost-effective services; and

(b) Make recommendations to the governor on how state government and private purchasers may be prudent purchasers of cost-effective, adequate health services. [1995 c 269 § 2202; 1989 1st ex.s. c 9 § 109.]

***Reviser's note:** RCW 43.20.050 was amended by 2011 c 27 § 1, eliminating the "state health report."

Effective date—Part headings not law—Severability—1995 c 269: See notes following RCW 18.16.050.

RCW 43.70.075 Identity of whistleblower protected—Remedy for retaliatory action—Definitions—Rules. (1)(a) The identity of a whistleblower must remain confidential if that whistleblower:

(i) Complains, in good faith, to the department of health about the improper quality of care by a health care provider, or in a health care facility;

(ii) Initiates in good faith any investigation or administrative proceeding about a complaint of improper quality of care made to the department under this section; or

(iii) Submits a notification or report of an adverse event or an incident, in good faith, to the department of health under RCW 70.56.020 or to the independent entity under RCW 70.56.040.

(b) The provisions of RCW 4.24.500 through 4.24.520, providing certain protections to persons who communicate to government agencies, shall apply to complaints and notifications or reports of adverse events or incidents filed under this section. The identity of the whistleblower shall remain confidential unless the department determines that the complaint, initiation, notification, or report was not made or done in good faith.

(c) An employee who is a whistleblower, as defined in this section, and who as a result of being a whistleblower has been subjected to workplace reprisal or retaliatory action has the remedies provided under chapter 49.60 RCW.

(d) A whistleblower who is not an employee and who as a result of being a whistleblower has been subjected to reprisal or retaliatory action may initiate a civil action in a court of competent jurisdiction to either enjoin further violations, recover actual damages sustained by the whistleblower, or both, and recover the cost of the suit including reasonable attorneys' fees. The court shall award reasonable attorneys' fees in favor of the respondent if the civil action was initiated by a whistleblower who is not an employee and the court finds that the respondent has not engaged in the alleged reprisal or retaliatory action and that the complaint was frivolous, unreasonable, or groundless.

(2) A civil action under this section may not be brought more than two years after the date when the retaliation occurred.

(3) In this section:

(a) "Health care facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, ambulatory surgical facilities licensed under chapter 70.230 RCW, substance use disorder treatment facilities licensed under chapter 71.24 RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(b) "Improper quality of care" means any practice, procedure, action, or failure to act that violates any state law or rule of the applicable state health licensing authority under Title 18 or chapters 70.41, 71.24, 70.127, 70.175, 71.05, 71.12, and 71.24 RCW, and enforced by the department of health. Each health disciplinary authority as defined in RCW 18.130.040 may, with consultation and interdisciplinary coordination provided by the state department of health, adopt rules defining accepted standards of practice for their profession that shall further define improper quality of care. Improper quality of care shall not include good faith personnel actions related to employee performance or actions taken according to established terms and conditions of employment.

(c) "Reprisal or retaliatory action" means but is not limited to: Denial of adequate staff to perform duties; frequent staff changes; frequent and undesirable office changes; refusal to assign meaningful work; unwarranted and unsubstantiated report of misconduct pursuant to Title 18 RCW; letters of reprimand or unsatisfactory performance evaluations; demotion; reduction in pay; denial of promotion;

suspension; dismissal; denial of employment; a supervisor or superior encouraging coworkers to behave in a hostile manner toward the whistleblower; and the revocation, suspension, or reduction of medical staff membership or privileges without following a medical staff sanction process that is consistent with RCW 7.71.050.

(d) "Whistleblower" means a consumer, employee, or health care professional including a health care provider as defined in RCW 7.70.020(1) or member of a medical staff at a health care facility, who in good faith reports alleged quality of care concerns to the department of health or initiates, participates, or cooperates in any investigation or administrative proceeding under this section.

(4) Nothing in this section prohibits a health care facility from making any decision exercising its authority to terminate, suspend, or discipline an employee who engages in workplace reprisal or retaliatory action against a whistleblower.

(5) The department shall adopt rules to implement procedures for filing, investigation, and resolution of whistleblower complaints that are integrated with complaint procedures under Title 18 RCW for health professionals or health care facilities. [2019 c 62 § 1; 2006 c 8 § 109; 1995 c 265 § 19.]

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Captions not law—Effective dates—Savings—Severability—1995 c 265: See notes following RCW 70.47.015.

RCW 43.70.080 Transfer of powers and duties from the department of social and health services. The powers and duties of the department of social and health services and the secretary of social and health services under the following statutes are hereby transferred to the department of health and the secretary of health: Chapters 16.70, 18.46, 18.71, 18.73, 18.76, 69.30, 70.28, 70.30, 70.50, *70.58, 70.62, 70.83, 70.90, 70A.388, 70.104, 70A.100, 70A.105, 70A.120, 70A.125, 70A.310, 70.127, 70A.130, and 80.50 RCW. More specifically, the following programs and services presently administered by the department of social and health services are hereby transferred to the department of health:

(1) Personal health and protection programs and related management and support services, including, but not limited to: Immunizations; tuberculosis; sexually transmitted diseases; AIDS; diabetes control; primary health care; cardiovascular risk reduction; kidney disease; regional genetic services; newborn metabolic screening; sentinel birth defects; cytogenetics; communicable disease epidemiology; and chronic disease epidemiology;

(2) Environmental health protection services and related management and support services, including, but not limited to: Radiation, including X-ray control, radioactive materials, uranium mills, low-level waste, emergency response and reactor safety, and environmental radiation protection; drinking water; toxic substances; on-site sewage; recreational water contact facilities; food services sanitation; shellfish; and general environmental health services, including schools, vectors, parks, and camps;

(3) Public health laboratory;

(4) Public health support services, including, but not limited to: Vital records; health data; local public health services support; and health education and information;

(5) Licensing and certification services including, but not limited to: Behavioral health agencies, agencies providing problem and pathological gambling treatment, health and personal care facility survey, construction review, emergency medical services, laboratory quality assurance, and accommodations surveys; and

(6) Effective January 1, 1991, parent and child health services and related management support services, including, but not limited to: Maternal and infant health; child health; parental health; nutrition; services for children with disabilities; family planning; adolescent pregnancy services; high priority infant tracking; early intervention; parenting education; prenatal regionalization; and power and duties under RCW 43.20A.635. The director of the office of financial management may recommend to the legislature a delay in this transfer, if it is determined that this time frame is not adequate. [2021 c 65 § 44; 2018 c 201 § 8009; 1989 1st ex.s. c 9 § 201.]

***Reviser's note:** Chapter 70.58 RCW was repealed in its entirety by 2019 c 148 § 40, effective January 1, 2021. For later enactment, see chapter 70.58A RCW.

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

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

RCW 43.70.081 Transfer of certain behavioral health-related powers, duties, and functions from the department of social and health services. (1) The powers, duties, and functions of the department of social and health services pertaining to licensing and certification of behavioral health provider agencies and facilities, except for state-run mental health institutions, are hereby transferred to the department of health to the extent necessary to carry out the purposes of chapter 201, Laws of 2018. All references to the secretary or the department of social and health services in the Revised Code of Washington shall be construed to mean the secretary of the department of health or the department of health when referring to the functions transferred in this section.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material in the possession of the department of social and health services pertaining to the powers, duties, and functions transferred shall be delivered to the custody of the department of health. All cabinets, furniture, office equipment, motor vehicles, and other tangible property employed by the department of social and health services in carrying out the powers, duties, and functions transferred shall be made available to the department of health. All funds, credits, or other assets held by the department of social and health services in connection with the powers, duties, and functions transferred shall be assigned to the department of health.

(b) Any appropriations made to the department of social and health services for carrying out the powers, functions, and duties transferred shall, on July 1, 2018, be transferred and credited to the department of health.

(c) If any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

(3) All rules and all pending business before the department of social and health services pertaining to the powers, duties, and functions transferred shall be continued and acted upon by the department of health. All existing contracts and obligations shall remain in full force and shall be performed by the department of health.

(4) The transfer of the powers, duties, functions, and personnel of the department of social and health services shall not affect the validity of any act performed before July 1, 2018.

(5) If apportionments of budgeted funds are required because of the transfers directed by this section, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these shall make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification.

(6) On July 1, 2018, all employees of the department of social and health services engaged in performing the powers, functions, and duties transferred to the department of health are transferred to the department of health. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the department of health to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service law.

(7) Positions in any bargaining unit within the department of health existing on July 1, 2018, will not be removed from an existing bargaining unit as a result of this section unless and until the existing bargaining unit is modified by the public employment relations commission pursuant to Title 391 WAC. Nonsupervisory civil service employees of the department of social and health services assigned to the department of health under this section whose positions are within the existing bargaining unit description at the department of health shall become a part of that unit under the provision of chapter 41.80 RCW. The existing bargaining representative of the existing bargaining unit at the department of health shall continue to be certified as the exclusive bargaining representative without the necessity of an election.

(8) The department of health may enter into agreements as necessary with the department of social and health services to carry out the transfer of duties as set forth in chapter 201, Laws of 2018. [2018 c 201 § 10002.]

Findings—Intent—Effective date—2018 c 201: See notes following RCW 41.05.018.

RCW 43.70.090 Authority to administer oaths and issue subpoenas—Provisions governing subpoenas. (1) The secretary shall have full authority to administer oaths and take testimony thereunder, to issue subpoenas requiring the attendance of witnesses before the secretary

together with all books, memoranda, papers, and other documents, articles or instruments, and to compel the disclosure by such witnesses of all facts known to them relative to the matters under investigation.

(2) Subpoenas issued in adjudicative proceedings shall be governed by RCW 34.05.588(1).

(3) Subpoenas issued in the conduct of investigations required or authorized by other statutory provisions or necessary in the enforcement of other statutory provisions shall be governed by RCW 34.05.588(2). [1989 1st ex.s. c 9 § 252.]

RCW 43.70.095 Civil fines. This section governs the assessment of a civil fine against a person by the department. This section does not govern actions taken under chapter 18.130 RCW.

(1) The department shall give written notice to the person against whom it assesses a civil fine. The notice shall state the reasons for the adverse action. The notice shall be personally served in the manner of service of a summons in a civil action or shall be given in an other [another] manner that shows proof of receipt.

(2) Except as otherwise provided in subsection (4) of this section, the civil fine is due and payable twenty-eight days after receipt. The department may make the date the fine is due later than twenty-eight days after receipt. When the department does so, it shall state the effective date in the written notice given the person against whom it assesses the fine.

(3) The person against whom the department assesses a civil fine has the right to an adjudicative proceeding. The proceeding is governed by the Administrative Procedure Act, chapter 34.05 RCW. The application must be in writing, state the basis for contesting the fine, include a copy of the adverse notice, be served on and received by the department within twenty-eight days of the person's receiving the notice of civil fine, and be served in a manner which shows proof of receipt.

(4) If the person files a timely and sufficient appeal, the department shall not implement the action until the final order has been served. The presiding or reviewing officer may permit the department to implement part or all of the action while the proceedings are pending if the appellant causes an unreasonable delay in the proceedings or for other good cause. [1991 c 3 § 378.]

RCW 43.70.097 Enforcement in accordance with RCW 43.05.100 and 43.05.110. Enforcement action taken after July 23, 1995, by the director or the department shall be in accordance with RCW 43.05.100 and 43.05.110. [1995 c 403 § 626.]

Findings—Short title—Intent—1995 c 403: See note following RCW 34.05.328.

RCW 43.70.100 Reports of violations by secretary—Duty to institute proceedings—Notice to alleged violator. (1) It shall be the duty of each assistant attorney general, prosecuting attorney, or city attorney to whom the secretary reports any violation of chapter 43.20 or 43.70 RCW, or regulations promulgated under them, to cause

appropriate proceedings to be instituted in the proper courts, without delay, and to be duly prosecuted as prescribed by law.

(2) Before any violation of chapter 43.20 or 43.70 RCW is reported by the secretary to the prosecuting attorney for the institution of a criminal proceeding, the person against whom such proceeding is contemplated shall be given appropriate notice and an opportunity to present his or her views to the secretary, either orally or in writing, with regard to such contemplated proceeding. [1989 1st ex.s. c 9 § 262.]

RCW 43.70.110 License fees—Costs—Other charges—Waiver. (1) The secretary shall charge fees to the licensee for obtaining a license. Physicians regulated pursuant to chapter 18.71 RCW who reside and practice in Washington and obtain or renew a retired active license are exempt from such fees. Municipal corporations providing emergency medical care and transportation services pursuant to chapter 18.73 RCW shall be exempt from such fees, provided that such other emergency services shall only be charged for their pro rata share of the cost of licensure and inspection, if appropriate. The secretary may charge different fees for registered nurses licensed under chapter 18.79 RCW, licensed practical nurses licensed under chapter 18.79 RCW, and nurses who hold a valid multistate license issued by the state of Washington under chapter 18.80 RCW. The secretary may waive the fees when, in the discretion of the secretary, the fees would not be in the best interest of public health and safety, or when the fees would be to the financial disadvantage of the state.

(2) Except as provided in subsection (3) of this section, fees charged shall be based on, but shall not exceed, the cost to the department for the licensure of the activity or class of activities and may include costs of necessary inspection.

(3) License fees shall include amounts in addition to the cost of licensure activities in the following circumstances:

(a) For registered nurses and licensed practical nurses licensed under chapter 18.79 RCW, and for nurses who hold a valid multistate license issued by the state of Washington under chapter 18.80 RCW, support of a central nursing resource center as provided in RCW 18.79.202;

(b) For all health care providers licensed under RCW 18.130.040, the cost of regulatory activities for retired volunteer medical worker licensees as provided in RCW 18.130.360; and

(c) For physicians licensed under chapter 18.71 RCW, physician assistants licensed under chapter 18.71A RCW, osteopathic physicians licensed under chapter 18.57 RCW, naturopaths licensed under chapter 18.36A RCW, podiatrists licensed under chapter 18.22 RCW, chiropractors licensed under chapter 18.25 RCW, psychologists licensed under chapter 18.83 RCW, registered nurses and licensed practical nurses licensed under chapter 18.79 RCW, nurses who hold a valid multistate license issued by the state of Washington under chapter 18.80 RCW, optometrists licensed under chapter 18.53 RCW, mental health counselors licensed under chapter 18.225 RCW, massage therapists licensed under chapter 18.108 RCW, advanced social workers licensed under chapter 18.225 RCW, independent clinical social workers and independent clinical social worker associates licensed under chapter 18.225 RCW, midwives licensed under chapter 18.50 RCW, marriage and family therapists and marriage and family therapist

associates licensed under chapter 18.225 RCW, occupational therapists and occupational therapy assistants licensed under chapter 18.59 RCW, dietitians and nutritionists certified under chapter 18.138 RCW, speech-language pathologists licensed under chapter 18.35 RCW, acupuncturists or acupuncture and Eastern medicine practitioners licensed under chapter 18.06 RCW, and veterinarians and veterinary technicians licensed under chapter 18.92 RCW, the license fees shall include up to an additional twenty-five dollars to be transferred by the department to the University of Washington for the purposes of RCW 43.70.112.

(4) Department of health advisory committees may review fees established by the secretary for licenses and comment upon the appropriateness of the level of such fees. [2023 c 123 § 23; 2020 c 80 § 28. Prior: 2019 c 308 § 21; 2019 c 140 § 1; 2015 c 77 § 1; prior: 2013 c 249 § 1; 2013 c 77 § 1; 2011 c 35 § 1; 2010 c 286 § 15; 2009 c 403 § 5; 2007 c 259 § 11; 2006 c 72 § 3; 2005 c 268 § 2; 1993 sp.s. c 24 § 918; 1989 1st ex.s. c 9 § 263.]

Short title—2023 c 123: See RCW 18.80.900.

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Findings—2019 c 308: See note following RCW 18.06.010.

Effective date—2015 c 77: "This act takes effect August 1, 2015." [2015 c 77 § 2.]

Effective date—2013 c 77: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 25, 2013]." [2013 c 77 § 4.]

Intent—2010 c 286: See RCW 18.06.005.

Finding—Intent—2009 c 403: See note following RCW 18.71.080.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

Finding—2005 c 268: See note following RCW 18.79.202.

Severability—Effective dates—1993 sp.s. c 24: See notes following RCW 28A.310.020.

RCW 43.70.112 Online access to health care resources—Annual accounting of use of funds and use of online resources—University of Washington. Within the amounts transferred from the department of health under RCW 43.70.110(3), the University of Washington shall, through the health sciences library, provide online access to selected vital clinical resources, medical journals, decision support tools, and evidence-based reviews of procedures, drugs, and devices to the health professionals listed in RCW 43.70.110(3)(c). Online access shall be available no later than January 1, 2009. Each year, by

December 1st, the University of Washington shall provide an annual accounting of the use of the funds transferred, including which categories of health professionals are using the materials available under the program. The accounting must be transmitted by electronic mail to the members of the health care committees of the legislature. [2009 c 558 § 2; 2007 c 259 § 12.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 43.70.115 Licenses—Denial, suspension, revocation, modification. This section governs the denial of an application for a license or the suspension, revocation, or modification of a license by the department. This section does not govern actions taken under chapter 18.130 RCW.

(1) The department shall give written notice of the denial of an application for a license to the applicant or his or her agent. The department shall give written notice of revocation, suspension, or modification of a license to the licensee or his or her agent. The notice shall state the reasons for the action. The notice shall be personally served in the manner of service of a summons in a civil action or shall be given in another manner that shows proof of receipt.

(2) Except as otherwise provided in this subsection and in subsection (4) of this section, revocation, suspension, or modification is effective twenty-eight days after the licensee or the agent receives the notice.

(a) The department may make the date the action is effective later than twenty-eight days after receipt. If the department does so, it shall state the effective date in the written notice given the licensee or agent.

(b) The department may make the date the action is effective sooner than twenty-eight days after receipt when necessary to protect the public health, safety, or welfare. When the department does so, it shall state the effective date and the reasons supporting the effective date in the written notice given to the licensee or agent.

(c) When the department has received certification pursuant to chapter 74.20A RCW from the department of social and health services that the licensee is a person who is not in compliance with a child support order or *an order from a court stating that the licensee is in noncompliance with a residential or visitation order under chapter 26.09 RCW, the department shall provide that the suspension is effective immediately upon receipt of the suspension notice by the licensee.

(3) Except for licensees suspended for noncompliance with a child support order under chapter 74.20A RCW or noncompliance with a *residential or visitation order under chapter 26.09 RCW, a license applicant or licensee who is aggrieved by a department denial, revocation, suspension, or modification has the right to an adjudicative proceeding. The proceeding is governed by the Administrative Procedure Act, chapter 34.05 RCW. The application must be in writing, state the basis for contesting the adverse action, include a copy of the adverse notice, be served on and received by the department within twenty-eight days of the license applicant's or licensee's receiving the adverse notice, and be served in a manner that shows proof of receipt.

(4)(a) If the department gives a licensee twenty-eight or more days notice of revocation, suspension, or modification and the licensee files an appeal before its effective date, the department shall not implement the adverse action until the final order has been entered. The presiding or reviewing officer may permit the department to implement part or all of the adverse action while the proceedings are pending if the appellant causes an unreasonable delay in the proceeding, if the circumstances change so that implementation is in the public interest, or for other good cause.

(b) If the department gives a licensee less than twenty-eight days notice of revocation, suspension, or modification and the licensee timely files a sufficient appeal, the department may implement the adverse action on the effective date stated in the notice. The presiding or reviewing officer may order the department to stay implementation of part or all of the adverse action while the proceedings are pending if staying implementation is in the public interest or for other good cause. [1997 c 58 § 843; 1991 c 3 § 377.]

***Reviser's note:** 1997 c 58 § 886 requiring a court to order certification of noncompliance with residential provisions of a court-ordered parenting plan was vetoed. Provisions ordering the department of social and health services to certify a responsible parent based on a court order to certify for noncompliance with residential provisions of a parenting plan were vetoed. See RCW 74.20A.320.

Short title—Part headings, captions, table of contents not law—Exemptions and waivers from federal law—Conflict with federal requirements—Severability—1997 c 58: See RCW 74.08A.900 through 74.08A.904.

Effective dates—Intent—1997 c 58: See notes following RCW 74.20A.320.

RCW 43.70.117 Health care professionals licensed in another state or United States territory or the District of Columbia—In-state practice on a limited basis—Requirements—Limitations. (1) Persons licensed as health care professionals in another state or territory of the United States or the District of Columbia, but not licensed by a disciplining authority specified in RCW 18.130.040, may practice in this state on a limited voluntary basis only as provided in this section.

(2) The volunteer health care professional's license must be for a profession substantially equivalent to a profession regulated by a disciplining authority listed in RCW 18.130.040.

(3) At least ten working days prior to the first day of volunteer practice, the volunteer health care professional must submit to the department an attestation that includes, but is not limited to, the following:

(a) A confirmation that the health care professional holds an active license to practice in any state or territory of the United States or the District of Columbia;

(b) A confirmation that the health care professional is not presently subject to any disciplinary action or investigation for criminal or professional misconduct in any jurisdiction;

(c) An acknowledgment that the health care professional understands he or she may perform only within the relevant

professional scope of practice permitted under Washington law, or state of licensure, whichever is more restrictive;

(d) A confirmation that the health care professional has not volunteered in Washington for more than thirty days in the current calendar year;

(e) The contact information of the organization sponsoring the medical clinic or health care event, if any; and

(f) Anticipated volunteer practice dates.

(4) The attestation must be made on a form established by the secretary.

(5) Neither the volunteer health care professional nor the organization sponsoring a medical clinic or health care event, if any, may charge for any time or services performed in Washington. However, organizations sponsoring a medical clinic or health care event may pay or reimburse the volunteer health care professional for actual incurred travel costs.

(6) No health care professional permitted to practice in Washington under this section may volunteer more than thirty days in any calendar year.

(7) Any organization sponsoring a medical clinic or health care event using the services of any volunteer health care professional permitted to practice under this section must:

(a) Independently verify each requirement in subsection (3) of this section for each volunteer health care professional and retain proof of verification for two years after the last day of the medical clinic or health care event;

(b) Maintain the health care records of all patients evaluated or treated by a volunteer health care professional in compliance with chapter 70.02 RCW; and

(c) Ensure the health care records of all patients evaluated or treated by a volunteer health care professional are accessible to future health care professionals, if needed, in compliance with chapter 70.02 RCW.

(8) This section does not create any civil liability on the part of the state or any state agency, officer, employee, or agent.

(9) This section does not apply to the practice of health care professionals under chapter 38.10 or 38.52 RCW or under an agreement authorized by the United States congress for emergency management assistance. [2014 c 126 § 1.]

RCW 43.70.120 Federal programs—Rules—Statutes to be construed to meet federal law. In furtherance of the policy of this state to cooperate with the federal government in the public health programs, the department of health shall adopt such rules and regulations as may become necessary to entitle this state to participate in federal funds unless the same be expressly prohibited by law. Any section or provision of the public health laws of this state which may be susceptible to more than one construction shall be interpreted in favor of the construction most likely to satisfy federal laws entitling this state to receive federal funds for the various programs of public health. [1989 1st ex.s. c 9 § 264.]

RCW 43.70.125 Health care facility certification—Unfunded federal mandates—Applicant fees. The federal government requires

Washington health care facilities to be certified in order to receive federal health care program reimbursement. The department receives funding from the federal government to perform the certifications and recertifications of these health care facilities. When the federal government does not provide sufficient funding to cover all certifications and recertifications, the secretary may assess fees on certification and recertification applicants to fund the certifications and recertifications. [2007 c 279 § 1.]

RCW 43.70.130 Powers and duties of secretary—General. The secretary of health shall:

(1) Exercise all the powers and perform all the duties prescribed by law with respect to public health and vital statistics;

(2) Investigate and study factors relating to the preservation, promotion, and improvement of the health of the people, the causes of morbidity and mortality, and the effects of the environment and other conditions upon the public health, and report the findings to the state board of health for such action as the board determines is necessary;

(3) Strictly enforce all laws for the protection of the public health and the improvement of sanitary conditions in the state, and all rules, regulations, and orders of the state board of health;

(4) Enforce the public health laws of the state and the rules and regulations promulgated by the department or the board of health in local matters, when in its opinion an emergency exists and the local board of health has failed to act with sufficient promptness or efficiency, or is unable for reasons beyond its control to act, or when no local board has been established, and all expenses so incurred shall be paid upon demand of the secretary of the department of health by the local health department for which such services are rendered, out of moneys accruing to the credit of the municipality or the local health department in the current expense fund of the county;

(5) Investigate outbreaks and epidemics of disease that may occur and advise local health officers as to measures to be taken to prevent and control the same;

(6) Exercise general supervision over the work of all local health departments and establish uniform reporting systems by local health officers to the state department of health;

(7) Have the same authority as local health officers, except that the secretary shall not exercise such authority unless the local health officer fails or is unable to do so, or when in an emergency the safety of the public health demands it, or by agreement with the local health officer or local board of health;

(8) Cause to be made from time to time, personal health and sanitation inspections at state owned or contracted institutions and facilities to determine compliance with sanitary and health care standards as adopted by the department, and require the governing authorities thereof to take such action as will conserve the health of all persons connected therewith, and report the findings to the governor;

(9) Review and approve plans for public water system design, engineering, operation, maintenance, financing, and emergency response, as required under state board of health rules;

(10) Take such measures as the secretary deems necessary in order to promote the public health, to establish or participate in the

establishment of health educational or training activities, and to provide funds for and to authorize the attendance and participation in such activities of employees of the state or local health departments and other individuals engaged in programs related to or part of the public health programs of the local health departments or the state department of health. The secretary is also authorized to accept any funds from the federal government or any public or private agency made available for health education training purposes and to conform with such requirements as are necessary in order to receive such funds; and

(11) Establish and maintain laboratory facilities and services as are necessary to carry out the responsibilities of the department. [1990 c 132 § 2; 1989 1st ex.s. c 9 § 251; 1985 c 213 § 2; 1979 c 141 § 46; 1967 ex.s. c 102 § 1; 1965 c 8 § 43.20.010. Prior: (i) 1909 c 208 § 2; RRS § 6004. (ii) 1921 c 7 § 59; RRS § 10817. Formerly RCW 43.20A.600 and 43.20.010.]

