Board of Health Meeting
June 18, 2020
Jefferson County
Public Health

Agenda &
Minutes

June 18, 2020
JEFFERSON COUNTY BOARD OF HEALTH
June 18, 2020
Jefferson County Public Health
Virtual Meeting
2:30 – 4:30 PM
DRAFT AGENDA

COVID-19 NOTICE:
NO IN-PERSON ATTENDANCE ALLOWED
(Per Governor Inslee's Proclamation 20-28)

To view this meeting live go to www.co.jefferson.wa.us
Follow the links under “Quick Links: Videos of Meetings-Streaming Live”
Those without internet can listen by dialing: 1 (786) 535-3211 enter access code: 392-970-477

I. Approval of Agenda

II. Approval of Minutes of May 14, 2020 and May 21, 2020 Board of Health Meetings

III. Old Business and Information Reports
2. Jefferson County Health Officer Masking Directive and FAQ Press Release

IV. New Business
1. Racism as a Public Health Crisis
2. Health Officer Recommendations Re: Variance Request to Move from Phase 2 to Phase 3 of Safe Start Washington Plan
3. Draft Jefferson County Board of Health Variance Plan Request

V. Activity Update
1. Environmental Public Health Programs Update

VI. Agenda Planning Calendar:
1. Next Scheduled Meeting: July 16, 2020
   2:30 – 4:30 PM
   Jefferson County Public Health
   Virtual Meeting
Chair Sheila Westerman called the May 14, 2020 meeting of the Jefferson County Board of Health to order at 2:30 p.m. A quorum was present.

**Members Present:** Pamela Adams, Greg Brotherton, Kate Dean, Kees Kolff, Denis Stearns, David Sullivan, Sheila Westerman

**Staff Present:** Michael Dawson, Vicki Kirkpatrick, Thomas Locke, Apple Martine, Pinky Mingo, Veronica Shaw

**APPROVAL OF AGENDA**

Chair Shelia Westerman asked for approval of the agenda for May 14, 2020.

**Vice Chair Pamela Adams motioned to approve the agenda. The motion was seconded by member Kees Kolff. No further discussion. The motion passed unanimously.**

**NEW BUSINESS**

1. **Epidemiological Modeling of the Coronavirus Pandemic – CIDRAP and IDM reports**

   Dr. Tom Locke, Health Officer reviewed the possible pandemic wave scenarios for COVID-19 and recommendations published in *COVID-19: The CIDRAP Viewpoint* by the Center for Infectious Disease Research and Policy. He said another wave of COVID-19 will most likely come in the fall or early winter. Dr. Locke also reviewed the publication, *COVID-19 transmission was likely rising through April 22 across Washington State*, by the Institute of Disease Modeling and discussed future predictions and response plans.
The Board had questions about immunity after being infected with COVID, antibody tests, current reproduction of the virus, true infection rates, seasonal spikes of infection, tourism related cases, the recent confirmed case in Jefferson County, and vaccines.

2. Health Officer Recommendations Re: Variance Request to Move from Phase I to Phase II of Governor Inslee’s Stay Home – Stay Healthy Proclamation

Dr. Locke thanked the public for their thoughtful and detailed emails. He said the primary concern he has heard from the public is about opening activities that would encourage tourism in Jefferson County. He said his recommendations are based on the premise of preventing the spread of infectious disease and also emphasized this as not a partisan issue, but a basic human consideration.

The Board asked Dr. Locke questions about the guidelines and expected impacts of moving to Phase 2. Topics discussed included serving existing clientele only, contact tracing, stringency of standards and guidelines, enforcement, masking directives, tourism, etc.

Member Kees Kolff said Jefferson Healthcare has met the requirements to move to Phase 2 and agreed to write the letter of support that is required in the application for the variance.

The Board reviewed and discussed each of the activities recommended for the Phase 2 variance. These activities included outdoor recreation (including camping), gatherings, travel, and business and employers (including child care). The Board asked clarifying questions for each topic and provided feedback for Dr. Locke to move forward with the final recommendations, including adding drive-in theatres to the list of recommended activities. The Board also asked Dr. Locke to inquire about the restrictions for dog parks, play grounds and yoga and ballet studios.

AGENDA PLANNING CALENDAR

Topics planned for discussion at the next BOH meeting are 1) issuing a masking directive, and 2) clarifying glove use.

NEXT SCHEDULED MEETING

The next Board of Health meeting will be held online as a GoToMeeting on Thursday, May 21, 2020 from 2:30 – 4:30 p.m.
ADJOURNMENT

Chair Sheila Westerman adjourned the May 14, 2020 Jefferson County Board of Health meeting at 4:52 p.m.

JEFFERSON COUNTY BOARD OF HEALTH

Sheila Westerman, Chair
Pamela Adams, Vice Chair
David Sullivan, Member
Denis Stearns, Member

Kate Dean, Member
Greg Brotherton, Member
Kees Kolff, Member

Respectfully submitted
J. Matter
Chair Sheila Westerman called the May 21, 2020 meeting of the Jefferson County Board of Health to order at 2:30 p.m. A quorum was present.

**Members Present:** Pamela Adams, Greg Brotherton, Kate Dean, Kees Kolff, Denis Stearns, David Sullivan, Sheila Westerman

**Staff Present:** Michael Dawson, Vicki Kirkpatrick, Thomas Locke, Apple Martine, Pinky Mingo, Veronica Shaw

### APPROVAL OF AGENDA

Chair Shelia Westerman asked for approval of the agenda for May 21, 2020.

**Member Kees Kolff motioned to approve the agenda. The motion was seconded by Vice Chair Pamela Adams. No further discussion. The motion passed unanimously.**

### APPROVAL OF MINUTES

Vice Chair Pamela Adams asked for approval of the minutes for the April 16, 2020 BOH meeting.

**Member Kate Dean motioned to approve the minutes. The motion was seconded by member Greg Brotherton. No further discussion. The motion passed unanimously.**
PUBLIC COMMENTS

Public comments were submitted via email and saved on Laserfiche at:
http://test.co.jefferson.wa.us/WebLinkExternal/0/fol/2396166/Row1.aspx

OLD BUSINESS AND INFORMATIONAL ITEMS

1. Jefferson Healthcare Update
   Member Kees Kolff said Jefferson Healthcare has done a remarkable job at keeping staff and patients safe and surpassed all requirements to apply for the variance to proceed with Phase 2. He also said: 1) JHC is testing between 50-70 people a day for COVID, 2) 1,355 total COVID tests have been conducted, 3) JHC has been between 40-80% under capacity for inpatient and outpatient services, and 4) the Governor’s restrictions on non-urgent procedures expired on Monday and he encouraged the community to get the healthcare they needed.

NEW BUSINESS

1. Health Officer Recommendations Re: Variance Request to Move from Phase 1 to Phase 2 of Safe Start Washington Plan
   Dr. Tom Locke, Health Officer, introduced the draft resolution based on his recommendations to the Board.

2. Draft Jefferson County Board of Health Variance Plan Request
   Dr. Locke said the variance plan request for phase 2 has been drafted as a resolution that, once approved, will be submitted to the Washington State Board of Health.

   The Board discussed camping at the state, county and regional level, along with the economic and health risks of allowing retailers and restaurants to open under the Phase 2 variance.

   Dr. Locke recommended to add, “of the Safe Start Washington Plan” to the last sentence of the first paragraph.

   Member Kees Kolff motioned (#1) to adopt the first paragraph with the added language Dr. Locke recommended and adopt everything he recommends up until the last two items on the draft, understanding that the camping and recreation section still needs to be reconsidered. Motion (#1) failed for lack of a second.

   Member Kees Kolff motioned (#2) to adopt the first paragraph with the added language Dr. Locke recommended. The motion was seconded by member Greg Brotherton. The motion (#2) passed unanimously.
Member Greg Brotherton motioned (#3) to approve the recreation recommendation from Dr. Locke. The motion was seconded by member Kees Kolff. Discussion ensued regarding regional recreation. Motion (#3) failed for lack of a vote.

Member Kees Kolff motioned (#4) to adopt Dr. Locke's recommendation for Recreation under the section, *Phase 2 Modifications to be implemented after Department of Health approval*. The motion was seconded by Vice Chair Pamela Adams. Discussion ensued regarding regional camping.

Member Greg Brotherton motioned (#5) to amend the motion made by member Kees Kolff so the sentence following Recreation reads, “Outdoor recreation involving fewer than 5 people outside your household.” The motion was seconded by member Kees Kolff. Discussion ensued regarding regional camping. Vote taken to amend the motion (#5): 2 in favor, 5 opposed. The motion to amend the motion did not pass.

Vote taken to pass the motion (#4): 5 in favor, 2 opposed. The motion passed.

The Board discussed a mask directive, increased risk when gathering with visitors from high prevalence areas, recommendations for opening physical fitness centers, and guidance for dog parks.

Member Kees Kolff motioned (#6) to adopt the recommendations by Dr. Locke for Gatherings under the section, *Phase 2 Modifications to be implemented after Department of Health approval*. The motion was seconded by Vice Chair Pamela Adams. Vote taken: 6 in favor, 1 opposed. The motion (#6) passed.

