State Board of Health Quarterly Meeting

June 11th, 2026

Gloucester Point, Virginia

WELCOME AND INTRODUCTIONS

AGENDA

Agenda

Call to Order and Welcome	**Michael Desjadon**, Chair
Introductions	**Mr. Desjadon**
Review of Agenda	**Katelyn Briguglio, MPH** Policy Administrator
Approval of March 19th, 2026 Minutes	**Mr. Desjadon**
Commissioner's Report	**B.Cameron Webb, MD** State Health Commissioner
Regulatory Action Update	**John Kotyk** Legislative and Regulatory Coordinator
Public Comment Period	
Lunch Presentation: Office of Environmental Health Services & Three Rivers Health District Program Highlights	**Brenden Rivenbark** District Director, Three Rivers Health District **David Fridley** Environmental Health Manager, Three Rivers Health District **Holly Balderson, RN** Nurse Manager, Three Rivers Health District
<u>Regulatory Action Item:</u> Proposed Amendments: Regulations for the Licensure of Nursing Facilities (12VAC5-371)	**April Dovel, MSW, MBA** Director, Office of Licensure and Certification

Agenda cont.

Non- Regulatory Action Items: Decision Memo: Trauma Designation Adoption of the American College of Surgeons (ACS) Verification Model for Virginia Trauma Center Designation	**Ashley Camper** Trauma and Critical Care Program Manager, Office of Emergency Medical Services **Paula A. Ferrada, MD** Chair, State Emergency Medical Services Advisory Board
Presentation: JCHC Pharmacy Presentation	**Jen Piver-Renna, PhD** Deputy Director, Joint Commission on Health Care
Presentation: DMAS Pharmacy Presentation	**Greg Barabell, MD** Chief Medical Officer, Virginia Department of Medical Assistance Services **JoeMichael Fusco, PharmD** Pharmacy Operations Manager, Virginia Department of Medical Assistance Services
Electronic Meeting Policy	**Ms. Briguglio**
Report of Nominating Committee	**Dr. Lee Jones** Chair, Nominating Committee
Other Business	
Adjourn	

MINUTES FROM MARCH 19, 2026

State Board of Health Meeting
March 19th, 2026 - 9:00am
Perimeter Center,
Boardroom 2

Members Present: James Cole; Douglas Daniels, DVM; Michael Desjadon, Chair; Kevin Dillard, MBA; Julie Henderson; Lee Jones, DMD; Melissa Nelson, MD, Vice Chair; Walter Vest, MD; Cindy Warriner, BS, RPh, CDCES; and Thomasena Wicker, PhD.

Members Absent: Ann B.R. Vaughters, MD

Virginia Department of Health (VDH) Staff Present*:* Katelyn Briguglio, Policy Administrator; Michael Capps, Director of Policy and Planning; Stephanie Dunkel, Deputy Commissioner for Population Health and Preparedness; Charlotte Fajardo, Executive Assistant; Susan Fischer-Davis, MD, Chief Deputy Commissioner for Community Health Services; Breanne Forbes-Hubbard, Workforce Development and Engagement Director; Laurie Forlano, D.O., Director of the Office of Epidemiology; Kaitlyn Gentile, Strategic Initiatives Coordinator Sr.; Lance Gregory, Director of the Office of Environmental Health Services, Joe Hilbert, Deputy Commissioner for Governmental and Regulatory Affairs; Caitlin Hodge, Agency Star; John Kotyk, Legislative and Regulatory Coordinator; Arman Latif, Chief Information Officer; Wayne Perry, Deputy Director of Operations, Office of Emergency Medical Services; Maria Reppas, Director of Communications; John Ringer, Chief Financial Officer; John Sweat, Agency Star; B. Cameron Webb, MD, JD, State Health Commissioner, Khalida Willoughby, Director of Center for Community Health Improvement

Other Staff Present: Karen Cameron, Senior Health Policy Analyst, Virginia Commonwealth University & VCU Health System; Darrell Kuntz, Assistant Attorney General, Office of the Attorney General; Robin Kurz, Senior Assistant Attorney General, Office of the Attorney General; Allyson Tysinger, Deputy Attorney General, Office of the Attorney General

Call to Order

Mr. Desjadon called the meeting to order at 9:02 am and led all present in the Pledge of Allegiance.

Introduction

Mr. Desjadon welcomed those in attendance to the meeting. Mr. Desjadon then started the introductions of the Board members and VDH staff.

Review of Agenda

Ms. Briguglio reviewed the agenda and the items contained in the Board's binder.

Approval of December 12th Meeting Minutes

The minutes from the December 12th meeting were reviewed.
Motion: Mr. Dillard moved to approve the December 12th meeting minutes, seconded by Dr. Vest.

Final Action: The motion was approved unanimously by roll-call vote (10-Y, 0-N).

Commissioner's Report

Dr. Webb provided the Commissioner's Report to the Board. He updated the Board on key issues and projects VDH is engaged in including:

- Commissioner Introduction
- Agency Stars
- Key Personnel Changes
- Infectious Disease Update
- Commissioner's 75 Day Listening Tour
- Pediatric Vaccination Update
- Northeast Public Health Collaborative
- Federal Funding Update
- Ryan White Program
- Office of Licensure Update
- Workforce Stabilization
- Preparedness Update
- Strategic Initiatives and Capacity Alignment
- Rural Health Transformation Grant
- Maternal Health Update

During the topic of ACIP and HHS Immunization updates, Dr. Nelson discussed a children's vaccine resource from the Children's Hospital of Philadelphia (CHOP) that provides great information to help educate parents and build confidence around medical decisions for their children.

There was discussion regarding agency strategies for addressing the backlog of recertification surveys and increasing complaints received by the Office of Licensure and Certification (OLC). OLC is working to grow and fill the number of positions to address this issue and is stratifying complaints when collecting data to best prioritize cases that need immediate attention.

There was discussion regarding the Potomac River Sewage Spill, including the agency's response, collaboration with partners in the region, and monitoring of shellfish. Mr. Desjadon stated that during the next Board of Health meeting, in Three Rivers Health District, Board members will be learning more on the topic of shellfish sanitation.

Regulatory Action Update

Mr. Kotyk reviewed the summary of all pending VDH regulatory actions. There are 53 pending actions under development:

- 10 NOIRAs
- 2 Emergency/NOIRAs
- 17 Proposed Actions
- 5 Final Actions

- 19 Fast Track Actions

There were no Regulatory Actions Taken by the Commissioner on Behalf of the Board pursuant to § 32.1-20 of the Code of Virginia since the December 12th, 2025, Board Meeting while the Board was not in Session.

There were no Non-Regulatory Actions Taken by the Commissioner on Behalf of the Board pursuant to § 32.1-20 of the Code of Virginia since the December 12th, 2025 Board Meeting while the Board was not in Session.

Mr. Kotyk advised the Board that there are 5 periodic reviews in progress:

- 12 VAC 5-125: Regulations for Bedding and Upholstered Furniture Inspection Program
- 12 VAC 5-371: Regulations for the Licensure of Nursing Facilities
- 12 VAC 5-381: Home Care Organization Regulations
- 12 VAC 5-475: Regulations Implementing the Virginia Organ and Tissue Donor Registry
- 12 VAC 5-620: Regulations Governing Application Fees for Construction Permits for Onsite Sewage Disposal Systems and Private Wells

Mr. Desjadon asked if there is an update on the pending Noice of Intended Regulatory Action for Regulations Governing Biological Sex Specific or Separated Spaces and Activities (12VAC5-660). Mr. Kotyk deferred to counsel's response. Ms. Tysinger recommended that the Board go into closed session to receive legal advice the NOIRA.

Motion: Ms. Warriner made a motion to go into closed session to seek legal advice, pursuant to § 2.2-3711(A)(8), in the matter of 12VAC5-660 and that Dr. Webb, Ms. Kurz, Ms. Tysinger, Ms. Briguglio, Mr. Hilbert, and Mr. Capps join the Board for closed session. That motion was seconded by Dr. Vest.
Final Action: The motion was approved unanimously by roll-call vote (10-Y, 0-N).

The closed session took place in Board Room 1 at the same location. After the closed session, the Board returned to Board Room 2.

Motion: Dr. Nelson moved to return to regular session and certify that only public business matters lawfully exempted from open meeting requirements and only such public business matters as were identified in the motion for closed session were heard, discussed or considered during the closed session just concluded. The motion was seconded by Dr. Vest.
Final Action: The motion passed by unanimous roll-call vote (10-Y, 0-N).

Legislative and Budget Update – 2026 General Assembly (GA)

Mr. Kotyk provided the Board with an overview of the recent GA session. VDH initially had 145 Lead and Comment bills and prepared 178 Initial and revised Legislative Action Summaries and 69 Enrolled Bill Reviews.

As a result of the 2026 General Assembly session, pending the reconvened session and the

Budget special session, the VDH will implement approximately:

- 15 new reports;
- 25 regulatory action items;
- 10 new or expanded programs.

The GA will reconvene on April 22, 2026, to consider the Governor's vetoes and recommended amendments on legislation. Mr. Kotyk shared information on Agency Bills that were passed and other bills of note.

The legislature did not agree on a budget for the 2026 session by the date of this meeting. Mr. Ringer and Ms. Gilliam, the Director of the Office of Budget, will provide a presentation on the VDH budget at the June 11, 2026 Board of Health meeting.

Ms. Warriner and Mr. Dillard complimented VDH staff for the communications sent and the hard work put into this session.

Mr. Dillard asked if there are any unfunded mandates or resource challenges that could impact legislation enacted during the 2026 Session. Mr. Hilbert said that once there is a better understanding of the budget, the agency would provide that information as part of the Budget presentation at the June meeting.

Mr. Cole inquired about the role VDH, and the Board may have in the Pharmacy Drug Affordability Advisory Panel pursuant to HB 483 and SB 271 and if the Panel could contribute to an issue in accessing certain drugs. Mr. Capps stated that the Board of Health's role was removed in amendments to the original bills and that the authority to impose Upper Price Limits was also removed and was not included in the bills they passed. The bills do set certain maximum fair prices (MFPs), specifically tied to MFPs set by the federal government via Medicare negotiations.

Ms. Warriner noted that prescription access and affordability are intertwined, she asked if there would be an opportunity for a State Board of Health member or VDH staff member to have a seat on the Advisory Panel, so the Board of Health would be kept informed of the PDAAP's actions, and asked if the legislation lists who would be on the PDAAP.

Mr. Hilbert read the relevant legislation language stating the panel shall have a total of six members that shall consist of five nonlegislative citizen members and one ex officio member. The language does not specify that VDH or the Board have a seat but does specify the required expertise of members.

Dr. Jones inquired about if the Board had any emergency regulations emerge from the 2026 General Assembly session. Mr. Kotyk noted that there are no emergency regulations anticipated, but there are some regulations that have deadlines for enactment, and some regulations with Administrative Process Act (APA) exceptions.

Public Comment Period

There were 2 people signed up for the public comment period.

Sarah Ramsey, a citizen from the Commonwealth, shared her concerns regarding water fluoridation. She reviewed and cited legislative codes related to the oversight of the VDH and requested that the agency's recommendation to fluoridate be nullified. Ms. Ramsey submitted written comment that can be found at the end of these minutes.

Narissa Rahaman, Executive Director of Equality Virginia, discussed risks and data for LGBTQ populations regarding health. She asked VDH to consider collaborating with Equality Virginia to advance LGBTQ healthcare for LGBTQ people in the Commonwealth. Ms. Rahaman also noted opposition to the 12VAC5-660 regulatory action.

Lunch Presentation:
Karen L. Cameron, Chair of the State Health Services Plan (SHSP) Task Force, provided an overview of the Task Force's role and activities, including legislation enacted by the 2026 General Assembly which provided the Task Force with additional responsibilities. Ms. Cameron described the Task Force's committee structure and planned next steps. Ms. Cameron highlighted the Task Force's recent work concerning expedited review of Certificate of Public Need (COPN) applications.

Mr. Dillard thanked Ms. Cameron for the presentation and asked if freestanding emergency rooms (ERs) fall under COPN or Chapters 712 and 722 of the 2022 Acts of Assembly. Ms. Cameron noted that freestanding ERs are not specifically regulated by COPN or affected by the noted legislation, but that they operate under the license of the hospital that owns the ER.

There was discussion on the definition of "medical deserts," how to use the COPN process to alleviate health care disparities in "medical deserts," and the current data available for mapping these areas. Ms. Warriner requested to see a medical desert map from the Task Force when it is completed.

Proposed Amendments: Rules and Regulations Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501)
Lance Gregory presented Rules and Regulations on Governing the Construction and Maintenance of Migrant Labor Camps (12VAC5-501). The proposed amendment includes the addition of sections related to migrant labor camp operations including general sanitation and maintenance requirements, provisions for heating and cooling, food handling, safety and health, and the reporting of communicable disease. Many of the changes refine and provide further clarity to existing regulations, including general administrative provisions (definitions, variances, and permitting), inspections and enforcement, and references to federal standards and exemptions, water supplies, sewage disposal, trash and garbage, storage of hazardous materials, and compliance with building and fire codes. Mr. Gregory noted that Briana Bill of his staff, who manages the program, had spent a significant amount of time working closely with a diverse group around 50 stakeholders to come to consensus on the language being presented.

Motion: Dr. Jones moved to approve the Proposed Amendments, seconded by Ms. Henderson.

Discussion: There was discussion regarding the cooling requirements of this regulation, with inquiries about how neighboring states compare and if there is a cost and labor impact as a result. There was also discussion of outreach efforts to owners of migrant labor camps for awareness in the change of regulation.

Final Action: The motion passed by roll-call vote (9 Y, 0-N, 1-Abstention: Wicker).

Final Regulations: Prescription Drug Price Transparency Regulation (12VAC5-219)

Mr. Latif presented Final Prescription Drug Price Transparency Regulations (12VAC5-219). This Final Regulation governs the collection, reporting, and auditing of prescription price drug information provided by specific entities such as health carriers, pharmacy benefits managers, manufacturers, and wholesale distributors.

Motion: Mr. Dillard moved to approve the Final Regulation, seconded by Dr. Nelson.

Discussion: Ms. Warriner noted that the Department may get comments regarding the requirement to collect information from distributers on "all" drug products (12VAC5-219-80), because "all" drugs may not be available to patients in the Commonwealth, even with price transparency. Ms. Warriner also anticipates that the public may ask about rebates, as the process to fully understand the real cost of prescription drugs is complex. She also mentioned that the pharmacy dispensing fee was not included, but that is part of what contributes to pharmacy deserts. Mr. Hilbert noted that the reporting requirements in the regulation track closely to the enabling legislation. Ms. Warriner thanked the Department for their work on the regulation and did not wish to make any changes to the language.

Final Action: The motion passed unanimously by roll-call vote (10-Y, 0-N).

Board of Health Annual Report

Ms. Briguglio and Ms. Gentille presented the Board of Health Annual Report.

Motion: Ms. Warriner moved to approve the Board of Health Annual Report seconded by Mr. Cole.

Discussion: The Board and VDH staff discussed the importance of gathering data related to vaccinations regarding disease outbreaks such as measles, the importance of herd immunity, and the sensitivity of identifiable health information. Dr. Vest noted that the department seemed to be focusing on a variety of health outcomes, with limited change, and suggested focusing heavily on a smaller range of targeted health indicators. Dr. Vest and Mr. Desjadon also suggested examining the work of neighboring states and community partners to see what VDH can learn from them. There was discussion regarding evaluation of focus areas, types of data being collected by VDH and external partners and maximizing impact among the Commonwealth.

Dr. Jones inquired about the impact of moving certain workforce incentive programs at VDH to the Virginia Health Workforce Development Authority as a result of the 2026 General

Assembly. Ms. Dunkel expressed support for the relocation of those programs and noted the programs that will stay under VDH, including the Dental Scholarship Program, which is still unfunded. Dentists are eligible for awards under the State Loan Repayment Program (SLRP).

Mr. Desjadon generally discussed public-private partnerships, including one population health organization that focuses on blood pressure as their priority health outcome, noting improvements in related outcomes. Additionally, Mr. Desjadon discussed youth suicide and mental health, noting that often the problem is not with having beds for inpatient care in medical facilities, but other gaps in the system of care.

Motion to Amend: Mr. Desjadon moved to add a recommendation to the Annual Report's in the "Youth Suicide Prevention" section to "explore public-private partnerships to close care and communication gaps between schools, parents, and care resources." The motion was seconded by Dr. Vest. Mr. Desjadon clarified that "schools" includes colleges and universities.
Vote on Amendment: The motion passed by roll-call vote (10-Y, 0-N).

Final Action: The motion to approve the Board of Health Report, as amended, passed unanimously by roll-call vote (10-Y, 0-N).

Interim State Emergency Medical Services (EMS) Plan Extension
Mr. Perry presented the Interim State Emergency Medical Services (EMS) Plan Extension.

Motion: Mr. Dillard moved to approve the extension of the current Interim State EMS Plan and authorize the Office of Emergency Medical Services, in coordination with the State EMS Advisory Board, to initiate and complete an 18-month State EMS System and Community Needs Assessment aligned with *EMS Agenda for the Future 2050.* The motion was seconded by Dr. Vest.

Discussion: Ms. Henderson asked about use of the Agency for Toxic Substances and Disease Registry **(**ATSDR) social vulnerability index for equity focus analysis, stating that it seemed specific and other models are used elsewhere. Ms. Dunkel shared that the model is in alignment with Centers for Disease Control and Prevention (CDC) and VDH practices.

Final Action: The motion passed unanimously by roll-call vote (10-Y, 0-N).

2026-2030 Plan for Well Being:
Ms. Willoughby presented the 2026-2030 Plan for Well-Being.

There was a discussion of resources available to Board members for accessing data from the Plan for Well-Being and the frequency of reporting. Ms. Willoughby noted that the 2026 Annual Report will contain such data and noted the upcoming launch of the Plan for Well Being website. Members also discussed the intersectionality of various health factors and chronic diseases highlighted in the Plan. Ms. Willoughby noted that, although the Plan specifically identifies a limited number of priority areas, these categories encompass a broader range of conditions and diseases that will be monitored as part of the overall initiative, and many include strategies specifically related to chronic disease. She further

provided information on external partnerships across Virginia, including clinical, faith-based, and community-based organizations, that were leveraged in the development of the Plan.

Appointment of Nominating Committee:

Mr. Desjadon appointed Dr. Lee Jones, Dr. Walter Vest, and Mr. Kevin Dillard to the nominating committee. Dr. Jones will serve as the chair of the nominating committee. The nominating committee will meet in June prior to the Board meeting to recommend a slate of officers for the Board.

Other Business:

Dr. Vest commented that the Joint Commission on Health Care (JCHC) and Department of Medical Services (DMAS) studies provided to Board members in response to the resolution passed at the December 12, 2025, meeting address many of the questions raised by the Board at previous meetings throughout 2025.

Mr. Capps provided information to the Board regarding the agenda for the June 2026 Board of Health travel meeting. The June meeting will take place at the Virginia Institute for Marine Science (VIMS), within the Three Rivers Health District, on June 10th and 11th. The Board of Health meeting will take place on June 11th, and the Board will have site visits and presentations scheduled on June 10th.

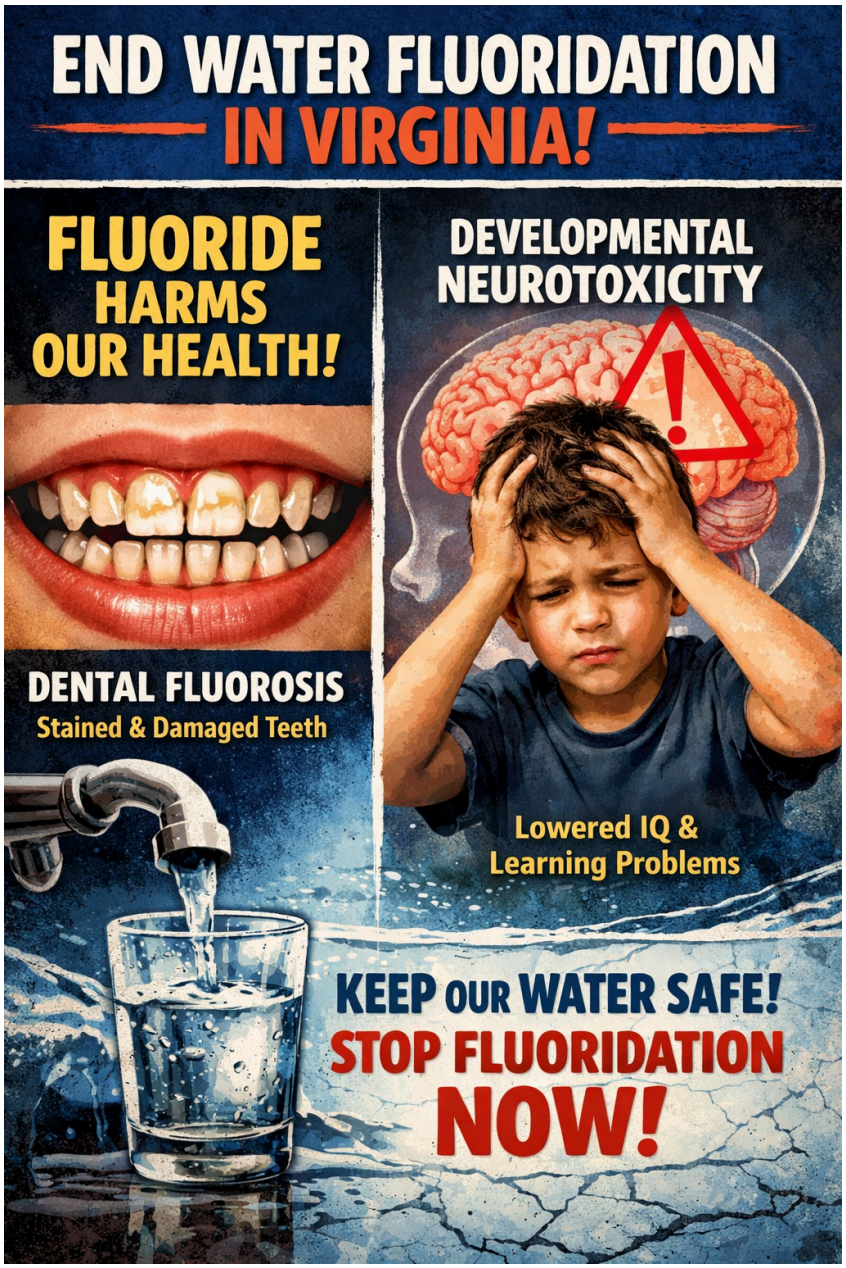
Adjourn

Motion: Ms. Warriner moved that the meeting adjourn, seconded by Dr. Vest.
Final Action: The motion passed unanimously

The remainder of the document is written comment submitted at the Board meeting. It may not reflect the position or opinions of the Board or members.

For the Record - Public Comment Handout

Quarterly Board of Health Meeting
Perimeter Center 9960 Mayland Drive,
Richmond, VA 23233
Boardroom 2 located on the 2nd floor



2 Minutes VDH Speech

In 1950 a law was passed to ensure **pure water** in the Commonwealth - that law stands today.

§ 32.1-170. Regulations states:

> "The regulations of the Board governing waterworks, water supplies, and **pure water** shall be designed to protect the public health"

Using the **"Best Interpretation Doctrine"**, it's clear that the intent of this law is to remove contaminations from the water to make it safe to drink.

Nowhere in this **"Pure Water Law"** does it say that the board shall govern fluoridation.

If the Legislature wanted to allow localities in VA to use the waterworks as a mechanism to mass medicate the public, then they would have passed this Bill in 1952.

The General Assembly did not pass this bill - instead the legislators stuck with the law that promoted **"Pure Water"**. The legislators chose laws that treated water - not people.

This means that - **12VAC5-590-930. Fluoridation -** which describes the board recommending fluoridation is an unlawful regulation that needs to be nullified immediately.

Recommending fluoridation after a federal judge ruled it to be an unreasonable risk is reckless disregard.

In 2025, more than a month's worth of fluoride was released into the drinking water in a matter of hours. You knew the risks and you recommended it anyway. That's child abuse.

You are responsible for protecting public health—not exceeding authority.

Tear up this regulation before more people get hurt.

§ 32.1-170. Regulations.

A. The regulations of the Board governing waterworks, water supplies, and **pure water** shall be designed to protect the public health and promote the public welfare and shall include criteria and procedures to accomplish these purposes.

The regulations may include, without limitation:

1. Requirements and procedures for the issuance of permits required by this article;

2. Minimum health and aesthetic standards for pure water;

3. Minimum standards for the quality of water which may be taken into a waterworks;

4. Criteria for the siting, design, and construction of water supplies and waterworks;

5. Requirements for inspections, examinations, and testing of raw or finished water;

6. A requirement that owners submit (i) regular samples of water for bacteriological, chemical, radiological, physical, or other tests or (ii) the results of such tests from such laboratory as may be acceptable to the Commissioner;

7. Requirements for record keeping and reporting;

8. Methodology for determining the waterworks operation fee authorized by § 32.1-171.1;

9. Requirements and criteria for the development and maintenance of an emergency management plan for each community public water supply for the provision of pure water during any extended power outage; and

10. Such other provisions as may be necessary to guarantee a supply of pure water.

B. The regulations of the Board governing waterworks, water supplies, and pure water shall include a procedure whereby waterworks serving fewer than 10,000 people may seek and the Board may grant a waiver of any requirement that the waterworks mail copies of its consumer confidence report to each customer of the waterworks at least once annually. In such cases, the waterworks owner shall publish, by July 1 of each year, in a newspaper of general circulation serving the area served by the waterworks, and by such other means as the Board may deem appropriate, (i) a copy of the consumer confidence report, (ii) notice that copies of the consumer confidence report will not be mailed to customers of the waterworks, and (iii) notice that copies of the consumer confidence report shall be made available to the public upon request. The waterworks owner shall certify compliance with the requirements of this subsection to the Board no later than October 1 of each year.