Legislative findings—Severability—1990 c 132: See note following RCW 43.20.240.

Savings—Effective date—1985 c 213: See notes following RCW 43.20.050.

Severability—1967 ex.s. c 102: "If any provision of this act, or its application to any person or circumstance is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances is not affected." [1967 ex.s. c 102 § 13.]

Public water systems—Complaint process: RCW 43.20.240.

RCW 43.70.140 Annual conference of health officers. In order to receive the assistance and advice of local health officers in carrying out the secretary's duties and responsibilities, the secretary of health shall hold annually a conference of local health officers, at such place as the secretary deems convenient, for the discussion of questions pertaining to public health, sanitation, and other matters pertaining to the duties and functions of the local health departments, which shall continue in session for such time not exceeding three days as the secretary deems necessary.

The health officer of each county, district, municipality and county-city department shall attend such conference during its entire session, and receive therefor his or her actual and necessary traveling expenses, to be paid by his or her county, district, and municipality or county-city department. No claim for such expenses shall be allowed or paid unless it is accompanied by a certificate from the secretary of health attesting the attendance of the claimant. [1989 1st ex.s. c 9 § 253; 1979 c 141 § 50; 1967 ex.s. c 102 § 10; 1965 c 8 § 43.20.060. Prior: 1915 c 75 § 1; RRS § 6005. Formerly RCW 43.20A.615 and 43.20.060.]

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

RCW 43.70.150 Registration of vital statistics. The secretary of health shall have charge of the state system of registration of births, deaths, fetal deaths, marriages, and decrees of divorce,

annulment and separate maintenance, and shall prepare the necessary rules, forms, and blanks for obtaining records, and insure the faithful registration thereof. [1989 1st ex.s. c 9 § 254; 1979 c 141 § 51; 1967 c 26 § 1; 1965 c 8 § 43.20.070. Prior: 1907 c 83 § 1; RRS § 6018. Formerly RCW 43.20A.620 and 43.20.070.]

Effective date—1967 c 26: "This act shall take effect on January 1, 1968." [1967 c 26 § 12.]

Vital statistics: Chapter 70.58A RCW.

RCW 43.70.170 Threat to public health—Investigation, examination or sampling of articles or conditions constituting—Access—Subpoena power. The secretary on his or her own motion or upon the complaint of any interested party, may investigate, examine, sample or inspect any article or condition constituting a threat to the public health including, but not limited to, outbreaks of communicable diseases, food poisoning, contaminated water supplies, and all other matters injurious to the public health. When not otherwise available, the department may purchase such samples or specimens as may be necessary to determine whether or not there exists a threat to the public health. In furtherance of any such investigation, examination or inspection, the secretary or the secretary's authorized representative may examine that portion of the ledgers, books, accounts, memorandums, and other documents and other articles and things used in connection with the business of such person relating to the actions involved.

For purposes of such investigation, the secretary or the secretary's representative shall at all times have free and unimpeded access to all buildings, yards, warehouses, storage and transportation facilities or any other place. The secretary may also, for the purposes of such investigation, issue subpoenas to compel the attendance of witnesses, as provided for in RCW 43.70.090 or the production of books and documents anywhere in the state. [1989 1st ex.s. c 9 § 256; 1979 c 141 § 53; 1967 ex.s. c 102 § 3. Formerly RCW 43.20A.640 and 43.20.150.]

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

RCW 43.70.180 Threat to public health—Order prohibiting sale or disposition of food or other items pending investigation. Pending the results of an investigation provided for under RCW 43.70.170, the secretary may issue an order prohibiting the disposition or sale of any food or other item involved in the investigation. The order of the secretary shall not be effective for more than fifteen days without the commencement of a legal action as provided for under RCW 43.70.190. [1989 1st ex.s. c 9 § 257; 1979 c 141 § 54; 1967 ex.s. c 102 § 4. Formerly RCW 43.20A.645 and 43.20.160.]

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

RCW 43.70.185 Inspection of property where marine species located—Prohibitions on harvest or landing—Penalties. (1) The

department may enter and inspect any property, lands, or waters, of this state in or on which any marine species are located or from which such species are harvested, whether recreationally or for sale or barter, and any land or water of this state which may cause or contribute to the pollution of areas in or on which such species are harvested or processed. The department may take any reasonably necessary samples to determine whether such species or any lot, batch, or quantity of such species is safe for human consumption.

(2) If the department determines that any species or any lot, batch, or other quantity of such species is unsafe for human consumption because consumption is likely to cause actual harm or because consumption presents a potential risk of substantial harm, the department may, by order under chapter 34.05 RCW, prohibit or restrict the commercial or recreational harvest or landing of any marine species except the recreational harvest of shellfish as defined in chapter 69.30 RCW if taken from privately owned tidelands.

(3) It is unlawful to harvest any marine species in violation of a departmental order prohibiting or restricting such harvest under this section or to possess or sell any marine species so harvested.

(4)(a) Any person who sells any marine species taken in violation of this section is guilty of a gross misdemeanor and subject to the penalties provided in RCW 69.30.140 and 69.30.150.

(b) Any person who harvests or possesses marine species taken in violation of this section is guilty of a civil infraction and is subject to the penalties provided in RCW 69.30.150.

(c) Notwithstanding this section, any person who harvests, possesses, sells, offers to sell, culls, shucks, or packs shellfish is subject to the penalty provisions of chapter 69.30 RCW.

(d) Charges shall not be brought against a person under both chapter 69.30 RCW and this section in connection with this same action, incident, or event.

(5) The criminal provisions of this section are subject to enforcement by fish and wildlife officers or ex officio fish and wildlife officers as defined in RCW 77.08.010.

(6) As used in this section, marine species include all fish, invertebrate or plant species which are found during any portion of the life cycle of those species in the marine environment. [2003 c 53 § 231; 2001 c 253 § 2; 1995 c 147 § 7.]

Intent—Effective date—2003 c 53: See notes following RCW 2.48.180.

RCW 43.70.190 Violations—Injunctions and legal proceedings authorized. The secretary of health or local health officer may bring an action to enjoin a violation or the threatened violation of any of the provisions of the public health laws of this state or any rules or regulation made by the state board of health or the department of health pursuant to said laws, or may bring any legal proceeding authorized by law, including but not limited to the special proceedings authorized in Title 7 RCW, in the superior court in the county in which such violation occurs or is about to occur, or in the superior court of Thurston county. Upon the filing of any action, the court may, upon a showing of an immediate and serious danger to residents constituting an emergency, issue a temporary injunctive

order ex parte. [1990 c 133 § 3; 1989 1st ex.s. c 9 § 258; 1979 c 141 § 55; 1967 ex.s. c 102 § 5. Formerly RCW 43.20A.650 and 43.20.170.]

Findings—Severability—1990 c 133: See notes following RCW 36.94.140.

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

RCW 43.70.195 Public water systems—Receivership actions brought by secretary—Plan for disposition. (1) In any action brought by the secretary of health or by a local health officer pursuant to chapter 7.60 RCW to place a public water system in receivership, the petition shall include the names of one or more suitable candidates for receiver who have consented to assume operation of the water system. The department shall maintain a list of interested and qualified individuals, municipal entities, special purpose districts, and investor-owned water companies with experience in the provision of water service and a history of satisfactory operation of a water system. If there is no other person willing and able to be named as receiver, the court shall appoint the county in which the water system is located as receiver. The county may designate a county agency to operate the system, or it may contract with another individual or public water system to provide management for the system. If the county is appointed as receiver, the secretary of health and the county health officer shall provide regulatory oversight for the agency or other person responsible for managing the water system.

(2) In any petition for receivership under subsection (1) of this section, the department shall recommend that the court grant to the receiver full authority to act in the best interests of the customers served by the public water system. The receiver shall assess the capability, in conjunction with the department and local government, for the system to operate in compliance with health and safety standards, and shall report to the court and the petitioning agency its recommendations for the system's future operation, including the formation of a water-sewer district or other public entity, or ownership by another existing water system capable of providing service.

(3) If a petition for receivership and verifying affidavit executed by an appropriate departmental official allege an immediate and serious danger to residents constituting an emergency, the court shall set the matter for hearing within three days and may appoint a temporary receiver ex parte upon the strength of such petition and affidavit pending a full evidentiary hearing, which shall be held within fourteen days after receipt of the petition.

(4) A bond, if any is imposed upon a receiver, shall be minimal and shall reasonably relate to the level of operating revenue generated by the system. Any receiver appointed pursuant to this section shall not be held personally liable for any good faith, reasonable effort to assume possession of, and to operate, the system in compliance with the court's orders.

(5) The court shall authorize the receiver to impose reasonable assessments on a water system's customers to recover expenditures for improvements necessary for the public health and safety.

(6) No later than twelve months after appointment of a receiver, the petitioning agency, in conjunction with the county in which the

system is located, and the appropriate state and local health agencies, shall develop and present to the court a plan for the disposition of the system. The report shall include the recommendations of the receiver made pursuant to subsection (2) of this section. The report shall include all reasonable and feasible alternatives. After receiving the report, the court shall provide notice to interested parties and conduct such hearings as are necessary. The court shall then order the parties to implement one of the alternatives, or any combination thereof, for the disposition of the system. Such order shall include a date, or proposed date, for the termination of the receivership. Nothing in this section authorizes a court to require a city, town, public utility district, water-sewer district, or irrigation district to accept a system that has been in receivership unless the city, town, public utility district, water-sewer district, or irrigation district agrees to the terms and conditions outlined in the plan adopted by the court.

(7) The court shall not terminate the receivership, and order the return of the system to the owners, unless the department of health approves of such an action. The court may impose reasonable conditions upon the return of the system to the owner, including the posting of a bond or other security, routine performance and financial audits, employment of qualified operators and other staff or contracted services, compliance with financial viability requirements, or other measures sufficient to ensure the ongoing proper operation of the system.

(8) If, as part of the ultimate disposition of the system, an eminent domain action is commenced by a public entity to acquire the system, the court shall oversee any appraisal of the system conducted under Title 7 RCW to assure that the appraised value properly reflects any reduced value because of the necessity to make improvements to the system. The court shall have the authority to approve the appraisal, and to modify it based on any information provided at an evidentiary hearing. The court's determination of the proper value of the system, based on the appraisal, shall be final, and only appealable if not supported by substantial evidence. If the appraised value is appealed, the court may order that the system's ownership be transferred upon payment of the approved appraised value. [1999 c 153 § 57; 1994 c 292 § 3; 1990 c 133 § 4.]

Part headings not law—1999 c 153: See note following RCW 57.04.050.

Findings—Intent—1994 c 292: See note following RCW 57.04.050.

Findings—Severability—1990 c 133: See notes following RCW 36.94.140.

RCW 43.70.200 Enforcement of health laws and state or local rules and regulations upon request of local health officer. Upon the request of a local health officer, the secretary of health is hereby authorized and empowered to take legal action to enforce the public health laws and rules and regulations of the state board of health or local rules and regulations within the jurisdiction served by the local health department, and may institute any civil legal proceeding authorized by the laws of the state of Washington, including a

proceeding under Title 7 RCW. [1990 c 133 § 5; 1989 1st ex.s. c 9 § 259; 1979 c 141 § 56; 1967 ex.s. c 102 § 6. Formerly RCW 43.20A.655 and 43.20.180.]

Findings—Severability—1990 c 133: See notes following RCW 36.94.140.

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

RCW 43.70.210 Right of person to rely on prayer to alleviate ailments not abridged. Nothing in chapter 43.20 or 43.70 RCW, or RCW 43.70.120 shall be construed to abridge the right of any person to rely exclusively on spiritual means alone through prayer to alleviate human ailments, sickness or disease, in accordance with the tenets and practice of the Church of Christ, Scientist, nor shall anything in chapters 43.20, 43.70 RCW, or RCW 43.70.120 be deemed to prohibit a person so relying who is inflicted with a contagious or communicable disease from being isolated or quarantined in a private place of his or her own choice, provided, it is approved by the local health officer, and all laws, rules and regulations governing control, sanitation, isolation and quarantine are complied with. [2009 c 549 § 5145; 1989 1st ex.s. c 9 § 260; 1979 c 141 § 59; 1967 ex.s. c 102 § 14. Formerly RCW 43.20A.665 and 43.20.210.]

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

Prayer: RCW 18.50.030, 70.127.040, 70.128.170, 74.09.190.

RCW 43.70.220 Transfer of powers and duties from the department of licensing. The powers and duties of the department of licensing and the director of licensing under the following statutes are hereby transferred to the department of health and the secretary of health: Chapters 18.06, 18.19, 18.22, 18.25, 18.29, 18.32, 18.34, 18.35, 18.36A, 18.50, 18.52, 18.52C, 18.53, 18.54, 18.55, 18.57, 18.59, 18.71, 18.71A, 18.74, 18.83, 18.84, 18.79, 18.89, 18.92, 18.108, and 18.138 RCW. More specifically, the health professions regulatory programs and services presently administered by the department of licensing are hereby transferred to the department of health. [2020 c 80 § 29; 1994 sp.s. c 9 § 727; 1989 1st ex.s. c 9 § 301.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Severability—Headings and captions not law—Effective date—1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

RCW 43.70.230 Office of health consumer assistance created—Duties. There is created in the department an office of health consumer assistance. The office shall establish a statewide hotline and shall assist and serve as an advocate for consumers who are

complainants or witnesses in a licensing or disciplinary proceeding. [1989 1st ex.s. c 9 § 303.]

RCW 43.70.240 Written operating agreements. The secretary and each of the professional licensing and disciplinary boards listed in RCW 18.130.040(2)(b) shall enter into written operating agreements on administrative procedures with input from the regulated profession and the public. The intent of these agreements is to provide a process for the department to consult each board on administrative matters and to ensure that the administration and staff functions effectively enable each board to fulfill its statutory responsibilities in a manner that supports the health care delivery system and evidence-based practices across all health professions. The agreements shall include, but not be limited to, the following provisions:

(1) Administrative activities supporting the board's policies, goals, and objectives;

(2) Development and review of the agency budget as it relates to the board;

(3) Board-related personnel issues;

(4) Use of performance audits to evaluate the consistent use of common business practices where appropriate; and

(5) Calculation and reporting of timelines and performance measures.

The agreements shall be reviewed and revised in like manner if appropriate at the beginning of each biennium, and at other times upon written request by the secretary or the board. Any dispute between a board and the department, including the terms of the operating agreement, must be mediated and determined by a representative of the office of financial management. [2013 c 81 § 7; 1998 c 245 § 73; 1989 1st ex.s. c 9 § 304.]

Effective date—2013 c 81: See note following RCW 18.25.0167.

RCW 43.70.250 License fees for professions, occupations, and businesses. (1) It shall be the policy of the state of Washington that the cost of each professional, occupational, or business licensing program be fully borne by the members of that profession, occupation, or business.

(2) The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. Any and all fees or assessments, or both, levied on the state to cover the costs of the operations and activities of the interstate health professions licensure compacts with participating authorities listed under chapter 18.130 RCW shall be borne by the persons who hold licenses issued pursuant to the authority and procedures established under the compacts. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the cost of regulating licensed volunteer medical workers in accordance with RCW 18.130.360, except as provided in RCW 18.79.202. In no case may the secretary impose any certification, examination, or renewal fee upon a person seeking certification as a certified peer

specialist trainee under chapter 18.420 RCW or, between July 1, 2025, and July 1, 2030, impose a certification, examination, or renewal fee of more than $100 upon any person seeking certification as a certified peer specialist under chapter 18.420 RCW.

(3) All such fees shall be fixed by rule adopted by the secretary in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW. [2023 c 469 § 21; 2019 c 415 § 966; 2017 c 195 § 26; 2016 c 146 § 1; 2013 c 77 § 2; 2006 c 72 § 4; 2005 c 268 § 3; 1996 c 191 § 1; 1989 1st ex.s. c 9 § 319.]

Effective date—2019 c 415: See note following RCW 28B.20.476.

Effective date—2013 c 77: See note following RCW 43.70.110.

Finding—2005 c 268: See note following RCW 18.79.202.

RCW 43.70.260 Appointment of temporary additional members of boards and committees for administration and grading of examinations. The secretary may, at the request of a board or committee established under Title 18 RCW under the administrative authority of the department of health, appoint temporary additional members for the purpose of participating as members during the administration and grading of practical examinations for licensure, certification, or registration. The appointment shall be for the duration of the examination specified in the request. Individuals so appointed must meet the same minimum qualifications as regular members of the board or committee, including the requirement to be licensed, certified, or registered. While serving as board or committee members, persons so appointed have all the powers, duties, and immunities and are entitled to the emoluments, including travel expenses in accordance with RCW 43.03.050 and 43.03.060, of regular members of the board or committee. This authority is intended to provide for more efficient, economical, and effective examinations. [1989 1st ex.s. c 9 § 320.]

RCW 43.70.270 License moratorium for persons in the service—Rules. (1) Notwithstanding any provision of law to the contrary, the license of any person licensed by the secretary of health to practice a profession or engage in an occupation, if valid and in force and effect at the time the licensee entered service in the armed forces, the United States public health service commissioned corps, or the merchant marine of the United States, shall continue in full force and effect so long as such service continues, unless sooner suspended, canceled, or revoked for cause as provided by law. The secretary shall renew the license of every such person who applies for renewal thereof within six months after being honorably discharged from service upon payment of the renewal fee applicable to the then current year or other license period.

(2) If requested by the licensee, the license of a spouse or registered domestic partner of a service member in the United States armed forces, including the United States public health service commissioned corps, if valid and in force and effect at the time the service member is deployed or stationed in a location outside Washington state, must be placed in inactive military spouse or registered domestic partner status so long as such service continues,

unless sooner suspended, canceled, or revoked for cause as provided by law. The secretary shall return to active status the license of every such person who applies for renewal thereof within six months after the service member is honorably discharged from service, or sooner if requested by the licensee, upon payment of the renewal fee applicable to the then current year or other license period.

(3) The secretary may adopt any rules necessary to implement this section. [2012 c 45 § 2; 1989 1st ex.s. c 9 § 321.]

RCW 43.70.280 Procedure for issuance, renewal, or reissuance of credentials—Extension or modification of licensing, certification, or registration period authorized. (1) The secretary, in consultation with health profession boards and commissions, shall establish by rule the administrative procedures, administrative requirements, and fees for initial issue, renewal, and reissue of a credential for professions under RCW 18.130.040, including procedures and requirements for late renewals and uniform application of late renewal penalties. Failure to renew invalidates the credential and all privileges granted by the credential. Administrative procedures and administrative requirements do not include establishing, monitoring, and enforcing qualifications for licensure, scope or standards of practice, continuing competency mechanisms, and discipline when such authority is authorized in statute to a health profession board or commission. For the purposes of this section, "in consultation with" means providing an opportunity for meaningful participation in development of rules consistent with processes set forth in RCW 34.05.310.

(2) Notwithstanding any provision of law to the contrary which provides for a licensing period for any type of license subject to this chapter including those under RCW 18.130.040, the secretary of health may, from time to time, extend or otherwise modify the duration of any licensing, certification, or registration period, whether an initial or renewal period, if the secretary determines that it would result in a more economical or efficient operation of state government and that the public health, safety, or welfare would not be substantially adversely affected thereby. However, no license, certification, or registration may be issued or approved for a period in excess of four years, without renewal. Such extension, reduction, or other modification of a licensing, certification, or registration period shall be by rule or regulation of the department of health adopted in accordance with the provisions of chapter 34.05 RCW. Such rules and regulations may provide a method for imposing and collecting such additional proportional fee as may be required for the extended or modified period. [1999 c 34 § 1; 1998 c 29 § 1; 1996 c 191 § 2; 1989 1st ex.s. c 9 § 322.]

RCW 43.70.290 Funeral directors and embalmers subject to chapter 18.130 RCW. Funeral directors and embalmers, licensed under chapter 18.39 RCW, are subject to the provisions of chapter 18.130 RCW under the administration of the department of licensing. The department of licensing shall review the statutes authorizing the regulation of funeral directors and embalmers, and recommend any changes necessary by January 1, 1990. [1989 1st ex.s. c 9 § 323.]

RCW 43.70.300 Secretary or secretary's designee ex officio member of health professional licensure and disciplinary boards. In order to provide liaison with the department of health, provide continuity between changes in board membership, achieve uniformity as appropriate in licensure or regulated activities under the jurisdiction of the department, and to better represent the public interest, the secretary, or a designee appointed by the secretary, shall serve as an ex officio member of every health professional licensure or disciplinary board established under Title 18 RCW under the administrative authority of the department of health. The secretary shall have no vote unless otherwise authorized by law. [1989 1st ex.s. c 9 § 318; 1983 c 168 § 11. Formerly RCW 43.24.015.]

RCW 43.70.310 Cooperation with department of ecology. Where feasible, the department and the state board of health shall consult with the department of ecology in order that, to the fullest extent possible, agencies concerned with the preservation of life and health and agencies concerned with protection of the environment may integrate their efforts and endorse policies in common. [1987 c 109 § 25; 1970 ex.s. c 18 § 12. Formerly RCW 43.20A.140.]

Purpose—Short title—Construction—Rules—Severability—Captions—1987 c 109: See notes following RCW 43.21B.001.

RCW 43.70.320 Health professions account—Fees credited—Requirements for biennial budget request—Unappropriated funds. (1) There is created in the state treasury an account to be known as the health professions account. All fees received by the department for health professions licenses, registration, certifications, renewals, compact privileges, or examinations and the civil penalties assessed and collected by the department under RCW 18.130.190 shall be forwarded to the state treasurer who shall credit such moneys to the health professions account.

(2) All expenses incurred in carrying out the health professions licensing activities of the department shall be paid from the account as authorized by legislative appropriation, except as provided in subsections (4) and (5) of this section. Any residue in the account shall be accumulated and shall not revert to the general fund at the end of the biennium.

(3) The secretary shall biennially prepare a budget request based on the anticipated costs of administering the health professions licensing activities of the department which shall include the estimated income from health professions fees.

(4) The fees received by the department from applicants for compact privilege under RCW 18.74.500 must be used for the purpose of meeting financial obligations imposed on the state as a result of this state's participation in the physical therapy licensure compact.

(5) The secretary shall, at the request of a board or commission as applicable, spend unappropriated funds in the health professions account that are allocated to the requesting board or commission to meet unanticipated costs of that board or commission when revenues exceed more than fifteen percent over the department's estimated six-year spending projections for the requesting board or commission. Unanticipated costs shall be limited to spending as authorized in

subsection (3) of this section for anticipated costs. [2019 c 220 § 1; 2017 c 108 § 7; 2015 c 70 § 39; 2008 c 134 § 16; 1993 c 492 § 411; 1991 sp.s. c 13 § 18; 1991 c 3 § 299; 1985 c 57 § 29; 1983 c 168 § 5. Formerly RCW 43.24.072.]

Effective date—2019 c 220: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2019." [2019 c 220 § 3.]

Short title—Findings—Intent—References to Washington state liquor control board—Draft legislation—2015 c 70: See notes following RCW 66.08.012.

Finding—Intent—Severability—2008 c 134: See notes following RCW 18.130.020.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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

Effective dates—Severability—1991 sp.s. c 13: See notes following RCW 18.08.240.

Effective date—1985 c 57: See note following RCW 18.04.105.

RCW 43.70.323 Hospital infection control grant account. The hospital infection control grant account is created in the custody of the state treasury. All receipts from gifts, grants, bequests, devises, or other funds from public or private sources to support its activities must be deposited into the account. Expenditures from the account may be used only for awarding hospital infection control grants to hospitals and public agencies for establishing and maintaining hospital infection control and surveillance programs, for providing support for such programs, and for the administrative costs associated with the grant program. Only the secretary or the secretary's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. [2007 c 261 § 5.]

Findings—2007 c 261: See note following RCW 43.70.056.