The Board briefly discussed the intent of Dr. Locke’s recommendation for travel.

Member Kees Kolff motioned (#7) to adopt Dr. Locke’s recommendation for Travel under the section, *Phase 2 Modifications to be implemented after Department of Health approval*. The motion was seconded by Vice Chair Pamela Adams. The motion (#7) passed unanimously.

Member Kate Dean motioned (#8) to adopt Dr. Locke’s recommendation for Business/Employers under the section, *Phase 2 Modifications to be implemented after Department of Health approval*. The motion was seconded by Vice Chair Pamela Adams. The motion (#8) passed unanimously.

Member Greg Brotherton motioned (#9) to add Island, Grey’s Harbor, Mason, and Pacific counties to the section, *Phase 2 Modifications to be implemented after Clallam County Phase 2 Implementation*. The motion was seconded by Vice Chair Pamela Adams. Discussion ensued regarding adding additional counties.

Member Greg Brotherton motioned (#10) to withdraw the motion. The motion was seconded by Vice Chair Pamela Adams. Motion (#10) failed for lack of a vote.

Vote taken to pass the motion (#9): 0 in favor, 7 opposed. The motion did not pass.
The Board discussed adding Mason county and retitling sections of the document.

**Member Kate Dean motioned (#10) to change the title of section 2 to, Modifications to be implemented after Regional adoption (Clallam, Kitsap and Mason Counties) Phase 2 Implementation.** The motion was seconded by member Kees Kolff. Discussion ensued regarding adding Mason County.

**Member Kees Kolff motioned (#11) to amend the motion made by member Kate Dean to eliminate Mason County from the proposed title of section 2.** The motion was seconded by member Kate Dean. The motion (#11) passed unanimously.

Motion (#10) failed for lack of a vote.

**Member Kees Kolff motioned (#12) to change the title of section 2 so it reads, “Modifications to be implemented after Clallam County Phase 2 Implementation.”** The motion was seconded by member Greg Brotherton. Discussion ensued regarding camping and restaurants in the tri-county area.

**Member Denis Stearns motioned (#13) to make a friendly amendment so a third section would be created.** Member Kees Kolff accepted the friendly amendment. Motion (#13) failed for lack of a vote.

Vote taken to pass the motion (#12): 0 in favor, 7 opposed. The motion did not pass.

**Member Kees Kolff motioned (#14) to change the format of the document so there are three sections.** The second section will read, “Phase 2 Modifications to be implemented after Clallam County Phase 2 Implementation. Recreation: Outdoor activities with 5 or fewer people involving overnight camping [State and County Lands].” The third section will read, “Phase 2 Modifications to be implemented after Clallam and Kitsap County Phase 2 Implementation. Business and Employers: Restaurants with sit down service, real estate (beyond current permitted activities), retail (in-store purchases), professional services/office-based business [tourism focused].” The motion was seconded by Vice Chair Pamela Adams. Motion tabled.

**Member Greg Brotherton motioned (#15) to amend the motion made by member Kees Kolff so retail and in-store purchases be allowed in phase 2 under Business/Employers.** The motion was seconded by member Kees Kolff. Discussion ensued regarding process to modify the document. Motion (#15) failed for lack of a vote.

**Member Greg Brotherton motioned (#16) to reconsider so retail (in-store purchases) is included under Phase 2 Modifications to be implemented after Clallam County Phase 2 Implementation.** The motion was seconded by member Kees Kolff. Discussion ensued regarding risk of opening retail establishments. Vote taken: 2 in favor, 5 opposed. The motion (#16) did not pass.

Motion (#14) back on the table from member Kees Kolff. Vote taken: 6 in favor, 1 opposed. The motion passed.

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The Board discussed state and county camping.

**Member Kees Kolff motioned (#17) to eliminate State and County Lands from the recommendations for Recreation. The motion was seconded by member Kate Dean. The motion (#17) passed unanimously.**

Dr. Locke read the resolution as amended by the Board.

**Member Kate Dean motioned (#18) to approve the resolution as amended and read by Dr. Locke. The motion was seconded by Vice Chair Pamela Adams. The motion (#18) passed unanimously.**

3. **Masking Directives**
Dr. Locke asked the Board for guidance on issuing a masking directive. The Board expressed unanimous support for a Health Officer masking directive.

**ACTIVITY UPDATE**

There was no activity update.

**AGENDA PLANNING CALENDAR**

There was no agenda planning.

**NEXT SCHEDULED MEETING**

The next Board of Health meeting will be held online as a GoToMeeting on Thursday, June 18, 2020 from 2:30 – 4:30 p.m.
ADJOURNMENT

Chair Sheila Westerman adjourned the May 21, 2020 Jefferson County Board of Health meeting at 5:03 p.m.

JEFFERSON COUNTY BOARD OF HEALTH

Sheila Westerman, Chair                              Kate Dean, Member
Pamela Adams, Vice Chair                            Greg Brotherton, Member
David Sullivan, Member                               Kees Kolff, Member
Denis Stearns, Member

Respectfully submitted
J. Matter
III
Old Business and Information Reports
Item 2
Jefferson County Health Officer Masking Directive and FAQ Press Release

June 18, 2020
DIRECTIVE NO. 2020-2

JEFFERSON COUNTY LOCAL HEALTH OFFICER DIRECTIVE REGARDING COVID-19; REQUIRING THE WEARING OF CLOTH FACE COVERINGS

WHEREAS, the coronavirus disease 2019 (COVID-19) is caused by a virus that spreads easily from person to person which may result in serious illness or death and has been classified by the World Health Organization as a worldwide pandemic;

WHEREAS, COVID-19 has spread throughout Washington State, including Jefferson County, significantly threatening the life and health of persons in Jefferson County;

WHEREAS, COVID-19 can spread from people without symptoms, including persons who are asymptomatic or pre-symptomatic, to others;

WHEREAS, in the absence of interventions to limit the spread of the disease, for every case of COVID-19 in the community we can expect 2.5 more cases in the community, leading to a dramatic increase in the number of cases over a short period of time;

WHEREAS, there are currently no known medications or vaccinations that are effective in preventing the spread of COVID-19;

WHEREAS, non-pharmaceutical interventions, such as social distancing and the wearing of cloth face coverings, are presently the only effective measures to control and prevent the spread of COVID-19;

WHEREAS, the primary modes of transmission of COVID-19 are surface contact routes and respiratory droplets and aerosols from infected individuals;

WHEREAS, respiratory droplets and aerosols from infected individuals can be transmitted not only through coughing or sneezing but also through other actions including talking, shouting, singing, or breathing;

WHEREAS, on February 29, 2020, Governor Inslee issued Proclamation 20-05, proclaiming a State of Emergency for all counties throughout the state of Washington as a result of COVID-19 outbreak in the United States and confirmed person-to-person spread of COVID19 in Washington State;

WHEREAS, since February 2020 Governor Inslee has issued a series of proclamations related to COVID-19 that place limitations on gatherings, business and leisure activity, and travel, including Proclamation 20-25, "Stay Home -Stay Healthy," adopted on March 23, 2020 ("Governor Proclamation 20-25");

WHEREAS, the Governor established a phased approach known as "Safe Start Washington" beginning on May 5, 2020, which provides for gradual increases over time in allowable business and leisure activity, travel, and gatherings with an emphasis on
simultaneously minimizing the health impacts of COVID-19, reducing the risk of COVID-19 to Washington’s most vulnerable populations, and preserving capacity in the health care system;

WHEREAS, Jefferson County is a popular travel and leisure destination which experiences a large influx of visitors throughout the year, particularly in and around the summer months;

WHEREAS, when Jefferson County moves from Phase I to Phase II of the Safe Start Washington plan there will be a substantial increase in the levels of allowable business and recreation activities, accompanied by a substantial increase in the amount of permissible travel to Jefferson County, including non-essential travel as authorized by the Safe Start Washington plan;

WHEREAS, the possibility of dangerous outbreaks of COVID-19 locally is substantially greater when there is an increase in travel to Jefferson County, particularly if there is also an increase in business activity;

WHEREAS, widespread use of cloth face coverings to cover the mouth and nose, also known as non-surgical face masks, is recommended in the Governor’s Safe Start Washington plan and can help to control the spread of COVID-19 by reducing the transmission of respiratory droplets and aerosols from infected individuals into the environment from asymptomatic or pre-symptomatic individuals, particularly in public spaces where social distancing is not possible or unpredictable, such as indoor businesses;

WHEREAS, the Safe Start Washington Plan contains detailed requirements for businesses which include requirements regarding the wearing of masks and face coverings by employees together with recommendations for the wearing of face coverings by customers;

WHEREAS, there is a national shortage of medical grade masks, surgical masks, and N95 respirators that are critically needed for healthcare providers who are on the front lines working to protect all of us, and health officials are increasingly urging non-medical workers to wear non-medical grade cloth face coverings to help curb the spread of COVID-19;

WHEREAS, workers of certain essential businesses and other frontline employees must be protected because they face greater exposure and risk of contracting COVID-19 due to their frequent in person contact with members of the public and inability to work from home and widespread mask use may decrease the risk of spread from someone with unrecognized infection;

WHEREAS, RCW 70.05.070 requires and empowers the local health officer to take such action as is necessary to control and prevent the spread of any contagious or infectious diseases within the jurisdiction;

WHEREAS, WAC 246-100-036, requires the local health officer, when necessary, to institute disease control measures as he or she deems necessary based on his or her professional judgment, current standards of practice, and the best available medical and scientific information; and

WHEREAS, in order to control and prevent the spread of COVID-19 in Jefferson County and protect our most vulnerable populations, in my professional judgment, based on the current standards
of practice and the best available medical and scientific information, a requirement for business owners and operators to require non-employees to wear cloth face coverings over the mouth and nostrils while inside businesses, together with appropriate notice requirements, should be established at the time Jefferson County transitions from Phase I to Phase II of the Safe Start Plan.