Code 1950, §§ 62.1-47, 62.1-48, 62.1-51; 1964, c. 475; 1968, c. 659; 1977, c. 7; 1979, c. 711; 1992, c. 804; 2004, c. 317; 2011, cc. 804, 843.

§ 32.1-167. Definitions.

"Pure water" means water fit for human consumption that is (i) sanitary and normally free of minerals, organic substances, and toxic agents in excess of reasonable amounts and (ii) adequate in quantity and quality for the minimum health requirements of the persons served.

12VAC5-590-930. Fluoridation.

A. The board **recommends** that all community waterworks in Virginia be optimally fluoridated. Fluoridation feed systems shall be designed to deliver the optimum fluoride ion concentration as determined by the U.S. Department of Health and Human Services.

§ 2.2-4026. Right, forms, venue; date of adoption or readoption for purposes of appeal.

A. Any person affected by and claiming the **unlawfulness** of any **regulation** or party aggrieved by and claiming unlawfulness of a case decision and whether exempted from the procedural requirements of Article 2 (§ 2.2-4006 et seq.) or 3 (§ 2.2-4018 et seq.) shall have a right to the direct review thereof by an appropriate and timely court action against the agency or its officers or agents in the manner provided by the Rules of Supreme Court of Virginia. Actions may be instituted in any court of competent jurisdiction as provided in § 2.2-4003, and the judgments of the courts of original jurisdiction shall be subject to appeal to or review by higher courts as in other cases unless otherwise provided by law. In addition, when any regulation or case decision is the subject of an enforcement action in court, it shall also be reviewable by the court as a defense to the action, and the judgment or decree therein shall be appealable as in other cases.

Reasons to End Water Fluoridation
A Science-Based Assessment

https://fluoridealert.org

https://fluoridealert.org/wp-content/uploads/2025/07/Reasons-to-End-Water-Fluoridation.pdf

Background

Fluoride is used to treat people - not water.

Fluoride is defined as a drug under 21 U.S.C. § 321(g)(1)(B).

There is no Statute in Virginia that authorizes a locality to put drugs, *including fluoride*, into the public drinking water.

Additionally, there is no Statute that authorizes the VDH "board" to *require* or *recommend* that a locality put drugs in the public drinking water.

12VAC5-590-930 (Fluoridation) does not have a stated purpose or justification.

Moreover, **12VAC5-590-930 (Fluoridation)**, promulgated by the Virginia Department of Health, cites **§§ 32.1-12 and 32.1-170 of the Code of Virginia** as its statutory authority, yet neither statute expressly authorizes the fluoridation of public drinking water. Administrative regulations must be grounded in a clear delegation of authority from the General Assembly and cannot create powers that the legislature has not granted. By relying on statutes that address general public health supervision for **Pure Water** —but do not mention fluoridation— the Department's regulation effectively creates new regulatory authority that the legislature never conferred, rendering the regulation vulnerable to challenge as exceeding the agency's delegated powers.

Simply put, 12VAC5-590-930 (Fluoridation) appears to be an ultra vires act and should be nullified.

"In contrast to all other water treatment chemicals, silicofluorides are added to water supplies to treat the residents consuming the water. Fluoride is categorized as a **drug** by the U.S. Food and Drug Administration (FDA) when employed for the prevention or mitigation of disease (Plaiseier, 2000). Thus, fluoridating water for the purpose of preventing tooth decay (a non-waterborne disease) is a form of medical treatment. It's the only pharmacologic agent being forced on the public at large, many of whom are unaware of the addition of this chemical or informed of its side effects and potential risks. This practice contradicts the prevailing trends in modern medical care, which emphasize targeted therapies, personalized medicine, and the importance of informed consent."

https://www.fluoridealert.org/wp-content/uploads/fluoride_drug.pdf
https://fluoridealert.org/wp-content/uploads/2025/07/Reasons-to-End-Water-Fluoridation.pdf
https://uscode.house.gov/view.xhtml?req=(title:21%20section:321%20edition:prelim

Reference

12VAC5-590-930. Fluoridation.

A. The board recommends that all community waterworks in Virginia be optimally fluoridated. Fluoridation feed systems shall be designed to deliver the optimum fluoride ion concentration as determined by the U.S. Department of Health and Human Services…..

Statutory Authority §§ 32.1-12 and 32.1-170 of the Code of Virginia.

Historical Notes
Derived from VR355-18-009.09 § 3.30, eff. August 1, 1991; amended, Virginia Register Volume 37, Issue 20, eff. June 23, 2021.

Look at Virginia Administration Code **12VAC5-590-930. Fluoridation** and then look at the cited statutory code at the bottom (**§§ 32.1-12 and 32.1-170 of the Code of Virginia**.)

12VAC5-590-930. Fluoridation https://law.lis.virginia.gov/admincode/title12/agency5/chapter590/section930/
Old VAC: https://web.archive.org/web/20160719204758/https://law.lis.virginia.gov/admincode/title12/agency5/chapter590/section930/

"**Statutory Authority"**

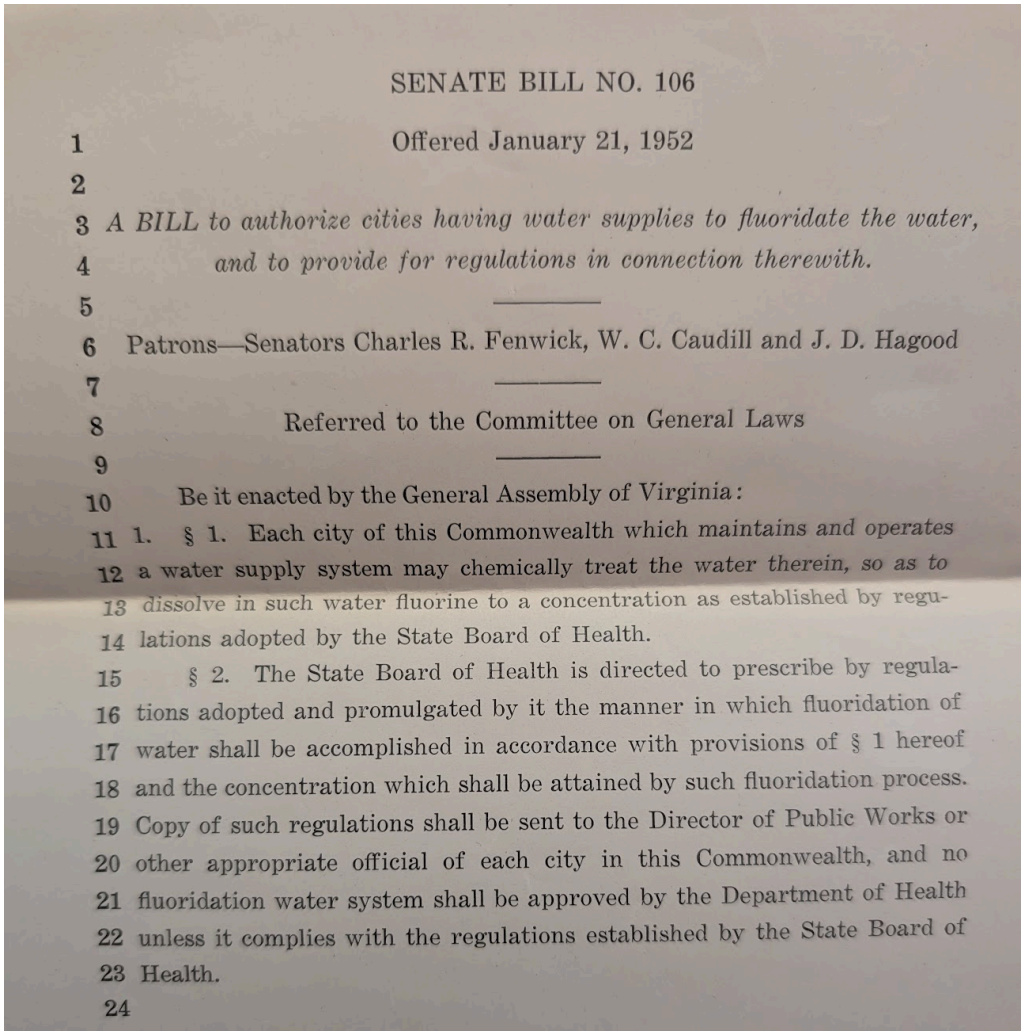
👉 **§ 32.1-170. Regulations.** https://law.lis.virginia.gov/vacode/32.1-170/

👉 **§ 32.1-12. Regulations, variances and exemptions.** https://law.lis.virginia.gov/vacode/32.1-12/

If you read the cited "Statutory Authority" for fluoridation, then you will see that no authority exists to fluoridate the water.

If the Legislature wanted to allow localities in VA to use the waterworks as a mechanism to mass medicate the public, then they would have passed Senate Bill NO. 106 Offered January 21, 1952.

The General Assembly did not pass this bill - instead the legislators went in a different direction that required **"Pure Water"** as defined under the code. The legislators chose laws that treated water, not people. The current laws on the books require **portability only**.



SENATE BILL NO. 106

Offered January 21, 1952

A BILL to authorize cities having water supplies to fluoridate the water, and to provide for regulations in connection therewith.

Patrons—Senators Charles R. Fenwick, W. C. Caudill and J. D. Hagood

Referred to the Committee on General Laws

Be it enacted by the General Assembly of Virginia:

§ 1. Each city of this Commonwealth which maintains and operates a water supply system may chemically treat the water therein, so as to dissolve in such water fluorine to a concentration as established by regulations adopted by the State Board of Health.

§ 2. The State Board of Health is directed to prescribe by regulations adopted and promulgated by it the manner in which fluoridation of water shall be accomplished in accordance with provisions of § 1 hereof and the concentration which shall be attained by such fluoridation process. Copy of such regulations shall be sent to the Director of Public Works or other appropriate official of each city in this Commonwealth, and no fluoridation water system shall be approved by the Department of Health unless it complies with the regulations established by the State Board of Health.

1952 Proposed Bill to all localities to fluoridate the water. (Did not become law).

FDA Classification

Fluoride is classified as a drug by the U.S. Food and Drug Administration (FDA) when used for the **prevention or mitigation** of disease (Plaiseier, 2000). Accordingly, fluoridation of public water supplies for the purpose of reducing tooth decay—an issue not related to waterborne pathogens—can be viewed as a population-wide medical intervention. Modern public health practices generally emphasize targeted treatment and informed consent. (Individualized medicine.) **21 U.S.C. § 321(g)(1)(B)**

21 USC 321: Definitions; generally

Text contains those laws in effect on December 23, 2025

From Title 21-FOOD AND DRUGS
CHAPTER 9-FEDERAL FOOD, DRUG, AND COSMETIC ACT
SUBCHAPTER II-DEFINITIONS
(f) The term "food" means (1) articles used for food or drink for man or other animals, (2) chewing gum, and (3) articles used for components of any such article.

21 U.S.C. § 321(g)(1)(B)

(g)(1) The term "drug" means (A) articles recognized in the official United States Pharmacopoeia,1 official Homoeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; and **(B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals;**

https://uscode.house.gov/view.xhtml?req=(title:21%20section:321%20edition:prelim

Union Calendar No. 787 – Delaney Committee Hearings 1952.

[The term "mass medication."]
“Fluoridation program does constitute medication.”

> “1952 - Since the question was raised at the hearings, the committee wishes to point out that the fluoridation program does constitute medication…
>
> The term "drug" is defined, in part, in section 201 (g) of the Federal Food, Drug, and Cosmetic Act, as articles intended for use in the diagnosis, cure,mitigation, treatment, or prevention of disease in man or other animals, and articles intended to affect the structure or any function of the body of man or other animals.
>
> It is safe to say that fluoridation is mass medication without parallel in the history of medicine.”

The historical record — including the 1952 Delaney Committee hearings — demonstrates that fluoridation has never been a scientifically settled, purely technical, or uncontroversial medical treatment. The fact that federal legislators debated its safety and debated bills restricting or limiting support for fluoridation, combined with the absence of clear enabling statutory language in Virginia, supports the legal argument that local government lacks an unambiguous statutory grant of authority to add fluoride to drinking water absent express legislative approval.

https://www.govinfo.gov/.../SERIALSET-11578_00_00-214…

Primacy

Moreover, VDH cannot "recommend" or “require” water fluoridation in their role as the Primacy Agency for the EPA.

> **January 2026**
> **EPA-821-P-26-001**
> **Fluoride [CASRN 7782-41-4] Human Health Toxicity Assessment:**
> **Preliminary Assessment Plan and Literature Survey**
>
> “**EPA does not make recommendations on adding fluoride to drinking water**, since SDWA prohibits EPA from requiring the addition of any substance to drinking water for preventive health care purposes (Section 1412(b)(11)) (U.S. EPA, 2020).”..... “The decision whether or not to add fluoride to drinking water is made on a state or local basis.”
>
> “The decision whether or not to add fluoride to drinking water is made on a state or local basis; **EPA does not make recommendations on adding fluoride to drinking water.”**
>
> https://www.epa.gov/system/files/documents/2026-01/fluoride-human-health-toxicity-assessment-preliminary-assessment-plan-and-literature-survey-1-22-26.pdf
> https://www.govinfo.gov/content/pkg/CPRT-106SPRT67528/pdf/CPRT-106SPRT67528.pdf

VDH derives specific authority regarding pure drinking water from several places:

1. The SDWA who allows the US EPA to award states with primacy; this would be VDH.
2. The Virginia General Assembly can grant authority to the “Board”; this is VDH.

VDH never received authority to recommend localities go out of their way to deliberately contaminate the drinking water with drugs such as artificial fluoride - neither from the EPA nor from the General Assembly. Therefore VDH is exceeding their authority.

- Under primacy, a state agency **cannot do what federal law forbids**.
- VDH cannot override Virginia Law that requires “Pure Water”. §§ 32.1-12 and 32.1-17.

Dillon Rule

Virginia is a strict **Dillon Rule** state. Under long-settled Virginia law, local governing bodies possess only those powers:

1. Expressly granted by the General Assembly;
2. Necessarily or fairly implied from an express grant; or
3. Essential and indispensable to the exercise of an expressly granted power.

Statutes conferring **supervisory or regulatory authority on a state agency** do not constitute an express or implied legislative grant of substantive authority to local governments. Likewise, **administrative regulations or recommendations cannot create authority that the General Assembly has not clearly conferred by statute**.

VDH’s inability to identify an express statutory authorization is therefore a material admission relevant to the legality of local water fluoridation under Virginia law.

"Best Interpretation" Doctrine

The "best interpretation" doctrine (often referred to as the "best meaning" approach) is a legal framework for statutory interpretation requiring courts to exercise their independent judgment to determine the most accurate, or "best," meaning of a statute. This doctrine explicitly rejects the notion that courts should defer to a government agency's "reasonable" interpretation of an ambiguous statute.

Key Aspects of the Best Interpretation Doctrine

- Replaces Chevron Deference: The doctrine was established by the Supreme Court's 2024 decision in *Loper Bright Enterprises v. Raimondo*, which overturned the 40-year-old *Chevron* doctrine.

- Independent Judicial Judgment: Courts must now interpret statutes directly, rather than relying on agency expertise when a law is ambiguous.

- Focus on Text and Context: Judges are expected to apply traditional tools of statutory interpretation—such as looking at plain meaning, statutory structure, and context—to find the "best" reading.

- Diminished Agency Authority: Under this doctrine, agency interpretations of law are no longer given controlling weight. However, they may still be considered for their "persuasive" value under the *Skidmore* standard.

- Contextual Tool: The Supreme Court has indicated that the "major questions doctrine" can be used as a tool to determine the best interpretation by analyzing the context and significance of a regulation, ensuring that major policy decisions are made by Congress rather than agencies.

The best interpretation approach is consistent with judicial philosophies like textualism and originalism, which prioritize the written law's meaning.

ROMAN CATHOLIC DIOCESE OF BROOKLYN, New York V. Andrew M. CUOMO, Governor of New York.

The mission of public health is to protect, preserve, and promote the health of the population. The challenge is to advance public health while also respecting such individual concerns as autonomy, privacy, and liberty in a diverse society. The conflict between population and individual interests also characterizes the inevitable legal disputes over public health policies, especially during public health emergencies. Historically, US courts have been highly deferential to reasonable and necessary public health measures to combat contagious diseases, even if they restrict individual liberties. **That is no longer the case.**

https://scholar.google.com/scholar_case?case=782073761559106414 6&hl=en&as_sdt=0,47

FOOD & WATER WATCH, INC., et al., V EPA

The Judgment

On September 24, 2024 the court ruled on behalf of the Fluoride Action Network and the plaintiffs. A U.S. federal court has now deemed fluoridation an “unreasonable risk” to the health of children, and the EPA will be forced to regulate it as such.
The decision is written very strongly in our favor.

Below is an excerpt from the introduction of the ruling:

"The issue before this Court is whether the Plaintiffs have established by a preponderance of the evidence that the fluoridation of drinking water at levels typical in the United States poses an unreasonable risk of injury to health of the public within the meaning of Amended TSCA. For the reasons set forth below, the Court so finds. Specifically, the Court finds that fluoridation of water at 0.7 milligrams per liter (“mg/L”) – the level presently considered “optimal” in the United States – poses an unreasonable risk of reduced IQ in children..the Court finds there is an unreasonable risk of such injury, a risk sufficient to require the EPA to engage with a regulatory response…One thing the EPA cannot do, however, in the face of this Court’s finding, is to ignore that risk.”

Note: The merits of this ruling stand.
https://fluoridealert.org/wp-content/uploads/2024/09/Court-Ruling.pdf

https://fluoridealert.org/content/epas-bid-to-overturn-landmark-fluoride-ruling-based-on-process-not-public-health-concerns/

https://fluoridealert.org/

Summary

In Henrico County, Virginia, fluoride has been intentionally added to the public drinking water without an ordinance or clearly expressed statutory authority, thereby constituting an ultra vires act.

I, Sarah Ramsey, sent numerous emails and delivered multiple public speeches outlining the legal, ethical, and safety concerns. Yet County officials (including the Public Utilities Director, the County Manager, and members of the Board of Supervisors) remained largely silent. I requested identification of the authorizing official and the legal authority supporting the program. None was produced. FOIA responses revealed **no stated purpose, justification, or safety analysis** supporting fluoridation.

Moreover, the County failed to comply with 12VAC5-590-540 (Public Notices)(4)(c)[1] and 12VAC5-590-510 (Acceptable Operating Practices)(E)[2] by not informing both the public and the Commissioner 90 days prior to initiating fluoridation.

The County omitted the fact that fluoride was being intentionally added to the water from the 2024 Water Quality Report[3], thereby depriving residents of critical information and concealing the chemical's presence.

This secretive and unauthorized addition of fluoride constitutes administrative overreach and violates the Dillon Rule which limits local government actions to clearly delegated legislative authority. Virginia law requires **"Pure Water"** – water fit for human consumption and free from toxic agents in excess of reasonable amounts [4] [5] [6]

Finally, the County erroneously relied upon a mere "recommendation" — 12VAC5-590-930 (Fluoridation) — which provides regulatory guidance without any clearly established or expressed statutory authority under § 32.1-170 (Regulations).

The central legal question is whether Henrico County possesses delegated authority to fluoridate absent an ordinance and express statutory authorization.

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[1] https://law.lis.virginia.gov/admincode/title12/agency5/chapter590/section540/
[2] https://law.lis.virginia.gov/admincode/title12/agency5/chapter590/section510/
[3] https://henrico.gov/public-data/water-quality-report-2024/
[4] 12VAC5-590-10. Definitions and units of measurement . **"Pure water"**
[5] § 32.1-167. Definitions. **"Pure Water"**
[6] § 32.1-170. Regulations. **"pure water"**
12VAC5-590-930. Fluoridation. (See Statutory Authority cited for 12VAC5-590-930. Fluoridation)
§ 32.1-12. Regulations, variances and exemptions.

[A Month's Worth of Fluoride in One Day]

In **April 2025**, the City of Richmond experienced a **catastrophic fluoride overfeed incident**. Using SCADA data and standard waterworks calculations, the incident involved approximately **65,400 pounds of hydrofluorosilicic acid solution—about 6,431 gallons—added in a single day**.

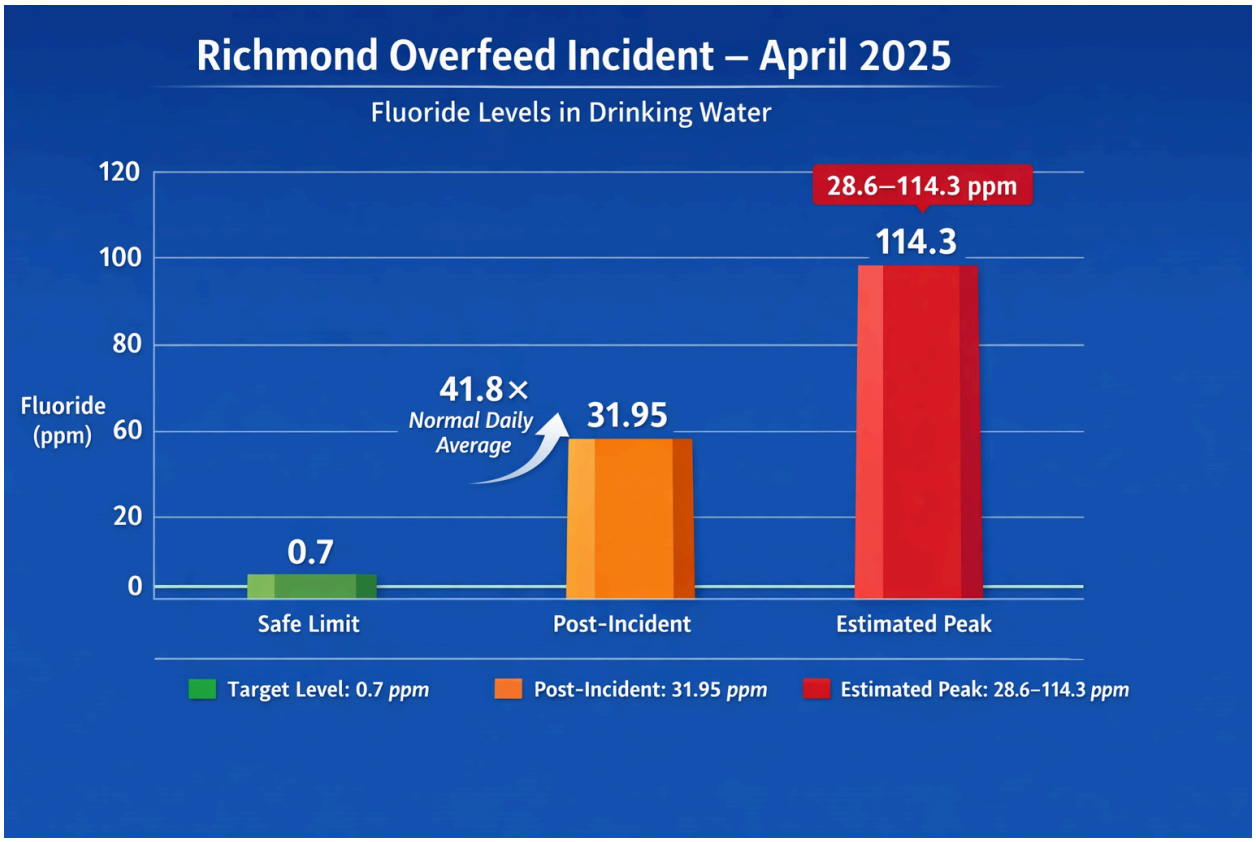
That amount was approximately **45.6 times the average daily fluoride addition** used in April 2024.

Post-incident water testing documented fluoride concentrations of **31.95 parts per million**, compared to the regulatory target of **0.7 ppm**. Based on injection volumes, peak concentrations may have ranged from **28.6 ppm to as high as 114.3 ppm**.

This demonstrates a critical fact: **fluoridation systems fail**. When they fail, exposure is immediate, involuntary, and undisclosed.