RCW 43.70.327 Public health supplemental account—Annual statement. (1) The public health supplemental account is created in the state treasury. All receipts from gifts, bequests, devises, or funds, whose use is determined to further the purpose of maintaining and improving the health of Washington residents through the public health system, and all receipts from breast cancer awareness special license plate fees collected under *RCW 46.17.220(1)(e), must be deposited into the account. Money in the account may be spent only after appropriation. Expenditures from the account may be used only for maintaining and improving the health of Washington residents

through the public health system, which may include funding for staff[,] and as specified under RCW 46.68.425(2).

(2) The department shall file an annual statement of the financial condition, transactions, and affairs of any program funded under this section in a form and manner prescribed by the office of financial management. A copy of the annual statement shall be filed with the speaker of the house of representatives and the president of the senate. [2014 c 94 § 1; 2014 c 77 § 4; 2001 c 80 § 3.]

Reviser's note: *(1) RCW 46.17.220 was amended by 2018 c 67 § 4, changing subsection (1)(e) to subsection (4), effective January 1, 2019.

(2) This section was amended by 2014 c 77 § 4 and by 2014 c 94 § 1, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2014 c 77: See note following RCW 46.18.200.

Findings—Intent—2001 c 80: See note following RCW 43.70.040.

RCW 43.70.334 Temporary worker housing—Definition. For the purposes of RCW 43.70.335, 43.70.337, and 43.70.340, "temporary worker housing" has the same meaning as provided in RCW 70.114A.020. [1999 c 374 § 9.]

RCW 43.70.335 Temporary worker housing operating license—Fee—Display—Suspension or revocation—Fines—Refunds—Rules—Application of department of labor and industries standards. (1) Any person providing temporary worker housing consisting of five or more dwelling units, or any combination of dwelling units, dormitories, or spaces that house ten or more occupants, or any person providing temporary worker housing who makes the election to comply with the temporary worker building code under RCW 70.114A.081(1)(g), shall secure an annual operating license prior to occupancy and shall pay a fee according to RCW 43.70.340. The license shall be conspicuously displayed on-site.

(2) Licenses issued under this chapter may be suspended or revoked upon the failure or refusal of the person providing temporary worker housing to comply with rules adopted under this section or chapter 70.114A RCW by the department. All such proceedings shall be governed by the provisions of chapter 34.05 RCW.

(3) The department may assess a civil fine in accordance with RCW 43.70.095 for failure or refusal to obtain a license prior to occupancy of temporary worker housing. The department may refund all or part of the civil fine collected once the operator obtains a valid operating license.

(4) Civil fines under this section shall not exceed twice the cost of the license plus the cost of the initial on-site inspection for the first violation of this section, and shall not exceed ten times the cost of the license plus the cost of the initial on-site inspection for second and subsequent violations within any five-year period. The department may adopt rules as necessary to assure compliance with this section. [1999 c 374 § 10; 1998 c 37 § 5.]

RCW 43.70.337 Temporary worker housing building permit—Plans and specifications—Fees—Rules. (1) Any person who constructs, alters, or makes an addition to temporary worker housing consisting of five or more dwelling units, or any combination of dwelling units, dormitories, or spaces that house ten or more occupants, or any person who constructs, alters, or makes an addition to temporary worker housing who elects to comply with the temporary worker building code under RCW 70.114A.081(1)(g), shall:

(a) Submit plans and specifications for the alteration, addition, or new construction of this housing prior to beginning any alteration, addition, or new construction on this housing;

(b) Apply for and obtain a temporary worker housing building permit from the department prior to construction or alteration of this housing; and

(c) Submit a plan review and permit fee to the department of health pursuant to RCW 43.70.340.

(2) The department shall adopt rules as necessary, for the application procedures for the temporary worker housing plan review and permit process.

(3) Any alteration of a manufactured structure to be used for temporary worker housing remains subject to chapter 43.22 RCW, and the rules adopted under chapter 43.22 RCW. [1998 c 37 § 6.]

RCW 43.70.340 Temporary worker housing inspection fund—Fees on temporary worker housing operating licenses and building permits—Licenses generally. (1) The temporary worker housing fund is established in the custody of the state treasury. The department shall deposit all funds received under subsections (2) and (3) of this section and from the legislature to administer a temporary worker housing permitting, licensing, and inspection program conducted by the department. Disbursement from the fund shall be on authorization of the secretary of health or the secretary's designee. The fund is subject to the allotment procedure provided under chapter 43.88 RCW, but no appropriation is required for disbursements.

(2) There is imposed a fee on each operating license issued by the department to every operator of temporary worker housing that is regulated by the state board of health. In establishing the fee to be paid under this subsection the department shall consider the cost of administering a license as well as enforcing applicable state board of health rules on temporary worker housing.

(3) There is imposed a fee on each temporary worker housing building permit issued by the department to every operator of temporary worker housing as required by RCW 43.70.337. The fee shall include the cost of administering a permit as well as enforcing the department's temporary worker building code as adopted under RCW 70.114A.081.

(4) The department shall conduct a fee study for:

(a) A temporary worker housing operator's license;

(b) On-site inspections; and

(c) A plan review and building permit for new construction.

After completion of the study, the department shall adopt these fees by rule by no later than December 31, 1998.

(5) The term of the operating license and the application procedures shall be established, by rule, by the department. [1998 c 37 § 7; 1990 c 253 § 3.]

Legislative finding and purpose—1990 c 253: "The legislature finds that the demand for housing for migrant and seasonal farmworkers far exceeds the supply of adequate housing in the state of Washington. In addition, increasing numbers of these housing units are in deteriorated condition because they cannot be economically maintained and repaired.

The legislature further finds that the lack of a clear program for the regulation and inspection of farmworker housing has impeded the construction and renovation of housing units in this state.

It is the purpose of this act for the various agencies involved in the regulation of farmworker housing to coordinate and consolidate their activities to provide for efficient and effective monitoring of farmworker housing. It is intended that this action will provide greater responsiveness in dealing with public concerns over farmworker housing, and allow greater numbers of housing units to be built." [1990 c 253 § 1.]

RCW 43.70.400 Head injury prevention—Legislative finding. The legislature finds that head injury is a major cause of death and disability for Washington citizens. The costs of head injury treatment and rehabilitation are extensive and resultant disabilities are long and indeterminate. These costs are often borne by public programs such as medicaid. The legislature finds further that many such injuries are preventable. The legislature intends to reduce the occurrence of head injury by educating persons whose behavior may place them at risk and by regulating certain activities. [1990 c 270 § 2.]

RCW 43.70.410 Head injury prevention—Program, generally. As used in RCW 43.70.400 through 43.70.440, the term "head injury" means traumatic brain injury.

A head injury prevention program is created in the department of health. The program's functions may be integrated with those of similar programs to promote comprehensive, integrated, and effective health promotion and disease prevention.

In consultation with the traffic safety commission, the department shall, directly or by contract, identify and coordinate public education efforts currently underway within state government and among private groups to prevent traumatic brain injury, including, but not limited to, bicycle safety, pedestrian safety, bicycle passenger seat safety, motorcycle safety, motor vehicle safety, and sports safety. If the department finds that programs are not available or not in use, it may, within funds appropriated for the purpose, provide grants to promote public education efforts. Grants may be awarded only after recipients have demonstrated coordination with relevant and knowledgeable groups within their communities, including at least schools, brain injury support organizations, hospitals, physicians, traffic safety specialists, police, and the public. The department may accept grants, gifts, and donations from public or private sources to use to carry out the head injury prevention program.

The department may assess or contract for the assessment of the effectiveness of public education efforts coordinated or initiated by any agency of state government. Agencies are directed to cooperate with assessment efforts by providing access to data and program

records as reasonably required. The department may seek and receive additional funds from the federal government or private sources for assessments. Assessments shall contain findings and recommendations that will improve the effectiveness of public education efforts. These findings shall be distributed among public and private groups concerned with traumatic brain injury prevention. [1990 c 270 § 3.]

Bicycle awareness program: RCW 43.43.390.

RCW 43.70.420 Head injury prevention—Information preparation. The department of health, the department of licensing, and the traffic safety commission shall jointly prepare information for driver license manuals, driver education programs, and driving tests to increase driver awareness of pedestrian safety, to increase driver skills in avoiding pedestrian and motor vehicle accidents, and to determine drivers' abilities to avoid pedestrian motor vehicle accidents. [1990 c 270 § 4.]

RCW 43.70.430 Head injury prevention—Guidelines on training and education—Training of emergency medical personnel. The department shall prepare guidelines on relevant training and education regarding traumatic brain injury for health and education professionals, and relevant public safety and law enforcement officials. The department shall distribute such guidelines and any recommendations for training or educational requirements for health professionals or educators to the disciplinary authorities governed by chapter 18.130 RCW and to educational service districts established under chapter 28A.310 RCW. Specifically, all emergency medical personnel shall be trained in proper helmet removal. [1990 c 270 § 6.]

RCW 43.70.435 Diagnosed concussions of students—Report. (1) The department must develop a procedure to, beginning in the 2020-21 school year, collect the information related to the diagnosed concussions of students as described in RCW 28A.600.192.

(2) Beginning October 1, 2021, by October 1st annually thereafter, and in compliance with RCW 43.01.036, the department shall report a summary of the diagnosed concussion information received in the prior school year to the appropriate committees of the legislature and the office of the superintendent of public instruction. The report must include rates, patterns, trends, and other relevant information. [2020 c 347 § 2.]

RCW 43.70.440 Head injury prevention act—Short title—1990 c 270. This act shall be known and cited as the Head Injury Prevention Act of 1990. [1990 c 270 § 1.]

RCW 43.70.442 Suicide assessment, treatment, and management training—Requirement for certain professionals—Exemptions—Model list of programs—Rules—Health profession training standards provided to the professional educator standards board. *(Effective until January 1, 2024.)* (1)(a) Each of the following professionals certified or

licensed under Title 18 RCW shall, at least once every six years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) An adviser or counselor certified under chapter 18.19 RCW;

(ii) A substance use disorder professional licensed under chapter 18.205 RCW;

(iii) A marriage and family therapist licensed under chapter 18.225 RCW;

(iv) A mental health counselor licensed under chapter 18.225 RCW;

(v) An occupational therapy practitioner licensed under chapter 18.59 RCW;

(vi) A psychologist licensed under chapter 18.83 RCW;

(vii) An advanced social worker or independent clinical social worker licensed under chapter 18.225 RCW; and

(viii) A social worker associate—advanced or social worker associate—independent clinical licensed under chapter 18.225 RCW.

(b) The requirements in (a) of this subsection apply to a person holding a retired active license for one of the professions in (a) of this subsection.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (1)(d) affects the validity of training completed prior to July 1, 2017.

(2)(a) Except as provided in (b) of this subsection:

(i) A professional listed in subsection (1)(a) of this section must complete the first training required by this section by the end of the first full continuing education reporting period after January 1, 2014, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(ii) Beginning July 1, 2021, the second training for a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical must be either: (A) An advanced training focused on suicide management, suicide care protocols, or effective treatments; or (B) a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy-suicide prevention. If a professional subject to the requirements of this subsection has already completed the professional's second training prior to July 1, 2021, the professional's next training must comply with this subsection. This subsection (2)(a)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(a)(ii) is not reasonably available.

(b)(i) A professional listed in subsection (1)(a) of this section applying for initial licensure may delay completion of the first training required by this section for six years after initial licensure if he or she can demonstrate successful completion of the

training required in subsection (1) of this section no more than six years prior to the application for initial licensure.

(ii) Beginning July 1, 2021, a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical exempt from his or her first training under (b)(i) of this subsection must comply with the requirements of (a)(ii) of this subsection for his or her first training after initial licensure. If a professional subject to the requirements of this subsection has already completed the professional's first training after initial licensure, the professional's next training must comply with this subsection (2)(b)(ii). This subsection (2)(b)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(b)(ii) is not reasonably available.

(3) The hours spent completing training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education or continuing competency requirements for each profession.

(4)(a) A disciplining authority may, by rule, specify minimum training and experience that is sufficient to exempt an individual professional from the training requirements in subsections (1) and (5) of this section. Nothing in this subsection (4)(a) allows a disciplining authority to provide blanket exemptions to broad categories or specialties within a profession.

(b) A disciplining authority may exempt a professional from the training requirements of subsections (1) and (5) of this section if the professional has only brief or limited patient contact.

(5)(a) Each of the following professionals credentialed under Title 18 RCW shall complete a one-time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority:

(i) A chiropractor licensed under chapter 18.25 RCW;

(ii) A naturopath licensed under chapter 18.36A RCW;

(iii) A licensed practical nurse, registered nurse, or advanced registered nurse practitioner, other than a certified registered nurse anesthetist, licensed under chapter 18.79 RCW;

(iv) An osteopathic physician and surgeon licensed under chapter 18.57 RCW, other than a holder of a postgraduate osteopathic medicine and surgery license issued under RCW 18.57.035;

(v) A physical therapist or physical therapist assistant licensed under chapter 18.74 RCW;

(vi) A physician licensed under chapter 18.71 RCW, other than a resident holding a limited license issued under RCW 18.71.095(3);

(vii) A physician assistant licensed under chapter 18.71A RCW;

(viii) A pharmacist licensed under chapter 18.64 RCW;

(ix) A dentist licensed under chapter 18.32 RCW;

(x) A dental hygienist licensed under chapter 18.29 RCW;

(xi) An athletic trainer licensed under chapter 18.250 RCW;

(xii) An optometrist licensed under chapter 18.53 RCW;

(xiii) An acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW; and

(xiv) A person holding a retired active license for one of the professions listed in (a)(i) through (xiii) of this subsection.

(b)(i) A professional listed in (a)(i) through (vii) of this subsection or a person holding a retired active license for one of the professions listed in (a)(i) through (vii) of this subsection must

complete the one-time training by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between June 12, 2014, and January 1, 2016, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(ii) A licensed pharmacist or a person holding a retired active pharmacist license must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2017, or during the first full continuing education reporting period after initial licensure, whichever is later.

(iii) A licensed dentist, a licensed dental hygienist, or a person holding a retired active license as a dentist shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2020, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between July 23, 2017, and August 1, 2020, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iii), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(iv) A licensed optometrist or a licensed acupuncture and Eastern medicine practitioner, or a person holding a retired active license as an optometrist or an acupuncture and Eastern medicine practitioner, shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2021, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between August 1, 2020, and August 1, 2021, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iv), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (5)(d) affects the validity of training completed prior to July 1, 2017.

(6)(a) The secretary and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management. Beginning July 1, 2021, for purposes of subsection (2)(a)(ii) of this section, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal.

(b) The secretary and the disciplining authorities shall update the list at least once every two years.

(c) By June 30, 2016, the department shall adopt rules establishing minimum standards for the training programs included on the model list. The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious

behaviors and that three-hour trainings for pharmacists or dentists include content related to the assessment of issues related to imminent harm via lethal means. By July 1, 2024, the minimum standards must be updated to require that both the six-hour and three-hour trainings include content specific to the availability of and the services offered by the 988 crisis hotline and the behavioral health crisis response and suicide prevention system and best practices for assisting persons with accessing the 988 crisis hotline and the system. Beginning September 1, 2024, trainings submitted to the department for review and approval must include the updated information in the minimum standards for the model list as well as all subsequent submissions. When adopting the rules required under this subsection (6)(c), the department shall:

(i) Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations; and

(ii) Consider standards related to the best practices registry of the American foundation for suicide prevention and the suicide prevention resource center.

(d) Beginning January 1, 2017:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection and any three-hour trainings that met the requirements of this section on or before July 24, 2015;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management, and three-hour trainings that include only screening and referral elements; and

(iii) A person or entity providing the training required in this section may petition the department for inclusion on the model list. The department shall add the training to the list only if the department determines that the training meets the minimum standards established in the rules adopted under (c) of this subsection.

(e) By January 1, 2021, the department shall adopt minimum standards for advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. Beginning July 1, 2021, all such training on the model list must meet the minimum standards. When adopting the minimum standards, the department must consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations.

(7) The department shall provide the health profession training standards created in this section to the professional educator standards board as a model in meeting the requirements of RCW 28A.410.226 and provide technical assistance, as requested, in the review and evaluation of educator training programs. The educator training programs approved by the professional educator standards board may be included in the department's model list.

(8) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under chapter 18.130 RCW.

(9) The secretary and the disciplining authorities affected by this section shall adopt any rules necessary to implement this section.

(10) For purposes of this section:

(a) "Disciplining authority" has the same meaning as in RCW 18.130.020.

(b) "Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training that includes only screening and referral elements if appropriate for the profession in question based on the profession's scope of practice. The board of occupational therapy may also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting.

(11) A state or local government employee is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

(12) An employee of a community mental health agency licensed under chapter 71.24 RCW or a chemical dependency program certified under chapter 71.24 RCW is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion. [2023 c 454 § 4. Prior: 2020 c 229 § 1; 2020 c 80 § 30; prior: 2019 c 444 § 13; (2019 c 444 § 12 expired August 1, 2020); 2019 c 358 § 5; (2019 c 358 § 4 expired August 1, 2020); 2017 c 262 § 4; 2016 c 90 § 5; 2015 c 249 § 1; 2014 c 71 § 2; prior: 2013 c 78 § 1; 2013 c 73 § 6; 2012 c 181 § 2.]

Effective date—2020 c 229 § 1: "Section 1 of this act takes effect August 1, 2020." [2020 c 229 § 4.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Effective dates—2019 c 444 §§ 13 and 19: "(1) Section 13 of this act takes effect August 1, 2020.

(2) Section 19 of this act takes effect July 1, 2026." [2019 c 444 § 32.]

Expiration dates—2019 c 444 §§ 12 and 18: "(1) Section 12 of this act expires August 1, 2020.

(2) Section 18 of this act expires July 1, 2026." [2019 c 444 § 33.]

Effective date—2019 c 358 § 5: "Section 5 of this act takes effect August 1, 2020." [2019 c 358 § 8.]

Expiration date—2019 c 358 § 4: "Section 4 of this act expires August 1, 2020." [2019 c 358 § 7.]

Effective date—2017 c 262 § 4: "Section 4 of this act takes effect August 1, 2020." [2017 c 262 § 7.]

Findings—Intent—2017 c 262: "The legislature finds that over one thousand one hundred suicide deaths occur each year in Washington and these suicide deaths take an enormous toll on families and communities across the state. The legislature further finds that: Sixty-five percent of all suicides, and most suicide deaths and attempts for young people ages ten to eighteen, occur using firearms and prescription medications that are easily accessible in homes; firearms are the most lethal method used in suicide and almost entirely account for more men dying by suicide than women; sixty-seven percent of all veteran deaths by suicide are by firearm; and nearly eighty percent of all deaths by firearms in Washington are suicides. The legislature further finds that there is a need for a robust public education campaign designed to raise awareness of suicide and to teach everyone the role that he or she can play in suicide prevention. The legislature further finds that important suicide prevention efforts include: Motivating households to improve safe storage practices to reduce deaths from firearms and prescription medications; decreasing barriers to prevent access to lethal means by allowing for temporary and voluntary transfers of firearms when individuals are at risk for suicide; increasing access to drug take-back sites; and making the public aware of suicide prevention steps, including recognizing warning signs, empathizing and listening, asking directly about suicide, removing dangers to ensure immediate safety, and getting help. The legislature intends by this act to create a public-private partnership fund to implement a suicide-safer home public education campaign in the coming years." [2017 c 262 § 1.]

Effective date—2016 c 90 § 5: "Section 5 of this act takes effect January 1, 2017." [2016 c 90 § 8.]

Findings—2016 c 90: "The legislature finds that: Washington's suicide rate is fourteen percent higher than the national average; on average, two young people between the ages of ten and twenty-four die by suicide each week; almost a quarter of those who die by suicide are veterans; and many of the state's rural and tribal communities have the highest suicide rates. The legislature further finds that when suicide occurs, it has devastating consequences for communities and schools, yet, according to the United States surgeon general, suicide is the nation's most preventable form of death. The legislature further finds that one of the most immediate ways to reduce the tragedy of suicide is through suicide awareness and prevention education coupled with safe storage of lethal means commonly used in suicides, such as firearms and prescription medications. The legislature further finds that encouraging firearms dealers to voluntarily participate in suicide awareness and prevention education programs and provide certain safe storage devices at cost is an important step in creating safer homes and reducing suicide deaths in the state." [2016 c 90 § 1.]

Findings—Intent—2014 c 71; 2012 c 181: "(1) The legislature finds that:

(a) According to the centers for disease control and prevention:

(i) In 2008, more than thirty-six thousand people died by suicide in the United States, making it the tenth leading cause of death nationally.

(ii) During 2007-2008, an estimated five hundred sixty-nine thousand people visited hospital emergency departments with self-inflicted injuries in the United States, seventy percent of whom had attempted suicide.

(iii) During 2008-2009, the average percentages of adults who thought, planned, or attempted suicide in Washington were higher than the national average.

(b) According to a national study, veterans face an elevated risk of suicide as compared to the general population, more than twice the risk among male veterans. Another study has indicated a positive correlation between posttraumatic stress disorder and suicide.

(i) Washington state is home to more than sixty thousand men and women who have deployed in support of the wars in Iraq and Afghanistan.

(ii) Research continues on how the effects of wartime service and injuries, such as traumatic brain injury, posttraumatic stress disorder, or other service-related conditions, may increase the number of veterans who attempt suicide.

(iii) As more men and women separate from the military and transition back into civilian life, community mental health providers will become a vital resource to help these veterans and their families deal with issues that may arise.

(c) Suicide has an enormous impact on the family and friends of the victim as well as the community as a whole.

(d) Approximately ninety percent of people who die by suicide had a diagnosable psychiatric disorder at the time of death, such as depression. Most suicide victims exhibit warning signs or behaviors prior to an attempt.

(e) Improved training and education in suicide assessment, treatment, and management has been recommended by a variety of organizations, including the United States department of health and human services and the institute of medicine.

(2) It is therefore the intent of the legislature to help lower the suicide rate in Washington by requiring certain health professionals to complete training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements.

(3) The legislature does not intend to expand or limit the existing scope of practice of any health professional affected by this act." [2014 c 71 § 1; 2012 c 181 § 1.]

Short title—2012 c 181: "This act may be known and cited as the Matt Adler suicide assessment, treatment, and management training act of 2012." [2012 c 181 § 4.]

RCW 43.70.442 Suicide assessment, treatment, and management training—Requirement for certain professionals—Exemptions—Model list of programs—Rules—Health profession training standards provided to the professional educator standards board. *(Effective January 1,*

2024.) (1)(a) Each of the following professionals certified or licensed under Title 18 RCW shall, at least once every six years, complete training in suicide assessment, treatment, and management that is approved, in rule, by the relevant disciplining authority:

(i) An adviser or counselor certified under chapter 18.19 RCW;

(ii) A substance use disorder professional licensed under chapter 18.205 RCW;

(iii) A marriage and family therapist licensed under chapter 18.225 RCW;

(iv) A mental health counselor licensed under chapter 18.225 RCW;

(v) An occupational therapy practitioner licensed under chapter 18.59 RCW;

(vi) A psychologist licensed under chapter 18.83 RCW;

(vii) An advanced social worker or independent clinical social worker licensed under chapter 18.225 RCW; and

(viii) A social worker associate—advanced or social worker associate—independent clinical licensed under chapter 18.225 RCW.

(b) The requirements in (a) of this subsection apply to a person holding a retired active license for one of the professions in (a) of this subsection.

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (1)(d) affects the validity of training completed prior to July 1, 2017.

(2)(a) Except as provided in (b) of this subsection:

(i) A professional listed in subsection (1)(a) of this section must complete the first training required by this section by the end of the first full continuing education reporting period after January 1, 2014, or during the first full continuing education reporting period after initial licensure or certification, whichever occurs later.

(ii) Beginning July 1, 2021, the second training for a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical must be either: (A) An advanced training focused on suicide management, suicide care protocols, or effective treatments; or (B) a training in a treatment modality shown to be effective in working with people who are suicidal, including dialectical behavior therapy, collaborative assessment and management of suicide risk, or cognitive behavior therapy-suicide prevention. If a professional subject to the requirements of this subsection has already completed the professional's second training prior to July 1, 2021, the professional's next training must comply with this subsection. This subsection (2)(a)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(a)(ii) is not reasonably available.

(b)(i) A professional listed in subsection (1)(a) of this section applying for initial licensure may delay completion of the first training required by this section for six years after initial

licensure if he or she can demonstrate successful completion of the training required in subsection (1) of this section no more than six years prior to the application for initial licensure.

(ii) Beginning July 1, 2021, a psychologist, a marriage and family therapist, a mental health counselor, an advanced social worker, an independent clinical social worker, a social worker associate-advanced, or a social worker associate-independent clinical exempt from his or her first training under (b)(i) of this subsection must comply with the requirements of (a)(ii) of this subsection for his or her first training after initial licensure. If a professional subject to the requirements of this subsection has already completed the professional's first training after initial licensure, the professional's next training must comply with this subsection (2)(b)(ii). This subsection (2)(b)(ii) does not apply if the licensee demonstrates that the training required by this subsection (2)(b)(ii) is not reasonably available.

(3) The hours spent completing training in suicide assessment, treatment, and management under this section count toward meeting any applicable continuing education or continuing competency requirements for each profession.