NOW, THEREFORE, I, Thomas Locke, MD, MPH, Local Health Officer for Jefferson County, under the authority of RCW 70.05.070, RCW 43.20.050, and WAC 246-100-036, and on the basis of the foregoing recitals, make the following DIRECTIVE:

1. **Use of Cloth Face Coverings.** All individuals must wear face coverings over their noses and mouths when they will be at (1) indoor public settings, or (2) outdoor public locations and cannot maintain distancing of approximately six feet from another individual who does not share their household. Because there is still a shortage of medical-grade or N95 respirators for health care workers, unless a particular health reason requires it, individuals should use fabric coverings, such as cloth face masks, scarves and bandana coverings or other material as recommended by CDC.

Cloth face masks must be worn properly in order to avoid contaminating the hands or face of the user. Before putting on a mask and after removing a mask, an individual should clean their hands with alcohol-based hand rub or soap and water and change masks when moist and wash after use. While in use, avoid touching the mask. Worn masks may be contaminated with infectious agents.

Wearing of cloth face coverings should not be required for the following individuals:

(a) any child under two years of age;  
(b) any child who is at least two and less than twelve years of age unless a parent or caregiver supervises the use of cloth face coverings by children to avoid misuse;  
(c) any individual who is unable to remove the cloth face covering without assistance;  
(d) any individual who is deaf and uses facial and mouth movements as part of communication; or  
(e) any individual who has been advised by a medical professional that wearing a face covering may pose a risk to that individual for health reasons.

2. **Cloth Face Coverings Required.** Owners and operators of businesses in Jefferson County shall not permit or allow any non-employee to enter or remain inside a building owned or operated by the business unless the non-employee is wearing a cloth face covering over their mouth and nostrils. This does not apply to a restaurant, tavern, or bar patron while eating or drinking. Further, businesses that sell food, medicine, or medical supplies shall provide a method for customers to purchase these items without entering a building, such as curbside pick-up or delivery.

3. **Notice by Businesses, Ports, and Marina Facilities.** Owners and operators of all businesses, ports, and/or marina facilities in Jefferson County shall post notice at entry points indicating that the wearing of cloth face coverings is required inside businesses in Jefferson County. Said notice shall be posted no later than 7 days after Jefferson County begins full implementation of Phase II of the Safe Start Washington plan as authorized by the Governor or Washington Secretary of Health. This paragraph does not require posting of notice by a business that is not open to the public.

4. **Definitions.** "Cloth face covering" means a soft cloth or fabric covering that is worn on the face and fully covers a person's mouth and nostrils, such as a protective mask, scarf, bandana, or any
more protective covering. CDC guidance regarding the wearing and making of cloth face coverings can be found at: https://www.cdc.gov/coronavirus/2019ncov/prevent-getting-sick/diy-cloth-face-coverings.html.

5. Social Distancing and Hand Washing. A cloth face covering does not replace the need to adhere to social distancing standards or requirements, wash hands frequently, and avoiding touching of the face.

6. Critical Supplies. Surgical masks and N-95 respirators are critical supplies that should be reserved for health care workers, medical first responders, and other workers as recommended by CDC guidance. Such items should not be worn as cloth face coverings unless necessary.

Section 2 of this order is effective on after Jefferson County begins full implementation of Phase II of the Safe Start Washington plan as authorized by the Governor or Washington Secretary of Health. All other provisions of this order are effective at midnight on June 1, 2020.

This order shall remain in effect until further order of the County Health Officer following a determination that the wearing of cloth face coverings is no longer necessary.

DATED this ___28___ day of ___MAY______, 2020 at ___4:00___pm.

Thomas Locke, MD, MPH
Jefferson County Health Officer
Press Release – June 9, 2020

Frequency Asked Questions Regarding Masking to Prevent COVID-19 Transmission

Thomas Locke, MD, MPH
Jefferson County Health Officer

**Why should people wear masks to prevent coronavirus infection?**

SARS CoV-2, the virus responsible for COVID-19 infection, has been spreading in the United States for 4-5 months. There is still much that is uncertain about this pandemic infection but it is known that the main way it is spread is through respiratory droplets and aerosols. Masks provide an effective form of “source control”, catching respiratory secretions before they can spread to other people. We have also learned that many people who have COVID-19 do not have symptoms (asymptomatic cases) or are infectious for several days before they develop symptoms (presymptomatic cases). This means that people can carry and spread the virus without knowing they are infected. This does not appear to be a rare occurrence and may, in fact, be the major way the virus is spread. Masking (to prevent spread of infectious respiratory particles) and physical distancing (to lessen risk of exposure to airborne particles) are the best currently available strategies for controlling asymptomatic and presymptomatic spread of coronavirus. Until we have something better, we have to rely on these basic strategies to prevent as many cases of COVID-19 as we can.

**Do face masks protect the person wearing the mask?**

Different types of masks provide different levels of protection to their users. Simple cloth masks are the least effective at filtering the air that is inhaled. Depending on their fit and the fabric type used in their construction, they do provide some filtering effect. Their greatest value is to trap respiratory droplets and aerosols that are exhaled, preventing the exposure of others to any potentially infectious particles we might breath or cough out. Medical masks (surgical and N-95) provide more filtration and user protection from inhaled aerosols. Fit tested N-95 masks (used in high risk health care settings) offer the highest level of protection. Unfortunately, medical masks are in short supply, especially N-95 masks, and their use for health care workers and first responders is prioritized.

**Why should I wear a mask the protects someone else but not me?**

The coronavirus pandemic presents many unprecedented challenges. Health care workers and first responders have been asked to put their health on the line, often with inadequate supplies of personal protective equipment like medical masks. They have done this heroically and at great person cost. More than 60,000 health care workers have been infected with COVID-19 and
almost 300 have died. Essential workers have been on duty since the beginning of the pandemic, also taking risks for the benefit of others. Non-medical personnel have their part to play in controlling this pandemic as well. One of thing we can all do is to wear masks in indoor public places and outdoor settings where physical distancing cannot be maintained. Some people want to look at mask wearing solely as a matter of personal risk – if a person wants to go mask free, they willingly take the risk. But it’s not that simple. If they are unwittingly infected with COVID-19 they are putting other people at risk as well. In an infectious disease pandemic, our personal choices have public health consequences.

What scientific evidence support the use of masks to prevent COVID-19?

We are in the early stages of the coronavirus pandemic. It will likely be another year or longer before it is under control. Most scientific research on masks as a communicable disease control strategy were done for the control of influenza, including the 4 influenza pandemics which have occurred over the last 100 years. Scientific studies support the value of masks as both a source control strategy (i.e. worn by people with acute influenza infection) and for worker protection (for health care workers taking care of hospitalized influenza patients). Not all studies shown benefit and there is ongoing uncertainty. Several recent U.S. studies have indicated that simple cloth masks are an effective source control strategy and this has led the Centers for Disease Control, the World Health Organization, and a growing number of state and local health officials to recommend masks as part of a comprehensive pandemic coronavirus control strategy.

What good is a mask directive if there are not strict criminal penalties for violation of the directive?

A community masking policy that depends on criminal penalties and punitive enforcement is doomed to failure. If we cannot come together as a community and accept the mild inconvenience of having to wear masks in public places, then we are unlikely to successfully rise to the challenge that this public health emergency presents. Masking does not have to be 100%. Some people cannot wear masks due to age or an underlying medical condition. Some people will refuse to wear masks as a political statement or to show their opposition to public health authority. Not everyone is a responsible member of society. For those who are concerned about the welfare of others and who accept the concept that the choices we make affect the health and safety of others, use of cloth masks in public is a way to protect fellow community members. When they do the same, they are protecting us. The more people who wear masks in situations where airborne spread of coronavirus can occur, the safer those places become. Even those not wearing masks benefit from the inconvenience others have accepted on their behalf.

On May 28, 2020 I issued a masking directive for the citizens of Jefferson County. It gives business owners the authority to exclude unmasked individuals from publicly accessible places unless they meet one of the directive’s exemptions. I am not requiring businesses or community members to enforce this directive. I am giving them the opportunity to use this
public health authority to protect themselves, their employees, and their customers. We need to give ourselves a chance to act like responsible adults and engaged citizens. Some community members cannot wear masks due to medical or psychological conditions. They should not be stigmatized or made to feel unwelcome. It is reasonable to ask an unmasked individual to put on a face covering while in an indoor environment or outdoors in close proximity to others. If they state they have a medical exemption, this should be accepted in good faith. If they refuse on ideological grounds, they can be asked to leave the private business. If they become belligerent or threatening, they are creating a nuisance and law enforcement can be called to assist. Increasingly, indoor masking will become the social norm.