Henrico County operates a similar system—yet without an ordinance, without transparency, and without consent.

https://www.vdh.virginia.gov/content/uploads/sites/6/2025/05/4760100_NOAV_FluorideIncident_2025-05-12.pdf



Timeline & Key Facts:
Richmond Fluoride Overfeed Incident

April 2024
Avg. 375 lbs HFS Pure Acid
(~1,563 lbs HFS Solution)

April 23, 2025
Massive Overfeed
~65,400 lbs HFS Solution
(~6,431 gallons)

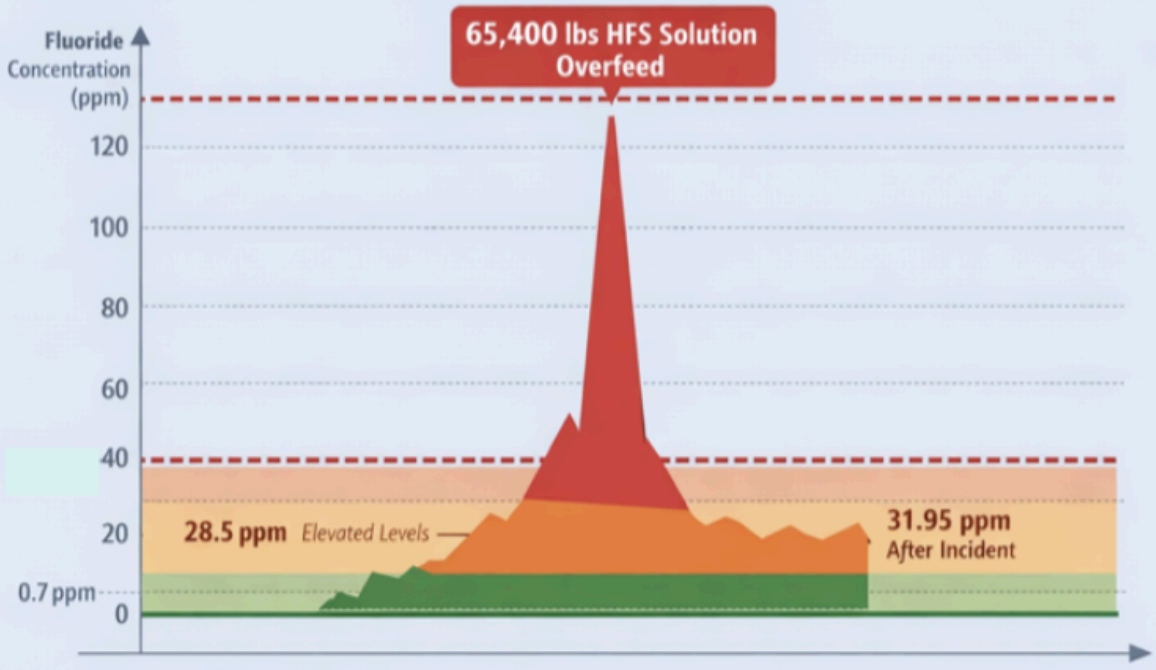
April 23, 2025
Public Reaction
Illnesses Reported by Residents

May 12, 2025
VDH Violation Notice
NOAV Issued by VDH

Fluoride Levels: *28.5 - 114 ppm*

'Optimum" Level: *0.7 ppm*

Fluoride Levels in Richmond Water



- **Massive overfeed** spiked fluoride levels far beyond safe limits.
- **Illnesses** reported by residents following the incident.

Reasons to End Water Fluoridation

A Science-Based Assessment

Fluoride Action Network

fluoridealert.org

UPDATED APRIL 2025

"The evidence that fluoridation is more harmful than beneficial is now overwhelming."

Hardy Limeback, DDS, PhD
Former President of the Canadian Association for Dental Research

"Fluoridation goes against all principles of pharmacology. It's obsolete."

Arvid Carlsson, MD, PhD
Nobel Laureate in Medicine/Physiology

"In summary, we hold that fluoridation is an unreasonable risk."

U.S. Environmental Protection Agency's Headquarters Union of Scientists and Professionals (2001)

"We've gone with the status quo regarding fluoride for many years—for too long, really—and now we need to take a fresh look. In the scientific community, people tend to think this is settled. But when we looked at the studies that have been done, we found that many of these questions are unsettled and we have much less information than we should, considering how long this has been going on."

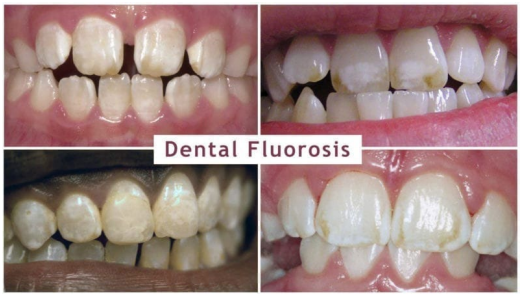
John Doull, MD, PhD
Chairman, National Research Council's Review on Fluoride in Drinking Water

"The Court finds that fluoridation of water at 0.7 milligrams per liter ("mg/L") – the level presently considered "optimal" in the United States – poses an unreasonable risk of reduced IQ in children…the Court finds there is an unreasonable risk of such injury, a risk sufficient to require the EPA to engage with a regulatory response."

United States District Court of the Northern District of California (2024)

Overview

Water fluoridation is the practice of using the public's drinking water as a delivery system to increase the amount of fluoride residents ingest on a daily basis. This is done by adding industrial waste by-products known as "silicofluorides" (i.e., hydrofluorosilicic acid and sodium fluorosilicate) to public water systems during the treatment process in either liquid or powder form to artificially elevate the fluoride content to 0.7 ppm (parts per million).



Prior to 2015, U.S. Health and Human Services recommended fluoride levels in water up to 1.2 ppm. However, this recommendation was significantly lowered to the present level of 0.7 ppm following the acknowledgment of government research from 2006, eight years prior. This research revealed that most adolescents in the U.S. experienced overexposure to fluoride during childhood development, resulting in visible side effects. According to the EPA and peer-reviewed research, the primary source of this overexposure was the consumption of water and water-based beverages. Unfortunately, even the reduced level of 0.7 ppm has continued to contribute substantially to over-ingestion of fluoride, with the percentage of children in the United States with visible side effects from overexposure now exceeding 70%, according to the U.S. Centers for Disease Control (CDC).

Throughout North America and the world, most fresh ground and surface water naturally contains very low "trace" levels of fluoride, with an average concentration of less than 0.1 ppm. This is 7 to 10 times lower than the levels added by water departments in fluoridated communities, where levels typically fluctuate between 0.7 and 1.0 ppm due to imprecision in the injection process as well as variations in water usage and temperature. This significant increase in fluoride is neither a small adjustment nor typical of the naturally occurring levels found in most water sources.

Fluoride in water is regulated by the Environmental Protection Agency (EPA) as a contaminant. Naturally occurring fluoride in water results from the erosion of fluoride-rich rocks and soil by surface and groundwater. Fluoride can also be found in water as the result of pollution from coal-burning facilities and from the production of steel, glass, aluminum, ceramics, solar panels, and semiconductors. The silicofluorides used for water fluoridation are largely derived from the pollution abatement scrubbers installed on smokestacks at aluminum smelting and phosphate fertilizer manufacturing plants. It's important to note that the fluoride compounds used in the fluoridation of public water supplies are not of pharmaceutical or food-grade quality and do not undergo additional refinement or filtration to remove contaminants before being added to drinking water.

Silicofluorides are the only chemicals added to public water supplies that are not intended to improve the safety or potability of drinking water. Unlike chlorine and coagulants that are added to purify and clarify the water, silicofluorides offer no such benefits. Conversely, batch samples and certificates of analysis that accompany shipments of fluoridation additives reveal that silicofluorides are contaminated with harmful toxins, including lead, aluminum, and arsenic. Due to the extreme acidity of silicofluorides, they can increase corrosion of the water infrastructure, resulting in the leaching of heavy metals from pipes and fixtures into the water that residents rely on for drinking, cooking, and bottle-feeding their infants. Moreover, the caustic nature of fluoridation chemicals requires the introduction of an additional treatment chemical to the drinking water to inhibit corrosion, called orthophosphate.

In contrast to all other water treatment chemicals, silicofluorides are added to water supplies to treat the residents consuming the water. Fluoride is categorized as a drug by the U.S. Food and Drug Administration (FDA) when employed for the prevention or mitigation of disease (Plaiseier, 2000). Thus, fluoridating water for the purpose of preventing tooth decay (a non-water borne disease) is a form of medical treatment. It's the only pharmacologic agent being forced on the public at large, many of whom are unaware of the addition of this chemical or informed of its side effects and potential risks. This practice contradicts the prevailing trends in modern medical care, which emphasize targeted therapies, personalized medicine, and the importance of informed consent.

With fluoridation, the same concentration is delivered to the entire population, regardless of age, weight, health, or nutritional status, and it does so without the individual oversight of a doctor or any control over the dosage administered. While water departments can generally control the concentration of fluoride being added to water, they cannot control the amount (dose) individuals receive or protect them from overexposure because everyone drinks varying amounts of water. Some residents will drink substantially more water than others, particularly bottle-fed infants who have an impaired ability to excrete fluoride and receive up to 400% more fluoride (per pound of body weight) than adults consuming the same level of fluoride in water due to their small size and potential reliance on formula reconstituted with fluoridated tap water for most of their diet. Clearly, this practice from the 1940s contradicts modern pharmacology, which recognizes that individuals respond differently to the same dosage of a given drug.

For over 50 years, proponents of fluoridation hypothesized that following ingestion, fluoride would enter the bloodstream and some of it would be excreted in the saliva, providing a continuous fluoride bath for the teeth. However, subsequent research has since confirmed that any potential benefit from fluoride occurs after the teeth have erupted from the gums and predominantly from topical exposure rather than from ingestion. Consequently, this research confirms that there is little to no potential oral health benefit from swallowing fluoride,

particularly for fetuses and infants. Instead, there is only a risk of overexposure and harm to other exposed tissues.

The brain is just one of the tissues that fluoride impacts aside from teeth. There's now a large body of government-funded research indicating that fluoride is neurotoxic to the developing brain and is associated with lowered IQ in children and a doubling of neurobehavioral disorders, including a significant increase in ADHD diagnosis in children at doses experienced in fluoridated communities. A federal judge has ruled that "optimally" fluoridated water poses an unreasonable risk to human health, and the U.S. EPA must eliminate that risk with new rules. Experts in toxicology have drawn parallels between the cognitive impairment caused by fluoride and that of lead. Basic logic tells us that while a cavity can easily be filled and repaired, damage to a child's brain is lifelong and irreversible; there are no second chances.

In stark contrast to the CDC's claim that fluoridation is one of the top ten public health achievements of the 20th century, it is actually one of the most widely rejected health interventions in the world. Out of 196 nations, only 24 have any fluoridation, and only 10, like the U.S., have it for more than half their population. Over 95% of the world's population is fluoridation-free. None of the largest Asian nations, including China, India and Japan, fluoridate. All African nations are virtually fluoridation-free. In Europe, only four out of 48 countries fluoridate (less than 2% of the population). A few have fluoridated salt, but only as a consumer choice.

International health authorities have made this decision primarily due to the low safety margin of fluoride and the lack of control over individual intake when it is administered to an entire population. Even those affiliated with Harvard's School of Public Health cited their concerns in Harvard Public Health magazine by saying, "Now, evidence is mounting that in an era of fluoridated toothpastes and other consumer products that boost dental health, the potential risks from consuming fluoridated water may outweigh the benefits for some individuals" (Davis, 2016). Evolving science should inspire decision makers and health authorities to re-evaluate claims about the safety of fluoridation, especially for the fetus and infant for whom there is no claimed benefit.

I urge you to stand with the majority of the world against water fluoridation. Let us ensure the safety of public drinking water for all citizens, including bottle-fed infants, the developing fetus, the hypersensitive, and those with thyroid, liver, and kidney impairment, among other vulnerable subpopulations. Fluoride ingestion ought to be a choice, not a mandate.

Stuart Cooper
Executive Director
Fluoride Action Network (FAN)

Publication History & Contributors

This document used the 2012 version of "50 Reasons to Oppose Water Fluoridation" as its foundation. Updates were made by FAN's Director, Stuart Cooper, in cooperation with JANA Life Sciences and with contributions from Rick North and Hardy Limeback, DDS, PhD.

The 50 reasons were first compiled by professor and environmental toxicologist Paul Connett, PhD, and presented in person to the Irish Fluoridation Forum in October 2000. The document was refined in 2004 and published in Medical Veritas.

The document was updated in 2012, after there had been many major scientific developments including the publication of the U.S. National Research Council report (NRC, 2006), FAN's translation of over 20 Chinese studies on fluoride toxicity, publication of the Harvard team's meta-review of fluoride and IQ (Choi 2012), the publication of Bassin's study on Osteosarcoma (Bassin 2006), and any more studies of fluoride's interaction with the brain. That update was made with the generous assistance of James Beck, MD, PhD, Michael Connett, JD, Hardy Limeback, DDS, PhD, David McRae and Spedding Micklem, D.*Phil*.

Key Facts

- The U.S. is an extreme outlier when it comes to the use of fluoridation chemicals. More people drink artificially fluoridated water in the U.S. than the rest of the world combined. Out of 196 nations, only 24 have any fluoridation. This means that over 95% of the world's population is fluoridation-free. This includes most developed nations, with 98% of the population in Western Europe drinking public water without fluoridation chemicals. In fact, France, Germany, Belgium, the Netherlands, Denmark, Norway, and Sweden have all made fluoridation illegal, many citing the ethical problem of putting any drug in drinking water. Several European nations do allow table salt to be fluoridated, but the vast majority do not, and in contrast with water fluoridation, this practice gives the consumer the choice of whether to purchase salt with or without added fluoride.

- According to World Health Organization data, fluoridated countries DO NOT have less dental decay than non-fluoridated countries. Developed nations have experienced the same decline in tooth decay over the past 50+ years regardless of fluoridation status. CDC data comparing childhood dental decay in U.S. states also shows no correlation between fluoridation rates and decay rates. Many of the states and cities with the highest rates of fluoridation for decades continue to have some of the highest rates of decay and tooth loss, while many states with the lowest decay are among the least fluoridated.

- The largest, most recent, and highest-quality published studies on water fluoridation's effectiveness have shown no significant reduction in cavities and no meaningful reduction in social inequalities or benefit to low-income families.

- It is now well established that fluoride is not an essential nutrient. This means that no human disease, including tooth decay, will result from ingesting less fluoride.

- Modern dental research shows that swallowing fluoride is unnecessary. Studies have confirmed that fluoride's potential benefit comes from topical exposure and not from ingestion, which unnecessarily exposes many other tissues in the body that are only harmed by fluoride. Under oath, the CDC has confirmed this fact as well. There is no shortage of topical fluoride products in the developed world, and thus no justifiable reason to continue the practice. Fluoride-containing toothpastes, mouthwashes, and flosses are inexpensive and abundant in virtually every local supermarket, pharmacy, big box store, corner convenience store, online, and at food banks and W.I.C. offices.

- The dose cannot be controlled. Once the water is fluoridated, it is impossible to control the dose each individual receives because people drink varying amounts of water.

- CDC data has repeatedly confirmed that over 70% of adolescents in the U.S. have permanent unsightly defects in their enamel, called dental fluorosis. This is a biomarker of systemic overexposure to fluoride during infancy and childhood, with the primary source of exposure being the ingestion of fluoridated tap water. The stains and discoloration lower the sufferer's confidence and often weaken the enamel, increasing dental decay.

- Fluoride is the only medicine added to the water supply. It's a drug as defined by the FDA, but fluoride ingestion or supplementation has never been FDA approved for safety or efficacy. There has also never been a single randomized controlled trial (RCT) confirming fluoridation's safety or efficacy after nearly 80 years. All drugs can have harmful health effects. Putting it in the drinking water takes away your right to informed consent. Using the public water supply to administer ANY drug is unethical. All citizens should be free to hydrate without having to regulate their total fluoride intake. Fluoride ingestion should be a choice, not a mandate.

- There is now very strong evidence that fluoride damages both the fetal and infant brain at the levels used in artificially fluoridated areas. Over 400 studies have found that fluoride is a neurotoxin (a chemical that can damage the brain). This research includes over 200 animal studies showing that prolonged exposure to varying levels of fluoride can damage the brain, particularly when coupled with an iodine deficiency or aluminum excess, and 79 human studies linking low to moderately high fluoride exposures with reduced intelligence. The National Institutes of Health (NIH) have funded 10 studies on fluoride and the brain, and all 10 found neurotoxic side effects.

- After an 8-year long systematic review, the National Toxicology Program found "with moderate confidence, that higher estimated fluoride exposures are consistently associated with lower IQ in children." The NTP reported that out of 72 human studies assessing the association between fluoride exposure and cognitive impairment in children, 64 linked higher fluoride exposures with significantly lower IQs in children, an 89% consistency. Out of the 19 highest-quality studies, 18 found neurotoxicity – 7 of those studies at levels present in "optimally" fluoridated communities.

- A federal court has found that "there is substantial and scientifically credible evidence establishing that fluoride poses a risk to human health." In August 2024, the court ruled that "fluoridation of water at 0.7 [mg/L] -- the level presently considered 'optimal' in the United States –- poses and unreasonable risk of reduced IQ in children." The EPA is now required by law to promulgate rules to eliminate the "unreasonable risk" to the health of children.

- Fluoridation chemicals are not pharmaceutical-grade or food-grade products; they're classified as hazardous waste originating from phosphate fertilizer production and aluminum factories, as noted in the EPA's National Primary Drinking Water Regulations (NPDWR). These silicofluorides undergo no purification procedures and, as a result, can contain elevated levels of arsenic and other heavy metal contaminants, more than any other water treatment chemical. In addition, recent research suggests that the addition of silicofluorides to water is a risk factor for elevated lead exposure, particularly among residents who live in homes with old pipes.

- Apart from reverse osmosis, distillation, or buying properly tested spring or bottled water with low fluoride, it is difficult to avoid ingesting fluoride, making fluoridation a water equity issue. Reverse osmosis filtration systems and distillation units are expensive and require regular maintenance and continued expense to operate. Those with a low income are the least able to avoid fluoride if it's added to the water supply.

- Fluoridation is a significant waste of taxpayer money. Cities are spending tens of millions of dollars on fluoridation equipment and chemicals, with even the smallest communities spending tens of thousands of dollars. It's estimated that 99% of all tap water is used for purposes other than drinking, meaning that 99% of fluoridation chemicals, representing hundreds of thousands of tons of siliocofluoride waste goes directly into the environment and watershed. This takes funds away from more effective oral health strategies.

- There are better and safer alternatives for preventing cavities. Good nutrition, as well as brushing, flossing, and regular dental care, are at the top of the list. Nations with the lowest decay rates have focused on school-based programs, such as oral health screenings, sealant, and voluntary topical rinse programs instead of resorting to fluoridation chemicals.

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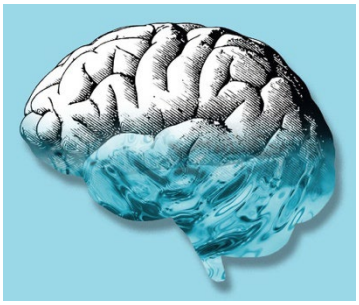
I. Fluoride is Neurotoxic, Especially to the Developing Brain.



One of the most alarming effects of fluoride is its neurotoxicity, which has been shown to be 'on par' with that of lead. The fetus and infants are the most susceptible to fluoride exposure given their brains are still developing and their body mass and ability to excrete fluoride is radically different from that of an older child, much less than that of an adult. In particular, exclusively bottle-fed infants are most susceptible when infant formula is prepared with fluoridated 'tap' water. Canadian researchers "investigated the association between water fluoride concentrations and intellectual abilities of Canadian children who were formula-fed or breastfed", and they found "formula-fed infants who reside in fluoridated areas have a 70-fold higher intake of fluoride than exclusively breastfed infants." In addition, they noted that formula-fed infants also retain more fluoride than breastfed infants, because infants have a limited capacity to excrete fluoride before renal function reaches its full capacity at about two years of age. Their conclusion statement reads, "Exposure to increasing levels of fluoride in tap water was associated with diminished non-verbal intellectual abilities; the effect was more pronounced among formula-fed children" (Till et al. 2019).

For the fetus and for infants, fluoridation provides only risk.
The CDC has admitted under oath that there is no known benefit to ingesting fluoride for the fetus or an infant. Meanwhile, a substantial body of government-funded research now indicates that fluoride possesses neurotoxic properties. This neurotoxicity may be associated with a decline in children's IQ levels and a rise in ADHD diagnoses and related behaviors. There are studies that suggest this is happening even at levels to which fluoridated communities are commonly exposed (Fiore, 2023).

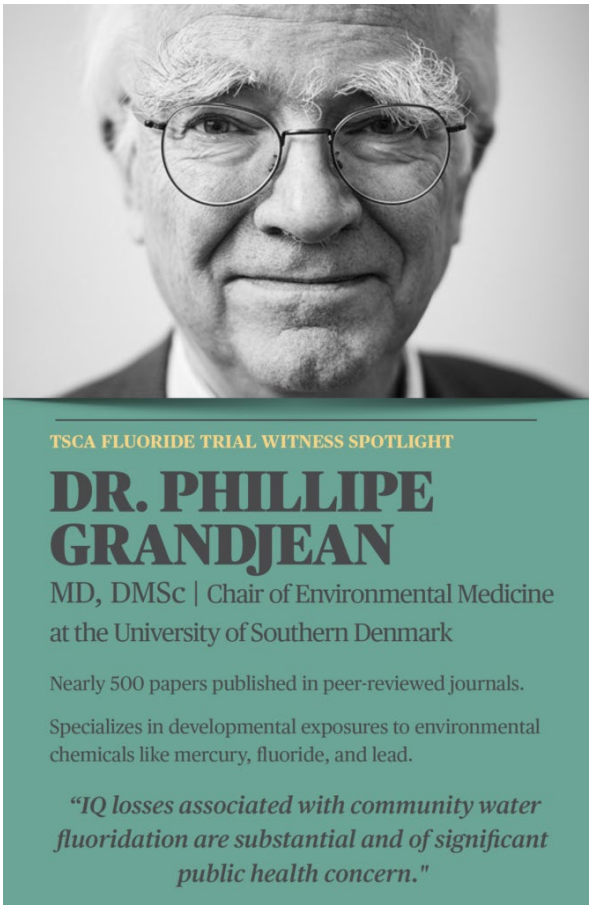
Experts in the field of toxicology have drawn parallels between the magnitude of this effect and that observed with lead exposure. As of January 2025, there are at least 85 human studies that have reported an association between fluoride exposure and reduced IQ. The current depth of evidence demonstrating the neurotoxicity of fluoride surpasses the evidence that led to the removal of lead from gasoline. It's essential to emphasize that, while cavities can easily be treated, damage to a child's brain is permanent.

In July of 2012, scientists from Harvard University warned that the developing brain may be another target for fluoride toxicity in the medical journal *The Lancet* (Choi et al., 2012). The Harvard team based their warning on a large number of studies from China that have found reduced IQ scores among children exposed to elevated fluoride during their early years of life. [This source of the elevated fluoride levels was attributed to groundwater adversely affected by the geological composition of the affected areas, particularly in shallow wells used for drinking.] Twelve of the studies the Harvard team reviewed found IQ loss at fluoride levels deemed safe in the U.S. and a study sponsored by UNICEF found IQ loss in iodine-deficient children at the so-called "optimal" fluoridation level. The possibility that fluoridated water can reduce IQ is a matter that "definitely deserves concern."

Since 2012, the National Institutes of Health (NIH) has funded ten consecutive studies showing that fluoride significantly impacts brain development in young children. Many of these studies were conducted in optimally fluoridated communities in North America.

First-ever benchmark dose analysis conducted on fluoride in water and its impact on IQ. A Benchmark Dose Analysis (BMD) by Grandjean et al., published in the journal *Risk Analysis*, confirms that extremely low fluoride exposure during pregnancy impairs fetal brain development and at the population level may currently be causing more damage than lead, mercury, or arsenic (2021). The study found that a maternal urine fluoride concentration of just 0.2mg/L, **which is actually exceeded 4 to 5 times in pregnant women living in fluoridated communities**, was enough to lower IQ by 1 point. They state that:

> "These findings provide additional evidence that fluoride is a developmental neurotoxicant … and the benchmark results should inspire a revision of water-fluoride recommendations aimed at protecting pregnant women and young children."



While fluoridation promoters claim that IQ loss only occurs at fluoride concentrations much higher than the levels used in fluoridation programs (0.7 ppm), in reality pregnant women's urine levels in fluoridated communities are about four to five times higher than this estimated benchmark dose of 0.2 ppm (Northern California and across Canada) (Abduweli Uyghurturk et al., 2020; Riddell et al., 2021)." Grandjean et al. used pooled data from the ELEMENT and MIREC birth cohorts in Mexico and Canada. These cohorts were used in two major mother-offspring studies (Bashash, 2017 and Green, 2019) funded by the U.S. National Institutes of Health.