(4)(a) A disciplining authority may, by rule, specify minimum training and experience that is sufficient to exempt an individual professional from the training requirements in subsections (1) and (5) of this section. Nothing in this subsection (4)(a) allows a disciplining authority to provide blanket exemptions to broad categories or specialties within a profession.

(b) A disciplining authority may exempt a professional from the training requirements of subsections (1) and (5) of this section if the professional has only brief or limited patient contact.

(5)(a) Each of the following professionals credentialed under Title 18 RCW shall complete a one-time training in suicide assessment, treatment, and management that is approved by the relevant disciplining authority:

(i) A chiropractor licensed under chapter 18.25 RCW;

(ii) A naturopath licensed under chapter 18.36A RCW;

(iii) A licensed practical nurse, registered nurse, or advanced registered nurse practitioner, other than a certified registered nurse anesthetist, licensed under chapter 18.79 RCW;

(iv) An osteopathic physician and surgeon licensed under chapter 18.57 RCW, other than a holder of a postgraduate osteopathic medicine and surgery license issued under RCW 18.57.035;

(v) A physical therapist or physical therapist assistant licensed under chapter 18.74 RCW;

(vi) A physician licensed under chapter 18.71 RCW, other than a resident holding a limited license issued under RCW 18.71.095(3);

(vii) A physician assistant licensed under chapter 18.71A RCW;

(viii) A pharmacist licensed under chapter 18.64 RCW;

(ix) A dentist licensed under chapter 18.32 RCW;

(x) A dental hygienist licensed under chapter 18.29 RCW;

(xi) An athletic trainer licensed under chapter 18.250 RCW;

(xii) An optometrist licensed under chapter 18.53 RCW;

(xiii) An acupuncture and Eastern medicine practitioner licensed under chapter 18.06 RCW;

(xiv) A dental therapist licensed under chapter 18.265 RCW; and

(xv) A person holding a retired active license for one of the professions listed in (a)(i) through (xiv) of this subsection.

(b)(i) A professional listed in (a)(i) through (vii) of this subsection or a person holding a retired active license for one of the professions listed in (a)(i) through (vii) of this subsection must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2016, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between June 12, 2014, and January 1, 2016, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(ii) A licensed pharmacist or a person holding a retired active pharmacist license must complete the one-time training by the end of the first full continuing education reporting period after January 1, 2017, or during the first full continuing education reporting period after initial licensure, whichever is later.

(iii) A licensed dentist, a licensed dental hygienist, or a person holding a retired active license as a dentist shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2020, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between July 23, 2017, and August 1, 2020, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iii), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(iv) A licensed optometrist or a licensed acupuncture and Eastern medicine practitioner, or a person holding a retired active license as an optometrist or an acupuncture and Eastern medicine practitioner, shall complete the one-time training by the end of the full continuing education reporting period after August 1, 2021, or during the first full continuing education reporting period after initial licensure, whichever is later. Training completed between August 1, 2020, and August 1, 2021, that meets the requirements of this section, other than the timing requirements of this subsection (5)(b)(iv), must be accepted by the disciplining authority as meeting the one-time training requirement of this subsection (5).

(c) The training required by this subsection must be at least six hours in length, unless a disciplining authority has determined, under subsection (10)(b) of this section, that training that includes only screening and referral elements is appropriate for the profession in question, in which case the training must be at least three hours in length.

(d) Beginning July 1, 2017, the training required by this subsection must be on the model list developed under subsection (6) of this section. Nothing in this subsection (5)(d) affects the validity of training completed prior to July 1, 2017.

(6)(a) The secretary and the disciplining authorities shall work collaboratively to develop a model list of training programs in suicide assessment, treatment, and management. Beginning July 1, 2021, for purposes of subsection (2)(a)(ii) of this section, the model list must include advanced training and training in treatment modalities shown to be effective in working with people who are suicidal.

(b) The secretary and the disciplining authorities shall update the list at least once every two years.

(c) By June 30, 2016, the department shall adopt rules establishing minimum standards for the training programs included on

the model list. The minimum standards must require that six-hour trainings include content specific to veterans and the assessment of issues related to imminent harm via lethal means or self-injurious behaviors and that three-hour trainings for pharmacists or dentists include content related to the assessment of issues related to imminent harm via lethal means. By July 1, 2024, the minimum standards must be updated to require that both the six-hour and three-hour trainings include content specific to the availability of and the services offered by the 988 crisis hotline and the behavioral health crisis response and suicide prevention system and best practices for assisting persons with accessing the 988 crisis hotline and the system. Beginning September 1, 2024, trainings submitted to the department for review and approval must include the updated information in the minimum standards for the model list as well as all subsequent submissions. When adopting the rules required under this subsection (6)(c), the department shall:

(i) Consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations; and

(ii) Consider standards related to the best practices registry of the American foundation for suicide prevention and the suicide prevention resource center.

(d) Beginning January 1, 2017:

(i) The model list must include only trainings that meet the minimum standards established in the rules adopted under (c) of this subsection and any three-hour trainings that met the requirements of this section on or before July 24, 2015;

(ii) The model list must include six-hour trainings in suicide assessment, treatment, and management, and three-hour trainings that include only screening and referral elements; and

(iii) A person or entity providing the training required in this section may petition the department for inclusion on the model list. The department shall add the training to the list only if the department determines that the training meets the minimum standards established in the rules adopted under (c) of this subsection.

(e) By January 1, 2021, the department shall adopt minimum standards for advanced training and training in treatment modalities shown to be effective in working with people who are suicidal. Beginning July 1, 2021, all such training on the model list must meet the minimum standards. When adopting the minimum standards, the department must consult with the affected disciplining authorities, public and private institutions of higher education, educators, experts in suicide assessment, treatment, and management, the Washington department of veterans affairs, and affected professional associations.

(7) The department shall provide the health profession training standards created in this section to the professional educator standards board as a model in meeting the requirements of RCW 28A.410.226 and provide technical assistance, as requested, in the review and evaluation of educator training programs. The educator training programs approved by the professional educator standards board may be included in the department's model list.

(8) Nothing in this section may be interpreted to expand or limit the scope of practice of any profession regulated under chapter 18.130 RCW.

(9) The secretary and the disciplining authorities affected by this section shall adopt any rules necessary to implement this section.

(10) For purposes of this section:

(a) "Disciplining authority" has the same meaning as in RCW 18.130.020.

(b) "Training in suicide assessment, treatment, and management" means empirically supported training approved by the appropriate disciplining authority that contains the following elements: Suicide assessment, including screening and referral, suicide treatment, and suicide management. However, the disciplining authority may approve training that includes only screening and referral elements if appropriate for the profession in question based on the profession's scope of practice. The board of occupational therapy may also approve training that includes only screening and referral elements if appropriate for occupational therapy practitioners based on practice setting.

(11) A state or local government employee is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion.

(12) An employee of a community mental health agency licensed under chapter 71.24 RCW or a chemical dependency program certified under chapter 71.24 RCW is exempt from the requirements of this section if he or she receives a total of at least six hours of training in suicide assessment, treatment, and management from his or her employer every six years. For purposes of this subsection, the training may be provided in one six-hour block or may be spread among shorter training sessions at the employer's discretion. [2023 c 460 § 22; 2023 c 454 § 4. Prior: 2020 c 229 § 1; 2020 c 80 § 30; prior: 2019 c 444 § 13; (2019 c 444 § 12 expired August 1, 2020); 2019 c 358 § 5; (2019 c 358 § 4 expired August 1, 2020); 2017 c 262 § 4; 2016 c 90 § 5; 2015 c 249 § 1; 2014 c 71 § 2; prior: 2013 c 78 § 1; 2013 c 73 § 6; 2012 c 181 § 2.]

Reviser's note: This section was amended by 2023 c 454 § 4 and by 2023 c 460 § 22, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2023 c 460 §§ 1-22: See note following RCW 18.265.005.

Effective date—2020 c 229 § 1: "Section 1 of this act takes effect August 1, 2020." [2020 c 229 § 4.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Effective dates—2019 c 444 §§ 13 and 19: "(1) Section 13 of this act takes effect August 1, 2020.

(2) Section 19 of this act takes effect July 1, 2026." [2019 c 444 § 32.]

Expiration dates—2019 c 444 §§ 12 and 18: "(1) Section 12 of this act expires August 1, 2020.

(2) Section 18 of this act expires July 1, 2026." [2019 c 444 § 33.]

Effective date—2019 c 358 § 5: "Section 5 of this act takes effect August 1, 2020." [2019 c 358 § 8.]

Expiration date—2019 c 358 § 4: "Section 4 of this act expires August 1, 2020." [2019 c 358 § 7.]

Effective date—2017 c 262 § 4: "Section 4 of this act takes effect August 1, 2020." [2017 c 262 § 7.]

Findings—Intent—2017 c 262: "The legislature finds that over one thousand one hundred suicide deaths occur each year in Washington and these suicide deaths take an enormous toll on families and communities across the state. The legislature further finds that: Sixty-five percent of all suicides, and most suicide deaths and attempts for young people ages ten to eighteen, occur using firearms and prescription medications that are easily accessible in homes; firearms are the most lethal method used in suicide and almost entirely account for more men dying by suicide than women; sixty-seven percent of all veteran deaths by suicide are by firearm; and nearly eighty percent of all deaths by firearms in Washington are suicides. The legislature further finds that there is a need for a robust public education campaign designed to raise awareness of suicide and to teach everyone the role that he or she can play in suicide prevention. The legislature further finds that important suicide prevention efforts include: Motivating households to improve safe storage practices to reduce deaths from firearms and prescription medications; decreasing barriers to prevent access to lethal means by allowing for temporary and voluntary transfers of firearms when individuals are at risk for suicide; increasing access to drug take-back sites; and making the public aware of suicide prevention steps, including recognizing warning signs, empathizing and listening, asking directly about suicide, removing dangers to ensure immediate safety, and getting help. The legislature intends by this act to create a public-private partnership fund to implement a suicide-safer home public education campaign in the coming years." [2017 c 262 § 1.]

Effective date—2016 c 90 § 5: "Section 5 of this act takes effect January 1, 2017." [2016 c 90 § 8.]

Findings—2016 c 90: "The legislature finds that: Washington's suicide rate is fourteen percent higher than the national average; on average, two young people between the ages of ten and twenty-four die by suicide each week; almost a quarter of those who die by suicide are veterans; and many of the state's rural and tribal communities have the highest suicide rates. The legislature further finds that when suicide occurs, it has devastating consequences for communities and schools, yet, according to the United States surgeon general, suicide is the nation's most preventable form of death. The legislature

further finds that one of the most immediate ways to reduce the tragedy of suicide is through suicide awareness and prevention education coupled with safe storage of lethal means commonly used in suicides, such as firearms and prescription medications. The legislature further finds that encouraging firearms dealers to voluntarily participate in suicide awareness and prevention education programs and provide certain safe storage devices at cost is an important step in creating safer homes and reducing suicide deaths in the state." [2016 c 90 § 1.]

Findings—Intent—2014 c 71; 2012 c 181: "(1) The legislature finds that:

(a) According to the centers for disease control and prevention:

(i) In 2008, more than thirty-six thousand people died by suicide in the United States, making it the tenth leading cause of death nationally.

(ii) During 2007-2008, an estimated five hundred sixty-nine thousand people visited hospital emergency departments with self-inflicted injuries in the United States, seventy percent of whom had attempted suicide.

(iii) During 2008-2009, the average percentages of adults who thought, planned, or attempted suicide in Washington were higher than the national average.

(b) According to a national study, veterans face an elevated risk of suicide as compared to the general population, more than twice the risk among male veterans. Another study has indicated a positive correlation between posttraumatic stress disorder and suicide.

(i) Washington state is home to more than sixty thousand men and women who have deployed in support of the wars in Iraq and Afghanistan.

(ii) Research continues on how the effects of wartime service and injuries, such as traumatic brain injury, posttraumatic stress disorder, or other service-related conditions, may increase the number of veterans who attempt suicide.

(iii) As more men and women separate from the military and transition back into civilian life, community mental health providers will become a vital resource to help these veterans and their families deal with issues that may arise.

(c) Suicide has an enormous impact on the family and friends of the victim as well as the community as a whole.

(d) Approximately ninety percent of people who die by suicide had a diagnosable psychiatric disorder at the time of death, such as depression. Most suicide victims exhibit warning signs or behaviors prior to an attempt.

(e) Improved training and education in suicide assessment, treatment, and management has been recommended by a variety of organizations, including the United States department of health and human services and the institute of medicine.

(2) It is therefore the intent of the legislature to help lower the suicide rate in Washington by requiring certain health professionals to complete training in suicide assessment, treatment, and management as part of their continuing education, continuing competency, or recertification requirements.

(3) The legislature does not intend to expand or limit the existing scope of practice of any health professional affected by this act." [2014 c 71 § 1; 2012 c 181 § 1.]

Short title—2012 c 181: "This act may be known and cited as the Matt Adler suicide assessment, treatment, and management training act of 2012." [2012 c 181 § 4.]

RCW 43.70.444 Washington plan for suicide prevention—Steering committee—Report. (1) The secretary, in consultation with the steering committee convened in subsection (3) of this section, shall develop a Washington plan for suicide prevention. The plan must, at a minimum:

(a) Examine data relating to suicide in order to identify patterns and key demographic factors;

(b) Identify key risk and protective factors relating to suicide; and

(c) Identify goals, action areas, and implementation strategies relating to suicide prevention.

(2) When developing the plan, the secretary shall consider national research and practices employed by the federal government, tribal governments, and other states, including the national strategy for suicide prevention. The plan must be written in a manner that is accessible, and useful to, a broad audience. The secretary shall periodically update the plan as needed.

(3) The secretary shall convene a steering committee to advise him or her in the development of the Washington plan for suicide prevention. The committee must consist of representatives from the following:

(a) Experts on suicide assessment, treatment, and management;

(b) Institutions of higher education;

(c) Tribal governments;

(d) The department of social and health services;

(e) The state department of veterans affairs;

(f) Suicide prevention advocates, at least one of whom must be a suicide survivor and at least one of whom must be a survivor of a suicide attempt;

(g) Primary care providers;

(h) Local health departments or districts; and

(i) Any other organizations or groups the secretary deems appropriate.

(4) The secretary shall complete the plan no later than November 15, 2015, publish the report on the department's website, and submit copies to the governor and the relevant standing committees of the legislature. [2014 c 71 § 4.]

RCW 43.70.446 Suicide-safer homes project—Suicide-safer homes project account. (1) The suicide-safer homes project is created within the department of health for the purpose of accepting private funds for use by the suicide-safer homes task force created in *RCW 43.70.445 in developing and providing suicide education and prevention materials, training, and outreach programs to help create suicide-safer homes. The secretary may accept gifts, grants, donations, or moneys from any source for deposit in the suicide-safer homes project account created in subsection (2) of this section.

(2) The suicide-safer homes project account is created in the custody of the state treasurer. The account shall consist of funds appropriated by the legislature for the suicide-safer homes project

account and all receipts from gifts, grants, bequests, devises, or other funds from public and private sources to support the activities of the suicide-safer homes project. Only the secretary of the department of health, or the secretary's designee, may authorize expenditures from the account to fund projects identified and prioritized by the suicide-safer homes task force. Funds deposited in the suicide-safer homes project account may be used for the development and production of suicide prevention materials and training programs, for providing financial incentives to encourage firearms dealers and others to participate in suicide prevention training, and to implement pilot programs involving community outreach on creating suicide-safer homes.

(3) The suicide-safer homes project account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. [2017 c 262 § 3.]

***Reviser's note:** RCW 43.70.445 expired July 1, 2021.

Findings—Intent—2017 c 262: See note following RCW 43.70.442.

RCW 43.70.447 Suicide assessment, treatment, and management—Curriculum for dental students and dentists. (1) By July 1, 2020, the school of dentistry at the University of Washington shall develop a curriculum on suicide assessment, treatment, and management for dental students and licensed dentists. The curriculum must meet the minimum standards established under RCW 43.70.442 and must include material on identifying at-risk patients and limiting access to lethal means. When developing the curriculum, the school of dentistry must consult with experts on suicide assessment, treatment, and management and with the suicide-safer homes task force established in *RCW 43.70.445. The school of dentistry shall submit a progress report to the governor and the relevant committees of the legislature by July 1, 2019.

(2) The dental quality assurance commission shall, for purposes of RCW 43.70.442(4)(a), consider a dentist who has successfully completed the curriculum developed under subsection (1) of this section prior to licensure as possessing the minimum training and experience necessary to be exempt from the training requirements in RCW 43.70.442. [2017 c 262 § 5.]

***Reviser's note:** RCW 43.70.445 expired July 1, 2021.

Findings—Intent—2017 c 262: See note following RCW 43.70.442.

RCW 43.70.452 Agricultural industry workforce behavioral health improvement and suicide prevention—Pilot program. (1) Subject to the availability of amounts appropriated for this specific purpose not to exceed two hundred thousand dollars per fiscal year, the department shall establish a pilot program to support behavioral health improvement and suicide prevention efforts for members of the agricultural industry workforce. By March 1, 2019, the pilot program shall be established in a county west of the Cascade crest that is reliant on the agricultural industry.

(2) When implementing the pilot program, the department shall consider the report of the task force on behavioral health and suicide

prevention in the agricultural industry established in section 2, chapter 95, Laws of 2018.

(3) In implementing the pilot program, the department shall contract with an entity that has behavioral health and suicide prevention expertise to develop a free resource for workers in the agricultural industry. When selecting an entity, the department shall seek to use an entity that has an existing telephonic and web-based resource, including entities that have prepared similar resources for other states. The contracting entity must be responsible for constructing and hosting the free resource and linking the free resource to the websites of the department, the department of agriculture, and other relevant stakeholders.

(4) At a minimum, the free resource must:

(a) Be made publicly available through a web-based portal or a telephone support line;

(b) Provide a resource to train agricultural industry management, workers, and their family members in suicide risk recognition and referral skills;

(c) Provide a resource to build capacity within the agricultural industry to train individuals to deliver training in person;

(d) Contain model crisis protocols that address behavioral health crisis and suicide risk identification, intervention, reentry, and postvention;

(e) Contain model marketing materials and messages that promote behavioral health in the agricultural industry; and

(f) Be made available in English and Spanish.

(5) A preliminary report shall be made to the legislature on the elements and implementation of the pilot program by December 1, 2019. A final report containing information about results of the pilot program and recommendations for improving the pilot program and expanding its availability to other counties shall be made to the legislature by December 1, 2020. [2018 c 95 § 3.]

Findings—2018 c 95: "(1) The legislature finds that the agricultural industry is an integral part of Washington's economy and sense of common identity, and that the behavioral health of workers in the industry and their family members is a statewide concern.

(2) Several factors related to the agricultural industry may affect the behavioral health of workers in the agricultural industry, including job-related isolation and demands, stressful work environments, the heightened potential for financial losses, lack of access to behavioral health services, and barriers to or unwillingness to seek mental health services.

(3) A 2016 report from the federal centers for disease control and prevention studied suicide data from the year 2012 and found that workers in the farming, fishing, and forestry industries had the highest rate of suicide, eighty-four and one-half suicides per one hundred thousand workers, among the occupational groups that it studied.

(4) The legislature finds that there is an urgent need to develop resources and interventions specifically targeted to helping workers in the agricultural industry and their family members manage their behavioral health needs." [2018 c 95 § 1.]

RCW 43.70.460 Retired primary and specialty care provider liability malpractice insurance—Program authorized. (1) The department may establish a program to purchase and maintain liability malpractice insurance for retired primary and specialty care providers who provide health care services to low-income patients. The following conditions apply to the program:

(a) Health care services shall be provided at clinics serving low-income patients that are public or private tax-exempt corporations or other established practice settings as defined by the department;

(b) Health care services provided at the clinics shall be offered to low-income patients based on their ability to pay;

(c) Retired health care providers providing health care services shall not receive compensation for their services; and

(d) The department shall contract only with a liability insurer authorized to offer liability malpractice insurance in the state.

(e) Specialists in this program will be limited to those whose malpractice insurance premiums are comparable to primary care providers.

(2) This section and RCW 43.70.470 shall not be interpreted to require a liability insurer to provide coverage to a health care provider should the insurer determine that coverage should not be offered to a health care provider because of past claims experience or for other appropriate reasons.

(3) The state and its employees who operate the program shall be immune from any civil or criminal action involving claims against clinics or health care providers that provided health care services under this section and RCW 43.70.470. This protection of immunity shall not extend to any clinic or health care provider participating in the program.

(4) The department may monitor the claims experience of retired health care providers covered by liability insurers contracting with the department.

(5) The department may provide liability insurance under chapter 113, Laws of 1992 only to the extent funds are provided for this purpose by the legislature. If there are insufficient funds to support all applications for liability insurance coverage, priority shall be given to those retired health care providers working at clinics operated by public or private tax-exempt corporations rather than clinics operated by for-profit corporations. [2005 c 156 § 1; 2004 c 184 § 1; 1993 c 492 § 276; 1992 c 113 § 2.]

Finding—1993 c 492: See note following RCW 28B.115.080.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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

Legislative declaration—1992 c 113: "There are a number of retired physicians who wish to provide, or are providing, health care services to low-income patients without compensation. However, the cost of obtaining malpractice insurance is a burden that is deterring them from donating their time and services in treating the health problems of the poor. The necessity of maintaining malpractice insurance for those in practice is a significant reality in today's litigious society.

A program to alleviate the onerous costs of malpractice insurance for retired physicians providing uncompensated health care services to low-income patients will encourage philanthropy and augment state resources in providing for the health care needs of those who have no access to basic health care services.

An estimated sixteen percent of the nonelderly population do not have health insurance and lack access to even basic health care services. This is especially problematic for low-income persons who are young and who are either unemployed or have entry-level jobs without health care benefits. The majority of the uninsured, however, are working adults, and some twenty-nine percent are children.

The legislature declares that this act will increase the availability of primary care to low-income persons and is in the interest of the public health and safety." [1992 c 113 § 1.]

RCW 43.70.470 Retired health care provider liability malpractice insurance—Conditions. The department may establish by rule the conditions of participation in the liability insurance program by retired health care providers at clinics utilizing retired health care providers for the purposes of this section and RCW 43.70.460. These conditions shall include, but not be limited to, the following:

(1) The participating health care provider associated with the clinic shall hold a valid license to practice as a physician under chapter 18.71 or 18.57 RCW, a naturopath under chapter 18.36A RCW, a physician assistant under chapter 18.71A RCW, an advanced registered nurse practitioner under chapter 18.79 RCW, a dentist under chapter 18.32 RCW, or other health professionals as may be deemed in short supply by the department. All health care providers must be in conformity with current requirements for licensure, including continuing education requirements;

(2) Health care shall be limited to noninvasive procedures and shall not include obstetrical care. Noninvasive procedures include injections, suturing of minor lacerations, and incisions of boils or superficial abscesses. Primary dental care shall be limited to diagnosis, oral hygiene, restoration, and extractions and shall not include orthodontia, or other specialized care and treatment;

(3) The provision of liability insurance coverage shall not extend to acts outside the scope of rendering health care services pursuant to this section and RCW 43.70.460;

(4) The participating health care provider shall limit the provision of health care services to primarily low-income persons provided that clinics may, but are not required to, provide means tests for eligibility as a condition for obtaining health care services;

(5) The participating health care provider shall not accept compensation for providing health care services from patients served pursuant to this section and RCW 43.70.460, nor from clinics serving these patients. "Compensation" shall mean any remuneration of value to the participating health care provider for services provided by the health care provider, but shall not be construed to include any nominal copayments charged by the clinic, nor reimbursement of related expenses of a participating health care provider authorized by the clinic in advance of being incurred; and

(6) The use of mediation or arbitration for resolving questions of potential liability may be used, however any mediation or

arbitration agreement format shall be expressed in terms clear enough for a person with a sixth grade level of education to understand, and on a form no longer than one page in length. [2020 c 80 § 31; 2005 c 156 § 2; 2004 c 184 § 2; 1993 c 492 § 277; 1992 c 113 § 3.]

Effective date—2020 c 80 §§ 12-59: See note following RCW 7.68.030.

Intent—2020 c 80: See note following RCW 18.71A.010.

Finding—1993 c 492: See note following RCW 28B.115.080.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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

Legislative declaration—1992 c 113: See note following RCW 43.70.460.

RCW 43.70.480 Emergency medical personnel—Futile treatment and natural death directives—Guidelines. The department of health shall adopt guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment.

The guidelines shall include development of a simple form that shall be used statewide. [2000 c 70 § 1; 1992 c 98 § 14.]

Application—1992 c 98: See RCW 70.122.915.