Is a public health directive to wear a mask in public a violation of an individual’s right to enjoy their personal freedom?

Neither public health authority or individual rights are absolute, they must be in balance. Public health codes exist to protect everyone (including the person who feels their rights are being violated). They balance the rights of individuals against the right of everyone to be free from a preventable health threat. A person with a contagious disease might feel aggrieved by a public health order that keeps them in isolation for the duration of their illness but that order protects other people from being exposed and infected with that disease. In the case of masking, people are being required to protect each other. If it were solely a matter of personal risk, it would be much simpler – everyone could take whatever risk they want without effecting anyone else (like mountain climbing or downhill skiing). Public health is seldom simple. The “personal” risk you take can also affect the risk you are imposing on others. In the case of pandemic coronavirus, these risks can be substantial. A health young adult may feel that they can weather a case of COVID-19 without difficulty. If they spread it to an elderly relative with chronic health issues the outcome could be tragically different. For those who want to see wearing masks in public during this pandemic as yet another front in the bitter and divisive “culture war” that is engulfing America, I urge them to satisfy your need for political conflict elsewhere. COVID-19 is real, not a hoax. People are getting sick and dying. It will get worse before it gets better. Accepting the minor inconvenience of wearing a cloth mask is not too much to ask to protect community health. Refusing to wear a mask (if you otherwise don’t have a legitimate age or medical reason) is not a bold political statement. It’s selfish and self-centered.

What is the specific requirement for masking in Jefferson County?

There are three different directives that compel use of masks to prevent coronavirus transmission that effect Jefferson County residents:

1) Governor Inslee’s proclamation that covers employers and employees,
2) the Jefferson County Health Officer’s directive on mask use, and
3) the requirements of individuals businesses for public access to their private business (“No shirt, no shoes, no mask, no service”).
The Governor’s proclamation requires that employers and employees wear cloth masks in indoor settings (unless alone in a separate room) and in outdoor settings where a 6-foot physical distance cannot be maintained. Enforcement is through Labor and Industries occupational health regulations and penalties are strict.

The Health Officer’s directive of May 28, 2020 requires individuals not meeting one of its 5 exemptions to wear a face covering when in indoor public settings or outdoor public locations when a 6-foot physical separation cannot be maintained. Additionally, businesses are directed to not allow non-employees to enter or remain inside a building without a mask, except under certain circumstances.

And finally, businesses are free to set reasonable health criteria for people entering their buildings. Costco and Goodwill require customers to wear masks as a matter of corporate policy. Hospitals and clinics require patient and visitors to wear facial masks. This is a growing trend.

**How does masking initiatives relate to Phase 2 and Phase 3 of the Safe Start WA plan?**

The coronavirus pandemic of 2020 is still in its early stages. Outbreaks, hospitalizations, and deaths will continue until a vaccine is developed or effective antiviral medications are discovered. Washington State is attempting a phased reopening of businesses and community activities in what is known as the Safe Start Washington Plan. This reopening will inevitably increase the risk of coronavirus transmission. Jefferson County is currently in Phase 2 of this reopening plan, allowing restaurants and other businesses to partially reopen. If we are able to prevent surges of COVID-19 during this phase, Jefferson County will be eligible for further reopening of businesses, movie theatres, museums, libraries, and other community functions.

Successful reopening is by no means guaranteed. The public health and medical systems have spent the last 10 weeks preparing for the increase in COVID-19 that will occur when community life resumes and summer travelers flock to the area. These systems can only react to new infections – treating disease complications and trying to limit the community spread of infection. The only thing that can PREVENT new cases of COVID-19 is widespread community implementation of the things we have learned are effective control strategies – physical distancing, masking, hand hygiene, disinfection of surfaces, cough etiquette, and staying home (and getting tested) at the early signs of COVID-like illness. These actions are the “make it or break it” activities that will determine whether we move forward to a reopened community or we succumb to the outbreaks and hospital surges we have tried so hard to prevent.

Those who see masking as a burdensome nuisance and something they just “don’t believe in” fail to see the severity of the situation we are in. Those who insist on seeing this pandemic through the “us against them” lens of partisan politics fail to see that there is no “them”. It’s only “us”. The pandemic coronavirus is indifferent to political ideology or social status. It sickens and kills whether we believe in it or not. Communities have come together and paid a heavy economic cost to “flatten the curve” and buy ourselves more time to respond to the pandemic. Now we are called to action and must see if we can come together as a community and successfully deal with the worst public health threat of the last century. Masking is a small but crucial part of this pandemic response plan.
Board of Health

IV
New Business
Item 1
Racism as a Public Health Issue

June 18, 2020
Open letter advocating for an anti-racist public health response to demonstrations against systemic injustice occurring during the COVID-19 pandemic

On April 30, heavily armed and predominantly white protesters entered the State Capitol building in Lansing, Michigan, protesting stay-home orders and calls for widespread public masking to prevent the spread of COVID-19. Infectious disease physicians and public health officials publicly condemned these actions and privately mourned the widening rift between leaders in science and a subset of the communities that they serve. As of May 30, we are witnessing continuing demonstrations in response to ongoing, pervasive, and lethal institutional racism set off by the killings of George Floyd and Breonna Taylor, among many other Black lives taken by police. A public health response to these demonstrations is also warranted, but this message must be wholly different from the response to white protesters resisting stay-home orders. Infectious disease and public health narratives adjacent to demonstrations against racism must be consciously anti-racist, and infectious disease experts must be clear and consistent in prioritizing an anti-racist message.

White supremacy is a lethal public health issue that predates and contributes to COVID-19. Black people are twice as likely to be killed by police compared to white people, but the effects of racism are far more pervasive. Black people suffer from dramatic health disparities in life expectancy, maternal and infant mortality, chronic medical conditions, and outcomes from acute illnesses like myocardial infarction and sepsis. Biological determinants are insufficient to explain these disparities. They result from long-standing systems of oppression and bias which have subjected people of color to discrimination in the healthcare setting, decreased access to medical care and healthy food, unsafe working conditions, mass incarceration, exposure to pollution and noise, and the toxic effects of stress. Black people are also more likely to develop COVID-19. Black people with COVID-19 are diagnosed later in the disease course and have a higher rate of hospitalization, mechanical ventilation, and death. COVID-19 among Black patients is yet another lethal manifestation of white supremacy. In addressing demonstrations against white supremacy, our first statement must be one of unwavering support for those who would dismantle, uproot, or reform racist institutions.

Staying at home, social distancing, and public masking are effective at minimizing the spread of COVID-19. To the extent possible, we support the application of these public health best practices during demonstrations that call attention to the pervasive lethal force of white supremacy. However, as public health advocates, we do not condemn these gatherings as risky for COVID-19 transmission. We support them as vital to the national public health and to the threatened health specifically of Black people in the United States. We can show that support by facilitating safest protesting practices without detracting from demonstrators’ ability to gather and demand change. This should not be confused with a permissive stance on all gatherings, particularly protests against stay-home orders. Those actions not only oppose public health interventions, but are also rooted in white nationalism and run contrary to respect for Black lives. Protests against systemic racism, which fosters the disproportionate burden of COVID-19 on Black communities and also perpetuates police violence, must be supported.

Therefore, we propose the following guidance to support public health:

- Support local and state governments in upholding the right to protest and allow protesters to gather.
- Do not disband protests under the guise of maintaining public health for COVID-19 restrictions.
Advocate that protesters not be arrested or held in confined spaces, including jails or police vans, which are some of the highest-risk areas for COVID-19 transmission.

Oppose any use of tear gas, smoke, or other respiratory irritants, which could increase risk for COVID-19 by making the respiratory tract more susceptible to infection, exacerbating existing inflammation, and inducing coughing.

Demand that law enforcement officials also respect infection prevention recommendations by maintaining distance from protesters and wearing masks.

Reject messaging that face coverings are motivated by concealment and instead celebrate face coverings as protective of the public's health in the context of COVID-19.

Prepare for an increased number of infections in the days following a protest. Provide increased access to testing and care for people in the affected communities, especially when they or their family members put themselves at risk by attending protests.

Support the health of protesters by encouraging the following:
  - Use of face coverings.
  - Distance of at least 6 feet between protesters, where possible.
  - Demonstrating consistently alongside close contacts and moving together as a group, rather than extensively intermingling with multiple groups.
  - Staying at home when sick, and using other platforms to oppose racism for high-risk individuals, and those unable or uncomfortable to attend in person.

Encourage allies who may wish to facilitate safe demonstrations through the following:
  - Providing masks, hand-washing stations, or hand sanitizer to demonstrators.
  - Providing eye protection, such as face shields or goggles, for protection against COVID-19 and chemical irritants used to disperse crowds.
  - Bringing wrapped, single-serving food or beverages to sustain people protesting.
  - Providing chalk markings or other designations to encourage appropriate distancing between protesters.
  - Supplying ropes, which can be knotted at 6-foot intervals, to allow people to march together while maintaining spacing.
  - Donating to bail funds for protesters

Listen, and prioritize the needs of Black people as expressed by Black voices.