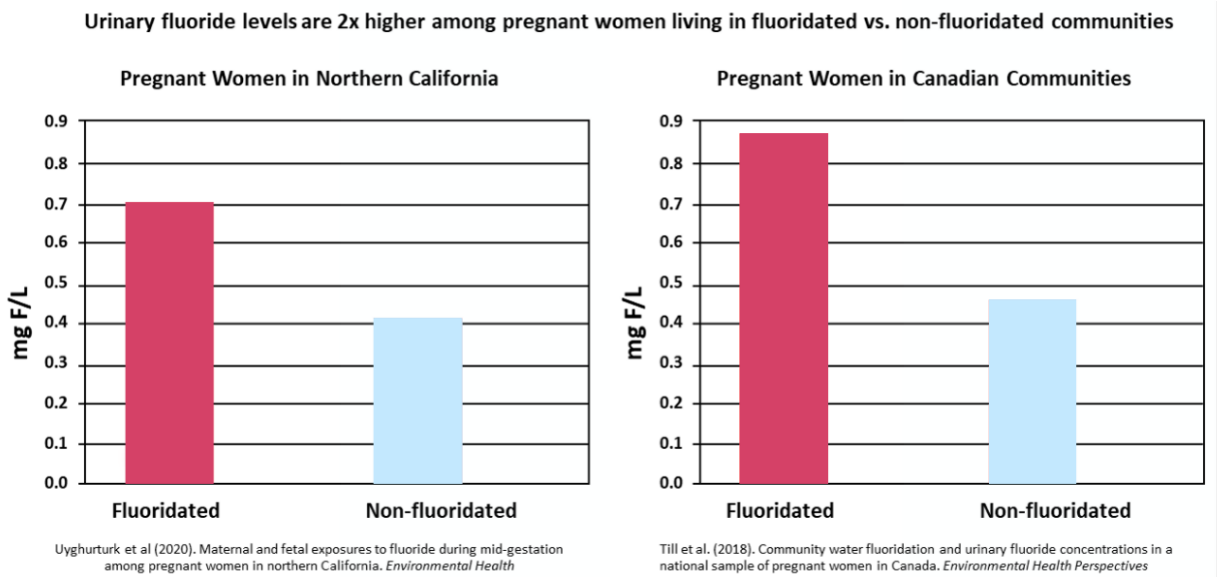
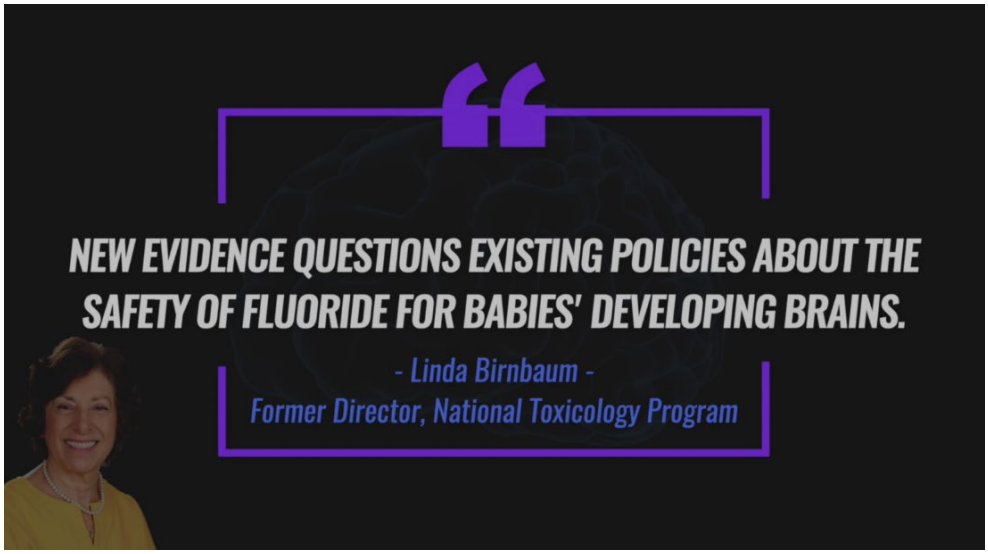


Figure 1. Comparison of urinary fluoride levels among pregnant women in California (left), and Canada (right). Red bars represent urinary fluoride levels of those women residing in fluoridated communities, while blue bars represent those women residing in non-fluoridated communities. In both California and Canada, the urinary fluoride concentrations were higher in women from fluoridated communities compared to non-fluoridated.

A Benchmark Dose Analysis is used to identify a dose that would likely cause a defined amount of harm, in this case a loss of 1 IQ point. This benchmark (loss of one IQ point) has been used by the Environmental Protection Agency (EPA) in other risk assessments. It is well established that a loss of one IQ point leads to a reduced lifetime earning ability of $18,000. It is estimated that over 70% of drinking water systems in America are fluoridated, thus millions of pregnant women are currently being exposed to levels of fluoride that has the potential to lower their children's IQ by at least 4 points.

Former director of National Toxicology Program warns pregnant women to avoid fluoridated water.

The former director of the NIH National Institute of Environmental Health Sciences (NIEHS), Dr. Linda Birnbaum, along with leading experts in the study of fluoride's neurotoxic effects, including Dr. Bruce Lanphear and Dr. Christine Till, have jointly authored a significant Op-ed. In this piece, they underscore the growing body of evidence suggesting fluoride may be impeding brain development and diminishing the IQ of infants and children, saying: "Given the weight of evidence that fluoride is toxic to the developing brain, it is time [to] protect pregnant women and their children [and recommend they] reduce their fluoride intake."



World-renowned neuroscientists consider fluoride's effect size (on the brain) to be on par with lead.

The issue of fluoride exposure and its potential impact on cognitive abilities has garnered significant attention from experts and researchers in the medical and scientific communities.

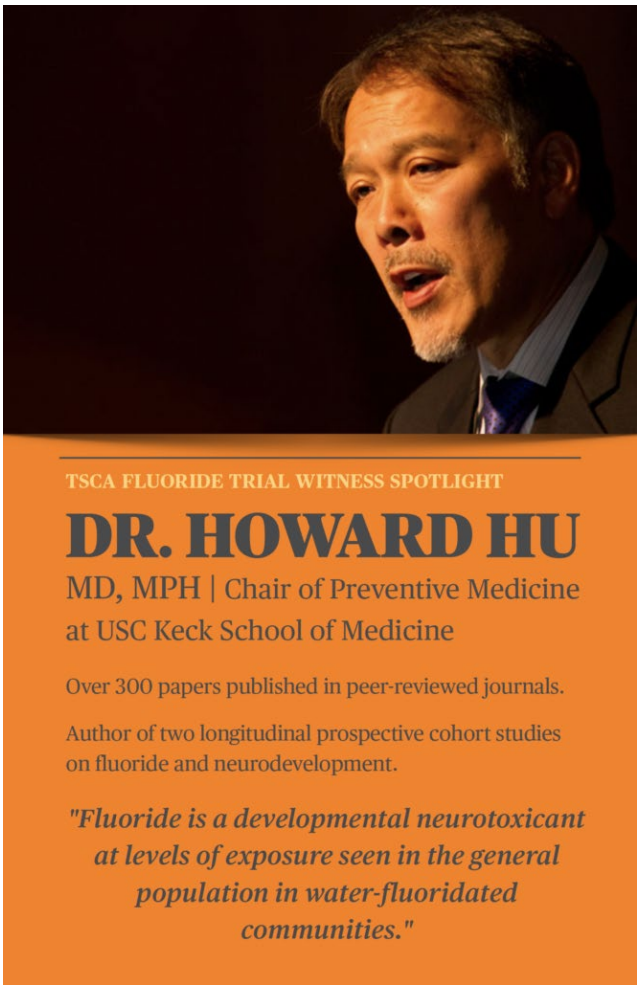
- Editors from the Journal of the American Medical Association (JAMA) described the IQ drop of 4.5 IQ points in one study (Green et al. 2019): "An effect size which is sizeable – on par with lead" (Feder & Connor, 2019).

- David Bellinger, author of over 400 epidemiology papers on neurotoxic chemicals, including over 100 on lead, said "It's actually very similar to the effect size that's seen with childhood exposure to lead" (Harris, 2019).

- Christine Till, leader of a research team that has published rigorous studies of fluoride neurotoxicity funded by the National Institutes of Health (NIH) says [Dunham, Canada CTV, 2019]: “4.5 points is a dramatic loss of IQ, comparable to what you’d see with lead exposure.”

- And [Farmus et al., 2021]: “A 2- to 4-point decrement in PIQ [Performance IQ] may seem like a small difference at the individual level. However, a small shift in the mean of IQ scores at the population level translates to millions of lost IQ points given the ubiquity of fluoride exposure.”

- Philippe Grandjean, editor-in-chief of the journal Environmental Health, and author of over 500 peer-reviewed papers on toxicity of fluoride, lead, mercury, perfluorinated compounds (like PFAS), and other chemicals says [Grandjean, 2013 book & website]: “Fluoride seems to fit in with lead, mercury and other poisons that cause chemical brain drain.”



This comprehensive collection of expert opinions serves as a stark reminder of the imperative to rigorously examine the potential risks linked to fluoride exposure. Given its profound implications for cognitive health across the population, urgent and meticulous examination of fluoride's effects is not just advisable but essential for informed public health policies.

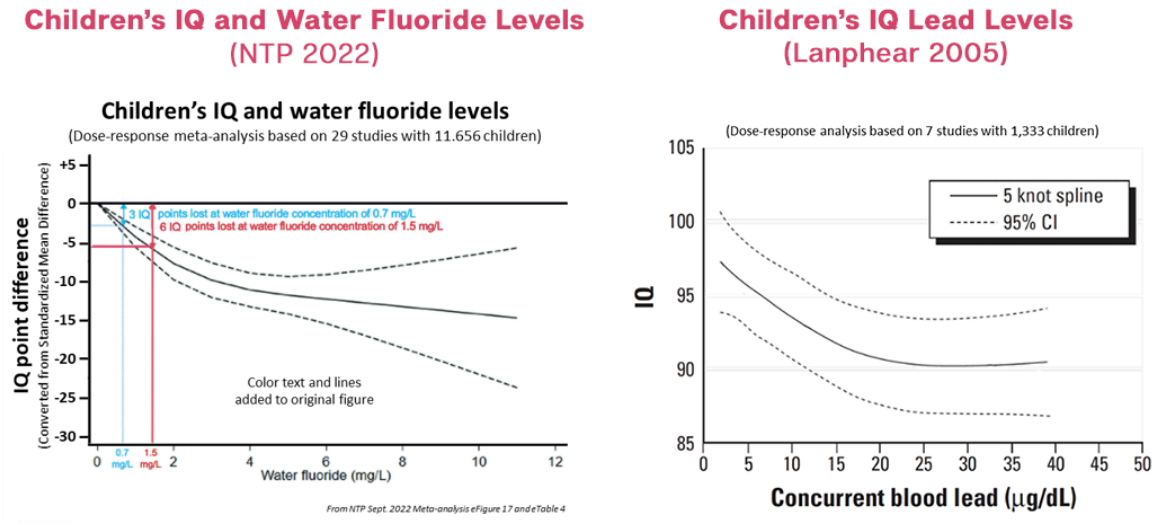
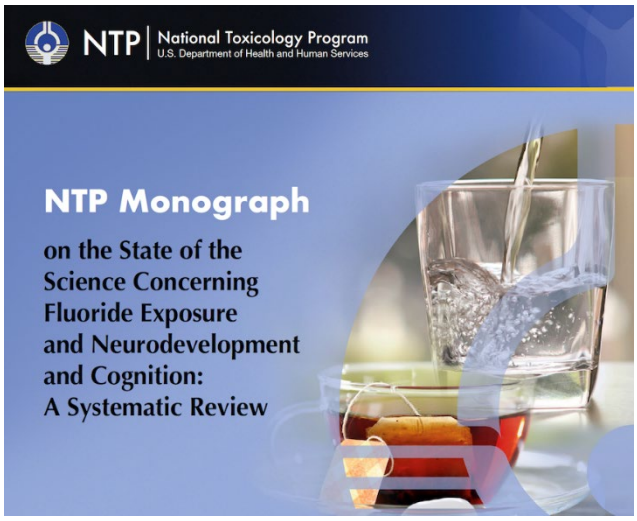


Figure 2. Left: Children's IQ loss with increased fluoride concentration in water, based on 29 studies. Right: Children's IQ loss with increased lead concentration in blood, based on 7 studies. This comparison serves to highlight the similarities between the potential effects of fluoride and lead on child IQ.

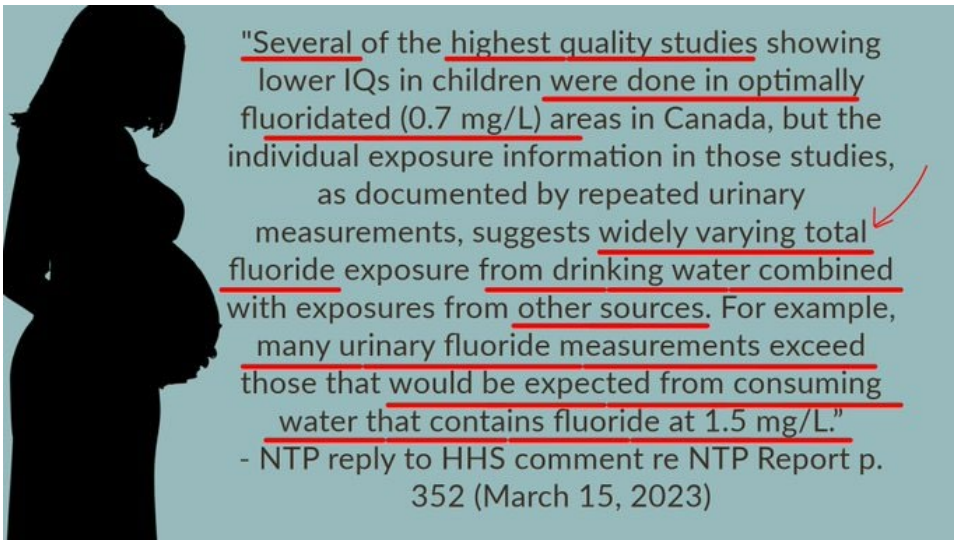
The National Toxicology Program (NTP) has confirmed fluoride's neurotoxicity and shown consistent inverse association between fluoride exposure and a child's IQ.
The comprehensive 8-year National Toxicology Program investigation into the neurotoxicity of fluoride culminated in a final report that comprised two components: a monograph (NTP, 2024) and a meta-analysis (Taylor et al., 2025).

The comprehensive 8-year National Toxicology Program investigation into the neurotoxicity of fluoride culminated in a final report that comprised two components: a monograph (NTP, 2024) and a meta-analysis (Taylor et al., 2025). The NTP found "with moderate confidence, that higher estimated fluoride exposures are consistently associated with lower IQ in children." The NTP reported that out of 72 human studies assessing the association between fluoride exposure and cognitive impairment in children, 64 linked higher fluoride exposures with significantly lower IQs in children, an 89% consistency. Out of the 19 highest-quality studies, 18 found neurotoxicity – 7 of those studies at levels present in "optimally" fluoridated communities.



In the NTP Monograph, authors stated clearly on page 84 of the report that "because people receive fluoride from multiple sources (not just drinking water), individuals living in areas with optimally fluoridated water can have total fluoride exposures higher than the concentration of their drinking water." They continue, "The moderate confidence conclusion may also be relevant to people living in optimally fluoridated areas of the United States depending on the extent of their additional exposures to fluoride…"

The NTP published their meta-analysis in the Journal of the American Medical Association (JAMA) Pediatrics in January of 2025. The average loss NTP found after combining information from 59 studies was 7 points. Reduced IQ was also found in meta-analyses that combined seven high-quality studies having exposures below 1.5 milligrams fluoride per liter of water (mg/L), the range directly relevant to fluoridated areas. The report's dose-response analyses had studies with concentrations as low as 0.3 mg/L finding loss of IQ. Seven studies had concentrations below 1.5 mg/L and an average IQ loss of about 3 points.



The authors emphasized the finding's 'consistency' and 'robustness.' The report also found a clear trend between studies, with IQ losses increasing as study fluoride levels increased. This dose-response relationship strengthens the NTP's conclusion that the effect is real and not an artifact of confounding factors or chance.

The authors warned that:

> "*Although the estimated decreases in IQ … may seem small … research on other neurotoxicants has shown that subtle shifts in IQ at the population level can affect people who fall within the high and low ranges of the population's IQ distribution. For context, a 5-point decrease in a population's IQ would nearly double the number of people classified as intellectually disabled*."

The dose-response curve calculated by NTP provides evidence of a relationship between fluoride exposure and reduced IQ, as illustrated in the reproduced figure below (**Figure 3**).

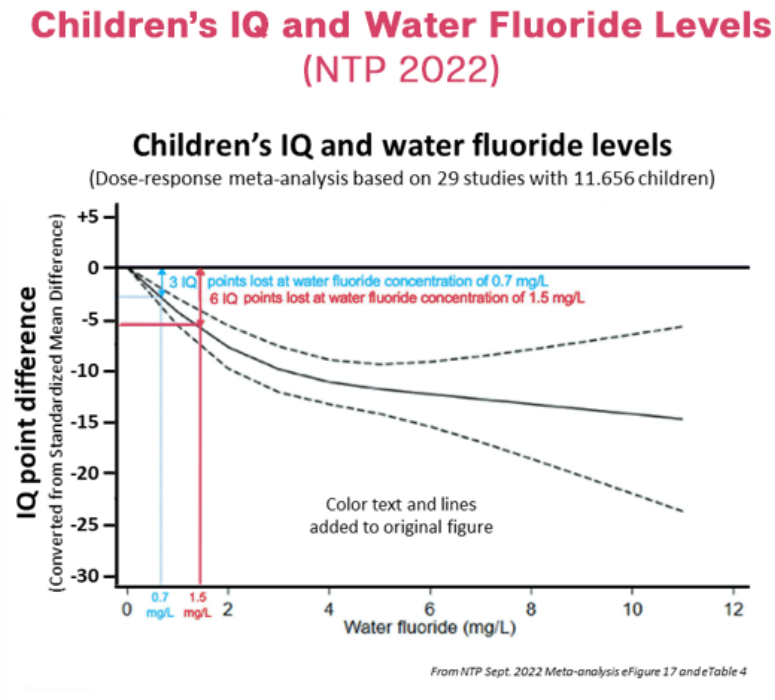


Figure 3. Results of the National Toxicology Program's (2022) meta-analysis of 29 studies investigating the relationship between child IQ and fluoride concentration in water. These results indicate a decline in child IQ with increased fluoride concentration.

A federal court has ruled that fluoridation poses an unreasonable risk to human health.
A lawsuit was brought under the Toxic Substances Control Act of 1976 (TSCA) which allows citizens to petition the Environmental Protection Agency (EPA) to evaluate whether a chemical presents an unreasonable risk to public health and should be regulated. It also empowers citizen groups to challenge the EPA in court after denial of a petition. TSCA gives EPA the authority to prohibit "the particular use" of a chemical substance if it's found to present an unreasonable risk to the general public or susceptible subpopulations.

FAN submitted a Citizens Petition under Section 21 of TSCA to the EPA in November 2016 requesting a ban on the addition of fluoridation chemicals to water. When the EPA denied our Petition, FAN filed suit in federal court in 2017, joined by consumer advocacy groups, Food and Water Watch and Moms Against Fluoridation, public health associations, the American Academy of Environmental Medicine, and the International Academy of Oral Medicine and Toxicology, as well as several individuals representing themselves and/or their children.

After a precedent-setting 7-year legal battle in federal court, an historic ruling by the United States District Court of the Northern District of California has ordered the U.S. Environmental Protection Agency (EPA) to take regulatory action to eliminate the "unreasonable risk" to the health of children posed by the practice of water fluoridation.

The court found that the claims of safety made for over 75 years by the promoters of fluoridation like the American Dental Association and the US Centers For Disease Control were in fact not supported by evidence.

Senior Judge Edward Chen wrote:

> "The Court finds that fluoridation of water at 0.7 milligrams per liter ("mg/L") – the level presently considered "optimal" in the United States – poses an unreasonable risk of reduced IQ in children…the Court finds there is an unreasonable risk of such injury, a risk sufficient to require the EPA to engage with a regulatory response." [page 2]

> "In all, there is substantial and scientifically credible evidence establishing that fluoride poses a risk to human health; it is associated with a reduction in the IQ of children and is hazardous at dosages that are far too close to fluoride levels in the drinking water of the United States…Reduced IQ poses serious harm. Studies have linked IQ decrements of even one or two points to, e.g., reduced educational attainment, employment status, productivity, and earned wages." [page 2]
>
> "The pooled benchmark dose analysis concluded that a 1-point drop in IQ of a child is to be expected for each 0.28 mg/L of fluoride in a pregnant mother's urine. This is highly concerning, because maternal urinary fluoride levels for pregnant mothers in the United States range from 0.8 mg/L at the median and 1.89 mg/L depending upon the degree of exposure. Not only is there an insufficient margin between the hazard level and these exposure levels, for many, the exposure levels exceed the hazard level of 0.28 mg/L." [page 2] "The EPA's default margin of error requires a factor of 10 between the hazard level and exposure level due to variability in human sensitivities…Here, an even greater margin (100x) is owed because the methodology (which yields the 4 mg/L hazard level) uses the lowest observed adverse effect level ("LOAEL"); this methodology adds an additional level of uncertainty (and hence the application of a 100x rather than 10x margin). But even if only the default 10x margin is required, the safe level of fluoride exposure would be 0.4 mg/L (4 mg/L (hazard level) divided by 10). The "optimal" water fluoridation level in the United States of 0.7 mg/L is nearly double that safe level of 0.4 mg/L for pregnant women and their offspring." [page 2]
>
> "The size of the affected population is vast. Approximately 200 million Americans have fluoride intentionally added to their drinking water at a concentration of 0.7 mg/L. Other Americans are indirectly exposed to fluoridated water through consumption of commercial beverages and food manufactured with fluoridated water... Approximately two million pregnant women, and over 300,000 exclusively formula-fed babies are exposed to fluoridated water." [page 76]

The silica fluorides may increase the uptake of lead into children's blood.
Research conducted by Masters and Coplan (1999, 2000, 2007), and to a somewhat lesser extent Macek (2006), has consistently revealed a noteworthy association between the use of fluorosilicic acid (and its sodium salt) for water fluoridation and an increased uptake of lead into children's blood. This correlation received some strong biochemical support from an animal study by Sawan et al. (2010). The study demonstrated that rats exposed to a combination of fluorosilicic acid and lead in their drinking water exhibited a staggering threefold rise in lead absorption into their bloodstream compared to exposure to lead alone. These findings are particularly disconcerting, given the well-documented capacity of lead to damage the developing brain. Nevertheless, this subject is being largely overlooked by countries that continue to implement water fluoridation practices.

Fluoride's neurotoxic effects extend well beyond lowering IQ.

Reduced IQ is not the sole neurotoxic effect that may result from fluoride exposure. Multiple human studies have reported an association between fluoride exposure and impaired visual-spatial organization (Calderon et al., 2000; Li, 2004; Rocha-Amador et al., 2009). Other studies have found an association between prenatal fluoride exposure and fetal brain damage

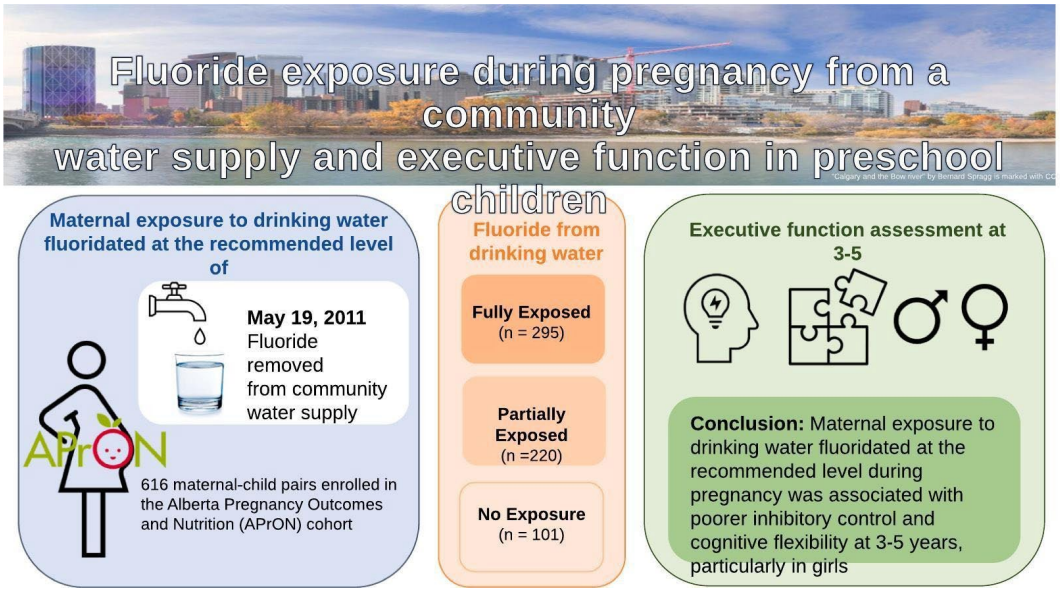
(Han et al., 1989; Du, 1992; Dong et al., 1993; Yu et al., 1996).A study (Malin et al., 2024) published in the Journal of the American Medical Association (JAMA) in May of 2024 found that in fluoridated Los Angeles, the children of mothers with higher fluoride exposures during pregnancy had double the odds of several neurobehavioral problems compared to mothers with lower exposures. Funding for the study was provided by the National Institutes of Health (NIH) and the US Environmental Protection Agency (EPA), reports the Fluoride Action Network (FAN).

Children exposed to more fluoride had significantly more problems with emotional reactivity, somatic complaints (such as headaches), anxiety, and symptoms linked to autism.

In addition to these findings, several studies have reported an increased diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in areas with fluoridated water (Riddell et al., 2019; Malin & Till, 2015; Bashash et al., 2018).

In the Riddell study, which was conducted in fluoridated Canada, they "…found that higher water fluoride levels and fluoridation of municipal water supplies were associated with a higher risk of an ADHD diagnosis as well as increased symptoms of hyperactivity and inattention, especially among adolescents. These findings, which point to a potential cumulative effect of fluoride exposure, highlight the need for further investigation of the potential for fluoride-mediated developmental neurotoxicity in populations with water fluoridation."

Further, there is evidence of a link between exposure to "optimally" fluoridated tap water and diminished inhibitory control and cognitive flexibility (Dewey et al., 2023). These diverse studies underscore the importance of continued research and assessment of the potential neurological effects associated with fluoride exposure.



A graphical abstract from (Dewey et al., 2023) summarizing the study's findings that a mother's exposure to optimally fluoridated water during pregnancy was associated with cognitive impairment for the child.