RCW 43.70.490 Emergency medical service personnel training program—Assistance to persons with disabilities—Requirements—Law enforcement officer training—Definitions. (1) Subject to the availability of amounts appropriated for this specific purpose, the department, in collaboration with the department of social and health services, the state fire marshal's office, the superintendent of public instruction, and the Washington state council of firefighters, must review existing local training programs and training programs being used in other states and design a statewide training program that will familiarize fire department and emergency medical service personnel with the techniques, procedures, and protocols for best handling situations in which persons with disabilities are present at the scene of an emergency in order to maximize the safety of persons with disabilities, minimize the likelihood of injury to persons with disabilities, and promote the safety of all persons present. The program must include a checklist of disabilities, symptoms of such disabilities, and things to do and not to do relevant to a particular disability so fire department and emergency medical services personnel can easily and quickly determine the specific scenario into which they are entering. The department must make the training program available on the department's website for use by all fire departments and emergency medical service agencies in the state. The department must

include on its website a list of public and private nonprofit disability-related agencies and organizations and the contact information of each agency and organization. Fire departments and emergency medical service agencies must ensure their employees are adequately trained in and familiarized with techniques, procedures, and protocols for best handling situations in which persons with particular disabilities are present at the scene of an emergency.

(2) Subject to the availability of amounts appropriated for this specific purpose, the criminal justice training commission, in consultation with the Washington state patrol and other stakeholders, must examine existing training programs and curricula related to law enforcement officers responding to an emergency where a person with a disability may be present, to ensure that those programs and curricula are consistent with best practices.

(3) For purposes of this section:

(a) Both "accident" and "emergency" mean an unforeseen combination of circumstances or a resulting situation that results in a need for assistance or relief and calls for immediate action; and

(b) "Persons with disabilities" means individuals who have been diagnosed medically to have a physical, mental, emotional, intellectual, behavioral, developmental, or sensory disability. [2017 c 295 § 2.]

Short title—2017 c 295: "This act may be known and cited as the Travis alert act." [2017 c 295 § 1.]

RCW 43.70.495 Telemedicine training for health care professionals. (1) The legislature finds that a large segment of Washington residents do not have access to critical health care services. Telemedicine is a way to increase access to health care services to those who would otherwise not have reasonable access. The legislature therefore intends to ensure that health care professionals who provide services through telemedicine, as defined in RCW 70.41.020, in cities and rural areas alike, have current information available, making it possible for them to provide telemedicine services to the entire state of Washington.

(2) Except as permitted under subsection (3) of this section, beginning January 1, 2021, a health care professional who provides clinical services through telemedicine, other than a physician licensed under chapter 18.71 RCW or an osteopathic physician licensed under chapter 18.57 RCW, shall complete a telemedicine training. By January 1, 2020, the telemedicine collaborative shall make a telemedicine training available on its website for use by health care professionals who use telemedicine technology. If a health care professional completes the training, the health care professional shall sign and retain an attestation. The training:

(a) Must include information on current state and federal law, liability, informed consent, and other criteria established by the collaborative for the advancement of telemedicine, in collaboration with the department and the Washington state medical quality assurance commission [medical commission];

(b) Must include a question and answer methodology to demonstrate accrual of knowledge; and

(c) May be made available in electronic format and completed over the internet.

(3) A health care professional is deemed to have met the requirements of subsection (2) of this section if the health care professional:

(a) Completes an alternative telemedicine training; and

(b) Signs and retains an attestation that he or she completed the alternative telemedicine training.

(4) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Alternative telemedicine training" means training that includes components that are substantively similar to the telemedicine training developed by the telemedicine collaborative under subsection (2) of this section. "Alternative telemedicine training" may include, but is not limited to:

(i) Training offered by hospitals and other health care facilities to employees of the facility;

(ii) Continuing education courses; and

(iii) Trainings developed by a health care professional board or commission.

(b) "Health care professional" means a person licensed, registered, or certified to provide health services. [2020 c 147 § 1; 2019 c 48 § 1.]

RCW 43.70.500 Health care services practice indicators and risk management protocols. The department of health shall consult with health care providers and facilities, purchasers, health professional regulatory authorities under RCW 18.130.040, appropriate research and clinical experts, and consumers of health care services to identify specific practice areas where practice indicators and risk management protocols have been developed, including those that have been demonstrated to be effective among persons of color. Practice indicators shall be based upon expert consensus and best available scientific evidence. The department shall:

(1) Develop a definition of expert consensus and best available scientific evidence so that practice indicators can serve as a standard for excellence in the provision of health care services.

(2) Establish a process to identify and evaluate practice indicators and risk management protocols as they are developed by the appropriate professional, scientific, and clinical communities.

(3) Recommend the use of practice indicators and risk management protocols in quality assurance, utilization review, or provider payment to the health services commission. [1993 c 492 § 410.]

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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

RCW 43.70.510 Health care services coordinated quality improvement program—Rules. (1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject

to the jurisdiction and regulation of any state agency or any subdivision thereof may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.56.360(1)(c) and subsection (5) of this section shall apply. In reviewing plans submitted by licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.56.360(1)(c) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of five or more providers may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200. For purposes of this section, a health care provider group may be a consortium of providers consisting of five or more providers in total. All such programs shall comply with the requirements of RCW 70.41.200(1) (a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.56.360(1)(c) and subsection (5) of this section shall apply.

(3) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity. Any person or entity participating in a coordinated quality improvement program that, in substantial good faith, shares information or documents with one or more other programs, committees, or boards under subsection (6) of this section is not subject to an action for civil damages or other relief as a result of the activity or its consequences. For the purposes of this section, sharing information is presumed to be in substantial good faith. However, the presumption may be rebutted upon a showing of clear, cogent, and convincing evidence that the information shared was knowingly false or deliberately misleading.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee are not subject to review or disclosure, except as provided in this section, or discovery or introduction into

evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created, collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (f) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by, a quality improvement committee are exempt from disclosure under chapter 42.56 RCW.

(6) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by, a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 70.41.200, a coordinated quality improvement committee maintained by an ambulatory surgical facility under RCW 70.230.070, a quality assurance committee maintained in accordance with RCW 18.20.390 or 74.42.640, or a peer review committee under RCW 4.24.250, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The privacy protections of chapter 70.02 RCW and the federal health insurance portability and accountability act of 1996 and its implementing regulations apply to the sharing of individually identifiable patient information held by a coordinated quality improvement program. Any rules necessary to implement this section shall meet the requirements of applicable federal and state privacy laws. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program or a peer review committee under RCW 4.24.250 and any information and documents created or maintained as a result of the sharing of information and documents shall not be subject to the discovery process and confidentiality

shall be respected as required by subsection (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section. [2007 c 273 § 21. Prior: 2006 c 8 § 113; 2005 c 291 § 2; 2005 c 274 § 302; 2005 c 33 § 6; 2004 c 145 § 2; 1995 c 267 § 7; 1993 c 492 § 417.]

Effective date—Implementation—2007 c 273: See RCW 70.230.900 and 70.230.901.

Findings—Intent—Part headings and subheadings not law—Severability—2006 c 8: See notes following RCW 5.64.010.

Findings—2005 c 33: See note following RCW 18.20.390.

Captions not law—Severability—Effective dates—1995 c 267: See notes following RCW 43.70.052.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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

RCW 43.70.512 Public health system—Foundational public health services—Intent. (1) Protecting the public's health across the state is a fundamental responsibility of the state and is accomplished through the governmental public health system. This system is comprised of the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs.

(2)(a) The legislature intends to define a limited statewide set of core public health services, called foundational public health services, which the governmental public health system is responsible for providing in a consistent and uniform way in every community in Washington. These services are comprised of foundational programs and cross-cutting capabilities.

(b) These governmental public health services should be delivered in ways that maximize the efficiency and effectiveness of the overall system, make best use of the public health workforce and evolving technology, and address health equity.

(c) Funding for the governmental public health system must be restructured to support foundational public health services. In restructuring, there must be efforts to both reinforce current governmental public health system capacity and implement service delivery models allowing for system stabilization and transformation. [2019 c 14 § 1; 2007 c 259 § 60.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 43.70.515 Foundational public health services—Funding. (1) With any state funding of foundational public health services, the state expects that measurable benefits will be realized to the health of communities in Washington as a result of the improved capacity of

the governmental public health system. Close coordination and sharing of services are integral to increasing system capacity.

(2)(a) Funding for foundational public health services shall be appropriated to the office of financial management. The office of financial management may only allocate funding to the department if the department, after consultation with federally recognized Indian tribes pursuant to chapter 43.376 RCW, jointly certifies with a state association representing local health jurisdictions and the state board of health, to the office of financial management that they are in agreement on the distribution and uses of state foundational public health services funding across the public health system.

(b) If joint certification is provided, the department shall distribute foundational public health services funding according to the agreed-upon distribution and uses. If joint certification is not provided, appropriations for this purpose shall lapse.

(3) By October 1, 2020, the department, in partnership with sovereign tribal nations, local health jurisdictions, and the state board of health, shall report on:

(a) Service delivery models, and a plan for further implementation of successful models;

(b) Changes in capacity of the governmental public health system; and

(c) Progress made to improve health outcomes.

(4) For purposes of this section:

(a) "Foundational public health services" means a limited statewide set of defined public health services within the following areas:

(i) Control of communicable diseases and other notifiable conditions;

(ii) Chronic disease and injury prevention;

(iii) Environmental public health;

(iv) Maternal, child, and family health;

(v) Access to and linkage with medical, oral, and behavioral health services;

(vi) Vital records; and

(vii) Cross-cutting capabilities, including:

(A) Assessing the health of populations;

(B) Public health emergency planning;

(C) Communications;

(D) Policy development and support;

(E) Community partnership development; and

(F) Business competencies.

(b) "Governmental public health system" means the state department of health, state board of health, local health jurisdictions, sovereign tribal nations, and Indian health programs located within Washington.

(c) "Indian health programs" means tribally operated health programs, urban Indian health programs, tribal epidemiology centers, the American Indian health commission for Washington state, and the Northwest Portland area Indian health board.

(d) "Local health jurisdictions" means a public health agency organized under chapter 70.05, 70.08, or 70.46 RCW.

(e) "Service delivery models" means a systematic sharing of resources and function among state and local governmental public health entities, sovereign tribal nations, and Indian health programs to increase capacity and improve efficiency and effectiveness. [2019 c 14 § 2.]

RCW 43.70.525 Immunization assessment and enhancement proposals by local jurisdictions. (1) The department, in conjunction with local health jurisdictions, shall require each local health jurisdiction to submit an immunization assessment and enhancement proposal, consistent with the standards established in the public health [services] improvement plan, to provide immunization protection to the children of the state to further reduce vaccine-preventable diseases.

(2) These plans shall include, but not be limited to:

(a) A description of the population groups in the jurisdiction that are in the greatest need of immunizations;

(b) A description of strategies to use outreach, volunteer, and other local educational resources to enhance immunization rates; and

(c) A description of the capacity required to accomplish the enhancement proposal.

(3) This section shall be implemented consistent with available funding.

(4) The secretary shall report through the public health [services] improvement plan to the health care and fiscal committees of the legislature on the status of the program and progress made toward increasing immunization rates in population groups of greatest need. [1994 c 299 § 29.]

Intent—Finding—Severability—Conflict with federal requirements—1994 c 299: See notes following RCW 74.12.400.

Immunization: RCW 28A.210.060.

RCW 43.70.526 Childhood immunizations—Resources for expecting parents. The department shall develop and make available resources for expecting parents regarding recommended childhood immunizations. The resources are intended to be provided to expecting parents by their health care providers to encourage discussion on childhood immunizations and postnatal care. [2016 c 141 § 1.]

RCW 43.70.533 Chronic conditions—Training and technical assistance for primary care providers. (1) The department shall conduct a program of training and technical assistance regarding care of people with chronic conditions for providers of primary care. The program shall emphasize evidence-based high quality preventive and chronic disease care and shall collaborate with the health care authority to promote the adoption of primary care health homes established under chapter 316, Laws of 2011. The department may designate one or more chronic conditions to be the subject of the program.

(2) The training and technical assistance program shall include the following elements:

(a) Clinical information systems and sharing and organization of patient data;

(b) Decision support to promote evidence-based care;

(c) Clinical delivery system design;

(d) Support for patients managing their own conditions; and

(e) Identification and use of community resources that are available in the community for patients and their families.

(3) In selecting primary care providers to participate in the program, the department shall consider the number and type of patients with chronic conditions the provider serves, and the provider's participation in the medicaid program, the basic health plan, and health plans offered through the public employees' benefits board.

(4) For the purposes of this section, "health home" and "primary care provider" have the same meaning as in RCW 74.09.010. [2011 c 316 § 3; 2007 c 259 § 5.]

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

RCW 43.70.540 Data collection—Finding—Intent. The legislature recognizes that the state patrol, the administrative office of the courts, the sheriffs' and police chiefs' association, the department of social and health services, the department of commerce, the sentencing guidelines commission, the department of corrections, and the superintendent of public instruction each have comprehensive data and analysis capabilities that have contributed greatly to our current understanding of crime and violence, and their causes.

The legislature finds, however, that a single health-oriented agency must be designated to provide consistent guidelines to all these groups regarding the way in which their data systems collect this important data. It is not the intent of the legislature by RCW 43.70.545 to transfer data collection requirements from existing agencies or to require the addition of major new data systems. It is rather the intent to make only the minimum required changes in existing data systems to increase compatibility and comparability, reduce duplication, and to increase the usefulness of data collected by these agencies in developing more accurate descriptions of violence. [2023 c 470 § 2057; 2005 c 282 § 45; 1995 c 399 § 76; 1994 sp.s. c 7 § 201.]

Explanatory statement—2023 c 470: See note following RCW 10.99.030.

Legislative finding and intent—1994 sp.s. c 7: "The legislature finds that the increasing violence in our society causes great concern for the immediate health and safety of our citizens and our social institutions. Youth violence is increasing at an alarming rate and young people between the ages of fifteen and twenty-four are at the highest risk of being perpetrators and victims of violence. Additionally, random violence, including homicide and the use of firearms, has dramatically increased over the last decade.

The legislature finds that violence is abhorrent to the aims of a free society and that it cannot be tolerated. State efforts at reducing violence must include changes in criminal penalties, reducing the unlawful use of and access to firearms, increasing educational efforts to encourage nonviolent means for resolving conflicts, and allowing communities to design their prevention efforts.

The legislature finds that the problem of violence can be addressed with many of the same approaches that public health programs have used to control other problems such as infectious disease, tobacco use, and traffic fatalities.

Addressing the problem of violence requires the concerted effort of all communities and all parts of state and local governments. It is

the immediate purpose of chapter 7, Laws of 1994 sp. sess. to: (1) Prevent acts of violence by encouraging change in social norms and individual behaviors that have been shown to increase the risk of violence; (2) reduce the rate of at-risk children and youth, as defined in *RCW 70.190.010; (3) increase the severity and certainty of punishment for youth and adults who commit violent acts; (4) reduce the severity of harm to individuals when violence occurs; (5) empower communities to focus their concerns and allow them to control the funds dedicated to empirically supported preventive efforts in their region; and (6) reduce the fiscal and social impact of violence on our society." [1994 sp.s. c 7 § 101.]

***Reviser's note:** The governor vetoed 1994 sp.s. c 7 § 302, which amended RCW 70.190.010 to define "at-risk children and youth." RCW 70.190.010 was subsequently amended by 1996 c 132 § 2, which now includes a definition for "at-risk children." RCW 70.190.010 was subsequently repealed by 2011 1st sp.s. c 32 § 13, effective June 30, 2012.

Severability—1994 sp.s. c 7: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1994 sp.s. c 7 § 913.]

Effective dates—Contingent expiration date—1994 sp.s. c 7: "(1) Sections 201 through 204, 302, 323, 411, 412, 417, and 418 of this act are necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect immediately [April 6, 1994].

(2) Sections 904 through 908 of this act shall take effect July 1, 1995.

*(3) Notwithstanding other provisions of this section, if sections 901 through 909 of this act are referred to the voters at the next succeeding general election and sections 901 through 909 of this act are rejected by the voters, then the amendments by sections 510 through 512, 519, 521, 525, and 527 of this act shall expire on July 1, 1995." [1994 sp.s. c 7 § 915 (Referendum Bill No. 43, subsection (3) approved November 8, 1994).]

***Reviser's note:** Sections 901 through 909, chapter 7, Laws of 1994 sp. sess. were approved and ratified by the voters on November 8, 1994, in Referendum Bill No. 43. Therefore, the amendments to sections 510 through 512, 519, 521, 525, and 527, chapter 7, Laws of 1994 sp. sess. do not expire on July 1, 1995.

RCW 43.70.545 Data collection and reporting rules. (1) The department of health shall develop, based on recommendations in the public health services improvement plan and in consultation with affected groups or agencies, comprehensive rules for the collection and reporting of data relating to acts of violence, at-risk behaviors, and risk and protective factors. The data collection and reporting rules shall be used by any public or private entity that is required to report data relating to these behaviors and conditions. The department may require any agency or program that is state-funded or that accepts state funds and any licensed or regulated person or

professional to report these behaviors and conditions. To the extent possible the department shall require the reports to be filed through existing data systems. The department may also require reporting of attempted acts of violence and of nonphysical injuries. For the purposes of this section "acts of violence" means self-directed and interpersonal behaviors that can result in suicide, homicide, and nonfatal intentional injuries. "At-risk behaviors," "protective factors," and "risk factors" have the same meanings as provided in *RCW 70.190.010. A copy of the data used by a school district to prepare and submit a report to the department shall be retained by the district and, in the copy retained by the district, identify the reported acts or behaviors by school site.

(2) The department is designated as the statewide agency for the coordination of all information relating to violence and other intentional injuries, at-risk behaviors, and risk and protective factors.

(3) The department shall provide necessary data to the local health departments for use in planning by or evaluation of any community network authorized under RCW 70.190.060.

(4) The department shall by rule establish requirements for local health departments to perform assessment related to at-risk behaviors and risk and protective factors and to assist community networks in policy development and in planning and other duties under chapter 7, Laws of 1994 sp. sess.

(5) The department may, consistent with its general authority and directives under RCW 43.70.540 through 43.70.560, contract with a college or university that has experience in data collection relating to the health and overall welfare of children to provide assistance to:

(a) State and local health departments in developing new sources of data to track acts of violence, at-risk behaviors, and risk and protective factors; and

(b) Local health departments to compile and effectively communicate data in their communities. [1998 c 245 § 76; 1994 sp.s. c 7 § 202.]

***Reviser's note:** RCW 70.190.010 was repealed by 2011 1st sp.s. c 32 § 13, effective June 30, 2012.

Finding—Intent—Severability—Effective dates—Contingent expiration date—1994 sp.s. c 7: See notes following RCW 43.70.540.

RCW 43.70.550 Public health services improvement plan—Contents. The public health services improvement plan developed under *RCW 43.70.520 shall include:

(1) Minimum standards for state and local public health assessment, performance measurement, policy development, and assurance regarding social development to reduce at-risk behaviors and risk and protective factors. The department in the development of data collection and reporting requirements for the superintendent of public instruction, schools, and school districts shall consult with the joint select committee on education restructuring and local school districts.

(2)(a) Measurable risk factors that are empirically linked to violent criminal acts by juveniles, teen substance abuse, teen

pregnancy and male parentage, teen suicide attempts, dropping out of school, child abuse or neglect, and domestic violence; and

(b) An evaluation of other factors to determine whether they are empirically related risk factors, such as: Out-of-home placements, poverty, single-parent households, inadequate nutrition, hunger, unemployment, lack of job skills, gang affiliation, lack of recreational or cultural opportunities, school absenteeism, court-ordered parenting plans, physical, emotional, or behavioral problems requiring special needs assistance in K-12 schools, learning disabilities, and any other possible factors.

(3) Data collection and analysis standards on at-risk behaviors and risk and protective factors for use by the local public health departments and the **state council and the local community networks to ensure consistent and interchangeable data.

(4) Recommendations regarding any state or federal statutory barriers affecting data collection or reporting.

The department shall provide an annual report to the Washington state institute for public policy on the implementation of this section. [1994 sp.s. c 7 § 203.]

Reviser's note: *(1) RCW 43.70.520 was repealed by 2019 c 14 § 3.

**(2) RCW 70.170.030, which created the health care access and cost control council, was repealed by 1995 c 269 § 2204.

Finding—Intent—Severability—Effective dates—Contingent expiration date—1994 sp.s. c 7: See notes following RCW 43.70.540.

RCW 43.70.555 Assessment standards. The department shall establish, by rule, standards for local health departments and networks to use in assessment, performance measurement, policy development, and assurance regarding social development to prevent health problems caused by risk factors empirically linked to: Violent criminal acts by juveniles, teen substance abuse, teen pregnancy and male parentage, teen suicide attempts, dropping out of school, child abuse or neglect, and domestic violence. The standards shall be based on the standards set forth in the public health services improvement plan as required by RCW 43.70.550. [2011 1st sp.s. c 32 § 8; 1998 c 245 § 77; 1994 sp.s. c 7 § 204.]

Transition plan—Report to the legislature—2011 1st sp.s. c 32: See note following RCW 70.305.005.

Finding—Intent—Severability—Effective dates—Contingent expiration date—1994 sp.s. c 7: See notes following RCW 43.70.540.

RCW 43.70.560 Media violence—Reporting reduction efforts. The legislature encourages the use of a statewide voluntary, socially responsible policy to reduce the emphasis, amount, and type of violence in all public media. The department shall develop a suggested reporting format for use by the print, television, and radio media in reporting their voluntary violence reduction efforts. Each area of the public media may carry out the policy in whatever manner that area deems appropriate. [1994 sp.s. c 7 § 205.]

Finding—Intent—Severability—1994 sp.s. c 7: See notes following RCW 43.70.540.

RCW 43.70.570 Intent—1995 c 43. The legislature declares its intent to implement the recommendations of the public health improvement plan by initiating a program to provide the public health system with the necessary capacity to improve the health outcomes of the population of Washington state and establishing the methodology by which improvement in the health outcomes and delivery of public health activities will be assessed. [1995 c 43 § 1.]

Severability—1995 c 43: "If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected." [1995 c 43 § 14.]

Effective dates—Contingent effective dates—1995 c 43: See note following RCW 70.05.030.

RCW 43.70.575 Definitions. Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW 43.70.570 through *43.70.580.

(1) "Capacity" means actions that public health jurisdictions must do as part of ongoing daily operations to adequately protect and promote health and prevent disease, injury, and premature death. The public health improvement plan identifies capacity necessary for assessment, policy development, administration, prevention, including promotion and protection, and access and quality.

(2) "Department" means the department of health.

(3) "Local health jurisdiction" means the local health agency, either county or multicounty, operated by local government, with oversight and direction from a local board of health, that provides public health services throughout a defined geographic area.

(4) "Health outcomes" means long-term objectives that define optimal, measurable, future levels of health status, maximum acceptable levels of disease, injury, or dysfunction, or prevalence of risk factors in areas such as improving the rate of immunizations for infants and children to ninety percent and controlling and reducing the spread of tuberculosis and that are stated in the public health improvement plan.

(5) "Public health improvement plan," also known as the public health services improvement plan, means the public health services improvement plan established under *RCW 43.70.520, developed by the department, in consultation with local health departments and districts, the state board of health, the health services commission, area Indian health services, and other state agencies, health services providers, and residents concerned about public health, to provide a detailed accounting of deficits in the core functions of assessment, policy development, and assurance of the current public health system, how additional public health funding would be used, and to describe the benefits expected from expanded expenditures.

(6) "Public health" means activities that society does collectively to assure the conditions in which people can be healthy.

This includes organized community efforts to prevent, identify, preempt, and counter threats to the public's health.

(7) "Public health system" means the department, the state board of health, and local health jurisdictions. [1995 c 43 § 2.]

***Reviser's note:** RCW 43.70.580 and 43.70.520 were repealed by 2019 c 14 § 3.

Effective dates—Contingent effective dates—1995 c 43: See note following RCW 70.05.030.

Severability—1995 c 43: See note following RCW 43.70.570.

RCW 43.70.590 American Indian health care delivery plan. Consistent with funds appropriated specifically for this purpose, the department shall establish in conjunction with the area Indian health services system and providers an advisory group comprised of Indian and non-Indian health care facilities and providers to formulate an American Indian health care delivery plan. The plan shall include:

(1) Recommendations to providers and facilities methods for coordinating and joint venturing with the Indian health services for service delivery;

(2) Methods to improve American Indian-specific health programming; and

(3) Creation of co-funding recommendations and opportunities for the unmet health services programming needs of American Indians. [1995 c 43 § 4; 1993 c 492 § 468. Formerly RCW 41.05.240.]

Reviser's note: RCW 41.05.240 was amended and recodified as RCW 43.70.590 by 1995 c 43 without cognizance of the repeal by 1995 1st sp.s. c 6 § 9. For rule of construction concerning sections amended and repealed in the same legislative session, see RCW 1.12.025.

Effective dates—Contingent effective dates—1995 c 43: See note following RCW 70.05.030.

Severability—1995 c 43: See note following RCW 43.70.570.

Findings—Intent—1993 c 492: See notes following RCW 43.20.050.

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

RCW 43.70.595 Health equity zones. (1) Subject to the availability of amounts appropriated for this specific purpose, the department, in coordination with the governor's interagency council on health disparities, local health jurisdictions, and accountable communities of health, must share and review population health data, which may be related to chronic and infectious diseases, maternal birth complications, preterm births and other newborn health complications, and any other relevant health data, including hospital community health needs assessments, to identify, or allow communities to self-identify, potential health equity zones in the state and develop projects to meet the unique needs of each zone. The department

must provide technical support to communities in the use of data to facilitate self-identification of health equity zones.