These are strategies for harm reduction. It is our sincere hope that all participants will be able to follow these suggestions for safer public demonstrations, assisted by allies where possible and necessary, but we recognize that this may not always be the case. Even so, we continue to support demonstrators who are tackling the paramount public health problem of pervasive racism. We express solidarity and gratitude toward demonstrators who have already taken on enormous personal risk to advocate for their own health, the health of their communities, and the public health of the United States. We pledge our services as allies who share this goal.

This letter is signed by 1,288 public health professionals, infectious diseases professionals, and community stakeholders.
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Racism is a public health issue

Fighting health inequity means fighting against racism. Black lives matter.

Recent events including the killings of George Floyd, Breonna Taylor, Manuel Ellis, Tony McDade, James Scurlock, and Ahmaud Arbery testify to the racial injustice that persists across our country and within our communities. We share in the outrage and anguish expressed around the United States in response to the treatment of Black Americans by the police and the toll of police killings. And similar injustices are pervasive in many other parts of the world. We commit to working to produce the evidence that racism and discrimination are critical public health issues that demand an urgent response, wherever they occur.

IHME can and will do more to illuminate the public health impacts of systemic racism. We will undertake research to address racial disparities in a range of areas, including life expectancy, child mortality, education, and economic opportunity. We will expand our work on COVID-19 to specifically examine the differential impacts of the disease by race. And we will make every effort to bring attention to police brutality.

We will do this work while making our own organization more diverse and inclusive.

We are committed to this fight.

Christopher Murray
IHME Director
Diagnosing and Treating Systemic Racism

Michele K. Evans, M.D., Lisa Rosenbaum, M.D., Debra Malina, Ph.D., Stephen Morrissey, Ph.D., and Eric J. Rubin, M.D., Ph.D.

For physicians, the words "I can't breathe" are a primal cry for help. As many physicians have left their comfort zones to care for patients with Covid-19–associated respiratory failure, the role of the medical profession in addressing this life-defining need has rarely been clearer. But as George Floyd's repeated cry of "I can't breathe" while he was being murdered by a Minneapolis police officer has resounded through the country, the physician's role has seemed less clear. Police brutality against black people, and the systemic racism of which it is but one lethal manifestation, is a festering public health crisis. Can the medical profession use the tools in its armamentarium to address this deep-rooted disease?

The role of the physician in times of social injustice and societal distress is difficult to navigate. Since the importation of enslaved Africans as chattel to provide the labor that built this country began, Americans have functioned within the intricate injustices that are the vestiges of that institution. Slavery has produced a legacy of racism, injustice, and brutality that runs from 1619 to the present, and that legacy infects medicine as it does all social institutions. Slaves provided economic security for physicians and clinical material that permitted the expansion of medical research, improvement of medical care, and enhancement of medical training. This long and troubled history has permeated the physician–patient relationship with mistrust, reducing the potency of one of medicine's most powerful tools for healing and changing behavior.

In an effort to engender trust in what they would like to see as a "postracial" society, some U.S. clinicians proclaim that they "don't see color." But color must be seen. By looking through a racially impervious lens, clinicians neglect the life experiences and historical inequities that shape patients and disease processes. They may inadvertently feed the robust structural racism that influences access to care, quality of care, and resultant health disparities. At times, we fail to make even the simplest efforts: for instance, even though Covid-19 disproportionately affects black Americans, when physicians describing its manifestations have presented images of dermatologic effects, black skin has not been included. The "Covid toes" have all been pink and white.

In the review of systems, we query patients about exposure to toxicants, but we never ask about one of the most dangerous toxicants: racism. The work of David Williams details the morbidity and risk of death related to perceived discrimination. Discrimination and racism as social determinants of health act through biologic transduction pathways to promote subclinical cerebrovascular disease, accelerate aging, and impede vascular and renal function, producing disproportionate burdens of disease on black Americans and other minority populations.

Such research is part of a growing body of literature on health and health care disparities and their manifestations at every level of care. One recent study, for instance, found racial bias baked into a commercial algorithm used to predict the needs of patients with uncontrolled illnesses. Using health spending as a proxy for gravity of illness, the algorithm ignored the fact that disparities in access result in lower spending on black patients and thus failed to identify black patients with complex needs. Such studies, if pri-
oritized by health care institutions and journals — and approached with the same rigor we expect for the treatment of any disease — could lead to critical evidence-based interventions, whether medical or social.

Other research shows that in a world still shaped by systemic racism, black patients are more likely to trust, and heed the advice of, black physicians: a randomized, controlled trial found that black men assigned to a racially concordant doctor sought more preventive care than those assigned to a racially discordant one. The investigators estimated that black doctors could reduce the cardiovascular mortality gap between black and white patients by 19%, but structural racism in medicine and medical education continue to compromise our ability to deliver the best culturally competent care. Black patients, who are already affected by health inequities and impaired health care access, have a much lower chance than white or Asian-American patients of finding a racially concordant physician. Correcting this disparity requires bringing more black people into the medical workforce, beginning with early messages sent to black children about their abilities and possible careers, and working to remove racial bias all along their educational path.

Even as the social contract between the government and the American people has frayed in the complex struggle over the pandemic, racial injustice, and police brutality, physicians must reflect on the condition of medicine's own contract with society. Our society expects physicians to live up to standards of professionalism, deliver state-of-the-art, timely care with competence and integrity, and promote the public good. To carry out these duties, physician-citizens must recognize the harm inflicted by discrimination and racism and consider this environmental agent of disease as a vital sign — alongside blood pressure, pulse, weight, and temperature — that provides important information about a patient's condition. Medical skill has allowed us to respond rapidly to a novel virus to save lives; we must also use our expertise to address racism and injustice and to protect vulnerable people from harm.

Now, amid an acute public health crisis that is transforming medicine, perhaps we have an opportunity to reset our priorities to face this deeper, more chronic crisis as well. It is time to reimage the medical interaction and the doctor-patient relationship, recommitting ourselves to the quiet work of doctoring and building trust with individual patients. We can become more conscious of our biases when we care for minority patients and push ourselves to go the extra mile. Even if we can't change the social determinants of health for any individual patient in any given encounter, we can think more seriously about how they affect what the patient can and can't do, tailor the patient's care accordingly, and show that we're invested.

As the vulnerability and inadequacy of our health care system are once again exposed, it is also time to reconceive that system, including the development of its workforce. Our actions must be driven by the data highlighting inequity in medical school admission and graduation rates, the dearth of black medical faculty, and the low grant-funding success rates for black biomedical researchers. We must also acknowledge past injustices and the persistent pain experienced by minority trainees and faculty, by listening and openly discussing racism and its health effects on rounds and at conferences and by broadening medical school curricula to include cultural sensitivity, cultural humility, and upstander training to equip students with advocacy tools to assist their patients and colleagues. Direct action to eliminate persistent health disparities obliges us to redouble our demands for a system that recognizes health care as a human right, providing an avenue to health equity for all.

Although effecting such fundamental transformation may feel impossible, the energy, idealism, and visions of young people have long fueled movements for change. Martin Luther King, Jr., was 26 when he led the Montgomery bus boycott and 34 when he delivered his powerful "I have a dream" oration. If we blend our voices with those of the newest members of our profession to advocate for the most vulnerable and to reinvigorate every aspect of their care, perhaps we can use our current public health crisis as a catalyst to, as Reverend Al Sharpton put it, "turn this moment into a movement."

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RACISM IS A PUBLIC HEALTH CRISIS: THE TRANSFORMATION STARTS HERE. IT STARTS WITH US.

Public Health Insider

By King County Executive Dow Constantine and Public Health — Seattle & King County Director Patty Hayes

"There's nothing new under the sun but there are new suns." Octavia E. Butler, Parable of the Trickster

Today, we declare that racism is a public health crisis. Public Health – Seattle & King County and all of King County government are committed to implementing a racially equitable response to this crisis, centering on community.

King County government and Public Health – Seattle & King County are committed to working in stronger and better resourced partnerships with community organizations and leaders to disrupt and dismantle racism and protect the health and well-being of Black, Indigenous People and People of Color. We recognize that historically and currently King County has been complicit in maintaining and perpetuating structural racism, and that as an institution we must be a vital player in dismantling oppressive systems that are grounded in white supremacy.

Community leaders and organizations will be provided resources to develop solutions. We make these commitments because we know that together we can stop both disease and racism and lay the foundation for a better, stronger community.

We will use quantitative data, including data about racial inequities, along with voices and know-how from community leaders and residents to get to solutions that work and that are sustainable.

We will share power and resources and work on community-defined problems using community-driven solutions. We commit to working side-by-side with anti-racist organizations, driven by people
most negatively impacted by racism. We commit to convening other jurisdictions and agencies across sectors and to creating shared, measurable accountability.

White privilege and anti-blackness cannot be fully addressed until the same systems that have “worked just fine” for white people while acting as the foot of oppression for indigenous, Black and brown communities are dismantled. In its place, we need new systems coming from the communities most affected by racism, oppression, and colonization.