II. Fluoride Adversely Impacts Human Health Beyond Neurotoxicity.

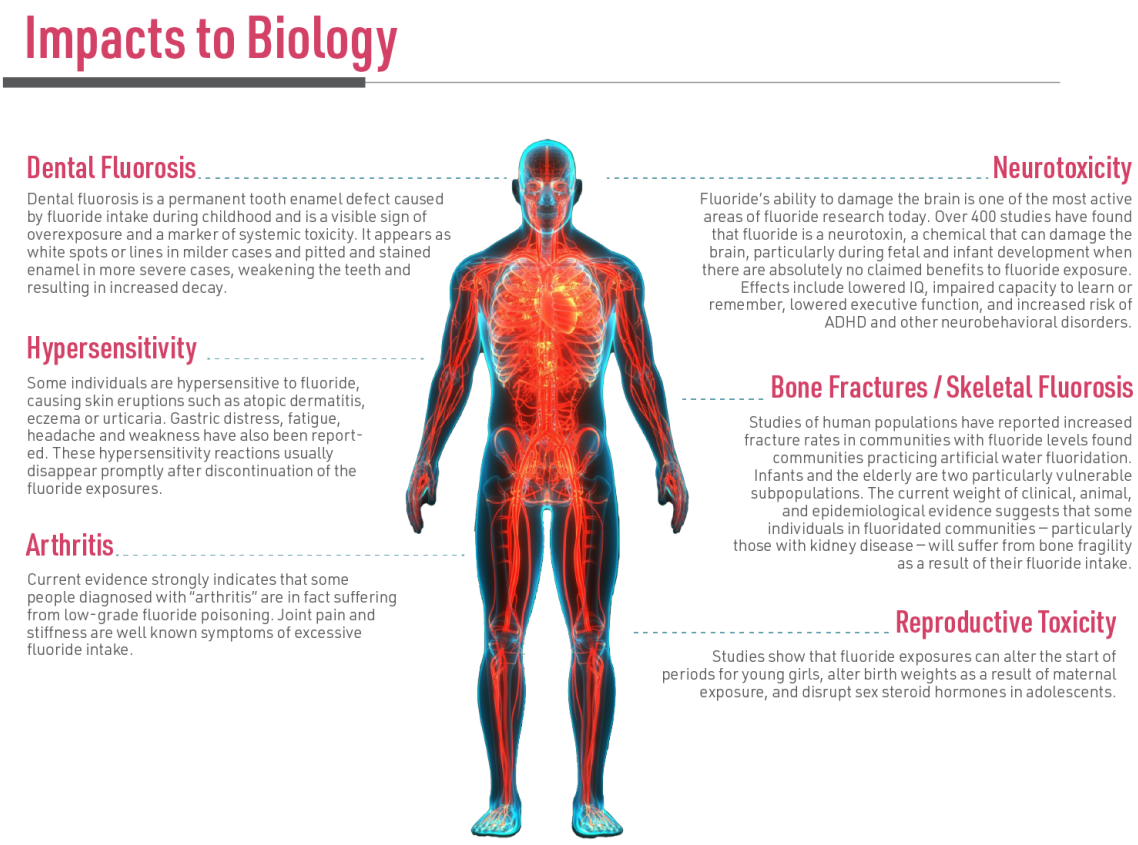


Figure 4. There are many systemic effects of fluoride ingestion beyond dental fluorosis and neurotoxicity. This figure explores the various impacts that fluoride may have on the human body, including to the skin, bones, and reproductive system.

Not a single biological process has been shown to require fluoride. No disease, including tooth decay, can be attributed to a "fluoride deficiency" (National Research Council (NRC), 1993; Institute of Medicine, 1997; NRC, 2006). Furthermore, there is no Recommended Dietary Allowance for fluoride as nutritional requirements have never been established (Harvard T.H. Chan School of Public Health, 2023). Furthermore, there is increasing evidence that fluoride is an enzymatic poison that results in oxidative stress, hormonal disruptions and more. Considering this understanding, large populations are being exposed to fluoridation compounds that have been implicated in a host of diseases, not the least of which is thyroid dysfunction. Fluoride has been implicated in adversely impacting bone remodeling, disrupting melatonin production (and thereby sleep cycles), and accelerating the onset of puberty. At the same time, subsets of the general population are at increased risk, including the elderly and those suffering from kidney disease. The young are at risk as well, as substantiated by the FDA's requirement that all toothpaste sold in the USA be labeled with a poison warning and that it should be kept out of reach of children under 6 years of age.

The FDA mandates a poison warning for all fluoride toothpaste.
The Food and Drug Administration (FDA) requires all fluoride toothpaste sold in the USA to be labeled with a poison warning, instructing those that swallow more than is used for brushing to contact the Poison Control Center. The FDA's Code of Federal Regulations Title 21 (2023); Subchapter D – Drugs for Human Use reads: "**Keep out of reach of children under 6 years of age. If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away.**"

Figure 5. Toothpaste drug fact label showing a warning of ingestion beyond that which is used for brushing teeth.

There is extensive, longstanding evidence that fluoride interferes with many important biological processes.

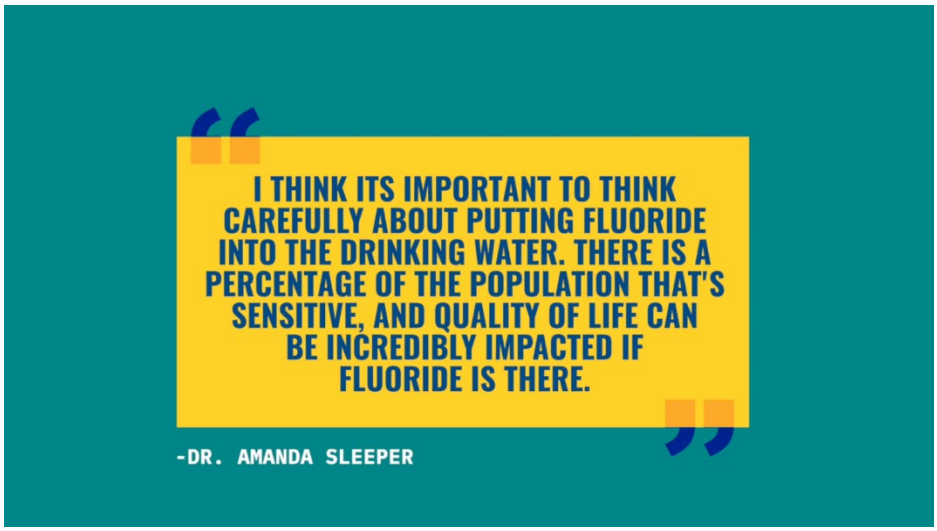
Studies increasingly indicate that fluoride can interfere with biochemistry in fundamental ways (Barbier, 2010). One way in which fluoride can interfere, is with:

- Enzymes: Since 1978, researchers have been aware of fluoride's potential interference with various enzymes (Waldbott, 1978). Research by Ewa Admaek et al. in 2005 provided insights into how fluoride ions may impact enzymes involved in essential cellular metabolic processes such as energy production, and carbohydrate and lipid metabolism. A 2020 meta-analysis conducted by Anna Strunecka and Otakar Strunecky presented compelling evidence indicating that fluoride acts as an enzymatic poison, leading to oxidative stress, hormonal disruptions, and neurotoxic effects.

- G-proteins: Since the 1980s, researchers have known that the combination of fluoride and aluminum disrupts G-proteins (Bigay, 1985; 1987). Recent analysis by Strunecka and Strunecky indicates that fluoride, when combined with aluminum, generates false signals in G-protein cascades responsible for hormonal and neuronal regulations. This occurs at much lower concentrations than when fluoride acts alone. They propose a shift in research focus within the scientific community towards understanding fluoride's toxicity on integrated networks, suggesting that fluoride's diverse toxic effects could potentially contribute to unforeseen future epidemics.

- Hormones and neurotransmitters: Interactions between fluoride and aluminum have been recognized since the 1990s for their potential to disrupt biological signals, impacting growth, hormones, and neurotransmitters (Strunecka & Patocka, 1999; Li, 2003). This interference is compounded by exposure to aluminum fluoride, which can occur through various avenues, including industrial settings such as emissions from aluminum reduction processes (DHHS, 2003). Human exposure to aluminum fluoride can arise from ingesting fluoride sources (e.g., drinking water or residue from fluoride-based pesticides) alongside aluminum sources, such as drinking water, tea, food residues, infant formula, aluminum-containing antacids or medications, deodorants, cosmetics, and glassware (NRC, 2006). Additionally, fluoridation chemicals might contain aluminum fluoride (Mullenix, 2014). Information on the potential neurotoxic effects of chronic exposure to aluminum in water is limited (Carson, 2000). However, many neurotoxic effects associated with fluoride stem from the creation of aluminum fluoride complexes, which mimic the chemical structure of phosphate, influencing ATP phosphohydrolases and phospholipase D activity. Remarkably, only small concentrations of aluminum are required to form aluminum fluoride (NRC, 2006). Repeated or prolonged inhalation exposure to these compounds might lead to asthma and can affect the bone and nervous system, resulting in bone alterations (fluorosis) and nervous system impairment (ILO & WHO, 2012).

Subsets of the population are both highly sensitive and vulnerable to fluoride's toxicity. Some individuals are highly sensitive to even the lowest levels of fluoride as demonstrated by case studies and double-blind studies (Waldbott, 1958, 1959; Feltman & Kosel, 1961; Shea et al., 1967; Grimbergen, 1974). One 13-year study showed that approximately 1% of patients given 1 mg of fluoride daily developed negative reactions (Feltman & Kosel, 1961). Related to this, many individuals have reported suffering from symptoms such as fatigue, headaches, rashes and stomach and gastrointestinal tract problems, which disappear when they avoid fluoride in their water and diet. (Shea, 1967; Waldbott et al., 1978; Moolenburgh 1987) Frequently, the symptoms reappear when they are unwittingly exposed to fluoride again (Spittle, 2008). Yet, no government in countries where fluoridating water takes place has conducted scientific studies to take this issue beyond these anecdotal reports. Without the willingness of governments to investigate these reports scientifically, it begs the question of whether we as a society should be forcing these people to ingest fluoride?



In addition to people suffering from impaired kidney function (as discussed previously), fluoride's toxicity can disproportionately affect other subsets of the population as well. According to the Agency for Toxic Substances and Disease Registry (ATSDR, 2010), these include: infants, pregnant women, the elderly, and those with renal problems or diabetes mellitus. Also vulnerable are those who suffer from malnutrition (e.g., calcium, magnesium, vitamin C, vitamin D and iodine deficiencies and protein-poor diets) and those who have diabetes insipidus. See: Massler & Schour, 1952; Greenberg et al., 1974; Klein, 1975; Marier & Rose, 1977; Seow & Thomsett, 1994; Lin et al., 1991; Chen et al., 1997; Teotia et al., 1998.

Dental fluorosis may be an indicator of wider systemic damage.
There have been many suggestions as to the possible biochemical mechanisms underlying the development of dental fluorosis (DenBesten, 1999; Matsuo et al., 1998; Sharma et al., 2008; Duan et al., 2011; Tye et al., 2011). While promoters of fluoridation are content to dismiss mild dental fluorosis as merely a cosmetic effect, it is rash to assume that fluoride is not impacting other tissues (Colquhoun, 1997). Moreover, ingested fluoride causes dental fluorosis during the period of tooth enamel formation, which occurs before the permanent teeth have erupted (typically around age 6 to 8); meaning other tissues are potentially susceptible to damage throughout life (and long before it may be realized). On a related note, fluorosis is endemic in at least two dozen countries with millions of people in India, China, and Africa suffering from skeletal fluorosis in particular (a fluoride-induced bone and joint disease).

Fluoride damages bone, especially in those suffering from kidney disease.
Unsurprisingly, fluoride can also damage bone. An early fluoridation trial (Newburgh-Kingston 1945–55) found a significant, two-fold increase in cortical bone defects among children in the fluoridated community (Schlesinger et al., 1956). The cortical bone is the outside layer of the bone and is important to protect against fracture. While this result was not considered important at the time with respect to bone fractures, it did prompt questions about a possible link to osteosarcoma (Caffey, 1955; Groth, 1973). In 2001, Alarcon-Herrera and co-workers reported a linear correlation between the severity of dental fluorosis and the frequency of bone fractures in both children and adults in a high fluoride area in Mexico.

Notably, individuals with kidney disease, due to their potential difficulty in effectively excreting fluoride, are prone to accumulating high levels of fluoride in their bones and bloodstream, (Schiffl, 2008). As a result of this high fluoride body burden, kidney patients have an elevated risk for developing skeletal fluorosis. In one of the few U.S. studies investigating the matter, crippling skeletal fluorosis was documented among patients with severe kidney disease drinking water with just 1.7 ppm fluoride (Johnson et al., 1979). Given severe skeletal fluorosis in kidney patients has been detected in small case studies, it is possible that larger, systematic studies would detect skeletal fluorosis at even lower fluoride levels.

Fluoride may adversely impact bone density and bone remodeling and put the elderly at risk of osteoporosis and fractures, including hip fractures.
Several studies have investigated the effect of fluoride concentration on patients with osteoporosis, expecting higher doses to reduce fracture rates. Instead, researchers observed the opposite effect, with higher doses associated with greater numbers of fractures, particularly hip fractures (Inkovaara et al., 1975; Gerster et al., 1983; Dambacher et al., 1986; O'Duffy et al., 1986; Hedlund et al., 1989; Bayley et al., 1990; Gutteridge et al., 1990, 2002; Orcel et al., 1990; Riggs et al., 1990; Schnitzler et al., 1990). Hip fractures are a serious issue for older adults, often leading to a loss of independence and/or a shortened lifespan.

Since 1990, more than a dozen studies have investigated a possible relationship between hip fractures and long-term consumption of artificially fluoridated water or water with naturally high fluoride levels. However, the findings have been somewhat mixed, with some studies reporting an association while others have not. Interestingly, some have even claimed a protective effect (Sowers et al., 1991; Karagas et al., 1996; Kurttio et al., 1999; Hillier et al., 2000; Phipps et al., 2000; Li et al., 2001).

One important study conducted in China, which investigated hip fractures across six Chinese villages, observed what appears to be a dose-dependent increase in hip fractures as fluoride concentrations rose from 1 ppm to 8 ppm (Li et al., 2001). This discovery provides little comfort for individuals who regularly consume fluoridated water.

Furthermore, the only human epidemiological study to evaluate bone strength as a function of bone fluoride concentration, conducted by researchers from the University of Toronto, found that (consistent with animal studies) the strength of bone declined with increasing fluoride content (Chachra et al., 2010). Another study from Iowa published data suggesting that even low-level fluoride exposure may have an adverse effect on cortical bone density in girls (Warren et al., 2009). This effect on cortical bone density has been repeatedly documented in clinical trials and has been proposed as an important mechanism by which fluoride may increase bone fracture rates (Levy et al., 2009). Finally, a recent high-quality study from Sweden investigating the relationship between fluoride and hip fractures found a 50% higher rate of hip fractures associated with a 1 mg/L increase in urine fluoride levels (Helte et al., 2021; Nicole, 2021).

Fluoride may cause bone cancer (osteosarcoma).
A government-funded animal study conducted in the United States found a dose-dependent increase in bone cancer (osteosarcoma) in male rats treated with fluoride (NTP, 1990). Following the results of this study, the National Cancer Institute (NCI) reviewed national cancer data in the U.S. and found a significantly higher rate of osteosarcoma in young men in fluoridated versus unfluoridated areas (Hoover et al., 1991a). Despite the NCI's conclusion, which, due to statistical limitations, did not definitively attribute fluoridation as the cause (Hoover et al 1991b), it failed to provide an explanation for the heightened rates in the fluoridated areas.

A smaller-scale study conducted in New Jersey (Cohn, 1992) further underscored these concerns by demonstrating that osteosarcoma rates in young men living in fluoridated areas were up to six times higher than those in unfluoridated areas.

While it is essential to acknowledge that various epidemiological studies, differing in size and quality, have not consistently substantiated this fluoride-osteosarcoma association (a comprehensive summary of these can be found in Bassin, 2001 and Connett et al., 2005), there are three reasons why such a connection remains plausible:

1) Fluoride accumulates to a high level in bone.

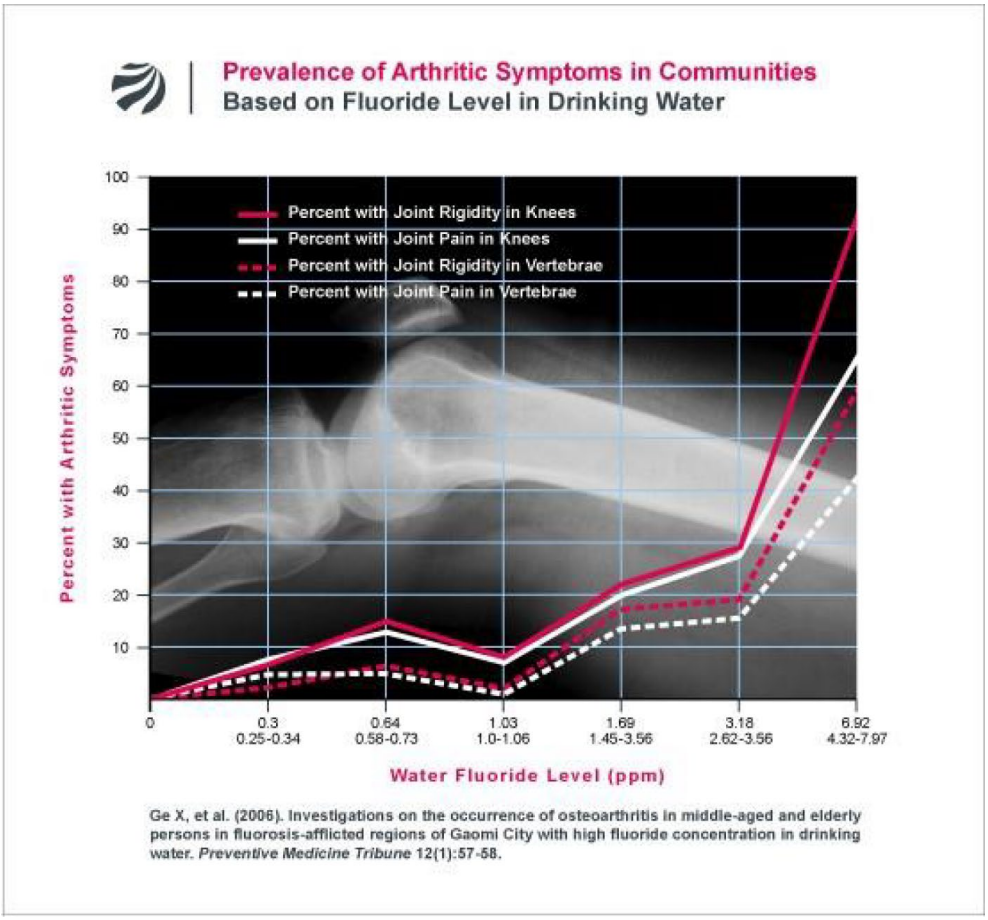
2) Fluoride stimulates bone growth and at the same time disrupts bone remodeling.

3) Fluoride can interfere with the genetic apparatus of bone cells in several ways. Fluoride has been shown to be mutagenic, cause chromosome damage, and interfere with the enzymes involved with DNA repair in both cell and tissue studies (Tsutsui et al., 1984; Caspary et al., 1987; Kishi & Ishida, 1993; Mihashi & Tsutsui, 1996; Zhang et al., 2009).

In addition to cell and tissue studies, a correlation between fluoride exposure and chromosome damage in humans has also been reported (Sheth et al., 1994; Wu & Wu, 1995; Meng & Zhang, 1997; Joseph et al., 2000).

Fluoride causes clinical symptoms that mimic arthritis, and as such, leads to misdiagnoses. Some of the early symptoms of skeletal fluorosis often resemble those of arthritis (Singh, 1963; Franke et al., 1975; Teotia et al., 1976; Carnow & Conibear, 1981; Czerwinski et al., 1988; DHHS, 1991). A review paper published in Chemical & Engineering News underlines this similarity by stating, "Because some of the clinical symptoms mimic arthritis, the first two clinical phases of skeletal fluorosis could be easily misdiagnosed" (Hileman 1988). There have been few, if any, comprehensive studies conducted to determine the extent of these misdiagnoses and whether the high prevalence of arthritis in America (where 1 in 3 Americans have some form of arthritis – CDC, 2002) and other fluoridated countries is related to growing fluoride exposure.

Even when individuals in the U.S. develop advanced forms of skeletal fluorosis, it is not uncommon for them to endure years of misdiagnoses before finally receiving an accurate diagnosis. This underscores the urgent need for further research and awareness in this critical area.



Fluoride adversely affects the pineal gland, leading to reduced melatonin production and early onset of puberty.
Evidence suggests that elevated levels of fluoride can accumulate within the human pineal gland (Luke, 2001). Moreover, there exists a significant correlation between this phenomenon and animal studies revealing fluoride's potential to inhibit melatonin production, a crucial factor that is integral to the 'sleep cycle' and that can also trigger the premature onset of puberty (Luke, 1997).

Consistent with these findings, one of the earliest fluoridation trials conducted in the U.S. (Schlesinger et al., 1956) reported that, on average, girls in the fluoridated community reached menstruation 5 months earlier than girls in the non-fluoridated community. Astonishingly, no fluoridating country has attempted to replicate either Luke's or Schlesinger's findings or to undertake a more comprehensive exploration of this issue.

Fluoride depletes iodine levels and adversely affects thyroid function.
Fluoride blocks iodine receptors, preventing iodine from being absorbed (and used by your body). Unlike fluoride, iodine is an essential nutrient that our bodies need to make thyroid hormones. According to the U.S. National Research Council (2006), "several lines of information indicate an effect of fluoride exposure on thyroid function." In the Ukraine, Bachinskii et al. (1985) observed a decrease in thyroid function among individuals exposed to 2.3 ppm fluoride in their water, despite being otherwise healthy. During the mid-20th century, fluoride was prescribed by a number of European doctors to reduce the activity of the thyroid gland for those suffering from hyperthyroidism (overactive thyroid) (Stecher, 1960; Waldbott et al., 1978). According to a clinical study by Galletti and Joyet (1958), the thyroid function of hyperthyroid patients was effectively reduced at just 2.3 to 4.5 mg/day due to fluoride ions.

To put this into context, the Department of Health and Human Services (DHHS, 1991) estimated that the total fluoride exposure in fluoridated communities ranged from 1.6 to 6.6 mg daily. This is a remarkable fact, particularly when considering the escalating issue of hypothyroidism (underactive thyroid) in the United States and other fluoridated countries. Symptoms of hypothyroidism include depression, fatigue, weight gain, muscle and joint pains, increased cholesterol levels, and heart disease. In 2010, the second most prescribed drug of the year was Synthroid® (sodium levothyroxine), a hormone replacement medication used to treat underactive thyroid conditions. Recent research has further emphasized this concern, demonstrating that a half-milligram-per liter increase in drinking water fluoride levels (roughly equivalent to the difference in exposure level between the fluoridated and non-fluoridated communities) was associated with a 1.65 increase in the likelihood of a hypothyroidism diagnosis during pregnancy (Hall, 2023). This adds to a growing body of evidence indicating that fluoride exposures from artificially fluoridated water can indeed impair thyroid function. Prior studies that observed an effect include a study encompassing nearly the entire population of England (Peckham et al., 2015), a large nationally representative sample from Canada using the CHMS survey (Malin et al., 2018), a case-control study in Iran (Kheradpisheh et al., 2018); and a substantial analysis of children in China, where mean water and urine fluoride levels were found to be only slightly higher than in areas with artificial fluoridation (Wang et al., 2020)

Fluoride may cause reproductive and related hormonal problems.
Fluoride, when administered to animals in high doses, has been shown to have detrimental effects on the male animal's reproductive system. It damages sperm and increases the rate of infertility across several different species (Kour & Singh, 1980; Chinoy & Sequeria, 1989; Chinoy et al., 1991; Susheela & Kumar, 1991; Kumar & Susheela, 1994; Narayana & Chinoy, 1994a; Narayana & Chinoy, 1994b; Zhao et al., 1995; Elbetieha et al., 2000; Ghosh et al., 2002; Zakrzewska et al., 2002).

However, certain animal studies conducted by FDA researchers have failed to find conclusive evidence of reproductive toxicity in fluoride-exposed rats (Sprando et al., 1996, 1997, 1998). Despite this, the National Research Council (2006) has recommended that "the relationship between fluoride and fertility requires additional study."

In line with this, an epidemiological study conducted from the United States discovered higher rates of infertility among couples residing in areas with water containing 3 ppm or more of fluoride (Freni, 1994). Conversely, two separate studies observed increased fertility among men living in regions with high –fluoride levels in China and India (Liu et al., 1988; Neelam et al., 1987). Additionally, four studies have reported reduced levels of circulating testosterone in males living in high-fluoride areas (Barot, 1998; Chen et al., 1997a; Susheela & Jethanandani, 1996; Hao et al., 2010), and a study involving fluoride-exposed workers documented a "subclinical reproductive effect" (Ortiz-Perez et al., 2003). These findings collectively suggest a need for further investigation into the potential reproductive implications of fluoride exposure.

Potentially related to reproductive and hormonal problems, several studies, including one using CDC data, have found changes to fetal development/ birthweight at fluoride exposure levels typically found in fluoridated communities (Arun et al., 2022; Ortiz-Garcia et al., 2022; Kampouri et al., 2022). Interestingly, the effects of fluoride were seen across all three trimesters.