(2) Communities' uses of data must align with projects and outcomes to be measured in self-identified zones.

(3) The department must use the first 12 months following July 25, 2021, to develop a plan and process to allow communities to implement health equity zone programs statewide. The department has authority to determine the number of health equity zones and projects based on available resources.

(4) Communities that self-identify zones or the department must notify relevant community organizations in the zones of the health equity zone designation and allow those organizations to identify projects to address the zone's most urgent needs related to health disparities. Community organizations may include, but are not limited to:

(a) Community health clinics;

(b) Local health providers;

(c) Federally qualified health centers;

(d) Health systems;

(e) Local government;

(f) Public school districts;

(g) Recognized American Indian organizations and Indian health organizations;

(h) Local health jurisdictions; and

(i) Any other nonprofit organization working to address health disparities in the zone.

(5) Local organizations working within zones may form coalitions to identify the needs of the zone, design projects to address those needs, and develop an action plan to implement the projects. Local organizations may partner with state or national organizations outside the specific zone designation. Projects may include, but are not limited to:

(a) Addressing health care provider access and health service delivery;

(b) Improving information sharing and community trust in providers and services;

(c) Conducting outreach and education efforts; and

(d) Recommending systems and policy changes that will improve population health.

(6) The department must provide:

(a) Support to the coalitions in identifying and applying for resources to support projects within the zones;

(b) Technical assistance related to project management and developing health outcome and other measures to evaluate project success; and

(c) Subject to availability, funding to implement projects.

(7) Subject to the availability of amounts appropriated for this specific purpose, by December 1, 2023, and every two years thereafter, the department must submit a report to the legislature detailing the projects implemented in each zone and the outcome measures, including year-over-year health data, to demonstrate project success.

(8) For the purposes of this section "health equity zone" or "zone" means a contiguous geographic area that demonstrates measurable and documented health disparities and poor health outcomes, which may include but are not limited to high rates of maternal complications, newborn health complications, and chronic and infectious disease, is populated by communities of color, Indian communities, communities

experiencing poverty, or immigrant communities, and is small enough for targeted interventions to have a significant impact on health outcomes and health disparities. Documented health disparities must be documented or identified by the department or the centers for disease control and prevention. [2021 c 262 § 2.]

Findings—Intent—2021 c 262: "(1) The legislature finds that people of color, Indian, people experiencing poverty, and immigrant populations experience significant health disparities compared to the general population, including more limited access to health care and poorer health outcomes. The legislature finds that these circumstances result in higher rates of morbidity and mortality for persons of color and immigrant populations than observed in the general population.

(2) Therefore, the legislature intends to create health equity zones to address significant health disparities identified by health outcome data. The state intends to work with community leaders within the health equity zones to share information and coordinate efforts with the goal of addressing the most urgent needs. Health equity zone partners shall develop, expand, and maintain positive relationships with communities of color, Indian communities, communities experiencing poverty, and immigrant communities within the zone to develop effective and sustainable programs to address health inequity." [2021 c 262 § 1.]

RCW 43.70.600 Survey regarding exposure to radio frequencies—Results. When funds are appropriated for this purpose, the department shall conduct a survey of scientific literature regarding the possible health effects of human exposure to the radio frequency part of the electromagnetic spectrum (300Hz to 300GHz). The department may submit the survey results to the legislature, prepare a summary of that survey, and make the summary available to the public. The department may update the survey and summary periodically. [1998 c 245 § 78; 1996 c 323 § 6.]

Findings—1996 c 323: "The legislature finds that concerns have been raised over possible health effects from exposure to some wireless telecommunications facilities, and that exposures from these facilities should be kept as low as reasonably achievable while still allowing the operation of these networks. The legislature further finds that the department of health should serve as the state agency that follows the issues and compiles information pertaining to potential health effects from wireless telecommunications facilities." [1996 c 323 § 1.]

RCW 43.70.605 Personal wireless services—Random testing on power density analysis—Rules. Unless this section is preempted by applicable federal statutes, the department may require that in residential zones or areas, all providers of personal wireless services, as defined in *section 1 of this act, provide random test results on power density analysis for the provider's licensed frequencies showing radio frequency levels before and after development of the personal wireless service antenna facilities, following national standards or protocols of the federal communications commission or other federal agencies. This section

shall not apply to microcells as defined in RCW 80.36.375. The department may adopt rules to implement this section. [1996 c 323 § 7.]

***Reviser's note:** The reference to section 1 of this act is erroneous. Section 2 of the act, codified as RCW 43.21C.0384, was apparently intended.

Findings—1996 c 323: See note following RCW 43.70.600.

RCW 43.70.610 Domestic violence education program—Established—Findings. The legislature finds that domestic violence is the leading cause of injury among women and is linked to numerous health problems, including depression, abuse of alcohol and other drugs, and suicide. Despite the frequency of medical attention, few people are diagnosed as victims of spousal abuse. The department, in consultation with the disciplinary authorities as defined in RCW 18.130.040, shall establish, within available department general funds, an ongoing domestic violence education program as an integral part of its health professions regulation. The purpose of the education program is to raise awareness and educate health care professionals regarding the identification, appropriate treatment, and appropriate referral of victims of domestic violence. The disciplinary authorities having the authority to offer continuing education may provide training in the dynamics of domestic violence. No funds from the health professions account may be utilized to fund activities under this section unless the disciplinary authority authorizes expenditures from its proportions of the account. A disciplinary authority may defray costs by authorizing a fee to be charged for participants or materials relating to any sponsored program. [1996 c 191 § 89.]

RCW 43.70.613 Health care professionals—Health equity continuing education. (1) By January 1, 2024, the rule-making authority for each health profession licensed under Title 18 RCW subject to continuing education requirements must adopt rules requiring a licensee to complete health equity continuing education training at least once every four years.

(2) Health equity continuing education courses may be taken in addition to or, if a rule-making authority determines the course fulfills existing continuing education requirements, in place of other continuing education requirements imposed by the rule-making authority.

(3)(a) The secretary and the rule-making authorities must work collaboratively to provide information to licensees about available courses. The secretary and rule-making authorities shall consult with patients or communities with lived experiences of health inequities or racism in the health care system and relevant professional organizations when developing the information and must make this information available by July 1, 2023. The information should include a course option that is free of charge to licensees. It is not required that courses be included in the information in order to fulfill the health equity continuing education requirement.

(b) By January 1, 2023, the department, in consultation with the boards and commissions, shall adopt model rules establishing the minimum standards for continuing education programs meeting the

requirements of this section. The department shall consult with patients or communities with lived experience of health inequities or racism in the health care system, relevant professional organizations, and the rule-making authorities in the development of these rules.

(c) The minimum standards must include instruction on skills to address the structural factors, such as bias, racism, and poverty, that manifest as health inequities. These skills include individual-level and system-level intervention, and self-reflection to assess how the licensee's social position can influence their relationship with patients and their communities. These skills enable a health care professional to care effectively for patients from diverse cultures, groups, and communities, varying in race, ethnicity, gender identity, sexuality, religion, age, ability, socioeconomic status, and other categories of identity. The courses must assess the licensee's ability to apply health equity concepts into practice. Course topics may include, but are not limited to:

(i) Strategies for recognizing patterns of health care disparities on an individual, institutional, and structural level and eliminating factors that influence them;

(ii) Intercultural communication skills training, including how to work effectively with an interpreter and how communication styles differ across cultures;

(iii) Implicit bias training to identify strategies to reduce bias during assessment and diagnosis;

(iv) Methods for addressing the emotional well-being of children and youth of diverse backgrounds;

(v) Ensuring equity and antiracism in care delivery pertaining to medical developments and emerging therapies;

(vi) Structural competency training addressing five core competencies:

(A) Recognizing the structures that shape clinical interactions;

(B) Developing an extraclinical language of structure;

(C) Rearticulating "cultural" formulations in structural terms;

(D) Observing and imagining structural interventions; and

(E) Developing structural humility; and

(vii) Cultural safety training.

(4) The rule-making authority may adopt rules to implement and administer this section, including rules to establish a process to determine if a continuing education course meets the health equity continuing education requirement established in this section.

(5) For purposes of this section the following definitions apply:

(a) "Rule-making authority" means the regulatory entities identified in RCW 18.130.040 and authorized to establish continuing education requirements for the health care professions governed by those regulatory entities.

(b) "Structural competency" means a shift in medical education away from pedagogic approaches to stigma and inequalities that emphasize cross-cultural understandings of individual patients, toward attention to forces that influence health outcomes at levels above individual interactions. Structural competency reviews existing structural approaches to stigma and health inequities developed outside of medicine and proposes changes to United States medical education that will infuse clinical training with a structural focus.

(c) "Cultural safety" means an examination by health care professionals of themselves and the potential impact of their own culture on clinical interactions and health care service delivery. This requires individual health care professionals and health care

organizations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care organizations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires health care professionals and their associated health care organizations to influence health care to reduce bias and achieve equity within the workforce and working environment. [2021 c 276 § 2.]

Findings—2021 c 276: "The legislature finds that:

(1) Healthy Washingtonians contribute to the economic and social welfare of their families and communities, and access to health services and improved health outcomes allows all Washington families to enjoy productive and satisfying lives;

(2) The COVID-19 pandemic has further exposed that health outcomes are experienced differently by different people based on discrimination and bias by the health care system. Research shows that health care resources are distributed unevenly by intersectional categories including, but not limited to, race, gender, ability status, religion, sexual orientation, socioeconomic status, and geography; and

(3) These inequities have permeated health care delivery, deepening adverse outcomes for marginalized communities. This bill aims to equip health care workers with the skills to recognize and reduce these inequities in their daily work. In addition to their individual impact, health care workers need the skills to address systemic racism and bias." [2021 c 276 § 1.]

RCW 43.70.614 Female genital mutilation—Education program. (1) The department must establish an education program for the prevention of female genital mutilation. The program must be designed to provide information about the health risks and emotional trauma inflicted by the practice of female genital mutilation, as well as the civil and criminal penalties for committing female genital mutilation.

(2) The department must develop policies and procedures to promote partnerships with relevant stakeholders to prevent female genital mutilation and to protect and provide assistance to victims of female genital mutilation, including partnerships with:

(a) Relevant state agencies that provide services to persons at risk of female genital mutilation or persons who have been subjected to female genital mutilation;

(b) The department of children, youth, and families;

(c) The Washington state patrol;

(d) The attorney general; and

(e) Other government entities and nongovernmental organizations.

(3) The department must make recommendations and develop procedures regarding strategies and methodologies for training health care providers as defined in RCW 70.02.010 on recognizing the risk factors associated with female genital mutilation and the signs that a person may be a victim of female genital mutilation.

(4) Subject to the availability of amounts appropriated for this specific purpose, the department may contract with nongovernmental organizations, entities, or persons with experience working with victims of female genital mutilation to provide training and materials and other services as the department deems necessary.

(5) The department may adopt rules necessary to implement this section.

(6) For purposes of this section, "female genital mutilation" has the meaning provided in RCW 18.130.460. [2023 c 122 § 6.]

Finding—Intent—Effective date—2023 c 122: See notes following RCW 9A.36.170.

RCW 43.70.615 Multicultural health awareness and education program—Integration into health professions basic education preparation curriculum. (1) For the purposes of this section, "multicultural health" means the provision of health care services with the knowledge and awareness of the causes and effects of the determinants of health that lead to disparities in health status between different genders and racial and ethnic populations and the practice skills necessary to respond appropriately.

(2) The department, in consultation with the disciplining authorities as defined in RCW 18.130.040, shall establish, within available department general funds, an ongoing multicultural health awareness and education program as an integral part of its health professions regulation. The purpose of the education program is to raise awareness and educate health care professionals regarding the knowledge, attitudes, and practice skills necessary to care for diverse populations to achieve a greater understanding of the relationship between culture and health. Any such education shall be developed in collaboration with education programs that train students in that health profession. No funds from the health professions account may be utilized to fund activities under this section unless the disciplining authority authorizes expenditures from its proportions of the account.

(3) By July 1, 2008, each education program with a curriculum to train health professionals for employment in a profession credentialed by a disciplining authority under chapter 18.130 RCW shall integrate into the curriculum instruction in multicultural health as part of its basic education preparation curriculum. The department may not deny the application of any applicant for a credential to practice a health profession on the basis that the education or training program that the applicant successfully completed did not include integrated multicultural health curriculum as part of its basic instruction. [2021 c 276 § 3; 2006 c 237 § 2.]

Findings—2021 c 276: See note following RCW 43.70.613.

Findings—2006 c 237: "The legislature finds that women and people of color experience significant disparities from the general population in education, employment, healthy living conditions, access to health care, and other social determinants of health. The legislature finds that it shall be a priority for the state to develop the knowledge, attitudes, and practice skills of health professionals and those working with diverse populations to achieve a greater

understanding of the relationship between culture and health and gender and health." [2006 c 237 § 1.]

RCW 43.70.617 Prenatal nutrition best practices—Educational resources for pregnant women. The department shall develop and make available educational resources for pregnant women regarding prenatal nutrition best practices to promote infant health. The educational resources may include, but are not limited to, courses delivered in-person or electronically and pamphlets printed on paper or made available on the department's website. The educational resources are intended to provide pregnant women knowledge of healthy foods and essential daily nutrients needed to promote infant growth and development. [2014 c 38 § 1.]

RCW 43.70.619 Pregnancy complications—Informational resources. By December 31, 2021, the department shall design, prepare, and make available online, written materials to clearly inform health care providers and staff of the provisions of, and authority to act under, chapter 70.400 RCW. [2021 c 235 § 5.]

Conflict with federal requirements—2021 c 235: See RCW 70.400.900.

RCW 43.70.620 List of contacts—Health care professions. The secretary shall create and maintain a list of contacts with each of the health care professions regulated under the following chapters for the purpose of policy advice and information dissemination: RCW 18.06.080, 18.89.050, and 18.138.070 and chapters *18.135, 18.55, and 18.88A RCW. [1999 c 151 § 402.]

***Reviser's note:** Chapter 18.135 RCW was repealed by 2012 c 153 § 20.

Part headings not law—Effective date—1999 c 151: See notes following RCW 18.28.010.

RCW 43.70.630 Cost-reimbursement agreements. (1) The department may enter into a written cost-reimbursement agreement with a permit applicant or project proponent to recover from the applicant or proponent the reasonable costs incurred by the department in carrying out the requirements of this chapter, as well as the requirements of other relevant laws, as they relate to permit coordination, environmental review, application review, technical studies, and permit processing.

(2) The cost-reimbursement agreement shall identify the tasks and costs for work to be conducted under the agreement. The agreement must include a schedule that states:

(a) The estimated number of weeks for initial review of the permit application;

(b) The estimated number of revision cycles;

(c) The estimated number of weeks for review of subsequent revision submittals;

(d) The estimated number of billable hours of employee time;

(e) The rate per hour; and

(f) A date for revision of the agreement if necessary.

(3) The written cost-reimbursement agreement shall be negotiated with the permit applicant or project proponent. Under the provisions of a cost-reimbursement agreement, funds from the applicant or proponent shall be used by the department to contract with an independent consultant to carry out the work covered by the cost-reimbursement agreement. The department may also use funds provided under a cost-reimbursement agreement to hire temporary employees, to assign current staff to review the work of the consultant, to provide necessary technical assistance when an independent consultant with comparable technical skills is unavailable, and to recover reasonable and necessary direct and indirect costs that arise from processing the permit. The department shall, in developing the agreement, ensure that final decisions that involve policy matters are made by the agency and not by the consultant. The department shall make an estimate of the number of permanent staff hours to process the permits, and shall contract with consultants or hire temporary employees to replace the time and functions committed by these permanent staff to the project. The billing process shall provide for accurate time and cost accounting and may include a billing cycle that provides for progress payments.

(4) The cost-reimbursement agreement must not negatively impact the processing of other permit applications. In order to maintain permit processing capacity, the agency may hire outside consultants, temporary employees, or make internal administrative changes. Consultants or temporary employees hired as part of a cost-reimbursement agreement or to maintain agency capacity are hired as agents of the state not of the permit applicant. The restrictions of chapter 42.52 RCW apply to any cost-reimbursement agreement, and to any person hired as a result of a cost-reimbursement agreement. [2009 c 97 § 10; 2007 c 94 § 12; 2003 c 70 § 3; 2000 c 251 § 4.]

Intent—Captions not law—Effective date—2000 c 251: See notes following RCW 43.21A.690.

RCW 43.70.640 Workplace breastfeeding policies—Infant-friendly designation. (1) An employer may use the designation "infant-friendly" on its promotional materials if the employer has an approved workplace breastfeeding policy addressing at least the following:

(a) Flexible work scheduling, including scheduling breaks and permitting work patterns that provide time for expression of breast milk;

(b) A convenient, sanitary, safe, and private location, other than a restroom, allowing privacy for breastfeeding or expressing breast milk;

(c) A convenient clean and safe water source with facilities for washing hands and rinsing breast-pumping equipment located in the private location specified in (b) of this subsection; and

(d) A convenient hygienic refrigerator in the workplace for the mother's breast milk.

(2) Employers seeking approval of a workplace breastfeeding policy must submit the policy to the department of health. The department of health shall review and approve those policies that meet the requirements of this section. The department may directly develop

and implement the criteria for "infant-friendly" employers, or contract with a vendor for this purpose.

(3) For the purposes of this section, "employer" includes those employers defined in RCW 49.12.005 and also includes the state, state institutions, state agencies, political subdivisions of the state, and municipal corporations or quasi-municipal corporations. [2001 c 88 § 3.]

Acknowledgment—Declaration—Findings—2001 c 88: "(1) The legislature acknowledges the surgeon general's summons to all sectors of society and government to help redress the low breastfeeding rates and duration in the United States, including the social and workplace factors that can make it difficult for women to breastfeed. The legislature also acknowledges the surgeon general's report on the health and economic importance of breastfeeding which concludes that:

(a) Breastfeeding is one of the most important contributors to infant health;

(b) Breastfeeding provides a range of benefits for the infant's growth, immunity, and development; and

(c) Breastfeeding improves maternal health and contributes economic benefits to the family, health care system, and workplace.

(2) The legislature declares that the achievement of optimal infant and child health, growth, and development requires protection and support for the practice of breastfeeding. The legislature finds that:

(a) The American academy of pediatrics recommends exclusive breastfeeding for the first six months of a child's life and breastfeeding with the addition of solid foods to continue for at least twelve months, and that arrangements be made to provide expressed breast milk if the mother and child must separate during the first year. Children should be breastfed or fed expressed breast milk when they show signs of need, rather than according to a set schedule or the location;

(b) Breast milk contains all the nutrients a child needs for optimal health, growth, and development, many of which can only be found in breast milk;

(c) Research in developed countries provides strong evidence that breastfeeding decreases the incidence and/or severity of diarrhea, lower respiratory tract infection, otitis media, bacteremia, bacterial meningitis, urinary tract infection, and necrotizing enterocolitis. In addition, a number of studies show a possible protective effect of breastfeeding against SIDS, Type 1 diabetes mellitus, Crohn's disease, lymphoma, ulcerative colitis, and allergic diseases;

(d) Studies also indicate health benefits in mothers who breastfeed. Breastfeeding is one of the few ways that mothers may be able to lower their risk of developing breast and ovarian cancer, with benefits proportional to the duration that they are able to breastfeed. In addition, the maternal hormonal changes stimulated by breastfeeding also help the uterus recover faster and minimize the amount of blood mothers lose after birth. Breastfeeding inhibits ovulation and menstrual bleeding, thereby decreasing the risk of anemia and a precipitous subsequent pregnancy. Breastfeeding women also have an earlier return to prepregnancy weight;

(e) Approximately two-thirds of women who are employed when they become pregnant return to the workforce by the time their children are six months old;

(f) Employers benefit when their employees breastfeed. Breastfed infants are sick less often; therefore, maternal absenteeism from work is lower in companies with established lactation programs. In addition, employee medical costs are lower and employee productivity is higher;

(g) According to a survey of mothers in Washington, most want to breastfeed but discontinue sooner than they hope, citing lack of societal and workplace support as key factors limiting their ability to breastfeed;

(h) Many mothers fear that they are not making enough breast milk and therefore decrease or discontinue breastfeeding. Frequency of breastfeeding or expressing breast milk is the main regulator of milk supply, such that forcing mothers to go prolonged periods without breastfeeding or expressing breast milk can undermine their ability to maintain breastfeeding; and

(i) Maternal stress can physiologically inhibit a mother's ability to produce and let down milk. Mothers report modifiable sources of stress related to breastfeeding, including lack of protection from harassment and difficulty finding time and an appropriate location to express milk while away from their babies.

(3) The legislature encourages state and local governmental agencies, and private and public sector businesses to consider the benefits of providing convenient, sanitary, safe, and private rooms for mothers to express breast milk." [2001 c 88 § 1.]

RCW 43.70.645 Donor human milk—Milk bank safety standards. The department shall adopt standards for ensuring milk bank safety. The standards adopted by the department must, at a minimum, consider the clinical, evidence-based guidelines established by a national accrediting organization. The standards must address donor screening, milk handling and processing, and recordkeeping. The department shall also review and consider requiring additional testing standards, including but not limited to testing for the presence of viruses, bacteria, and prescription and nonprescription drugs in donated milk. [2022 c 236 § 5.]

RCW 43.70.650 School sealant endorsement program—Rules—Fee—Report to the legislature. The secretary is authorized to create a school sealant endorsement program for dental hygienists and dental assistants. The secretary of health, in consultation with the dental quality assurance commission and the dental hygiene examining committee, shall adopt rules to implement this section.

(1) A dental hygienist licensed in this state after April 19, 2001, is eligible to apply for endorsement by the department of health as a school sealant dental hygienist upon completion of the Washington state school sealant endorsement program. While otherwise authorized to act, currently licensed hygienists may still elect to apply for the endorsement.

(2) A dental assistant employed after April 19, 2001, by a dentist licensed in this state, who has worked under dental supervision for at least two hundred hours, is eligible to apply for endorsement by the department of health as a school sealant dental assistant upon completion of the Washington state school sealant endorsement program. While otherwise authorized to act, currently

employed dental assistants may still elect to apply for the endorsement.

(3) The department may impose a fee for implementation of this section.

(4) The secretary shall provide a report to the legislature by December 1, 2005, evaluating the outcome of chapter 93, Laws of 2001. [2001 c 93 § 2.]

Findings—Intent—2001 c 93: "The legislature finds that access to preventive and restorative oral health services by low-income children is currently restricted by complex regulatory, financial, cultural, and geographic barriers that have resulted in a large number of children suffering unnecessarily from dental disease. The legislature also finds that very early exposure to oral health care can reverse this disease in many cases, thereby significantly reducing costs of providing dental services to low-income populations.

It is the intent of the legislature to address the problem of poor access to oral health care by providing for school-based sealant programs through the endorsement of dental hygienists." [2001 c 93 § 1.]

Effective date—2001 c 93: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [April 19, 2001]." [2001 c 93 § 5.]

RCW 43.70.660 Product safety education. (1) The legislature authorizes the secretary to establish and maintain a product safety education campaign to promote greater awareness of products designed to be used by infants and children that:

(a) Are recalled by the United States consumer products safety commission;

(b) Do not meet federal safety regulations and voluntary safety standards;

(c) Are unsafe or illegal to place into the stream of commerce under the infant crib safety act, chapter 70.111 RCW; or

(d) Contain chemicals of high concern for children as identified under RCW 70A.430.040.

(2) The department shall make reasonable efforts to ensure that this infant and children product safety education campaign reaches the target population. The target population for this campaign includes, but is not limited to, parents, foster parents and other caregivers, child care providers, consignment and resale stores selling infant and child products, and charitable and governmental entities serving infants, children, and families.

(3) The secretary may utilize a combination of methods to achieve this outreach and education goal, including but not limited to print and electronic media. The secretary may operate the campaign or may contract with a vendor.

(4) The department shall coordinate this infant and children product safety education campaign with child-serving entities including, but not limited to, hospitals, birthing centers, midwives, pediatricians, obstetricians, family practice physicians, governmental and private entities serving infants, children, and families, and relevant manufacturers.

(5) The department shall coordinate with other agencies and entities to eliminate duplication of effort in disseminating infant and children consumer product safety information.

(6) The department may receive funding for this infant and children product safety education effort from federal, state, and local governmental entities, child-serving foundations, or other private sources. [2021 c 65 § 45; 2008 c 288 § 6; 2001 c 257 § 2.]

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

Findings—Intent—2001 c 257: "(1) The legislature finds that infants and children in Washington are injured, sometimes fatally, by unsafe consumer products designed for use by infants and children.

(2) The legislature finds that parents and other persons responsible for the care of infants and children are often unaware that some of these consumer products have been recalled or are unsafe.

(3) The legislature intends to address this lack of awareness by establishing a statewide infant and children product safety campaign across Washington state." [2001 c 257 § 1.]