To confront this crisis, we will adopt and commit to a new “Anti-Racism Crisis Response Bill of Rights.” Our duties will include principles such as, do no harm; co-create with those most vulnerable both in the short- and long-term; provide safe, respectful and culturally responsive care, services and information, delivered in a manner centered in BIPOC communities; and provide access to crisis-related services and resources for all community members and provide redress to community members within established mechanisms when barriers or gaps are identified.

Using the current pandemic as an example, we see how COVID-19 is a new crisis on top of the existing crisis of racism, and we see how racism – despite amazing community resiliency – is an underlying root cause of the disproportionate impacts on communities of color.

King County will drive resources toward where they are needed most as indicated by those in that community. As we move into recovery from the pandemic, we cannot make the same mistakes made in the 2009 “Great Recession” that systematically stripped household wealth from black and brown communities.

In 2008, then King County Executive Ron Sims joined with Public Health to launch the Equity and Social Justice Initiative. Working with the County Council, Executive Dow Constantine and the King County Council subsequently passed the Equity and Social Justice Ordinance. In 2016, King County’s six-year Equity and Social Justice Strategic Plan led with racial justice.

While King County government has made strides for more than 12 years to operate in an equitable and socially just way, this crisis demands that we do more to transform our systems.

To respond to the crisis of racism, we will continue to change our organizations so that we can be the highest performing local government we can be. We commit ourselves to working in true partnership with community. As we work across many basic needs and social determinants of health, for us known as our determinants of equity, we will center Black and indigenous lives and community demands.

We will issue announcements in the near future as we are guided by community partners in this work. The transformation begins here. It begins with us.
Systemic racism is both a theoretical concept and a reality. As a theory, it is premised on the research-supported claim that the United States was founded as a racist society, that racism is thus embedded in all social institutions, structures, and social relations within our society. Rooted in a racist foundation, systemic racism today is composed of intersecting, overlapping, and codependent racist institutions, policies, practices, ideas, and behaviors that give an unjust amount of resources, rights, and power to white people while denying them to people of color.

**Definition of Systemic Racism**

Developed by sociologist Joe Feagin, systemic racism is a popular way of explaining, within the social sciences and humanities, the significance of race and racism both historically and in today's world. Feagin describes the concept and the realities attached to it in his well-researched and readable book, *Racist America: Roots, Current Realities, and Future Reparations*. In it, Feagin uses historical evidence and demographic statistics to create a theory that asserts that the United States was founded in racism since the Constitution classified black people as the property of whites. Feagin illustrates that the legal recognition of racialized slavery is a cornerstone of a racist social system in which resources and rights were and are unjustly given to white people and unjustly denied to people of color.

The theory of systemic racism accounts for individual, institutional, and structural forms of racism. The development of this theory was influenced by other scholars of race, including Frederick Douglass, W.E.B. Du Bois, Oliver Cox, Anna Julia Cooper, Kwame Ture, Frantz Fanon, and Patricia Hill Collins, among others.
Feagin defines systemic racism in the introduction to *Racist America: Roots, Current Realities, and Future Reparations*:

Systemic racism includes the complex array of antiblack practices, the unjustly gained political-economic power of whites, the continuing economic and other resource inequalities along racial lines, and the white racist ideologies and attitudes created to maintain and rationalize white privilege and power. Systemic here means that the core racist realities are manifested in each of society’s major parts [...] each major part of U.S. society—the economy, politics, education, religion, the family—reflects the fundamental reality of systemic racism.

While Feagin developed the theory based on the history and reality of anti-black racism in the U.S., it is usefully applied to understanding how racism functions generally, both within the U.S. and around the world.

Elaborating on the definition quoted above, Feagin uses historical data in his book to illustrate that systemic racism is primarily composed of seven major elements, which we will review here.

**The Impoverishment of People of Color and Enrichment of White People**

Feagin explains that the undeserved impoverishment of people of color (POC), which is the basis of the undeserved enrichment of white people, is one of the core aspects of systemic racism. In the U.S. this includes the role that Black slavery played in creating an unjust wealth for white people, their businesses, and their families. It also includes the way white people exploited labor throughout the European colonies prior to the founding of the United States. These historical practices created a social system that had racist economic inequality built into its foundation and was followed through the years in numerous ways, like the practice of "redlining" that prevented POC from buying homes that would allow their family wealth to grow while protecting and stewarding the family wealth of white people. Undeserved impoverishment also results from POC being forced into unfavorable mortgage rates, being channeled by unequal opportunities for education into low-wage jobs, and being paid less than white people for doing the same jobs.

There is no more telling proof of the undeserved impoverishment of POC and the undeserved enrichment of white people than the massive difference in average wealth of white versus Black and Latino families.

**Vested Group Interests Among White People**

Within a racist society, white people enjoy many privileges denied to POC. Among these is the way that vested group interests among powerful whites and “ordinary whites” allow white people to benefit from a white racial identity without even identifying it as such. This manifests in
support among white people for political candidates who are white, and for laws and political and economic policies that work to reproduce a social system that is racist and has racist outcomes. For example, white people as a majority have historically opposed or eliminated diversity-increasing programs within education and jobs, and ethnic studies courses that better represent the racial history and reality of the U.S. In cases like these, white people in power and ordinary white people have suggested that programs like these are "hostile" or examples of "reverse racism." In fact, the way white people wield political power in the protection of their interests and at the expense of others, without ever claiming to do so, maintains and reproduces a racist society.

Alienating Racist Relations Between White People and POC

In the U.S., white people hold most positions of power. A look at the membership of Congress, the leadership of colleges and universities, and the top management of corporations makes this clear. In this context, in which white people hold political, economic, cultural, and social power, the racist views and assumptions that course through U.S. society shape the way those in power interact with POC. This leads to a serious and well-documented problem of routine discrimination in all areas of life, and the frequent dehumanization and marginalization of POC, including hate crimes, which serves to alienate them from society and hurt their overall life chances. Examples include discrimination against POC and preferential treatment of white students among university professors, more frequent and severe punishment of Black students in K-12 schools, and racist police practices, among many others.

Ultimately, alienating racist relations make it difficult for people of different races to recognize their commonalities, and to achieve solidarity in fighting broader patterns of inequality that affect the vast majority of people in society, regardless of their race.

The Costs and Burdens of Racism are Borne by POC

In his book, Feagin points out with historical documentation that the costs and burdens of racism are disproportionately borne by people of color and by black people especially. Having to bear these unjust costs and burdens is a core aspect of systemic racism. These include shorter life spans, limited income and wealth potential, impacted family structure as a result of mass incarceration of Blacks and Latinos, limited access to educational resources and political participation, state-sanctioned killing by police, and the psychological, emotional, and community tolls of living with less, and being seen as "less than." POC are also expected by white people to bear the burden of explaining, proving, and fixing racism, though it is, in fact, white people who are primarily responsible for perpetrating and perpetuating it.

The Racial Power of White Elites
While all white people and even many POC play a part in perpetuating systemic racism, it is important to recognize the powerful role played by white elites in maintaining this system. White elites, often unconsciously, work to perpetuate systemic racism via politics, law, educational institutions, the economy, and via racist representations and underrepresentation of people of color in mass media. This is also known as white supremacy. For this reason, it is important that the public hold white elites accountable for combatting racism and fostering equality. It is equally important that those who hold positions of power within society reflect the racial diversity of the U.S.

The Power of Racist Ideas, Assumptions, and World Views

Racist ideology—the collection of ideas, assumptions, and worldviews—is a key component of systemic racism and plays a key role in its reproduction. Racist ideology often asserts that whites are superior to people of color for biological or cultural reasons, and manifests in stereotypes, prejudices, and popular myths and beliefs. These typically include positive images of whiteness in contrast to negative images associated with people of color, such as civility versus brutishness, chaste and pure versus hyper-sexualized, and intelligent and driven versus stupid and lazy.

Sociologists recognize that ideology informs our actions and interactions with others, so it follows that racist ideology fosters racism throughout all aspects of society. This happens regardless of whether the person acting in racist ways is aware of doing so.

Resistance to Racism

Finally, Feagin recognizes that resistance to racism is an important feature of systemic racism. Racism has never been passively accepted by those who suffer it, and so systemic racism is always accompanied by acts of resistance that might manifest as protest, political campaigns, legal battles, resisting white authority figures, and speaking back against racist stereotypes, beliefs, and language. The white backlash that typically follows resistance, like countering "Black Lives Matter" with "all lives matter" or "blue lives matter," does the work of limiting the effects of resistance and maintaining a racist system.

Systemic Racism Is All Around Us and Within Us

Feagin's theory and all of the research he and many other social scientists have conducted over 100 years illustrates that racism is in fact built into the foundation of U.S. society and that it has over time come to infuse all aspects of it. It is present in our laws, our politics, our economy; in our social institutions; and in how we think and act, whether consciously or subconsciously. It's all around us and inside of us, and for this reason, resistance to racism must also be everywhere if we are to combat it.
Voices

Racism, Not Genetics, Explains Why Black Americans Are Dying of COVID-19

Some scientists and politicians have invoked baseless ideas about unknown genes, ignoring systemic inequality and oppression

By Clarence Gravlee on June 7, 2020

Credit: Getty Images

There is still plenty we don’t know about COVID-19, but one fact is inescapable: African Americans are disproportionately represented among the dead. Although the numbers are incomplete, the non-profit APM Research Lab estimates that, as of May 27, the

overall death rate from COVID-19 is 2.4 times greater for African Americans than it is for white people.