III. Fluoridation Is Unnecessary.

The debate surrounding water fluoridation as a method to combat dental decay has been a topic of discussion for decades. Contrary to expectations, ingestion of fluoridation chemicals in water does not correlate with reduced tooth decay in fluoridating countries. In fact, between 1970 and 2010, non-fluoridating countries have witnessed similar declines in tooth decay rates as their fluoridating counterparts. Today, according to data from the World Health Organization (WHO), there is no discernible difference in tooth decay between the minority of developed countries that fluoridate water and the majority that do not.

These findings raise questions about the efficacy of water fluoridation in improving oral health. Additionally, fluoridation's purported benefits are overstated and based predominantly on outdated studies that are heavily criticized for their poor methodology and flawed selection of control communities and thus are deemed irrelevant by today's standards. The scientific consensus today is that the benefits of fluoride are derived predominantly when applied topically, making ingestion unnecessary. As we delve further into the evidence, it becomes increasingly apparent that the relationship between fluoridation and dental decay is far more complex than previously thought, prompting a reconsideration of the conventional approach to fluoride delivery.

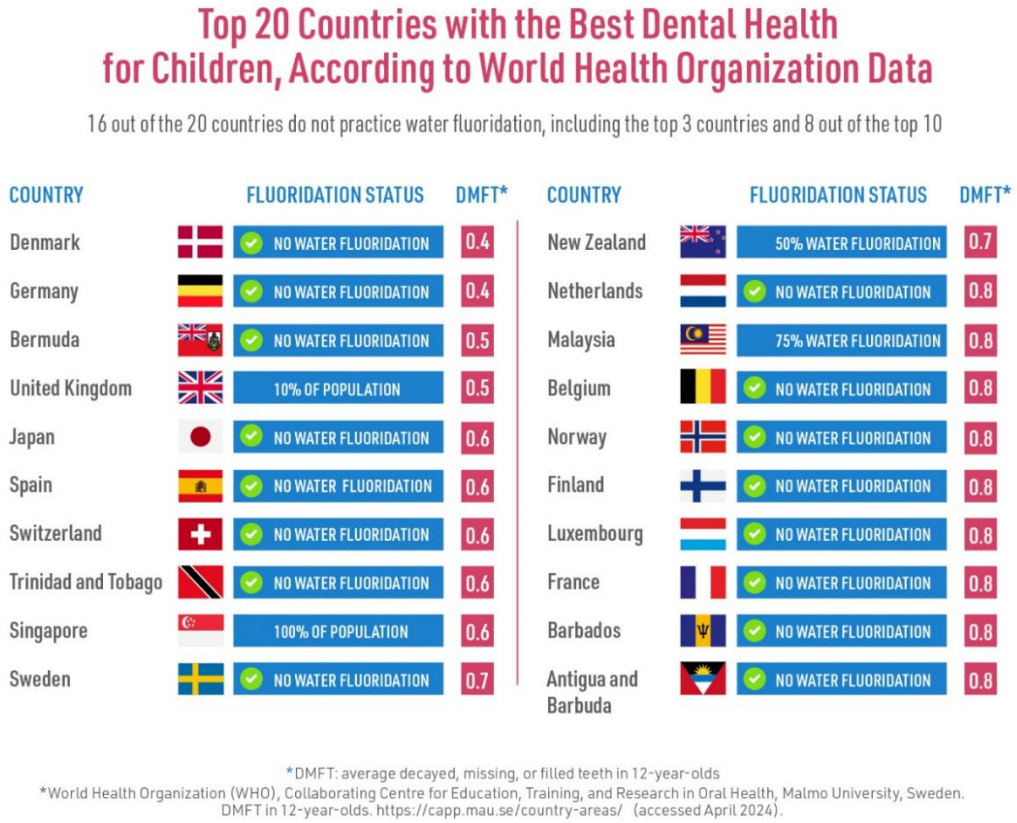


Figure 6. List of the top 20 countries with the best dental health measured by average Decayed, Missing, and Filled Permanent Teeth (DMFT) in 12-year-olds.

Fluoride acts topically, so swallowing it maximizes risk and minimizes potential benefit. The Centers for Disease Control and Prevention (CDC, 1999, 2001) has acknowledged that fluoride's benefits are derived mainly from its topical use, and not from systemic ingestion. The most recent relevant study found no significant correlation between ingested fluoride and cavity reduction, further validating a 2009 study that stated: "Achieving a caries-free status may have relatively little to do with fluoride intake ...recommending an 'optimal' fluoride intake is problematic." (Warren et al., 2009; Curtis et al., 2018).

In other words, the available evidence suggests there is insufficient justification for the widespread consumption of fluoridated water for the purpose of protecting one's teeth. This is especially pertinent when considering that the benefit of fluoride relates to its topical application, while the most significant concerns center around potential systemic effects. Considering this, it appears more reasonable to administer fluoride directly to the teeth through toothpaste, as opposed to mandating its ingestion through the water supply. This approach would align more closely with the principle of targeted and informed dental care while minimizing the potential risks associated with systemic exposure to fluoride.

NIH-funded study on individual fluoride ingestion and tooth decay found no significant correlation.
A multi-million dollar, U.S. National Institutes of Health (NIH)-funded study found no significant relationship between tooth decay and fluoride intake among children (Warren, 2009). In fact, the report's conclusion stated that "firmly recommending an 'optimal' fluoride intake is problematic." This was the first time that tooth decay was investigated as a function of individual exposure as opposed to mere residence in a fluoridated community.

Non-fluoridating countries have experienced the same level of decline in dental decay as fluoridating countries (between 1965 and 2021).
Most western, industrialized countries have not only rejected water fluoridation, but also have experienced the same decline in childhood dental decay as seen in countries that fluoridate their water, as evidenced in **Figure *7*.**

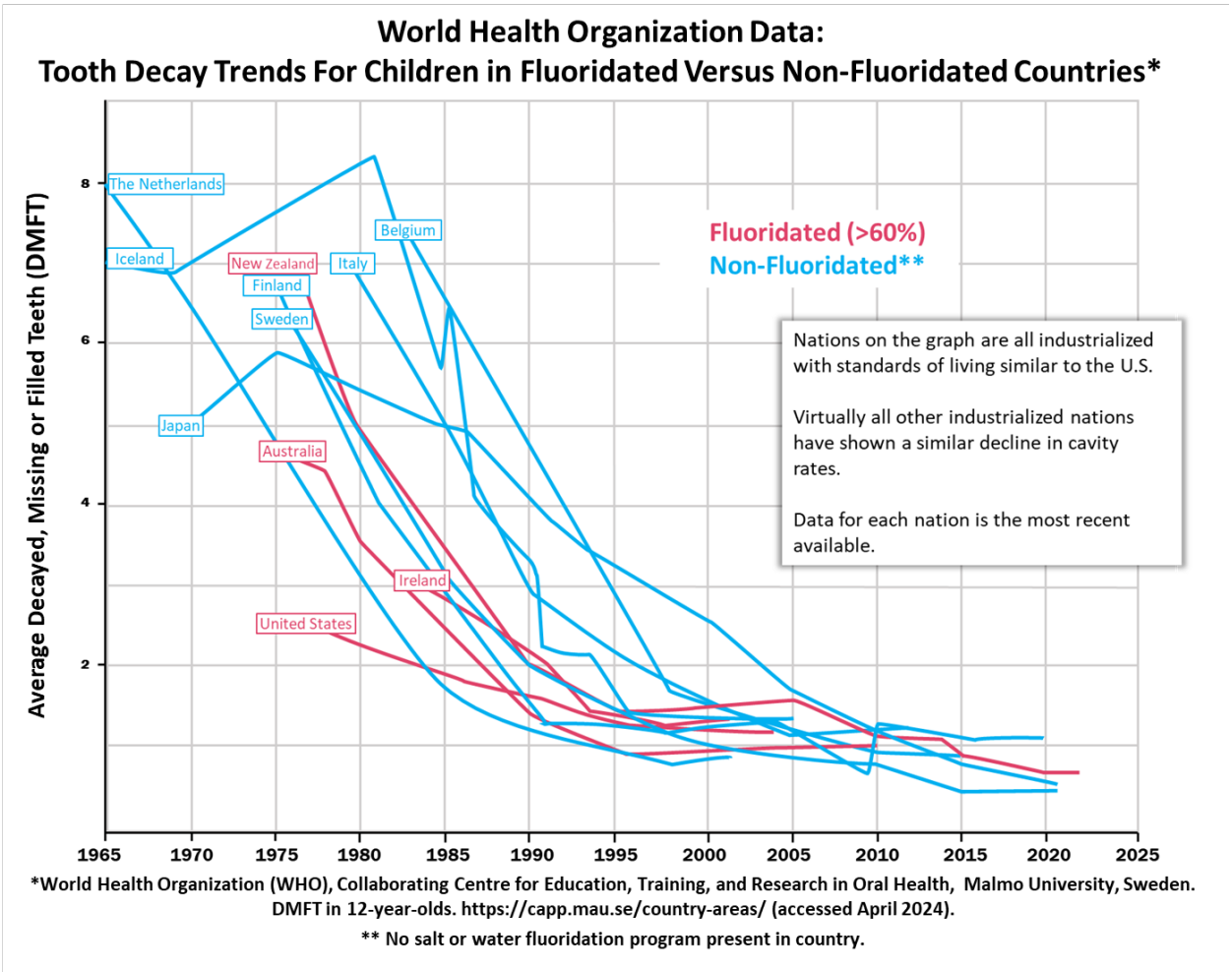


Figure 7. Trends of tooth decay in 12-year-olds from fluoridated (red) and non-fluoridated (blue) countries from 1965-2021. Data was collated from the World Health Organization (WHO). The non-fluoridated countries have generally seen the same decline in childhood tooth decay trends over this period as the fluoridating countries.

Tooth decay was declining before fluoridation started.
Research indicates that tooth decay rates were already declining in Australia and New Zealand before the introduction of fluoridation. Remarkably, this decline has persisted even beyond the point at which the full benefits of fluoridation would have been expected to take effect (Colquhoun 1997; Diesendorf 1986).

As **Figure 8** indicates, it is evident that multiple factors are inextricably associated with the reduction in tooth decay rates, and these include better diets and better dental care to name just a few. These findings are consistent with a broader pattern observed across the western world, emphasizing that the decline in tooth decay cannot be attributed solely to fluoridation, but rather is influenced by a range of interconnected factors.

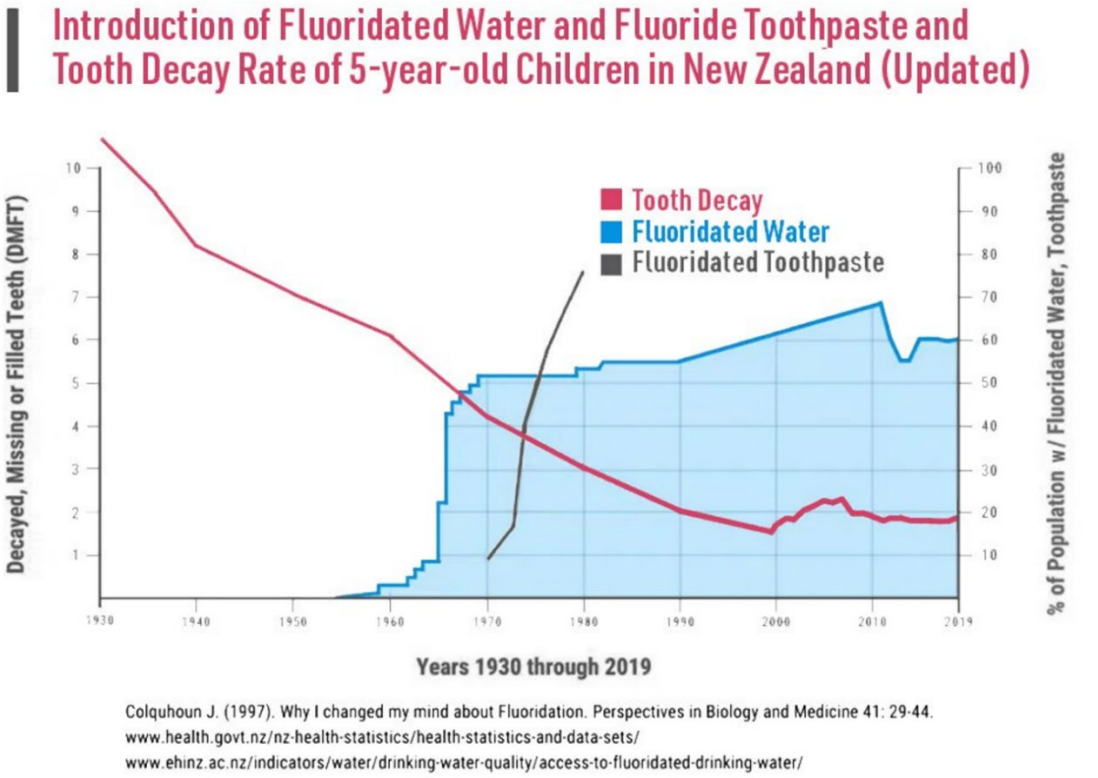


Figure 8. 50-year decline in tooth decay of 5-year-olds in New Zealand. Compiled from Health Department records of 5-year-olds' tooth decay, 1930-1990 fluoridation, and fluoride toothpaste sales. Tooth decay (red) was declining prior to the introduction of fluoridated water (blue).

Tooth decay does not increase when fluoridation is stopped.
In communities across Canada, Germany, Cuba and Finland where fluoridation has been discontinued, dental decay rates have not exhibited an increase as might be expected. Instead, they have generally continued their declining trend (Maupomé 2001; Kunzel & Fischer, 1997, 2000; Kunzel et al., 2000; Seppa et al., 2000, Iheozor-Ejiofor, 2015). These findings provide compelling evidence that the cessation of fluoridation does not necessarily lead to a resurgence in dental decay, and at the same time reinforces the notion that a range of factors are at play in influencing oral health outcomes.

U.S. Government data suggest that there is no association between fluoridation and childhood dental decay.

The CDC's data on the "Percentage of Students with Caries Experience–treated or untreated tooth decay" revealed some interesting findings regarding dental decay rates and fluoridation in various states (CDC, 2013). It should be noted that the reference can no longer be found on the CDC website; however, its findings are summarized in the paragraph that follows.

In Vermont, children exhibited the second-lowest overall rate of dental decay in the nation, despite the state ranking 39th for the percentage of the population receiving fluoridated water. Similarly, New Hampshire ranked third in low dental decay rates, despite ranking 43rd in terms of population fluoridation. Specifically, Vermont's rate of children's dental decay was 35%, while New Hampshire's was slightly higher at 35.5%. These statistics are particularly significant when compared to states, such as Kentucky, with some of the highest rates of dental decay among children, despite having the highest fluoridation rates in the nation for decades: At best, fluoridation results in a reduction of only one-half cavity per child and one cavity per adult (over a 40-year period).

State	Percentage of Population with Fluoridated Water	Dental Decay Rate
Kentucky	99.9%	59.6%
Minnesota	98.8%	54.9%
Illinois	98.5%	52.4%

According to multiple highly reputable studies, the effectiveness of fluoridation in preventing cavities is, at most, an average reduction of one-half cavity per child, with some low-end estimates finding no statistically significant reduction. The Cochrane Collaboration, known for its rigorous evaluations, has questioned the applicability of previous findings showing benefit, because they were "based predominantly on old studies and may not be applicable today." All of these studies also studied effects at higher fluoridation levels than we have presently, studying levels of 1.0 or 1.2 ppm. The Cochrane Collaboration also highlighted that "Over 97% of the 155 studies were at a high risk of bias, which reduces the overall quality of the results... We did not identify any evidence... to determine the effectiveness of water fluoridation for preventing caries in adults... There is insufficient evidence to determine whether water fluoridation results in a change in disparities in caries levels across socio-economic status" (Iheozor-Ejiofor, 2015).

Study / Findings	Year	Finding
Cochrane Collaboration	2015	0.5 fewer cavities per child and no evidence of fluoridation's effectiveness in adults. In aggregate, the data shows that children aged 6-17 average 2.1 cavities in their permanent teeth.
CDC (Slade et al.)	2018	0.5 fewer cavities per child
Iowa Fluoride Study	2018	No significant reduction
Warren et al.	2009	"...caries-free status may have relatively little to do with fluoride intake."
World Health Organization data	2005	No evidence of fluoridation's effectiveness

For adults, the strongest studies all found that fluoridation, at most, resulted in a one-cavity reduction over a 40-year period (Slade et al., 2013; Do et al., 2017; Slade et al., 2018), aligning with Cochrane's assertion of insufficient evidence for fluoridation's efficacy in preventing adult caries. Cochrane stated, "We did not identify any evidence . . . to determine the effectiveness of water fluoridation for preventing caries in adults."

Indeed, there is a consensus among organizations, including the CDC, National Research Council, Cochrane Collaboration, Iowa Fluoride Study and others that fluoride's primary effectiveness comes from topical contact with teeth, rather than ingestion (NRC, 2006; Cheng et al., 2007; Charone et al., 2012; Iheozor-Ejiofor, 2015; Curtis et al., 2018). Robust scientific evidence is lacking for the benefit of swallowing fluoride compared to targeted topical applications.

Notably, the largest U.S. survey conducted by the National Institute of Dental Research (NIDR) involving over 39,000 children from 84 communities, found a meager difference in tooth decay among children in fluoridated and non-fluoridated communities (Hileman 1989). The study found an average difference of only 0.6 DMFS (Decayed, Missing, and Filled Surfaces) in the permanent teeth of children aged 5-17 residing their entire lives in either fluoridated or unfluoridated areas (Brunelle & Carlos, 1990). This difference is less than one tooth surface, and less than 1% of the 100+ tooth surfaces available in a child's mouth.

The LOTUS study of over 6 million adults in England, published in January 2024 was the largest, strongest study of fluoridation effectiveness in adults ever done and found virtually no benefit: a lifetime reduction in decay of only 2%. The LOTUS study authors concluded:

> "This study suggests that exposure to optimal water fluoridation between 2010 and 2020 resulted in 'exceedingly small' health effects, 'very small' reductions in NHS dental service utilization, and no meaningful reduction in social inequalities." [Moore 2024, p. 7]

An accompanying economic analysis for the LOTUS study found the meager dental bill savings would be worth only about $1 a year per person; not enough to buy a single cup of coffee. Furthermore, the analysis did not consider the capital costs of new fluoridation schemes, let alone the cost of adverse effects, such as reduced IQ and dental fluorosis.

A large 10-year fluoridation study in the northwest of England concluded that fluoridation's effects on tooth decay in children are "very modest" and "much smaller than previous studies have reported (Goodwin, 2022). The authors summed up their findings by writing:

> "The 4% difference we found [in primary teeth] may not be large enough to convince communities to support water fluoridation schemes. Other ways of preventing tooth decay may be better now that use of fluoride toothpaste is so common and levels of tooth decay are much lower than they were 40 years ago."

Furthermore, the study results indicated that the benefit of fluoridation for permanent teeth was even smaller than that seen in deciduous teeth. Among 11-year-olds, there were only 3% fewer caries-free children in fluoridated communities than in non-fluoridated communities. Additionally, the study did not demonstrate any significant additional reduction in caries for fluoride-deprived children, thus indicating that fluoridation did not alleviate disparities. Large

surveys from three Australian states have observed even less of a benefit, with decay reductions ranging from 0 to 0.3 of one permanent tooth surface (Spencer 1996; Armfield & Spencer 2004). None of these studies have allowed for the possible delayed eruption of the teeth that may be caused by exposure to fluoride, for which there is some evidence (Komarek 2005). A one-year delay in eruption of the permanent teeth would eliminate the very small benefit recorded in these modern studies.

IV. An Unmet Burden of Proof: Fluoridation Has Not Been Proven Safe for Everyone.

The practice of water fluoridation has been a contentious issue for decades, marked by the periodic formation of review panels that often produce reports in favor of fluoridation. Recent examples of such panels are discussed in the sections below. It seems that, at least in certain instances, political considerations have taken precedence over scientific evidence and recommendations. This sets the stage for the following evaluation of fluoridation: delving into questions about its efficacy, the absence of randomized controlled trials, and concerns about the potential harms associated with fluoridation.

There has never been a single randomized controlled trial to demonstrate fluoridation's effectiveness or safety.
Despite the long-standing practice of adding fluoride to community water supplies for over 75 years, it is noteworthy that "there have been no randomized trials of water fluoridation" (Cheng et al., 2007) among the broader population. Randomized trials are a standard method for assessing the safety and efficacy of any proposed medical intervention, making their absence in this context a notable observation. Some fluoridation advocates say that "nature thought of fluoridation first". By this, they mean that fluoride occurs at naturally high levels in some water supplies. Lots of toxic substances, however, like lead, arsenic, and even some medicines, such as lithium, can occur at naturally high levels. This does not mean they are safe.

Systemic fluoride supplementation has never been FDA approved to verify safety or effectiveness.
The absence of rigorous randomized trials has led to the continued classification of fluoride by the U.S. Food and Drug Administration (FDA) as an "unapproved new drug." This classification underscores the need for further research and evaluation to better understand the potential benefits and risks associated with water fluoridation.

The chemicals used for fluoridation have not been tested comprehensively.
In animal studies, the chemical typically assessed is pharmaceutical grade sodium fluoride, rather than industrial grade fluorosilicic acid, which is typically the compound that is added to public water supplies. Advocates argue that once these silicon fluorides have been diluted at public water treatment facilities, they completely dissociate, resulting in the formation of free fluoride ions and hydrated silica. This, they claim, eliminates the need for toxicological examination of these compounds.

It is worth noting that a study conducted at the University of Michigan (Finney et al., 2006) demonstrated this complete dissociation (of silicofluorides) at a neutral pH, and it found that a stable complex in acidic conditions, comprising five fluoride ions, which contradicts the claim of complete dissociation in water. The possibility that such a complex could potentially reform in the sustained, highly acidic environment of the stomach (where the pH typically ranges between 1 and 2) warrants further investigation.

Fluoridation chemicals may leach lead from pipes, brass fittings and soldered joints.
In tightly controlled laboratory experiments, Maas et al (2007) have demonstrated that fluoridation chemicals in combination with chlorinating agents, such as chloramine, increase the leaching of lead (that is, releasing lead from the pipes and putting into the water) from brass fittings used in plumbing. While proponents may argue about the neurotoxic effects of low levels of fluoride, there is no argument that lead at very low levels lowers IQ in children.

Endorsements do not represent scientific evidence.
Numerous proponents of fluoridation often rely on a list of endorsements as part of their argument. The U.S. Public Health Service (PHS) first endorsed fluoridation in 1950, before any completed trials or significant health studies had been published (see chapters 9 and 10 in The Case Against Fluoride for the significance of this PHS endorsement for the future promotion of fluoridation). Many other endorsements swiftly followed with limited scientific justification. The continued use of these endorsements appears to be driven more by political considerations than rigorous medical science.

The studies that launched fluoridation were methodologically flawed.
The early trials conducted in North America between 1945 and 1955 that helped to launch fluoridation have faced substantial criticism for their poor methodology and flawed selection of control communities (De Stefano 1954; Sutton 1959, 1960, 1996; Ziegelbecker 1970). According to Dr. Hubert Arnold, a statistician from the University of California at Davis, these early fluoridation trials "are especially rich in fallacies, improper design, invalid use of statistical methods, omissions of contrary data, and just plain muddle-headedness and hebetude." Questions have also been raised concerning Trendley Dean's (the father of fluoridation) renowned 21-city study from 1942 (Ziegelbecker 1981).

There is an absence of credible research with respect to fluoridation's efficacy.
According to the well-known toxicologist, Dr. John Doull, who chaired the National Academy of Science's (NAS) review on fluoride, the safety of fluoridation remains "unsettled" and "we have much less information than we should, considering how long it has been going on." In 2006, Doull's committee at the National Academy of Sciences (NAS) published an exhaustive 500-page review of fluoride's toxicity. The report drafted by its central subcommittee, the National Research Council (NRC), concludes that fluoride is an "endocrine disruptor" and can adversely affect many things in the body, including the bones, the brain, the thyroid gland, the pineal gland, and even blood sugar levels.

Furthermore, in the January 2008 issue of Scientific American, Professor John Doull was quoted as highlighting the need for a fresh perspective on fluoride (Fagin, 2008). He stated:

"What the committee found is that we've gone with the status quo regarding fluoride for many years—for too long really—and now we need to take a fresh look . . . In the scientific community people tend to think this is settled. I mean, when the U.S. surgeon general comes out and says this is one of the top 10 greatest achievements of the 20th century, that's a hard hurdle to get over. But when we looked at the studies that have been done, we found that many of these questions are unsettled and we have much less information than we should, considering how long this [fluoridation] has been going on."

Meanwhile, in 2000, the British Government's "York Review" did not grant any fluoridation trial a Grade A classification, despite 50 years of research (McDonagh et al., 2000).

It is important to recognize that the absence of credible research on a particular topic should not automatically be interpreted as evidence of the absence of harm. Such an assumption can be irresponsible and potentially misleading. Responsible research and policymaking should take a precautionary approach when there is uncertainty about potential risks or harm. Public health and safety should always be paramount, and decision-makers should base their actions on a well-rounded evaluation of the available evidence, considering both potential benefits and potential harm.