RCW 43.70.665 Early detection breast and cervical cancer screening program—Medical advisory committee. (1) The legislature finds that Washington state has the highest incidence of breast cancer in the nation. Despite this, mortality rates from breast cancer have declined due largely to early screening and detection. Invasive cervical cancer is the most preventable type of cancer. The Pap test, used to detect early signs of this disease, has been called "medicine's most successful screening test." Applied consistently, invasive cervical cancer could nearly be eliminated. The legislature further finds that increasing access to breast and cervical cancer screening is critical to reducing incidence and mortality rates, and eliminating the disparities of this disease in women in Washington state. Furthermore, the legislature finds there is a need for a permanent program providing early detection and screening to the women and families of Washington state.

It is the intent of the legislature to establish an early detection breast and cervical cancer screening program as a voluntary screening program directed at reducing mortalities through early detection to be offered to eligible women only as funds are available.

(2) As used in this section:

(a) "Eligible woman" means a woman who is age forty to sixty-four, and whose income is at or below two hundred fifty percent of the federal poverty level, as published annually by the federal department of health and human services. Priority enrollment shall be given to women as defined by the federal national breast and cervical cancer early detection program, under P.L. 101-354.

(b) "Approved providers" means those state-supported health providers, radiology facilities, and cytological laboratories that are recognized by the department as meeting the minimum program policies and procedures adopted by the department to qualify under the federal national breast and cervical cancer early detection program, and are designated as eligible for funding by the department.

(c) "Comprehensive" means a screening program that focuses on breast and cervical cancer screening as a preventive health measure, and includes diagnostic and case management services.

(3) The department of health is authorized to administer a state-supported early detection breast and cervical cancer screening program to assist eligible women with preventive health services. To the extent of available funding, eligible women may be enrolled in the early detection breast and cervical cancer screening program and additional eligible women may be enrolled to the extent that grants and contributions from community sources provide sufficient funds for expanding the program.

(4) Funds appropriated for the state program shall be used only to operate early detection breast and cervical cancer screening programs that have been approved by the department, or to increase access to existing state-approved programs, and shall not supplant federally supported breast and cervical cancer early detection programs.

(5) Enrollment in the early detection breast and cervical cancer screening program shall not result in expenditures that exceed the amount that has been appropriated for the program in the operating budget. If it appears that continued enrollment will result in expenditures exceeding the appropriated level for a particular fiscal year, the department may freeze new enrollment in the program. Nothing in this section prevents the department from continuing enrollment in the program if there are adequate private or public funds in addition to those appropriated in the biennial budget to support the cost of such enrollment.

(6) The department shall establish a medical advisory committee composed of interested medical professionals and consumer liaisons with expertise in a variety of areas relevant to breast and cervical health to provide expert medical advice and guidance. The medical advisory committee shall address national, state, and local concerns regarding best practices in the field of early prevention and detection for breast and cervical cancer and assist the early detection breast and cervical cancer screening program in implementing program policy that follows the best practices of high quality health care for clinical, diagnostic, pathologic, radiological, and oncology services. [2006 c 55 § 1.]

RCW 43.70.670 Human immunodeficiency virus insurance program. (1) "Human immunodeficiency virus insurance program," as used in this section, means a program that provides health insurance coverage for individuals with human immunodeficiency virus, as defined in RCW 70.24.017(7), who are not eligible for medical assistance programs from the health care authority as defined in *RCW 74.09.010(10) and meet eligibility requirements established by the department of health.

(2) The department of health may pay for health insurance coverage on behalf of persons with human immunodeficiency virus, who meet department eligibility requirements, and who are eligible for "continuation coverage" as provided by the federal consolidated omnibus budget reconciliation act of 1985, group health insurance policies, or individual policies. [2011 1st sp.s. c 15 § 72; 2007 c 259 § 38; 2003 c 274 § 2.]

***Reviser's note:** RCW 74.09.010 was amended by 2011 c 316 § 2, changing subsection (10) to subsection (11). RCW 74.09.010 was

subsequently amended by 2013 2nd sp.s. c 10 § 8, changing subsection (10) to subsection (13). RCW 74.09.010 was subsequently amended by 2017 c 226 § 5, changing subsection (13) to subsection (14).

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Subheadings not law—2007 c 259: See note following RCW 7.70.060.

Rules—2003 c 274: "The department of health shall adopt rules to implement this act." [2003 c 274 § 3.]

Effective date—2003 c 274: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2003." [2003 c 274 § 4.]

RCW 43.70.675 Public health advisory board. (1) The public health advisory board is established within the department. The advisory board shall:

(a) Advise and provide feedback to the governmental public health system and provide formal public recommendations on public health;

(b) Monitor the performance of the governmental public health system;

(c) Develop goals and a direction for public health in Washington and provide recommendations to improve public health performance and to achieve the identified goals and direction;

(d) Advise and report to the secretary;

(e) Coordinate with the governor's office, department, state board of health, local health jurisdictions, and the secretary;

(f) Evaluate public health emergency response and provide recommendations for future response, including coordinating with relevant committees, task forces, and stakeholders to analyze the COVID-19 public health response; and

(g) Evaluate the use of foundational public health services funding by the governmental public health system.

(2) The public health advisory board shall consist of representatives from each of the following appointed by the governor:

(a) The governor's office;

(b) The director of the state board of health or the director's designee;

(c) The secretary of the department or the secretary's designee;

(d) The chair of the governor's interagency council on health disparities;

(e) Two representatives from the tribal government public health sector selected by the American Indian health commission;

(f) One member of the county legislative authority from a eastern Washington county selected by a statewide association representing counties;

(g) One member of the county legislative authority from a western Washington county selected by a statewide association representing counties;

(h) An organization representing businesses in a region of the state;

(i) A statewide association representing community and migrant health centers;

(j) A statewide association representing Washington cities;

(k) Four representatives from local health jurisdictions selected by a statewide association representing local public health officials, including one from a jurisdiction east of the Cascade mountains with a population between 200,000 and 600,000, one from a jurisdiction east of the Cascade mountains with a population under 200,000, one from a jurisdiction west of the Cascade mountains with a population between 200,000 and 600,000, and one from a jurisdiction west of the Cascade mountains with a population less than 200,000;

(l) A statewide association representing Washington hospitals;

(m) A statewide association representing Washington physicians;

(n) A statewide association representing Washington nurses;

(o) A statewide association representing Washington public health or public health professionals; and

(p) A consumer nonprofit organization representing marginalized populations.

(3) In addition to the members of the public health advisory board listed in subsection (2) of this section, there must be four nonvoting ex officio members from the legislature consisting of one legislator from each of the two largest caucuses in both the house of representatives and the senate.

(4) Staff support for the public health advisory board, including arranging meetings, must be provided by the department.

(5) Legislative members of the public health advisory board may be reimbursed for travel expenses in accordance with RCW 44.04.120. Nonlegislative members are not entitled to be reimbursed for travel expenses if they are elected officials or are participating on behalf of an employer, governmental entity, or other organization. Any reimbursement for other nonlegislative members is subject to chapter 43.03 RCW.

(6) The public health advisory board is a class one group under chapter 43.03 RCW. [2021 c 205 § 2.]

Finding—2021 c 205: "The legislature finds that everyone in Washington state, no matter what community they live in, should be able to rely on a public health system that is able to support a standard level of public health service. Like public safety, there is a foundational level of public health delivery that must exist everywhere for services to work. A strong public health system is only possible with intentional investments into our state's public health system. Services should be delivered efficiently, equitably, and effectively, in ways that make the best use of technology, science, expertise, and leveraged resources and in a manner that is responsive to local communities." [2021 c 205 § 1.]

RCW 43.70.680 Volunteers for emergency or disaster assistance. (1) The department is authorized to contact persons issued credentials under this title for the purpose of requesting permission to collect his or her name, profession, and contact information as a possible volunteer in the event of a bioterrorism incident, natural disaster, public health emergency, or other emergency or disaster, as defined in RCW 38.52.010, that requires the services of health care providers.

(2) The department shall maintain a record of all volunteers who provide information under subsection (1) of this section. Upon request, the department shall provide the record of volunteers to:

(a) Local health departments;

(b) State agencies engaged in public health emergency planning and response, including the state military department;

(c) Agencies of other states responsible for public health emergency planning and response; and

(d) The centers for disease control and prevention. [2003 c 384 § 1.]

RCW 43.70.690 State asthma plan. (1) The department, in collaboration with its public and private partners, shall design a state asthma plan, based on clinically sound criteria including nationally recognized guidelines such as those established by the national asthma education prevention partnership expert panel report guidelines for the diagnosis and management of asthma.

(2) The plan shall include recommendations in the following areas:

(a) Evidence-based processes for the prevention and management of asthma;

(b) Data systems that support asthma prevalence reporting, including population disparities and practice variation in the treatment of asthma;

(c) Quality improvement strategies addressing the successful diagnosis and management of the disease; and

(d) Cost estimates and sources of funding for plan implementation.

(3) The department shall submit the completed state plan to the governor and the legislature by December 1, 2005.

(4) The department shall implement the state plan recommendations made under subsection (2) of this section only to the extent that federal, state, or private funds, including grants, are available for that purpose. [2009 c 518 § 8; 2005 c 462 § 4.]

Findings—2005 c 462: See note following RCW 28A.210.370.

RCW 43.70.700 Locally grown foods—Women, infant, and children farmers market nutrition program—Fruit and vegetable benefit—Rules. (1) The department shall adopt rules authorizing retail operation farms stores, owned and operated by a farmer and colocated with a site of agricultural production, to participate in the women, infant, and children farmers market nutrition program to provide locally grown, nutritious, unprepared fruits and vegetables to eligible program participants.

(2) Such rules must meet the provisions of 7 C.F.R. part 3016, uniform administrative requirements for grants and cooperative agreements to state and local governments, as it existed on June 12, 2008, or such subsequent date as may be provided by the department by rule, consistent with the purposes of this section.

(3) Subject to the availability of amounts appropriated for this specific purpose, the department shall distribute a fruit and vegetable benefit of no less than twenty-eight dollars per summer farmers market season to each eligible participant in the women,

infant, and children farmers market nutrition program. To the extent that federal funds are available, the department shall use federal funds up to the maximum benefit allowable under federal law. [2020 c 68 § 2; 2008 c 215 § 8.]

Findings—Intent—2020 c 68: "The legislature finds that our state has a robust agricultural system, with Washington farmers producing diverse foods available at regional markets throughout the state. The legislature further finds that one in six Washington children do not know where their next meal will come from and that promoting access to fresh foods supports Washington farmers as well as food-insecure families. Hunger for families with children continues to be a significant issue across our state and a growing concern. Hunger and unhealthy diets also impact the health and development of children and a child's ability to learn. Therefore, the legislature intends to expand access to nutritious foods by increasing the fruit and vegetable benefit for participants in the women, infant, and children farmers market nutrition program." [2020 c 68 § 1.]

Findings—Intent—Short title—Captions not law—Conflict with federal requirements—2008 c 215: See notes following RCW 15.64.060.

RCW 43.70.705 Fall prevention program. Within funds appropriated for this purpose, the department shall develop a statewide fall prevention program. The program shall include networking community services, identifying service gaps, making affordable senior-based, evaluated exercise programs more available, providing consumer education to older adults, their adult children, and the community at large, and conducting professional education on fall risk identification and reduction. [2008 c 146 § 7.]

Findings—Intent—Severability—2008 c 146: See notes following RCW 74.41.040.

RCW 43.70.710 Annual review of medication practices of five jails that use nonpractitioner jail personnel—Noncompliance. The department of health shall annually review the medication practices of five jails that provide for the delivery and administration of medications to inmates in their custody by nonpractitioner jail personnel. The review shall assess whether the jails are in compliance with sections 3 and 4, chapter 411, Laws of 2009. To the extent that a jail is found not in compliance, the department shall provide technical assistance to assist the jail in resolving any areas of noncompliance. [2009 c 411 § 5.]

RCW 43.70.715 COVID-19 public health response account. (1) The COVID-19 public health response account is created in the custody of the state treasurer. The account shall consist of funds appropriated by the legislature and grants received by the department of health for activities in response to the coronavirus pandemic (COVID-19). Only the secretary, or the secretary's designee, may authorize expenditures from the account for costs related to the public health response to COVID-19, subject to any limitations imposed by grant funding

deposited into the account. The COVID-19 public health response account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

(2)(a) The legislature finds that a safe, efficient, and effective delivery of vaccinations is of the utmost importance for restoring societal and economic functions. As we learn more about the virus, the vaccine, and challenges to vaccine allocation and distribution, it is anticipated that the state's COVID-19 vaccination distribution plan will evolve. To that end, the legislature has provided flexibility by funding expenditures for testing, contact tracing, mitigation activities, vaccine administration and distribution, and other allowable uses for the state, local health jurisdictions, and tribes at the discretion of the secretary and without an appropriation. However, to maintain fiscal control and to ensure spending priorities align, the department is required to collaborate and communicate with the chairs and ranking members of the health care and fiscal committees of the legislature and local health jurisdictions in advance of any significant revision of the state's COVID-19 vaccination plan and to provide regular updates on its implementation and spending.

(b) As part of the public health response to COVID-19, the expenditures from the account must be used to effectively administer the vaccine for COVID-19 and conduct testing and contact tracing. The department must ensure that COVID-19 outreach is accessible, culturally and linguistically appropriate, and that it includes community-driven partnerships and strategies.

(c) When making expenditures for administering the vaccine for COVID-19, the department must focus on identifying persons for vaccination, prioritizing underserved, underrepresented, and hard-to-reach communities, making the vaccine accessible, and providing support to schools for safe reopening. Strategies for vaccine distribution shall include the establishment and expansion of community vaccination centers, mobile vaccination units, reporting enhancements, in-home visits for vaccinations for the elderly, and transportation of individuals to vaccination sites.

(d) When making expenditures regarding testing and contact tracing, the department must provide equitable access, prioritize underserved, underrepresented, and hard-to-reach communities, and provide support and resources to facilitate the safe reopening of schools while minimizing community spread of the virus.

(e) The department may also make expenditures from the account related to developing the public health workforce using funds granted by the federal government for that purpose in section 2501, the American rescue plan act of 2021, P.L. 117-2.

(3) When making expenditures from the account, the department must include an emphasis on public communication regarding the availability and accessibility of the vaccine and testing, and the importance of vaccine and testing availability to the safe reopening of the state.

(4)(a) The department must report to the fiscal and health care committees of the legislature on a monthly basis regarding its COVID-19 response.

To the extent that it is available, the report must include data regarding vaccine distribution, testing, and contact tracing, as follows:

(i) The number of vaccines administered per day, including regional data regarding the location and age groups of persons

receiving the vaccine, specifically identifying hard-to-reach communities in which vaccines were administered; and

(ii) The number of tests conducted per week, including data specifically addressing testing conducted in hard-to-reach communities.

(b)(i) Beginning with the quarter ending March 31, 2022, the department must report to the fiscal and health care committees of the legislature on a quarterly basis regarding revenues and expenditures related to the COVID-19 response. The reports must include:

(A) Quarterly expenditures of funds, by fund source, including the appropriated amounts pursuant to section 222 (76) and (77), chapter 297, Laws of 2022 for:

(I) Diagnostic testing;

(II) Case investigation and contact tracing;

(III) Outbreak response;

(IV) Care coordination;

(V) Community outreach;

(VI) Information and technology operations;

(VII) Surveillance;

(VIII) Vaccines;

(IX) Client services;

(X) Local health jurisdictions; and

(XI) Tribes; and

(B) Grant amounts received during the reporting quarter that may be used in the COVID-19 response.

(ii) The quarterly reports must reflect the previous quarter, a projection of expected expenditures and revenue for the next quarter, and an accounting of the expenditures and revenue for the 2021-2023 fiscal biennium to date. The quarterly reports are due no later than 30 days after the end of the applicable quarter.

(c) The first monthly report pursuant to (a) of this subsection is due no later than one month from February 19, 2021. Monthly reports are no longer required upon the department's determination that the remaining balance of the COVID-19 public health response account is less than $100,000. [2022 c 297 § 955; 2022 c 157 § 7. Prior: 2021 c 334 § 1004; 2021 c 3 § 19.]

Reviser's note: This section was amended by 2022 c 157 § 7 and by 2022 c 297 § 955, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Effective date—2022 c 297: See note following RCW 43.79.565.

Conflict with federal requirements—Effective date—2021 c 334: See notes following RCW 43.79.555.

Conflict with federal requirements—2021 c 3: "If any part of this act is found to be in conflict with federal requirements that are a prescribed condition to the allocation of federal funds to the state, the conflicting part of this act is inoperative solely to the extent of the conflict and with respect to the agencies directly affected, and this finding does not affect the operation of the remainder of this act in its application to the agencies concerned. Rules adopted under this act must meet federal requirements that are a necessary condition to the receipt of federal funds by the state." [2021 c 3 § 21.]

Effective date—2021 c 3: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately [February 19, 2021]." [2021 c 3 § 22.]

RCW 43.70.720 Universal vaccine purchase account. The universal vaccine purchase account is created in the custody of the state treasurer. Receipts from public and private sources for the purpose of increasing access to vaccines for children may be deposited into the account. Expenditures from the account must be used exclusively for the purchase of vaccines, at no cost to health care providers in Washington, to administer to children under nineteen years old who are not eligible to receive vaccines at no cost through federal programs. Only the secretary or the secretary's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures. [2010 c 174 § 10; 2009 c 564 § 934.]

Effective date—2010 c 174: See RCW 70.290.900.

Effective date—2009 c 564: See note following RCW 2.68.020.

RCW 43.70.723 Medication for people living with HIV rebate revenue account. The medication for people living with HIV rebate revenue account is created in the custody of the state treasury. The early intervention program shall deposit any receipts from pharmaceutical rebates generated by the purchase of medications with federal grant funds and revenue generated from federal grant funds for any person enrolled in the early intervention program into the account. The expenditures may only be used for services defined in the grant award from the Ryan White HIV/AIDS program. Only the secretary or the secretary's designee may authorize expenditures from the account. An appropriation is not required for expenditures. The account is subject to allotment procedures under chapter 43.88 RCW. [2023 c 12 § 1.]

Effective date—2023 c 12: "This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2023." [2023 c 12 § 3.]

RCW 43.70.725 Health extension program—Dissemination of evidence-based tools and resources—Rules. (1) Subject to the availability of amounts appropriated for this specific purpose, the department shall establish a health extension program to provide training, tools, and technical assistance to primary care, behavioral health, and other providers. The program must emphasize high quality preventive, chronic disease, and behavioral health care that is comprehensive and evidence-based.

(2) The health extension program must coordinate dissemination of evidence-based tools and resources that promote:

(a) Integration of physical and behavioral health;

(b) Clinical decision support to promote evidence-based care;

(c) Reports of the Robert Bree collaborative created by RCW 70.250.050 and findings of health technology assessments under RCW 70.14.080 through 70.14.130;

(d) Methods of formal assessment;

(e) Support for patients managing their own conditions;

(f) Identification and use of resources that are available in the community for patients and their families, including community health workers; and

(g) Identification of evidence-based models to effectively treat depression and other conditions in primary care settings, such as the program advancing integrated mental health solutions, and others.

(3) The department may adopt rules necessary to implement this section, but may not adopt rules, policies, or procedures beyond the scope of authority granted in this section. [2014 c 223 § 5.]

Finding—2014 c 223: See note following RCW 41.05.690.

RCW 43.70.738 Down syndrome resources—Development. (1)(a) The department shall develop the following resources regarding Down syndrome:

(i) Up-to-date, evidence-based, written information about Down syndrome and people born with Down syndrome that has been reviewed by medical experts and national Down syndrome organizations; and

(ii) Contact information regarding support services, including information hotlines specific to Down syndrome, resource centers or clearinghouses, national and local Down syndrome organizations, and other education and support programs.

(b) The resources prepared by the department must:

(i) Be culturally and linguistically appropriate for expectant parents receiving a positive prenatal diagnosis or for the parents of a child receiving a postnatal diagnosis of Down syndrome; and

(ii) Include: Physical, developmental, educational, and psychosocial outcomes; life expectancy; clinical course; and intellectual and functional development and therapy options.

(2) The department shall make the information described in this section available to any person who renders prenatal care, postnatal care, or genetic counseling to expectant parents receiving a positive prenatal diagnosis or to the parents of a child receiving a postnatal diagnosis of Down syndrome.

(3) For the purposes of this section, "Down syndrome" means a chromosomal condition that results in the presence of an extra whole or partial copy of chromosome 21. [2016 c 70 § 1.]

RCW 43.70.740 Adjudicative proceedings. In all adjudicative proceedings before the secretary or the department, the secretary may delegate initial decision-making authority to a presiding officer. The presiding officer shall enter an initial order pursuant to RCW 34.05.461 subject to the review of the secretary or his or her designee. Pursuant to RCW 34.05.464, the secretary may, by rule, provide that initial orders in specified classes of cases may become final without further agency action unless, within a specified time period:

(1) The secretary upon his or her own motion determines that the initial order should be reviewed; or

(2) A party to the proceedings files a petition for administrative review of the initial order. [2013 c 109 § 3.]

RCW 43.70.750 Community assistance referral and education program—Review of certification and training—Recommendations to the legislature. The department of health must review the professional certification and training of health professionals participating in a community assistance referral and education program, review the certification and training requirements in other states with similar programs, and coordinate with the health care authority to link the certification requirements with the covered health care services recommended for payment in RCW 74.09.335. The department shall submit recommendations to the appropriate committees of the legislature for any changes and suggestions for implementation within six months of the development of the payment standards. [2017 c 273 § 3.]

RCW 43.70.765 Opioid drugs—Warning—Patient education materials. (1) The department must create a statement warning individuals about the risks of opioid use and abuse and provide information about safe disposal of opioids. The department must provide the warning on its website.

(2) The department must review the science, data, and best practices around the use of opioids and their associated risks. As evidence and best practices evolve, the department must update its warning to reflect these changes.

(3) The department must update its patient education materials to reflect the patient's right to refuse an opioid prescription or order. [2019 c 314 § 11.]

Declaration—2019 c 314: See note following RCW 18.22.810.

RCW 43.70.770 State opioid response plan. The secretary shall be responsible for coordinating the statewide response to the opioid epidemic and executing the state opioid response plan, in partnership with the health care authority. The department and the health care authority must collaborate with each of the agencies and organizations identified in the state opioid response plan. [2019 c 314 § 12.]

Declaration—2019 c 314: See note following RCW 18.22.810.

RCW 43.70.780 Fruit and vegetable incentives program. (1) The fruit and vegetable incentives program is established to increase fruit and vegetable consumption among food insecure individuals with limited incomes. The fruit and vegetable incentives program includes:

(a) Farmers market basic food incentives to provide eligible participants with extra benefits to purchase fruits and vegetables at authorized farmers markets when the participant uses basic food benefits;

(b) Grocery store basic food incentives to provide eligible participants with extra benefits to purchase fruits and vegetables at authorized grocery stores when the participant uses basic food benefits; and

(c) Fruit and vegetable vouchers provided by a health care provider, health educator, community health worker, or other health professional to an eligible participant for use at an authorized farmers market or grocery store.

(2) Subject to the availability of amounts appropriated for this specific purpose, the department shall administer the fruit and vegetable incentives program. As part of its duties, the department shall:

(a) Collaborate with other state agencies whose missions and programs closely align with the fruit and vegetable incentives program, including the department of social and health services and the department of agriculture, in the development and implementation of the program;

(b) Provide resources, coordination, and technical assistance to program partners for targeted outreach to food insecure populations and for administration of the program. Program partners may include farmers markets, grocery stores, government agencies, health care systems, and nonprofit organizations; and

(c) Adopt rules to implement this section.

(3) Farmers market basic food incentives may be provided to eligible participants for use at farmers markets authorized by the department. The incentives are additional funds that may be used to purchase eligible fruits and vegetables as defined by the department. When authorizing a participating farmers market, the department may give preference to a farmers market that accepts or has previously accepted supplemental nutrition assistance program benefits, has the capacity to accept supplemental nutrition assistance program benefits, or is located in a county with a high level of food insecurity, as defined by the department.

(4) Grocery store basic food incentives may be provided to eligible participants for use at a grocery store that is an authorized supplemental nutrition assistance program retailer and approved by the department. The incentives are additional funds that may be used to purchase eligible fruits and vegetables as defined by the department. When approving a participating grocery store, the department may give preference to a store that is located in a county with a high level of food insecurity.

(5) Fruit and vegetable vouchers are cash-value vouchers that may be distributed by a participating health care provider, health educator, community health worker, or other health professional to a patient who is eligible for basic food and has a qualifying health condition, as defined by the department, or is food insecure. The voucher may be redeemed at a participating retailer, including an authorized farmers market or grocery store. The department shall approve participating health care systems and may give preference to systems that have operated fruit and vegetable prescription programs, routinely screen patients for food insecurity, have a high percentage of patients who are medicaid clients, or are located in a county with a high level of food insecurity.

(6) Subject to the availability of funds, the department must evaluate the fruit and vegetable incentives program effectiveness. When conducting the evaluation, the department must collect information related to fruit and vegetable consumption by eligible participants, levels of food security, and likely impacts on public health outcomes as a result of the program. By July 1, 2021, and in compliance with RCW 43.01.036, the department must submit a progress report to the governor and the legislature describing the results of

the program and recommending any legislative or programmatic changes to improve the effectiveness of program delivery. By December 1, 2023, the department must submit a complete program evaluation describing the program's effectiveness and including any additional recommendations for program improvements.