It is easy to lose sight of what this ratio really means, the human toll it represents. So let’s be clear: If Black people were dying at the same rate as white Americans, at least 13,000 mothers, fathers, daughters, sons and other loved ones would still be alive.

One would expect this staggering inequality to provoke outrage. For some, it has. But much of the public and scientific reaction has instead invoked baseless ideas about unknown genes that make African Americans vulnerable to the virus, rather than focusing on abundant evidence for the devastating biological consequences of systemic inequality and oppression.

The racist idea that vulnerability is intrinsic to blackness comes from politicians, scientists, physicians, and others. In an NPR interview, Louisiana Sen. Bill Cassidy, who was a medical doctor before entering politics, claimed, without providing evidence, that “genetic reasons,” among other factors, put African Americans at risk of diabetes and, therefore, of serious complications from COVID-19. Scientists writing in the *Lancet*, one of the world’s leading medical journals, suggested—also without evidence—that ethnic disparities in COVID-19 mortality may be partly attributable to “genetic make-up” and speculated on a “genomically determined response to viral pathogens.” Epidemiologists writing in *Health Affairs* noted that “that there may be some unknown or unmeasured
genetic or biological factors that increase the severity of this illness for African Americans.”

This racialized view of biology is not only wrong but harmful. (Nor is it new in medicine, as documented in Dorothy Roberts’s *Fatal Invention*, Rana Hogarth’s *Medicalizing Blackness* or Harriet Washington’s *Medical Apartheid.*) For starters, we know that race is a poor proxy for human genetic variation. Compared to other primates, humans exhibit remarkably little genetic variation—a consequence of our relatively recent origin as a species—and the variation that does exist is patterned geographically but not racially. Consider skin color, which varies gradually from the equator to the poles but never reveals a discrete break corresponding to distinct “races.” Genetic variation, moreover, does not come in neatly colored packages. For example, the genes that influence skin color are distributed independently of genes that influence the risk for any particular disease. Given the heterogeneity of groups we call “black” or “white,” treating those categories as proxies for genetic variation almost always leads us astray.

How, then, do we explain that “black” and “white” still predict biological endpoints like hypertension, diabetes or—now—COVID-19? The answer is straightforward: Human biology is more than the genome. Our environments, experiences and exposures have profound impacts on how our bodies develop, turning genetic potential into whole beings. Most of us learned this lesson in high school—phenotype is the product of genotype and environment—but we tend to forget it when it comes to race. If we take the lesson seriously, it becomes clear that systemic racism is as much a part of biology as genomes are: The conditions in which we develop—including limited access to healthy food, exposure to toxic pollutants, the threat of police violence or the injurious stress of racial discrimination—influence the likelihood that any one of us will suffer from high blood pressure, diabetes or serious complications from COVID-19.

Unfortunately, this whole-person view of biology remains uncommon even in fields where it should be widespread. Consider a highly cited 2006 paper in Human Genetics by Hua Tang and colleagues from the University of Washington and the University of California, San Francisco. The researchers analyzed data from the Family Blood Pressure Program, a sizeable clinical study, to test whether DNA-based estimates of genetic ancestry—which they tellingly dubbed “racial admixture”—predicted body mass index and blood pressure in Mexican American and African American adults. Tang and
colleagues concluded that their results were “suggestive of genetic differences between Africans and non-Africans that influence blood pressure,” though they acknowledged that genetic effects were likely to be small compared to environmental ones.

In suggesting a genetic basis of racial disparities in blood pressure, Tang and colleagues reprised a long-standing but unsubstantiated assumption that people of African ancestry are predisposed to hypertension. This assumption matters anew because some are invoking it to account for racial inequalities in death rates from COVID-19. Renã Robinson, a professor of chemistry at Vanderbilt University, told NPR that African Americans can be characterized as “potentially having genetic risk factors that make them more salt sensitive,” an apparent reference to a widely disseminated yet discredited hypothesis for hypertension, which suggests that the Atlantic slave trade created conditions favoring salt-retaining genotypes among enslaved Africans and their descendants. (Robinson noted there are likely to be additional causes.) In fact, billions of dollars’ worth of effort to find alleged genetic contributors to racial disparities in cardiovascular disease has turned up nothing.

The study by Tang and colleagues illustrates two common errors that allow racial-genetic thinking to persist. The first, remarkably, is that the study found no statistically significant relationship between African genetic ancestry and blood pressure. The suggestion of “genetic differences,” then, clearly reaches beyond the data. Such unwarranted inferences are not as rare as you’d think. In April, the Journal of Internal
*Medicine* published a paper asserting a genetic basis for racial differences in obesity without actual genetic evidence.

The second problem is more subtle. Recall that Tang and colleagues examined two biological variables—genetic ancestry and blood pressure. If they found an association, they assumed it was because of some unidentified genetic variants that (a) increase susceptibility to high blood pressure and (b) were more common in people of African ancestry. Yet they did not test that assumption, nor did they pursue the alternative possibility that biological associations could be driven by sociocultural processes.

It is easy to take the logic used by Tang and colleagues for granted. Most researchers assume that genetic ancestry is related to health through genetic effects. But what if genetic ancestry and blood pressure are linked because of systemic racism, rather than DNA? What if people with more African ancestry in a racist society are more likely to be poor (they are), to experience discrimination (they do), or to face any number of other stressors we know are associated with high blood pressure? Evidence indicates such connections are better explanations than alleged genetic differences.

Not long after the Tang study came out, Amy Non, then a Ph.D. student in anthropology at the University of Florida and now an associate professor at the University of California, San Diego, took a hard look at the underlying data from the Family Blood Pressure Program. She noticed a single, crude proxy for the wide-ranging consequences of systemic racism: educational attainment. Working with myself and Connie Mulligan, a genetic anthropologist and Non’s advisor at Florida, she replicated Tang and colleagues’ analysis of genetic ancestry and blood pressure but added years of education as another variable. Whatever evidence there might have been for a genetic effect evaporated. Instead, as we reported in the *American Journal of Public Health*, every additional year of education was associated with an 0.51 mmHg drop in blood pressure, on average. Genetic ancestry added nothing.
In the time of COVID-19, this finding is a reminder that genetic ancestry might matter only because we think it should. If we assume that people who are racialized as “black” or “white” are fundamentally different and treat them accordingly, the paradoxical result is that it will produce the very biological differences we presumed to exist in the first place. But it’s not because of any deep-seated differences in our DNA. It’s because our social structures and attitudes promote the well-being of some and devalue others.

In his NPR interview, Cassidy downplayed the role of systemic racism as a root cause of COVID-19 inequalities. “That’s rhetoric, and it may be,” he said. “But as a physician, I’m looking at science.” However, the science does not say what Cassidy thinks it does. Thanks to decades of careful research, we know that what we gloss as “race” corresponds poorly to genetic variation, and we know that racism is deadly. An ethical, scientific response to COVID-19 demands that we honor the highest standards of evidence in evaluating genetic guesswork, while measuring the biological costs of systemic racism and intervening to stop it.

Read more about the coronavirus outbreak from Scientific American here. And read coverage from our international network of magazines here.

The views expressed are those of the author(s) and are not necessarily those of Scientific American.
Racism is an ongoing public health crisis that needs our attention now

Date: May 29 2020
FOR IMMEDIATE RELEASE
Contact: APHA Media Relations, 202-777-3913

Statement from APHA Executive Director Georges Benjamin, MD

"I can't breathe."

With those last words, George Floyd, an unarmed, handcuffed black man, died this week after being pinned down by a white Minneapolis police officer, an atrocious action that has sparked outrage throughout the nation.

We raise our voices, too, horrified, stunned and angered.

We are appalled but are not surprised by the despicable way Floyd was killed. We weep for the man, his family and a country that continues to allow this to happen. We also join in the chorus for justice and ring the alarm to all Americans. Racism is a longstanding systemic structure in this country that must be dismantled, through brutally honest conversations, policy changes and practices.

Racism attacks people's physical and mental health. And racism is an ongoing public health crisis that needs our attention now!

We see discrimination every day in all aspects of life, including housing, education, the criminal justice system and employment. And it is amplified during this pandemic as communities of color face inequities in everything from a greater burden of COVID-19 cases to less access to testing, treatment and care.

Americans cannot be silent about this. As Martin Luther King, Jr. observed, "The ultimate tragedy is not the oppression and cruelty by the bad people but the silence over that by the good people."

We refuse to be silent, and we call for you to join us in our advocacy for a healthier nation. At the American Public Health Association, every moment of our waking hours is poured into finding better, more healthful lives for all, so everyone has a chance to breathe. It's our life-blood.