Review panels hand-picked to deliver a pro-fluoridation result.
Periodically, governments that have promoted fluoridation as safe and effective for decades form selective panels to produce reports that publicly reaffirm water fluoridation, particularly when the practice is faced with new science showing harm or opposition from scientific professionals and the public. This tactic has been acknowledged even by proponents of fluoridation, such as Alan Freeze and Jay Lehr in their 2009 book "Fluoride Wars" when they write:

> "There is one anti-fluoridationist charge that does have some truth to it. Anti-fluoride forces have always claimed that the many government-sponsored review panels set up over the years to assess the costs and benefits of fluoridation were stacked in favor of fluoridation. A review of the membership of the various panels confirms this charge. The expert committees that put together reports by the American Association for the Advancement of Science in 1941, 1944 and 1954; the National Academy of Sciences in 1951, 1971, 1977 and 1993; the World Health Organization in 1958 and 1970; and the U.S. Public Health Service in 1991 are rife with the names of well-known medical and dental researchers who actively campaigned on behalf of fluoridation or whose research was held in high regard in the pro-fluoridation movement. Membership was interlocking and incestuous."

Recent examples of this trend can be seen in the reports by the Irish Fluoridation Forum (2002), the National Health and Medical Research Council (NHMRC, 2007), and Health Canada (2008, 2010). In the latter case, a panel of six experts reviewed the health literature, with four being pro-fluoridation dentists and the other two lacking demonstrated expertise on fluoride. However, there was a notable exception to this pattern when the U.S. National Research Council's appointed a balanced, expert panel to examine fluoride's toxicity in the U.S. This panel of twelve reviewed the US EPA's safe drinking water standards for fluoride. After three and half years, the panel concluded in a 507- page report that the safe drinking water standard was not protective of health and a new maximum contaminant level goal (MCLG) should be determined (NRC, 2006).

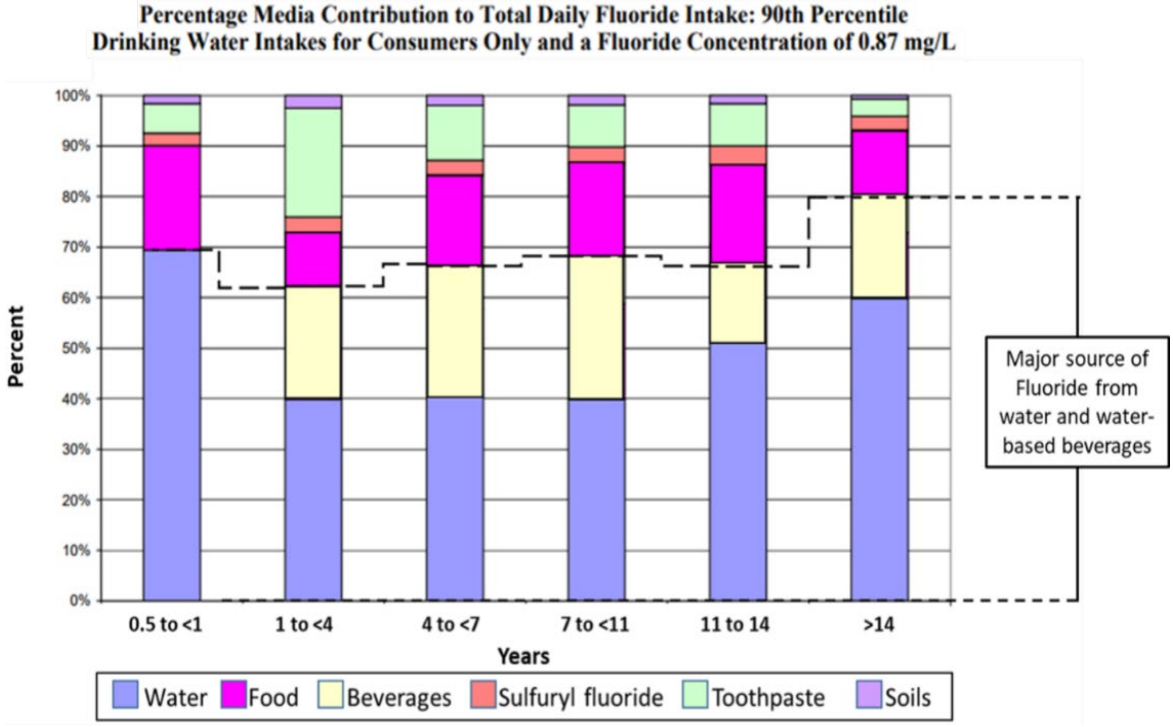
Despite the expectation that standard toxicological procedures and appropriate safety margins would lead to the end to water fluoridation based on their findings, the U.S. EPA Office of Water, in January 2011, indicated they would not determine a value for the MCLG that might jeopardize the water fluoridation program (EPA press release, Jan 7, 2011). Once again, political consideration appeared to outweigh scientific evidence and recommendations.

V. There is Widespread Overexposure to Fluoride, and It Bioaccumulates.

There are several important dimensions to consider when discussing fluoridation in relation to human health. Firstly, fluoride, once ingested, accumulates in the body. Studies reveal that healthy adult kidneys excrete only a fraction (60%) of the fluoride they consume, and infants and children retain a significant portion in their bones and calcifying tissues, including the pineal gland. Secondly, fluoride exposure does not merely originate from fluoridated water; it stems from various sources, including food and beverages processed with fluoridated water, dental products, tea, etc. Moreover, concerns emerge about the potential leaching of lead from pipes due to the presence of fluoridating agents in water, with lead exposure at very low levels being associated with lower IQ in children. Lastly, the dental consequences of water fluoridation present significant issues, with the prevalence of dental fluorosis, a defect of tooth enamel caused by fluoride's interference with the tooth-forming cells, reaching alarming levels. These crucial concerns underscore the need for comprehensive assessment and transparency in the practice of water fluoridation to ensure public health and safety.

Water Is primary source of exposure, but other sources add to the problem.
Fluoridated water is by far the most significant, making up upwards of 70% of exposures for infants, but not the only source of fluoride exposure for most U.S. citizens (EPA 2010). Other sources of fluoride include food and beverages processed with fluoridated water (Kiritsy et al., 1996; Heilman et al., 1999), fluoridated dental products (Bentley et al., 1999; Levy & Guha-Chowdhury, 1999), mechanically deboned meat (Fein & Cerklewski, 2001), tea (Levy & Guha-Chowdhury, 1999), pharmaceuticals (O'Hagan, 2010), food packaging, Teflon pans (Full & Parkins, 1975), workplace exposures (Hodge & Smith, 1977), and pesticide residues (e.g., from cryolite) on food (Stannard et al., 1991; Burgstahler & Robinson, 1997). It is now widely acknowledged that exposure to non-water sources of fluoride has significantly increased since the water fluoridation program first began (NRC, 2006). In fact, when fluoridation first began, there was not a single tube of toothpaste that contained fluoride. Today, over 95% of toothpastes are fluoridated (CDC, 2023). The concern today, therefore, is not only the safety of fluoridated water itself, but the safety of fluoridated water in combination with all the other sources to which we are now exposed. And yet, no regular measurements are being made of the levels of fluoride in urine, blood, bones, hair, or nails of either the general population or sensitive subparts of the population (e.g., individuals with kidney disease).

Figure 9. The percentage contributed by each of the media (water, food, beverages, sulfuryl fluoride, toothpaste, and soils) to daily total fluoride intake. It is apparent that, for most individuals in the population, the contribution from drinking water is substantially less than the 100% assumed in the EPA 1986 derivation of the MCLG for crippling skeletal fluorosis. However, the contribution from drinking water for adults who are not at risk for dental fluorosis (60%) is greater than the limiting value for children (40%), who are susceptible to severe dental fluorosis.



Tens-of-Millions of children have visible signs of overexposure to fluoride (dental fluorosis).

The fluoridation program has notably fallen short of achieving one of its primary objectives: reducing dental decay rates while minimizing a side-effect of overexposure to fluoride from ingestion during early childhood development, called dental fluorosis. It is characterized by permanent staining and discoloration of tooth enamel due to fluoride causing alterations in the mineralization process. Initially, the proponents of fluoridation aimed to restrict dental fluorosis (in its very mild form) to only 10% of children (NRC, 1993, pp. 6-7).

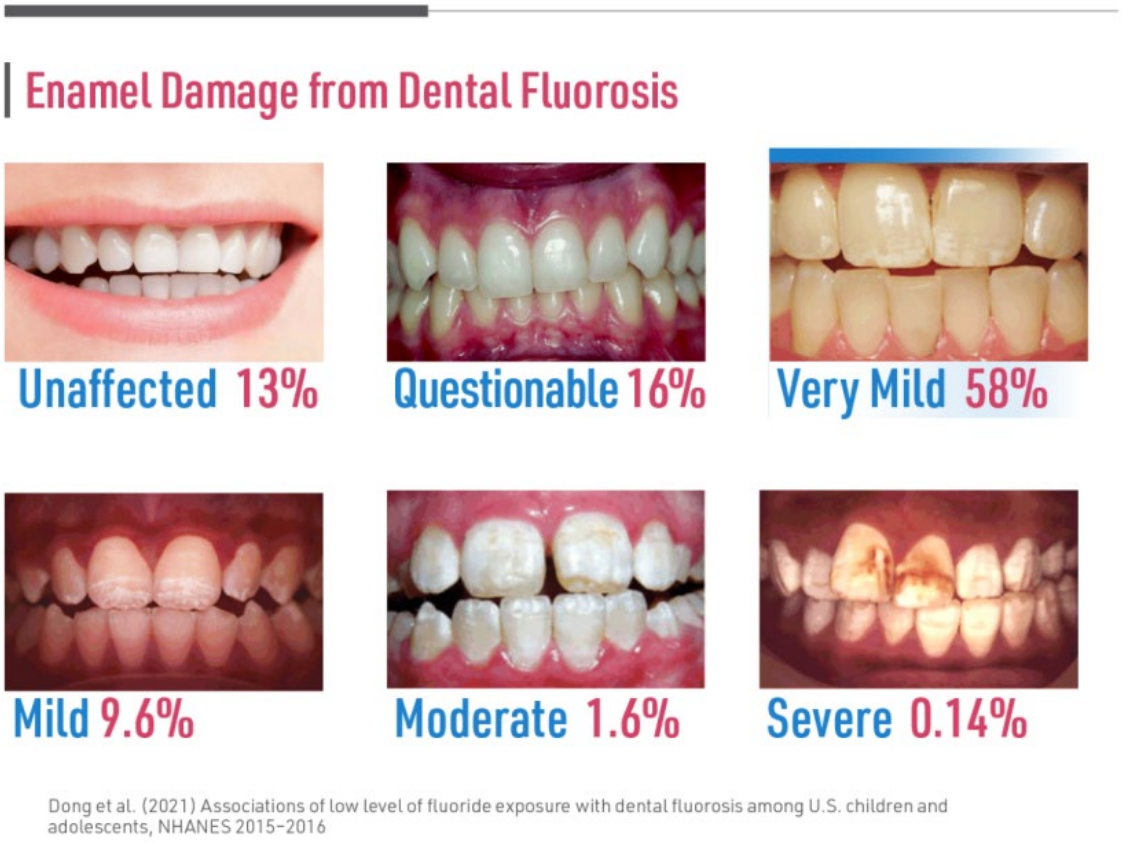


Figure 10. Pictorial representations of various severity levels of dental fluorosis. Percentages pertain to the proportion of the sampled population (n=2098) that exhibited a certain severity level of fluorosis. Statistics from Dong et al., 2021.

However, as of 2023, the US Centers For Disease Control and Prevention's (CDC) National Health and Nutrition Examination Survey (NHANES) reported that between 70% and 87.3% of adolescents aged 12 to 15 in the U.S. now exhibit dental fluorosis (Hung et al., 2023). This condition primarily results from ingestion of fluoride in water and beverages originating from fluoridated communities, especially among children up to the age of 8 (i.e., long before their permanent teeth have fully erupted). The CDC collected the aforementioned data in 2013–14, marking an increase from the 65% reported in 2011–2012 (Neurath et al., 2019) and the 41% reported in data generated between 1999 and 2004 (Beltrán-Aguilar et al., 2010).

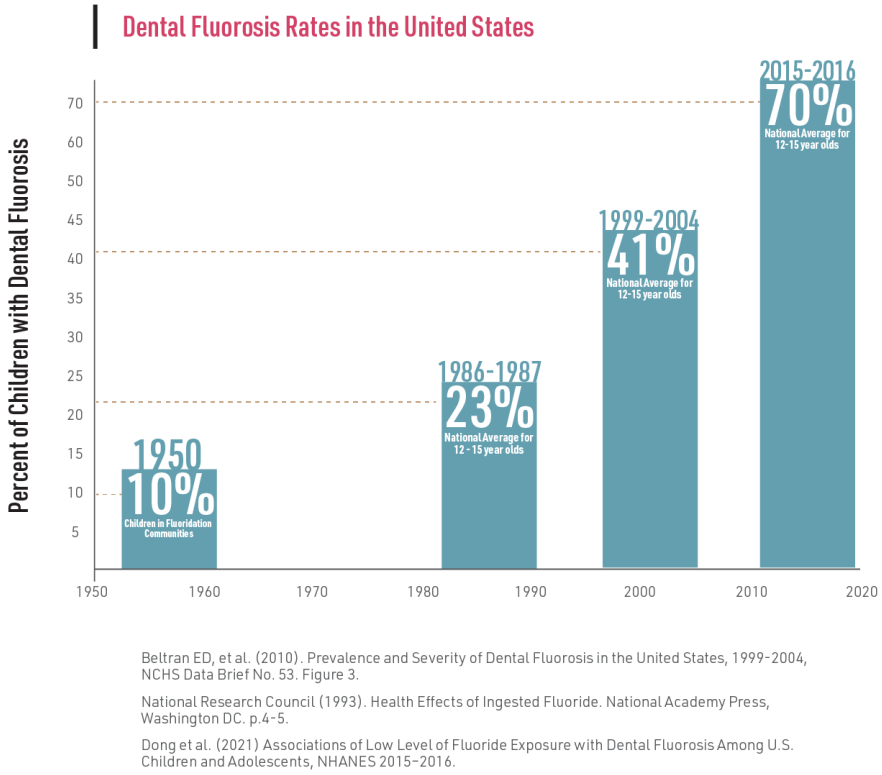


Figure 11. Dental fluorosis rates in the United States from 1950-2016. In 1950, 10% of children **in fluoridated communities** exhibited dental fluorosis. From 1986-1987, 23% of 12–15-year-olds in the U.S. (including those in fluoridated and non-fluoridated communities) exhibited dental fluorosis. From 1999-2004, 41% of 12-15-year-olds exhibited dental fluorosis. From 2015-2016, 70% of 12-15-year-olds exhibited dental fluorosis.

In 2000, the British Government's York Review estimated that up to 48% of children in fluoridated areas worldwide experienced dental fluorosis in all forms, with 12.5% having fluorosis of aesthetic concern (McDonagh, 2000). It is reasonable to assume that this figure has likely risen over the past two decades, mirroring the trend observed in the U.S.

The highest doses of fluoride are going to babies fed formula prepared with fluoridated water.

The concentration of fluoride in human breastmilk is low (0.004 ppm, NRC, 2006) compared to the range typically found in fluoridated water (0.6 to 1.0 ppm). Infants who consume formula made with fluoridated tap water consume up to 700 to 1,200 micrograms of fluoride, or about 100 times more than the recommended amount (Levy & Guha-Chowdhury, 1999; EWG, 2006; NRC, 2006). Moreover, not only do bottle-fed infants consume substantially higher levels of fluoride compared to their breast-fed counterparts, but they also exhibit the highest fluoride exposure in terms of their body weight within the entire population (NRC, 2006).

According to the CDC, these early spikes of fluoride exposure during infancy provide no known advantage to teeth (Frieden, 2012). Extensive research has consistently identified infant exposure to fluoridated water as a major risk factor for cognitive impairment and development of dental fluorosis later in life (Marshall et al., 2004; Hong et al., 2006; Levy et al., 2010; Till et al., 2019). In 2020, a study funded by the National Institute of Health (NIH) and published in the journal Environment International further underscored these concerns. The study suggested that infants fed formula prepared with fluoridated water exhibited average IQ scores 6 points lower than those mixed with non-fluoridated water. Notably, the losses in non-verbal IQ were even more substantial, averaging 13 points lower.

Considering these alarming risk factors, several dental researchers have recommended against using fluoridated water when reconstituting formula (Ekstrand 1996; Pendrys & Katz, 1998; Fomon et al., 2000; Brothwell & Limeback, 2003; Marshall 2004; Till et al., 2020). Even the American Dental Association (ADA), the most ardent institutional proponent of fluoridation, sent an email alert to its members on November 6, 2006, recommending that parents be advised to prepare formula with "low or no-fluoride water." However, the dissemination of this crucial information to parents has been limited, leaving many unaware of the risk of fluorosis from infant exposure to fluoridated water.

Today, the Institute of Medicine (1997) recommends that babies consume a minuscule 10 micrograms of fluoride per day. This is roughly the equivalent of what babies ingest from breast milk, which contains virtually no fluoride (Ekstrand et al., 1981)

Fluoride accumulates in the body.

Healthy adult kidneys excrete only 60% of the fluoride ingested daily (Buzalaf & Whitford, 2011). Infants and children excrete less fluoride from their kidneys and absorb up to 80% of ingested fluoride into their bones (Ekstrand et al., 1994). The remainder accumulates in the body, primarily in calcifying tissues, such as the bones and pineal gland (Luke, 1997, 2001). The fluoride concentration in bone steadily increases over a lifetime (NRC 2006). Recent studies have shown that fluoride accumulation can weaken bone, increase hip fractures in elderly women and arm fractures in children, as well as increase arthritic inflammation (Helte et al 2021; Lindsay et al., 2023; Meng et al., 2023).

VI. Health Injustice: Mandated Fluoride Ingestion from Cradle to Grave has Socioeconomic Implications.

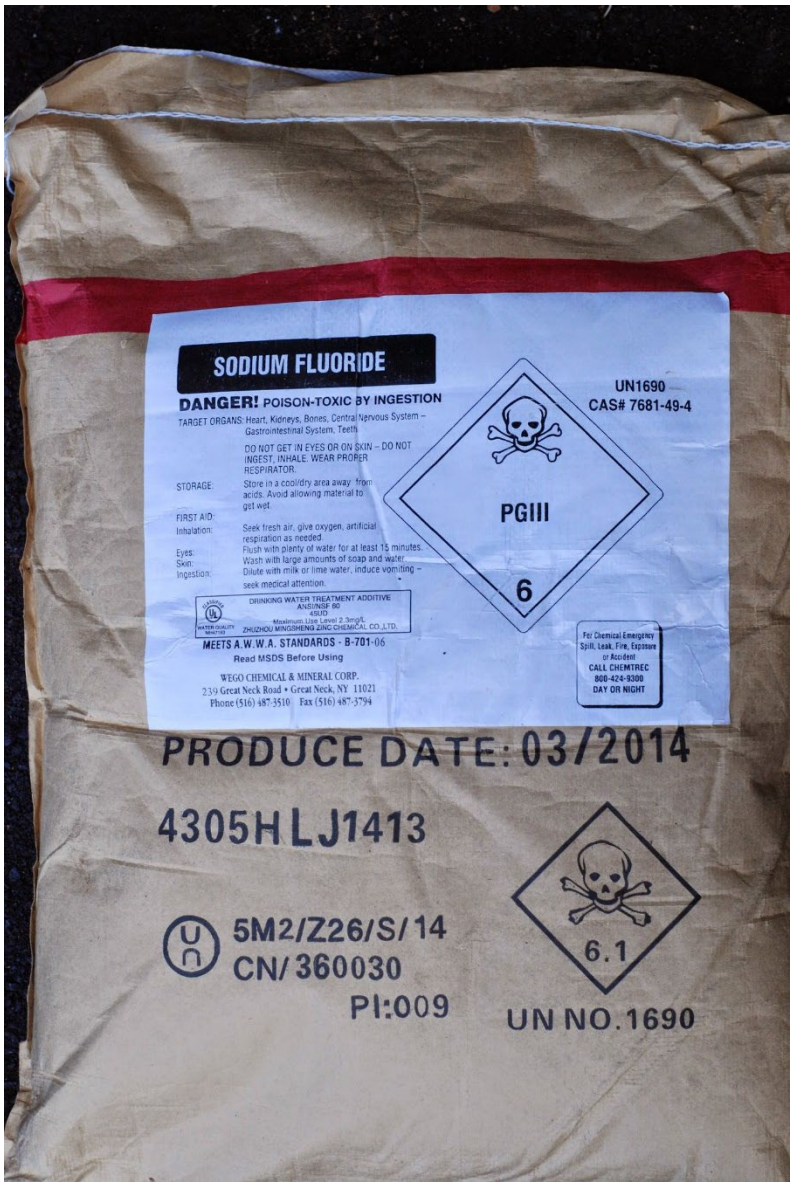
The ethical dimensions of water fluoridation present a profound concern, as the practice raises critical issues related to informed consent, precision in dosage, and the quality of chemicals used in the process. Informed consent, a fundamental principle in healthcare, stands at the heart of the debate, as it entails permitting governments to impose medication on entire communities without their individual consent. The inability to provide individualized care in water fluoridation further complicates the matter, as varying water consumption among different individuals leads to inconsistent dosage. The potential absence of a safety margin for several health effects and disparities in the dental health of low-income communities further deepen the debate, leading to concerns about health injustice and the heightened vulnerability of minority populations. The ethical, scientific, and socioeconomic implications of water fluoridation underscore the necessity of a comprehensive reevaluation of this public health practice.

Fluoride is administered without informed consent when put into public water supplies.
Although fluoride advocates sometimes claim that fluoride is a "nutrient", the National Academy of Sciences has repeatedly confirmed that this is not the case (1989). Because fluoride is not a nutrient, the FDA has defined fluoride as a medication when used to prevent disease (Plaisier, 2000). Since tooth decay is a disease, adding fluoride to water to prevent tooth decay is – as a matter of logic – a form of medication. Informed consent is a fundamental principle in the administration of medication, and it stands as one of the core reasons why the majority of Western European countries have rejected water fluoridation. Fluoridation essentially permits governments to impose on entire communities what individual healthcare professionals are ethically prohibited from doing to individual patients—namely, compelling them to undergo medical treatment without their informed consent. Put another way: Should a voter possess the authority to mandate that their neighbor ingest a certain medication, even when it goes against that neighbor's will and consent? With other medications, it is the patient, not the doctor, who has the right to decide which drug to take (AMA Council on Ethical and Judicial Affairs, 2012). Fluoridation denies people this right.

Fluoridation equates to a lack of individualized care.
While regulating the dosage of an individual's medication is a common practice, achieving this precision with fluoride is unattainable. Once water undergoes fluoridation, maintaining a consistent dose for each person becomes impossible due to the varying amounts of water people consume. Disparities arise as some individuals, such as manual laborers, athletes, diabetics, and those with kidney disease, ingest significantly larger volumes of water compared to others. According to Dr. Arvid Carlsson, the 2000 Nobel Laureate in Medicine and Physiology and one of the scientists who helped keep fluoridation out of Sweden: "Water fluoridation goes against

leading principles of pharmacotherapy, which is progressing from a stereotyped medication — of the type 1 tablet 3 times a day — to a much more individualized therapy as regards both dosage and selection of drugs. The addition of drugs to the drinking water means exactly the opposite of an individualized therapy" (Carlsson, 1978).

The chemicals used to fluoridate water are not pharmaceutical grade.
Surprisingly, the chemicals used to fluoridate water are not pharmaceutical grade. Instead, they primarily come from the wet scrubber systems of the phosphate fertilizer industry. These chemicals (90% of which are sodium fluorosilicate and fluorosilicic acid) are classified as hazardous wastes contaminated with various impurities (Mullenix, 2014). Recent testing by the National Sanitation Foundation suggests that the levels of arsenic in these silicon fluorides are relatively high (up to 1.6 ppb after dilution into public water) and of potential concern (NSF 2000; Weng et al,, 2000). Arsenic is a well-known human carcinogen for which there is no safe level. This one contaminant alone could be increasing cancer rates – and unnecessarily so.



There is no margin of safety for a number of significant health effects.
The evidence demonstrating the adverse effects of high natural fluoride levels on health is incontrovertible. In well over 15 countries with known fluoride-rich regions spanning from the United States to the Middle East and the Far East, millions of individuals suffer from compromised health due to excessive fluoride exposure (Undee et al., 2018).

The crucial question at hand revolves around whether there exists an adequate safety margin between the doses of fluoride that have been shown to cause harm in published studies and the total dose people are exposed to from various sources, including water and non-water sources. This margin of safety should consider the wide range of individual sensitivity expected within a large population. Typically, a safety factor of 10 is applied to the lowest observed level causing harm.

Additionally, it's essential to account for the wide spectrum of fluoride doses to which individuals are exposed. Alarmingly, there appears to be no discernable margin of safety for dental fluorosis (Beltrán-Aguilar et al., 2010; Neurath et al., 2019; Hung et al., 2023). Moreover, based on numerous studies, the evidence suggests that there is nowhere near an adequate margin of safety for concerns related to lowered IQ (Xiang et al., 2003 a,b; Ding et al., 2011; Choi et al., 2012; Bashash et al., 2017; Green et al., 2019), reduced thyroid function (Galletti & Joyet, 1958; Bachinskii et al., 1985; Lin et al., 1991), bone fractures in children (Alarcon-Herrera et al., 2001), hip fractures in the elderly (Kurttio et al., 1999; Li et al., 2001; Helte et al., 2021), reproductive health, kidney and liver function. For more information, see the 2006 NRC Review.