(7) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Eligible participant" means:

(i) For the purposes of subsection (1)(a) and (b) of this section, a recipient of basic food benefits, including the supplemental nutrition assistance program and the food assistance program, as authorized under Title 74 RCW; or

(ii) For the purposes of subsection (1)(c) of this section, a person who is determined to be food insecure by a participating health care provider.

(b) "Food insecure" means a state in which consistent access to adequate food is limited by a lack of money and other resources at times during the year. [2019 c 168 § 2.]

Findings—Intent—2019 c 168: "(1) The legislature finds that nearly eleven percent of Washington households, including more than two hundred eighty thousand children, are food insecure with limited or uncertain availability of nutritionally adequate and safe foods. The legislature further finds that food insecurity contributes to poor quality diets; chronic medical conditions such as diabetes, heart disease, and hypertension; and negative outcomes for children and families, including harmful effects on behavioral health. Further, food insecurity disproportionately affects people with low incomes, people of color, and rural residents.

(2) The legislature finds that food assistance programs such as the special supplemental nutrition program for women, infants, and children and the supplemental nutrition assistance program are effective in significantly reducing food insecurity; that participants report difficulty affording and accessing healthy foods; and that fruit and vegetable consumption among such food assistance program participants is far below national dietary guidelines.

(3) The legislature finds that the state department of health has successfully managed a food insecurity nutrition incentives grant from the United States department of agriculture that provides a framework for providing fruit and vegetable incentives for low-income shoppers and that those federal funds are set to expire in March 2020. Further, the legislature finds that more than two million dollars in fruit and vegetable incentives have been redeemed by food insecure Washingtonians through this grant, helping to alleviate food insecurity and increase fruit and vegetable consumption.

(4) Therefore, the legislature intends to create a state fruit and vegetable incentives program to benefit people who are food insecure, our agricultural industry, and retailers across the state." [2019 c 168 § 1.]

RCW 43.70.790 Health care facility inspection and investigation availability. As resources allow, the department shall make health care facility inspection and investigation statements of deficiencies, plans of correction, notice[s] of acceptance of plans of correction, enforcement actions, and notices of resolution available to the public

on the internet, starting with psychiatric hospitals and residential treatment facilities. [2020 c 115 § 4.]

Findings—Intent—Effective date—2020 c 115: See notes following RCW 71.12.700.

RCW 43.70.800 Oversight, consolidation, and standardization—Review. The department must conduct a review of statutes for all health care facility types licensed by the department under chapters 18.46, 18.64, 70.41, 70.42, 70.127, 70.230, 71.12, and 71.24 RCW to evaluate appropriate levels of oversight and identify opportunities to consolidate and standardize licensing and enforcement requirements across facility types. The department must work with stakeholders including, but not limited to, the statewide associations of the facilities under review to create recommendations that will be shared with stakeholders and the legislature for a uniform health care facility enforcement act for consideration in the 2021 legislative session. [2020 c 115 § 5.]

Findings—Intent—Effective date—2020 c 115: See notes following RCW 71.12.700.

RCW 43.70.810 Provision of medical information—Dissemination of requirements and authority. (1) The department must design, prepare, and make available online, written materials to clearly inform health care providers and staff of the provisions of, and authority to act under, chapter 70.03 RCW.

(2) The department must design, prepare, and make available online, written materials to provide information to providers and patients regarding Washington's death with dignity act, chapter 70.245 RCW. [2020 c 102 § 4.]

RCW 43.70.815 Environmental health disparities map. (1) In consultation with the environmental justice council established in RCW 70A.02.110, the department must continue to develop and maintain an environmental health disparities map with the most current available information necessary to identify cumulative environmental health impacts and overburdened communities. The department may also consult with other interested partners, such as the University of Washington department of environmental and occupational health sciences, other academic partners, members of overburdened communities and vulnerable populations, and other agencies. The environmental health disparities map must include tools to:

(a) Track changes in environmental health disparities over time in an interactive, regularly updated display; and

(b) Measure the link between overall environmental health disparity map ranks, environmental data, vulnerable populations characteristics, such as race and income, and human health data.

(2) In further developing and maintaining the environmental health disparities map, the department must:

(a) Solicit feedback from representatives from overburdened communities and vulnerable populations through community engagement

and listening sessions in all regions of the state and provide opportunities for public comment; and

(b) Request assistance from:

(i) State universities;

(ii) Other academic researchers, such as the Washington state institute for public policy, to perform modeling and create evidence-based indicators and to conduct sensitivity analyses to assess the impact of new indicators on communities and determinations of overburdened communities; and

(iii) Other state agencies to provide applicable statewide environmental and sampling data for air, water, soil, polluted sites, toxic waste, pesticides, toxic chemicals, and other applicable media.

(3) The department must:

(a) Document and publish a summary of the regular updates and revisions to the environmental health disparities map that happen over time as the new data becomes available, in order to help the public understand different versions of the map as they are published;

(b) At least every three years, perform a comprehensive evaluation of the map to ensure that the most current modeling and methods available to evaluate cumulative environmental health impacts are being used to develop and update the environmental health disparities map's indicators;

(c) Develop technical guidance for agencies that includes an online training video detailing a description of how to use the environmental health disparities map's features, access source data, and explanation of map and indicator limitations; and

(d) Provide support and consultation to agencies on the use of the environmental health disparities map by Washington tracking network staff.

(4)(a) By November 1, 2022, the Washington state institute for public policy must conduct a technical review of the measures and methods used in the environmental health disparities map. The review must, to the extent possible, address the following:

(i) Identify how the measures used in the map compare to measures used in other similar tools that aim to identify communities that are disproportionately impacted as a result of environmental justice issues;

(ii) Compare characteristics such as the reliability, validity, and clinical importance of individual and composite measures included in the map and other similar tools; and

(iii) Compare methodologies used in the map to statistical methodologies used in other similar tools.

(b) The department of health and the University of Washington must provide technical documentation regarding current methods to the Washington state institute for public policy and must consult with the institute as needed to ensure that the institute has adequate information to complete the technical review.

(c) By November 1, 2022, the Washington state institute for public policy must submit a report on their findings to the office of the governor, the appropriate committees of the legislature, and the environmental justice council. [2021 c 314 § 19.]

Conflict with federal requirements—2021 c 314: See note following RCW 70A.02.005.

RCW 43.70.820 Environmental justice obligations of the department of health. The department must apply and comply with the substantive and procedural requirements of chapter 70A.02 RCW. [2021 c 314 § 4.]

Conflict with federal requirements—2021 c 314: See note following RCW 70A.02.005.

RCW 43.70.825 School-based health center program office. (1) The school-based health center program office is established within the department, with the objective to expand and sustain the availability of school-based health center services to K-12 students in public schools, with a focus on historically underserved populations.

(2) Subject to the availability of amounts appropriated for this specific purpose, the school-based health center program office shall:

(a) Develop funding criteria and metrics for monitoring and evaluation in partnership with a statewide nonprofit organization providing training and technical assistance to school-based health centers;

(b) Award grant funding for school-based health centers. The department may grant funding for the following purposes:

(i) Planning a school-based health center;

(ii) Start-up costs associated with setting up a school-based health center; and

(iii) Ongoing costs of operating a school-based health center;

(c) Monitor and evaluate school-based health centers that receive grant funding from the program office;

(d) Partner with a statewide nonprofit organization to provide training and technical assistance to school-based health centers; and

(e) Coordinate with the statewide nonprofit organization providing training and technical assistance, educational service districts, the health care authority, hosting school districts, and the office of the insurance commissioner, to provide support to school-based health centers.

(3) For purposes of this section, a "school-based health center" means a collaboration between the community, the school, and a sponsoring agency that operates the school-based health center, which is a student-focused health center located in or adjacent to a school that provides integrated medical, behavioral health, and other health care services such as dental care. [2021 c 68 § 2.]

Findings—Intent—2021 c 68: "(1) The legislature finds that:

(a) Research shows that school-based health centers provide a crucial link between health and education, improving outcomes for students in both areas;

(b) Health and academic disparities are increasing during the COVID-19 pandemic, particularly for students of color;

(c) School-based health centers advance equity by providing health care access and support at schools;

(d) School-based health centers have been operating across the state for more than 30 years;

(e) Local control and decision making for school-based health centers is important; and

(f) In 2016, the legislature created the Washington integrated student supports protocol as a strategy to close educational opportunity gaps through school-based coordination of academic and nonacademic supports for students.

(2) Therefore, the legislature intends to create a school-based health center program office within the department of health to award grants and coordinate with other agencies and entities to provide support, training, and technical assistance to school-based health centers." [2021 c 68 § 1.]

RCW 43.70.830 Lead contamination in drinking water in school buildings—Sampling and testing—Data-sharing agreement. (1) The department shall conduct sampling and testing for lead contamination at drinking water outlets in school buildings built, or with all plumbing replaced, before 2016 as specified in this section. The department meets the requirements of this section when a school contracts for sampling and testing that meets the requirements of this section and submits the test results to the department according to a procedure and deadlines determined by the department.

(2) Sampling and testing for the presence and level of lead in drinking water must meet the technical requirements described in the technical guidance.

(3)(a) Initial testing for lead contamination in drinking water must be conducted between July 1, 2014, and June 30, 2026.

(b) Retesting for lead contamination in drinking water must be conducted no less than every five years beginning July 1, 2026.

(4)(a) The department shall develop and publish a two-year plan for sampling and testing. The plan must be updated at least annually. Prior to adding a school to the plan, the department must contact the school to determine whether the school has contracted, or is planning to contract, for sampling and testing.

(b) Beginning July 1, 2026, in developing the two-year plan for sampling and testing, the department must group school buildings by governing body and then prioritize the groups based on the combined length of time since each school building built, or with all plumbing replaced, before 2016 was sampled and tested.

(5) The department shall enter a data-sharing agreement with the office of the superintendent of public instruction for the purpose of compiling a list of school buildings built, or with all plumbing replaced, before 2016.

(6) The definitions in RCW 28A.210.410 apply throughout this section unless the context clearly requires otherwise. [2021 c 154 § 3.]

Findings—Intent—2021 c 154: "(1) The legislature recognizes that the United States environmental protection agency and centers for disease control and prevention acknowledge that there is no known safe level of lead in a child's blood. Even low levels of lead exposure can cause permanent cognitive, academic, and behavioral difficulties in children. The American academy of pediatrics recommends government action to ensure that the lead concentration in drinking water at schools does not exceed one part per billion.

(2) The legislature finds that the department of health sampled and tested drinking water outlets in 551 elementary schools between 2017 and 2020. 82 percent of these schools had lead contamination of

five or more parts per billion in one or more drinking water outlets and 49 percent of these schools had lead contamination of 15 or more parts per billion in one or more drinking water outlets.

(3) The legislature acknowledges that the department of health was appropriated $1,000,000 in the 2019-2021 fiscal biennium to continue the testing for lead contamination in school drinking water. The legislature also finds that the office of the superintendent of public instruction was appropriated funds in the 2019-2021 fiscal biennium for the healthy kids/healthy schools initiative. Part of these funds are for the purpose of distributing grants to school districts for remediation of elevated lead levels in drinking water. The legislature encourages districts to apply for these grants when lead test results reveal elevated lead levels, which are lead levels above five parts per billion.

(4) The legislature acknowledges the historically inequitable distribution of lead exposure for communities of color and of low socioeconomic status and plans to make a priority the protection of children from the dangers of lead exposure through school drinking water. The legislature, therefore, intends to require that drinking water outlets in elementary and secondary school buildings built, or with all plumbing replaced, before 2016 be tested for the presence and level of lead contamination by June 30, 2026, and every five years thereafter. The legislature also intends to require that schools notify the school community of lead test results and develop action plans for remediation if test results exceed the health-based standard of five parts per billion.

(5) The legislature recognizes that the youngest children are the most vulnerable to lead exposure and that many of these children spend significant amounts of time at child care facilities.

(6) This act is named for the director of the Washington public interest research group who developed and advocated for this legislation before dying of cancer in 2019 and may be known as the Bruce Speight protect children from being exposed to lead in school drinking water act." [2021 c 154 § 1.]

Short title—2021 c 154: "This act may be known and cited as the Bruce Speight protect children from being exposed to lead in school drinking water act." [2021 c 154 § 8.]

RCW 43.70.835 Lead contamination in drinking water in school buildings—State-tribal compact schools. The department shall allow state-tribal compact schools established under chapter 28A.715 RCW to opt into sampling and testing for lead contamination at drinking water outlets in school buildings built, or with all plumbing replaced, before 2016 pursuant to RCW 43.70.830. [2021 c 154 § 4.]

Findings—Intent—Short title—2021 c 154: See notes following RCW 43.70.830.

RCW 43.70.840 Lead contamination in drinking water in school buildings—Technical guidance. The department shall develop and make available technical guidance for reducing lead contamination in drinking water at schools that is at least as protective of student health as any technical guidance on this topic issued by the United

States environmental protection agency. The technical guidance must include the technical requirements for sampling, processing, and analysis, including that analysis must be conducted by a laboratory accredited by the department of ecology. The technical guidance must describe best practices for remediating elevated lead levels at drinking water outlets in schools. Best practices must include installing and maintaining filters certified by a body accredited by the American national standards institute. Provisions of the technical guidance related to testing for the presence and level of lead in drinking water, as opposed to testing to identify sources of lead for remediation, must be designed to maximize detection of lead in water, and therefore must prohibit sampling or analytical methods that tend to mask lead contamination, including prestagnation flushing and removal of aerators prior to sampling. [2021 c 154 § 5.]

Findings—Intent—Short title—2021 c 154: See notes following RCW 43.70.830.

RCW 43.70.845 Lead contamination in drinking water in school buildings—Department of health as lead agency—Waiver. (1) To the fullest extent permitted by federal law, the department, rather than community water systems, is designated as the lead or principal agency in regard to lead in drinking water sampling, testing, notification, remediation, public education, and other actions at public and private elementary and secondary schools as required by the federal lead and copper rule, 40 C.F.R. Part 141.

(2) The department must issue a written waiver that exempts community water systems that serve schools from the sampling and testing requirements of 40 C.F.R. Part 141.92 related to schools if the department determines that the mandatory requirements for sampling and testing for, and remediation of, lead contamination in drinking water outlets at elementary and secondary schools under chapter 154, Laws of 2021 are consistent with the requirements in 40 C.F.R. Part 141.92 of the federal lead and copper rule. [2021 c 154 § 7.]

Findings—Intent—Short title—2021 c 154: See notes following RCW 43.70.830.

RCW 43.70.850 Suicide-safer homes task force. *(Expires July 1, 2024.)* (1) Subject to the availability of amounts appropriated for this specific purpose, a suicide-safer homes task force is established to raise public awareness and increase suicide prevention education among new partners who are in key positions to help reduce suicide. The task force shall be administered and staffed by the department of veterans affairs. To the extent possible, the task force membership should include representatives from geographically diverse and priority populations, including tribal populations.

(2) The suicide-safer homes task force shall be cochaired by the director, or the director's designee, of the department of veterans affairs and the director, or the director's designee, of the forefront suicide prevention center and also consist of the following members:

(a) Two representatives of suicide prevention organizations, selected by the cochairs of the task force;

(b) Two representatives of the firearms industry, selected by the cochairs of the task force;

(c) Two individuals who are suicide attempt survivors or who have experienced suicide loss, selected by the cochairs of the task force;

(d) Two representatives of law enforcement agencies, selected by the cochairs of the task force;

(e) One representative from the department of health;

(f) One representative from the department of fish and wildlife;

(g) One individual representing veterans;

(h) One member of a Washington or federally recognized Indian tribe;

(i) Two veterans;

(j) One representative of the national rifle association;

(k) One representative of the Second Amendment foundation;

(l) One representative of a nonprofit organization working on gun safety issues;

(m) One representative of a national firearms trade association;

(n) One representative of a Washington state pharmacy association; and

(o) No more than five other interested parties, selected by the cochairs of the task force.

(3) The department of veterans affairs shall convene the initial meeting of the task force.

(4) The task force shall:

(a) Develop and prepare to disseminate online trainings on suicide awareness and prevention for firearms dealers and their employees and firearm range owners and their employees;

(b) Partner with medical providers, firearms dealers, firearms ranges, and pharmacies to develop and distribute suicide awareness and prevention messages for posters and brochures;

(c) In consultation with the department of fish and wildlife, develop strategies for creating and disseminating suicide awareness and prevention information for hunting safety classes, including messages to parents that can be shared during online registration, in either follow-up email communications, or in writing, or both;

(d) Create a website that will be a clearinghouse for the newly created suicide awareness and prevention materials developed by the task force;

(e) Continue to support medical providers with suicide prevention and awareness work through the dissemination of collateral education programs;

(f) Allocate funding towards the purchase of lock boxes for dissemination via the forefront suicide prevention center's TeleSAFER program;

(g) Develop and direct advocacy efforts with firearms dealers to pair suicide awareness and prevention training with distribution of safe storage devices;

(h) Partner with a statewide pharmacy association to market and promote medication disposal kits and safe storage devices;

(i) Train health care providers on suicide awareness and prevention, paired with distribution of medication disposal kits and safe storage devices; and

(j) Train local law enforcement officers on suicide awareness and prevention, paired with distribution of medication disposal kits and safe storage devices.

(5) The forefront suicide prevention center shall provide subject matter expertise, technical and programmatic support, and consultation and evaluation to the task force.

(6) Beginning December 1, 2022, the task force shall annually report to the legislature on the status of its work.

(7) This section expires July 1, 2024. [2022 c 191 § 7.]

Findings—Intent—2022 c 191: See note following RCW 43.60A.260.

RCW 43.70.855 Hospital staffing advisory committee—Appointments—Membership—Reporting. ***(Expires July 1, 2030.)*** (1) The department, in consultation with the department of labor and industries, must establish an advisory committee on hospital staffing by September 1, 2023.

(2) Appointments to the advisory committee on hospital staffing shall be jointly made by the secretary and the director of labor and industries. Members of the committee must have expertise in hospital staffing and working conditions and should reflect a diversity of hospital settings.

(3) The advisory committee membership includes:

(a) Six members representing hospitals and hospital systems and their alternates, selected from a list of nominees submitted by the Washington state hospital association; and

(b) Six members representing frontline hospital patient care staff and their alternates, selected from a list of nominees submitted by collective bargaining representatives of frontline hospital nursing staff.

(4) Any list submitted to the departments for the initial appointment under this section must be provided by August 4, 2023.

(5) If any member of the advisory committee is unable to continue to serve on the committee the secretary and the director of labor and industries shall select a new member based on the recommendations of either the hospital association for members appointed under subsection (3)(a) of this section or the collective bargaining representative for members appointed under subsection (3)(b) of this section.

(6) The advisory committee on hospital staffing shall meet at least once per month until the hospital staffing plan uniform form is developed.

(7) The advisory committee on hospital staffing shall advise the department on its development of the uniform hospital staffing plan form.

(8) The department and the department of labor and industries shall provide any necessary documentation to the advisory committee on hospital staffing in advance of the meetings to discuss technical assistance so that the advisory committee may consider areas of needed information.

(9) The advisory committee on hospital staffing must consider innovative hospital staffing and care delivery models, such as those that integrate on-site team-based care delivery, use of patient monitoring equipment and technology, and virtual or remote care delivery. This includes identifying and analyzing innovative hospital staffing and care delivery models including those explored by national organizations and evaluating feasibility of broad-based implementation of identified models. The advisory committee may consider disseminating this information and analysis.

(10) The department and the department of labor and industries must provide the advisory committee on hospital staffing with data on a quarterly basis related to compliance with this chapter, complaint filing and disposition trends, and notification of corrective plans of action plans and adherence to those plans.

(11) By December 1, 2023, the Washington state hospital association shall survey hospitals in Washington state and report to the advisory committee on hospital staffing on Washington hospitals' existing use of innovative hospital staffing and care delivery models including, but not limited to, integration of patient monitoring equipment, remote patient monitoring, team-based care models, apprenticeship and career ladder programs, and virtual or remote care delivery models, and any challenges with implementing the models.

(12) By December 1, 2024, the advisory committee on hospital staffing must review the report prepared by the Washington state institute for public policy as required by section 15, chapter 114, Laws of 2023.

(13) After January 1, 2027, when the forms are developed and effective, the advisory committee on hospital staffing may meet if it is determined by the department of health and committee members that such meetings are necessary.

(14) No earlier than July 1, 2029, the advisory committee on hospital staffing must discuss the issues related to applicability of RCW 70.41.420(7)(b) (i) and (ii) for hospitals listed under RCW 70.41.420(7)(b)(iv). This must include possible data collection options, potential costs, sources of funding, and implementation timeline.

(15) The advisory committee on hospital staffing must advise the department of labor and industries on the department's development by March 1, 2024, of a uniform form for reporting under RCW 49.12.480(2).

(16) This section expires July 1, 2030. [2023 c 114 § 1.]

RCW 43.70.900 References to the secretary or department of social and health services—1989 1st ex.s. c 9. All references to the secretary or department of social and health services in the Revised Code of Washington shall be construed to mean the secretary or department of health when referring to the functions transferred in RCW 43.70.080, 18.104.005, 70.08.005, 70.24.005, 70.40.005, 70.41.005, and 70.54.005. [2017 3rd sp.s. c 25 § 24; 2015 1st sp.s. c 4 § 31; 2007 c 52 § 2; 1990 c 33 § 580; 1989 1st ex.s. c 9 § 801.]

Purpose—Statutory references—Severability—1990 c 33: See RCW 28A.900.100 through 28A.900.102.

RCW 43.70.901 References to the director or department of licensing—1989 1st ex.s. c 9. All references to the director of licensing or department of licensing in the Revised Code of Washington shall be construed to mean the secretary or department of health when referring to the functions transferred in RCW 43.70.220. [1989 1st ex.s. c 9 § 802.]

RCW 43.70.902 References to the hospital commission—1989 1st ex.s. c 9. All references to the hospital commission in the Revised

Code of Washington shall be construed to mean the secretary or the department of health. [1989 1st ex.s. c 9 § 803.]

RCW 43.70.903 Licensure requirements review—Report and recommendations on removing barriers. (1) The department, in consultation with the workforce training and education coordinating board and the examining board of psychology, shall examine licensure requirements for the following professions to identify changes to statutes and rules that would remove barriers to entering and remaining in the health care workforce and to streamline and shorten the credentialing process:

(a) Advanced social workers and independent clinical social workers licensed under chapter 18.225 RCW;

(b) Marriage and family therapists licensed under chapter 18.225 RCW;

(c) Mental health counselors licensed under chapter 18.225 RCW;

(d) Substance use disorder professionals certified under chapter 18.205 RCW; and

(e) Psychologists licensed under chapter 18.83 RCW.

(2) The licensure requirements to be examined by the department shall include examinations, continuing education requirements, administrative requirements for license application and renewal, English language proficiency requirements, and supervised experience requirements, including supervisor requirements and costs associated with completing supervised experience requirements.

(3) When conducting the review required in subsection (1) of this section, the department shall at a minimum consider the following:

(a) The availability of peer-reviewed research and other evidence, including requirements in other states, indicating the necessity of specific licensure requirements for ensuring that behavioral health professionals are prepared to practice with reasonable skill and safety;

(b) Changes that would facilitate licensure of qualified, out-of-state and international applicants to promote reciprocity, including the adoption of applicable interstate compacts;

(c) Changes that would promote greater consistency across licensure requirements for professions licensed under chapter 18.225 RCW and allow for applicants' prior professional experience within relevant fields to be counted towards supervised experience requirements established under chapter 18.225 RCW, including the extent to which an applicant may use prior professional experience gained before graduation from a master's or doctoral level educational program to satisfy the applicant's supervised experience requirement;

(d) Technical assistance programs, such as navigators or dedicated customer service lines, to facilitate the completion of licensing applications;

(e) In consultation with the examining board of psychology and a statewide organization representing licensed psychologists, the creation of an associate-level license for psychologists;

(f) Whether agency affiliated counselors should be allowed to practice in federally qualified health centers; and

(g) Any rules that pose excessive administrative requirements for application or renewal or that place a disproportionate burden on applicants from disadvantaged communities.

(4) By November 1, 2023, the department shall provide a progress report and initial findings to the appropriate committees of the legislature on actions and recommendations to remove licensing barriers and improve credentialing time frames.

(5) By November 1, 2024, the department shall provide a final report to the appropriate committees of the legislature on actions and recommendations to remove licensing barriers and improve credentialing time frames. [2023 c 425 § 5.]

Effective date—2023 c 425 §§ 1-7, 13-20, and 22-26: See note following RCW 18.83.170.

RCW 43.70.910 Effective date—1989 1st ex.s. c 9. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and shall take effect July 1, 1989. [1989 1st ex.s. c 9 § 825.]

RCW 43.70.920 Severability—1989 1st ex.s. c 9. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected. [1989 1st ex.s. c 9 § 826.]