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IV
New Business
Item 2
Health Officer Recommendations Re: Variance Request to Move from Phase 2 to Phase 3 of Safe Start Washington Plan

June 18, 2020
June 11, 2020

To: Jefferson County Board of Health
From: Tom Locke, MD, MPH, Jefferson County Health Officer

Re: Health Officer Recommendations Regarding Application to Move from Phase 2 to Phase 3 of the Safe Start Washington Reopening Plan

Background: In response to the unprecedented public health crisis created by the SARS-CoV-2 pandemic, Governor Jay Inslee ordered a series of school and business closures and restrictions on community activity to halt the exponential spread of coronavirus and prevent a surge of case from overwhelming the health care system. This strategy has been a modified success, allowing for a gradual reopening of businesses and a cautious return to civic life. This success is precarious, however, as the virus continues to circulate within the state and nation and the risk of a resurgence is ever present. On May 5th, the Governor introduced his Safe Start Washington plan that envisioned a 4 phase reopening process. Jefferson County was one of the first counties in Western Washington to become eligible to move quickly from Phase 1 to Phase 2 and began a deliberative process that ended in the Jefferson County Board of Health voting on May 21st to submit a variance request. The Board of County Commissioners passed a companion resolution the next day and the variance request was approved on May 23rd. A number of businesses opened immediately, restaurants reopened on June 1 after Kitsap and Clallam Counties had done so. Overnight camping remains closed until the Clallam County Board of Health votes to open their parks to camping.

Process for Phase 3 Variance Application: A county becomes eligible for Phase 3 application 3 weeks after beginning Phase 2. For Jefferson County this date in June 13. As before, the process begins with a Health Officer recommendation to apply for reopening of all Phase 3 activities, a subset of services, or not apply for the variance. The Health Officer recommendation is followed by a Board of Health resolution and finalized with a vote of the Board of County Commissioners. The the Phase 3 variance application is even more detailed that the Phase 2 application and requires data and testimonials documenting the ability to response to surges in COVID-19 cases with prompt case investigation and contact tracing, case management of patients placed in isolation and contacts under quarantine, and adequate hospital resources to deal with a surge in medical needs. Various performance targets are set for testing levels, case levels, and outbreaks. Notably, the Phase 3 application asks for an explicit commitment by the Board of Health to provide ongoing resources to support case investigation and contact tracing.

Benefits of Moving from Phase 2 to Phase 3: Under Phase 3 high-risk populations are strongly encouraged (but not required) to stay home unless engaging in Phase 1, 2, or 3 permissible activities. Outdoor recreational and sports groups can increase to involve up to 50 people. Indoor recreational facilities can function at <50% capacity. Non-religious gatherings can include up to 50 people and non-essential travel can resume. Restaurants/taverns can increase from <50% to <75% capacity and bar areas in restaurant/taverns can open at <25% capacity. Theaters can open at <50% capacity. Customer-facing governmental services can resume. Libraries and museums can reopen. All other businesses except for nightclubs and events with >50 people can also reopen. All of these activities
allow the return to a more normal level of community life and allow businesses to operate at a more economically sustainable level. The social, cultural, and economic benefit of these changes to the community is substantial.

Risks of Moving from Phase 2 to Phase 3: A great deal of work has gone into detailed guidelines for businesses and community organizations to return to modified activity while controlling transmission of pandemic coronavirus. Most people have taken this guidance to heart and are carefully following physical distancing, masking, hand hygiene, cough etiquette and other disease control strategies. Others have chosen to ignore these restrictions either out of indifference or, in some cases, a misguided expression of personal liberty or partisan opposition to governmental directives. As with vaccinations and other public health interventions, if a majority of community members are responsible and diligent, they can offset the risky behaviors of a minority. Risk is a gradient and as risk increases, the likelihood of COVID-19 transmission increases. Given the markedly expanded opportunity for transmission that Phase 3 activities allow, additional cases of COVID-19 are inevitable. One important variable in the successful implementation of a Phase 3 reopening is the ability of the public health-medical care partnership to quickly diagnose, treat, and isolate new cases of COVID-19 and rapidly identify and quarantine their contacts. Jefferson County is fortunate to have a highly experienced team of CD epi (communicable disease epidemiology) investigators and a very well-organized team of health care practitioners at Jefferson Healthcare to provide medical case management and hospital services, when needed. Plans are in place to provide isolation and quarantine services for those who are not able to isolate or quarantine at home.

The most important variable of all, and the most uncertain, has to do with community behavior. While adherence to social distancing and shelter-at-home directives were remarkably high in the early days of the pandemic, adherence to these restrictions seems to be diminishing as people develop “quarantine fatigue”. Some community members have chosen to believe that the pandemic is over. Some have chosen to believe that violation of physical distancing and masking directives is an expression of personal liberty and risks only their personal health. They are wrong on both accounts.

COVID-19 activity in Jefferson County remains remarkably low. There have been only two additional cases added to Jefferson County’s tally since Phase 2 began on May 23rd. One of these cases occurred in a Jefferson County resident travelling in Arizona where she contracted the disease, was hospitalized, and recovered. The other case was a child with asymptomatic COVID-19 infection discovered during a pre-surgical screening test. Phase 3 will bring increased risks of transmission. This will either be offset by a growing adherence to physical distancing and respiratory protection measures or it will not. The public health-medical care partnership can quickly react to new cases but it cannot prevent them. That power rests solely with the public. Each community member must make and sustain behavioral changes for the duration of the pandemic. People have to be alert to the earliest signs of infection, consent to testing, and, if found to be infected, cooperate with isolation and quarantine restrictions until they are no longer infectious. And to do this they need the support of their fellow community members – to provide food deliveries, run errands, and offer psychological support.

Moving to Phase 3 is not just a test of our public health and health care systems, it is a test of the community’s will to pull together and make sacrifices for the good of the community at large. Those who don’t “believe” in masks or social distancing are up against a virus that is incapable of caring what they believe. The virus spreads person to person when the right conditions exist for transmission. People who appear completely well can carry the virus without knowing it and spread it to others with the mere act of face to face conversation. And right now, in the grand evolutionary scheme of things,
the pandemic coronavirus is winning. COVID-19 is spreading at an accelerating pace around the world and the death toll is mounting. Some countries have successfully brought it under control by a disciplined application of communicable disease control strategies. The United States is not one of these countries. COVID-19 cases are increasing in 21 states, most of whom are aggressively reopening their businesses and other activities despite a failure to adequately control the spread of infection. As summertime travel increases, the infection will inevitably spread across state lines. And there is the matter of an expected second wave of COVID-19 in September. A preview of this is about to occur in some areas of the Southern Hemisphere where COVID-19 is spreading rapidly and Winter is approaching.

Health Officer Recommendation: Risk can never be eliminated; it can only be controlled. The time will never be better than it is now to further open businesses and community activities. The warming weather and greater amount of time spent outdoors reduces the risk of virus transmission. We have learned a lot as a community about pandemic response. The public health and medical care systems are prepared. Emergency management and volunteer networks are ready to respond. The community is eager for greater freedom. Businesses need to survive and, hopefully, prosper. Phase 3 will be an extraordinary challenge, more difficult than many imagine. But challenges are best met head on, not deferred.

I recommend the Jefferson County Board of Health move forward with a full Phase 3 variance application without restriction.
Board of Health

IV
New Business
Item 3
Draft Jefferson County Board of Health Variance Plan Request

June 18, 2020
Resolution of the Jefferson County Board of Health
June 18, 2020

The Jefferson County Board of Health, having reviewed the recommendations of the Jefferson County Health Officer, hereby resolves to authorize the Jefferson County Public Health Director to submit a variance application to the Washington State Department of Health to move from Phase 2 to Phase 3 of the Safe Start Washington phased reopening plan without restriction.

Phase 3 Variance activities applied for:

High Risk Populations: Strongly encouraged, but not required, to stay home unless engaging in Phase 1, 2, or 3 permissible activities

Recreation: Outdoor group recreation and sports activities (50 or fewer people) and Recreational facilities at <50% capacity (gyms, public pools, etc.) allowed

Gatherings (non religious): Allow gatherings with no more than 50 people

Travel: Resume non-essential travel

Business/Employers (required to follow safety plans written by the State):
Restaurants/taverns <75% capacity/table size no larger than 10. Bar areas in restaurants/taverns a <25% capacity. Theaters at <50% capacity. Customer-facing government services resume (telework remains strongly encouraged). Libraries and museums reopen. All other business activities not yet listed except for nightclubs and events with greater than 50 people.

The Jefferson County Board of Health further recommends that Jefferson County commit to ongoing funding of case management, contact tracing, and needed isolation and quarantine support services as an essential component of Jefferson County’s pandemic coronavirus response efforts.

Member votes:

# Yea _______  # Nay _______  # Abstaining _______  # Absent _______

Signed: ________________________________
Sheila Westerman, Chair

Date: 05/21/20

Board Members
Sheila Westerman, Chair, Citizen at Large; Pamela Adams, Vice Chair, City of Port Townsend City Council; Kate Dean, Member, County Commissioner District #1; David Sullivan, Member, County Commissioner District #2; Greg Brotherton, Member, County Commissioner District #3; Denis Stearns, Member, Citizen at Large; Kees Kolff, Hospital Commissioner, District #2

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