Tooth decay is high in low-income communities that have been fluoridated for years.
Contrary to some assertions, water fluoridation alone cannot address the oral health crises stemming from inadequate nutrition and limited access to dental care, particularly prevalent in impoverished communities. There have been numerous reports of severe dental crises in low-income neighborhoods of fluoridated U.S. cities that have persisted for over two decades (e.g., Boston, Cincinnati, New York City, and Pittsburgh) (Kozol, 1991; Kong, 1999; Solvig, 2002; Law, 2005).

In addition, research consistently demonstrates that fluoridation is ineffective in preventing one of the most pressing oral health issues facing economically disadvantaged children—early childhood caries, commonly known as "baby bottle tooth decay" (Barnes et al., 1992; Shiboski et al., 2003).

Kentucky, a state that has mandated fluoridation for all communities serving 3,000 citizens or more for the past three decades, boasts the second-highest percentage of its population receiving fluoridated water (CDC, 2020). Despite this, Kentucky currently leads the nation in adult tooth loss (Benefield, 2023).

Considering dental decay disproportionately affects impoverished communities, our focus should be directed towards expanding access to dental care for low-income families. Presently, the most severe rates of tooth decay today are found in low-income areas that have been fluoridated for an extended period.

The true "Oral Health Crisis" confronting the United States today does not stem from a deficiency of fluoride, but rather from issues of poverty and a lack of dental insurance. The Surgeon General has estimated that approximately 80% of dentists in the U.S. do not provide treatment to children covered by Medicaid.

Low-income families penalized by fluoridation.
Fluoridation appears to be promoted within our most vulnerable communities primarily for economic reasons, potentially subjecting minorities and low-income families, along with their children, to unproven fluoridation practices. The conditions that make people more vulnerable to fluoride toxicity are more prevalent in poor communities than affluent ones (e.g., nutrient deficiencies, infant formula consumption, kidney disease, and diabetes) (Massler & Schour, 1952). Due to their limited economic and potentially political power, these groups find themselves categorized under the broader umbrella of those suffering from health injustices.

Moreover, disadvantaged families often lack the financial means to avoid fluoride exposure, and there is a notable absence of financial support to help them avoid it or to cover the costs of treating dental fluorosis. Despite claims that fluoridation can prevent the high rates of tooth decay seen in poor areas, the vast majority of poor urban communities have been fluoridated for over 30 years, and yet are still suffering from a severe oral health crisis (Solvig, 2002; Gerth, 2005; Conger, 2011). The simple fact is that poor populations need education on nutrition, proper home dental habits, and professional dental care, not fluoridation chemicals in their water. The millions of dollars spent each year promoting fluoridation would be better spent advocating for policies that provide real help to impoverished communities.

Rev. Alveda King

Dr. Alveda King, the niece of Dr. Martin Luther King, Jr., wrote the following on her blog on June 22, 2011:

Dr. Alveda King

> "The Fluoridegate scandal continues to unravel. All water fluoridation legislation should be repealed in all states that enact fluoridation. Generally people with built-in biases in support of fluoridation have been controlling the discussion about harm from fluorides. The Centers for Disease Control has clearly been trying to preserve fluoridation at all costs, but the facts about fluoride harm are coming out anyway.
>
> This is a civil rights issue. No one should be subjected to drinking fluoride in their water, especially sensitive groups like kidney patients and diabetics, babies in their milk formula, or poor families that cannot afford to purchase unfluoridated water. Black and Latino families are being disproportionately harmed."

Black and Hispanic children are more vulnerable to fluoride's toxicity.
According to the CDC's national survey of dental fluorosis, Black and Mexican-American children have significantly higher rates of dental fluorosis than White children (Beltrán-Aguilar et al., 2010). The recognition that minority children appear to be more vulnerable to toxic effects of fluoride, combined with the fact that low-income families are less able to avoid drinking fluoridated water, has prompted prominent leaders in the environmental-justice movement to oppose mandatory fluoridation in Georgia. In a statement issued in May 2011, Andrew Young, a colleague of Martin Luther King, Jr., and former Mayor of Atlanta and former US Ambassador to the United Nations, stated:

> "I am most deeply concerned for poor families who have babies: if they cannot afford unfluoridated water for their babies' milk formula, do their babies not count? Of course they do. This is an issue of fairness, civil rights, and compassion. We must find better ways to prevent cavities, such as helping those most at risk for cavities obtain access to the services of a dentist…My father was a dentist. I formerly was a strong believer in the benefits of water fluoridation for preventing cavities. But many things that we began to do 50 or more years ago we now no longer do, because we have learned further information that changes our practices and policies. So it is with fluoridation."

Notably, these vulnerable populations are not only more at risk, but the CDC also refrains from notifying Black and Mexican-American children about their elevated dental fluorosis rates compared to White children. This extra vulnerability may extend to other toxic effects of fluoride. Black Americans have higher rates of lactose intolerance, kidney problems, and diabetes, all of which may exacerbate fluoride's toxicity.

"Water fluoridation needs to end."
Rev. Bernice A. King, a pastor, attorney, and daughter of Dr. Martin Luther King Jr.

VII. Proponents' Dubious Tactics

Many scientists, doctors, and dentists who have spoken publicly on the issue of water fluoridation have been subjected to censorship and intimidation (Martin & Groth, 1991). A notable case is that of Dr. Phyllis Mullenix who lost her position as the Chair of Toxicology at Forsythe Dental Center due to her publication of research findings regarding the effects of fluoride on the brain (Mullenix et al., 1995). Similarly, Dr. William Marcus was terminated from his position at the EPA for raising questions about the government's management of the National Toxicology Program's (NTP's) study on fluoride and its potential link to cancer (Bryson, 2004). "A particularly nasty example of this political effort to derail science was a letter sent to Dr. Christine Till's University in an effort to have her reprimanded or dismissed for unprofessional conduct, when her only offence was to publish top quality studies on fluoride's neurotoxicity. This blatant form of intimidation should have no place in science" (Lennon et al. 2020; Connett, 2023).

Paul Connett, PhD was asked as an outside expert to present to the NRC subcommittee on the subject of fluoride in drinking water, and toward this end he submitted a written statement to the Board of Scientific Councilors (BSC) that opened up by saying, "This sad history has culminated in the most extreme example [of duplicitous actions] to date, namely the best review of fluoride's neurotoxicity ever undertaken which is currently being undermined by pro-fluoridation forces within the US department of Health and Human Services (HHS) which goes all the way up to Deputy Administer Rachel Levine who prevented the NTP's final report due for release on May 18, 2022 (which was six years in the making) from being published.

A particularly nasty example of this political effort to derail science was a letter sent to Dr. Christine Till's University in an effort to have her reprimanded or dismissed for unprofessional conduct, when her only offence was to publish top quality studies on fluoride's neurotoxicity. This blatant form of intimidation should have no place in science. (Lennon et al., 2020)."

In private conversations, many dentists and even medical doctors express their opposition to water fluoridation. However, they often refrain from voicing their concerns publicly due to peer pressure and fear of recrimination. Tactics like this would not be necessary if those advocating for water fluoridation were confident in the solid scientific and ethical foundation of their position.

Proponents have failed to refute the Bassin-Osteosarcoma study.
In 2001, Elise Bassin, a dentist, successfully defended her doctoral thesis at Harvard. Her research revealed a troubling correlation: young boys who consumed fluoridated water during their mid-childhood growth spurt (age 6 to 8) faced a five-to-seven-fold increased risk of developing osteosarcoma by the age of 20. The results of this study were published in 2006 (Bassin et al., 2006). However, fluoridating countries have largely dismissed these findings. This skepticism was due to her thesis adviser, Chester Douglass, an advocate of fluoridation and a consultant for Colgate. He had promised a more extensive study that he claimed would refute Bassin's thesis (Douglass & Joshipura, 2006).

After a 5-year wait, the Douglass study was finally published in 2011 (Kim et al., 2011). However, contrary to expectations, this study did not invalidate Bassin's findings in any significant way. Notably, the Douglass study used far fewer controls than Bassin's analysis and did not even attempt to assess the age-specific window of risk that Bassin had identified. Furthermore, by the author's own admission, the study lacked the capacity to assess the risk of osteosarcoma among children and adolescents—the precise population of concern. For a critique of the Douglass study, click here.

Proponents usually refuse to defend fluoridation in open debate.
While pro-fluoridation officials continue to promote fluoridation with undiminished fervor, they often refuse to engage in open public debates – even when invited to do so by moderate organizations, such as the Association for Science in the Public Interest, the American College of Toxicology, or the U.S. EPA (Bryson, 2004). According to Dr. Michael Easley, a prominent lobbyist for fluoridation in the US, "Debates give the illusion that a scientific controversy exists when no credible people support the fluorophobics' view" (Easley, 1999). In light of proponents' refusal to debate this issue, Dr. Edward Groth, a Senior Scientist at Consumers Union, observed that, "the political pro-fluoridation stance has evolved into a dogmatic, authoritarian, essentially anti-scientific posture, one that discourages open debate of scientific issues"
(Martin & Groth, 1991).

Conclusion

Proponents of fluoridation have long asserted that opposition to the practice comes exclusively from non-legitimate scientists, even though the earliest opponents of fluoridation were biochemists. Today, a large and increasing number of professionals, including doctors and dentists, are reading the primary literature themselves instead of relying on biased statements from organizations, such as the ADA and CDC. And while there has been a shortage of sound clinical research conducted to exam the potential efficacy of fluoridation, there is a mounting body of evidence generated from sound clinical research highlighting the adverse effects of fluoridation. As a result, these professionals are now realizing that both they and the general public have been inadequately informed by their respective professional bodies on this matter. As of January 2024, more than 5,500 of these professionals have signed a statement calling for an end to water fluoridation worldwide. This statement and a list of signatories can be found on the Fluoride Action Network (FAN) website. To grasp the caliber of those opposing fluoridation, one can watch the 28-minute video titled "Professional Perspectives on Water Fluoridation," available for viewing on the same FAN site

In this context, the recurring pattern emerges, where vested interests have sought to undermine studies and cast doubt on epidemiological findings in controversies concerning toxic chemicals. Political pressures have often caused government agencies to delay regulating hazardous substances such as asbestos, benzene, DDT, PCBs, tetraethyl lead, tobacco, and dioxins in the past. With fluoridation, this delay has endured over seventy years.

Unfortunately, government officials and dental leaders have staked much of their credibility on defending fluoridation. Worse, this stance is also partly driven by the potential liabilities they could face if they acknowledge that fluoridation may have contributed to an increase in hip fractures, arthritis, bone cancer, brain disorders, or thyroid problems. These concerns make it challenging for them to address the matter candidly. Nevertheless, we stress the ever-growing importance of the need for honesty when it comes to fluoridation. Their responsibility ought to be safeguarding millions from needless harm and upholding the principle that public health policies must rest on solid science rather than political convenience.

Government officials and dental leaders have a tool with which to accomplish this: The Precautionary Principle. Simply put: If in doubt, leave it out. This approach has been adopted by most European countries, and their children's teeth have not suffered, while the public's trust in them has been strengthened.

Just how much doubt is necessary on just one of the health concerns identified in this document to outweigh only a potential benefit to teeth that, when quantified in the largest survey ever conducted in the US (Yiamouyiannis, 1990), amounts to a dental decay reduction impacting less than one tooth surface (out of 128) in a child's mouth!

Experts in environmental toxicology have stated that because over 200 million U.S. residents are exposed to fluoridated water daily, the population impact of adverse effects from fluoride may be even greater than for other toxic elements, including lead, mercury, and arsenic (Nilsen et al. 2020). Leading neuroscientists have also compared the impact on the developing brain from fluoridated water to that of lead. However, this environmental toxin and the harm it causes remains one of the simplest to curtail. Ceasing fluoridation is as easy as turning off a spigot in

the public water works. But, achieving this requires political resolve, which in turn demands widespread awareness and organization. Kindly share these reasons with all your friends and encourage them to eliminate fluoride from their communities and contribute to a global ban of this practice.

Afterward - *History Repeating Itself*

Lead (Pb) has been recognized for its detrimental effects on the human body since the Roman era. Historically, the Romans identified lead carbonate [PbCO3] as the specific compound responsible for these harms. They deduced this in part based on their observations of laborers who exhibited a pallid complexion due to inhaling fumes emitted during the melting process of lead. Additionally, the Romans understood that lead was detrimental to one's blood, leading them to advise against using leaden pipes for supplying water to their homes. Despite this, the Romans used aqueducts lined with lead sheets and frequently used lead for their cooking and food vessels. While the extent to which lead contributed to Rome's decline is debatable, the undeniable fact remains that the Romans had significant exposure to this element.

Today, our comprehension of the dangers posed by lead exposure is well established, particularly with respect to neurotoxicity and especially among infants and children. This comprehensive understanding was developed over thousands of years and became irrefutable by the early twentieth century. However, it wasn't until 1975 and 1978, respectively, that the relatively new Environmental Protection Agency (EPA) moved to phase out the use of lead in gasoline (for most motor vehicles) and paint. Unfortunately, these measures followed extensive lead contamination worldwide, stemming from its widespread use. To think of the morbidity alone that resulted in pervasive lead exposure in this last century is both incomprehensible and unconscionable.

Shifting focus from ancient Rome to 1945, the year that marked the introduction of fluoridating public water supplies. While thousands of years separate these two periods, the narratives of lead and fluoride exhibit striking parallels. First, lead and fluoride rarely occur in their elemental forms, but rather are by-products of mining. Lead emerges from silver mining, while fluoride is a result of phosphate mining. The harmful product of lead is lead carbonate, while the harmful product for fluoridation tends to be hexafluorosilicic acid, also known as hydrofluorosilicic acid (H2SiF6). This compound is composed of tetrafluorosiliciate gas and other species of fluorine gases, which are derived from pollution scrubbers, and it is corrosive to both metals and tissue. Furthermore, exposure to its fumes or the liquid form can cause severe burns.

While the Roman lead workers exhibited overt signs of lead poisoning, the story unfolded somewhat differently in the U.S. During the 1950s, gases and dust from phosphate manufacturing spewed over farmlands, impacting cattle and leading to symptoms like dental fluorosis (white or brown staining resulting from hypomineralization of tooth enamel) and bone deformities. Subsequent medical studies of phosphate workers showed clear evidence of excessive fluoride exposure through elevated levels in urine, hair, and nails.

Postscript

Further arguments against fluoridation can be viewed at http://www.fluoridealert.org and in the book The Case Against Fluoridation (Connett, 2010). Follow us on Instagram @fluoridealert and X @FluorideAction

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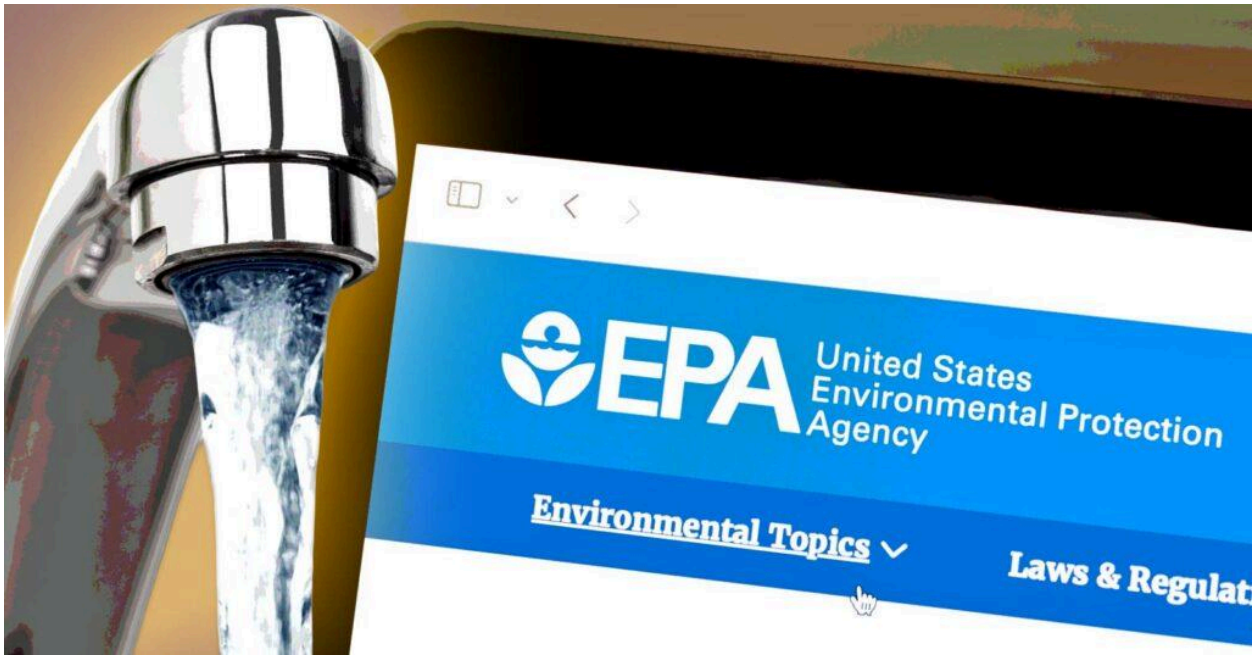
EPA's Bid to Overturn Landmark Fluoride Ruling Based on Process, Not Public Health Concerns

March 4, 2026 | Guest Author

The EPA on Tuesday asked a federal appeals court to overturn a groundbreaking 2024 decision requiring it to regulate fluoride in drinking water, not by challenging the court's finding that fluoridation poses an "unreasonable risk" to children's health, but by arguing the judge overstepped procedural bounds.

Guest Post By Brenda Baletti at Children's Health Defense



The U.S. Environmental Protection Agency (EPA) in a hearing on Tuesday urged a federal appeals court to reverse a landmark 2024 decision ordering the agency to regulate fluoride added to drinking water.

The EPA did not dispute the substance of the 2024 ruling — that fluoride added to drinking water poses an "unreasonable risk" to children's health and the agency must regulate it.

Instead, the agency argued to a three-judge panel that U.S. District Judge Edward Chen overstepped standard judicial process when he put the original trial on hold in 2020 to wait for new scientific evidence. That evidence was later considered during the second phase of the trial.

During the hearing, Robert Stander, an attorney for the EPA, accused Chen of making "a very dramatic departure" from the party-presentation principle when he decided to wait for new evidence before issuing his decision. Under the party-presentation principle, judges must decide cases based exclusively on arguments made by the parties.

However, attorneys for the groups that sued the EPA pointed out that they filed the lawsuit under a unique legal provision previously untested in the courts: Section 21 of the Toxic Substances Control Act of 1976 (TSCA).

Congress specifically designed Section 21 to allow a judge to preside over "de novo" proceedings if the EPA rejects a citizen petition to regulate a chemical. A "de novo" review means that the court reviews available evidence without deferring to the agency's position on an issue, and that a judge can consider a wide range of evidence.

Michael Connett, an attorney for the plaintiffs and a partner at Siri & Glimstad, called the EPA's argument "a policy critique … disguised as statutory interpretation." He suggested the EPA tried to narrowly interpret the statute to say the evidence considered during the second phase of the trial shouldn't have been allowed.

Under the statute, "de novo" proceedings are intentionally broad in both the standard and scope of review, Connett told the judges. Because of the unique nature of the proceedings, the court was "navigating some complex terrain," he said.

"The trial judge, who was the one with the responsibility to actually make the decision, was careful in how he approached this novel litigation and took his job as trier of fact very seriously," Connett said. "This was a case where the trial judge heard argument and

testimony at trial about important, new studies on the horizon which could shed important light on the very issue the judge was tasked with deciding."

'If the law disallows this, something is wrong with the law'

Several consumer advocacy organizations, including the Fluoride Action Network (FAN), Moms Against Fluoridation and Food & Water Watch, along with individual parents and children, sued the EPA in 2017 after the agency denied their 2016 citizen petition to regulate fluoride.

The fluoride trial was the first time a citizen petition filed under TSCA led to a lawsuit that won — or even made it to trial — in a federal court.

A seven-day trial took place in federal court in San Francisco in June 2020. But instead of ruling, Chen put the proceedings on hold pending the release of the National Toxicology Program's (NTP) systematic review of research available on the neurotoxic effects of fluoride.

Both parties referenced the ongoing review and other relevant ongoing cohort studies during the first phase of the trial.

The trial reconvened in 2024, with both parties presenting new evidence, including the NTP report. Chen issued his ruling in September 2024.

Stander asked the judges to send the case back to the court to be decided based on the evidence available at the time of the first trial. He argued that evidence presented in that trial alone, which included studies published after the 2016 petition, exhausted the requirements of Section 21.

He said that allowing new evidence in the second phase of the trial "renders the petition a meaningless formality," he said, because it allowed the plaintiffs to present different evidence to the EPA than they presented to the court.

Chief U.S. District Judge Brian Morris asked Connett why, after the first phase of the trial, the evidence shouldn't have first gone to the EPA "to give them a chance to analyze it and make a decision on appropriate regulation?"

Connett said the court gave the EPA that opportunity, but the agency declined to reconsider the petition based on new evidence.

"The district court did give the EPA that opportunity following the first trial. The judge allowed EPA the opportunity to consider all of the post-petition science using the correct standard of review. EPA declined in its discretion to do that."

Rick North, FAN board member, told The Defender that it was significant that EPA never challenged Chen's finding that fluoridation "poses an unreasonable risk of reduced IQ in children."

He said:

"In a nutshell, this is what happened in this lawsuit:

"The judge had to decide whether fluoridation is an unreasonable risk to human health.

"The premier scientific authority on the subject, the National Toxicology Program, was about to release a review of the highest-quality studies in the world.

"The judge wanted to wait for the review so he could make a more informed decision, based on the best science.

"If the law disallows this, something is wrong with the law."

The judges, who also included Ronald M. Gould, will consider arguments presented in the appeal and likely issue a decision in the coming months.

EPA says it's doing its own fluoride review

Since the 2024 fluoride ruling, more than 60 communities and two states have stopped adding fluoride to drinking water based on the growing body of evidence made public in the trial that fluoride poses a serious risk to children's health.

In the meantime, the EPA announced in January that it had taken the first steps toward implementing a "gold standard" review of the health effects of fluoride in drinking water — even though the NTP already completed a similar comprehensive review, focused on fluoride's neurotoxic effects on children.

The EPA said it plans to release a preliminary scientific assessment plan and literature survey to inform future protective recommendations. The agency announced the news on the same day it filed the appeal brief in the fluoride lawsuit.

The EPA is implementing its new review under the Clean Water Act rather than under TSCA.

In a January meeting during which the EPA gave an overview of the plan, the agency declined to answer a question from The Defender about why the agency launched a new process under different legislation, rather than complying with the judge's order under TSCA.

Lawmakers propose 'sweeping overhaul' of TSCA that would eliminate citizen petitions

Meanwhile, a group of federal lawmakers, backed by Big Chemical, is proposing to weaken TSCA, a law that environmental advocates said is "the nation's most important law protecting the public from toxic chemicals."

As part of the proposed "sweeping overhaul" of TSCA, experts said legislators want to eliminate the public's right to file citizen petitions — the provision of the act under which the plaintiffs filed the fluoride lawsuit and that led to the landmark 2024 decision.

Robert Sussman, former EPA deputy administrator, told The Defender that the proposed changes to TSCA are "basically intended to prevent courts from doing exactly what the court did" in the fluoride case.

The proposed changes to TSCA — debated in a contentious hearing of the U.S. House of Representatives Subcommittee on Energy and Commerce in January — go beyond eliminating the citizen petition.

Sussman said the proposed overhaul would make it "very, very difficult for EPA to prohibit or restrict unsafe chemicals" by setting an extremely high standard of proof.

On Tuesday, the same day the appeals court heard arguments in EPA's appeal of the fluoride decision, a Senate environment committee met to debate the Senate version of proposed changes to TSCA.

Original article online at:
https://childrenshealthdefense.org/defender/epa-hearing-overturn-landmark-fluoride-ruling-process-not-public-health/

COMMISSIONER'S REPORT

Commissioner's Report

B. Cameron Webb, MD, JD

State Health Commissioner

June 11, 2026

Agency Stars

Anne Powell, MAOSE

Environmental Health Coordinator, Office of Enviromental Heath Services

- **Began at VDH in 2008**
- **Demonstrates exceptional management/leadership of VDHs Onsite Sewage Training Program.**
- **Known for her professionalism, positivity, and engaging personality,**

Agency Stars

Juli Wilkinson, Environmental Health Supervisor Three Rivers Health District

- **Built the Chesapeake Bay Preservation Act Pump Out Program from the ground up**
- **Embodies VDH's values through her positive attitude and dedication to service**

Key Personnel Changes

Elaine Perry, MD, MS – Deputy Commissioner for Community Health Services

Rachel Stradling, JD – District Director, Rappahannock Area Health District

Hanima Amara, PhD – Assistant Chief Financial Officer

Ramesh Penmetsa – Deputy Chief Information Officer, Office of Information Management

Chad Mason – Division Director of Emergency Operations, Office of Emergency Medical Services

New & Coming Soon: Deputy Commissioner for External Affairs

Local Health Districts Updates

Comprehensive Harm Reduction Initatives

Portsmouth Health District

New River Health District

Portsmouth Health District

Portsmouth Access to Harm Reduction (PATH)

What It Takes

Steps to Launching a Comprehensive Harm Reduction Site

Build Community Coalition

- Convened cross-sector partners
- Established shared goals and role clarity

Lived-Experience Input

- Held listening sessions with people who use substances and families

Secure City & Stakeholder Buy-In

- Presented evidence and community data
- Aligned program benefits with city priorities

Stigma-Reduction Training

- Provided training for staff and community partners
- Promoted trauma-informed, person-first approaches

Final Program Setup & Launch

- Finalized operations, staffing, and communications
- Prepared for service rollout

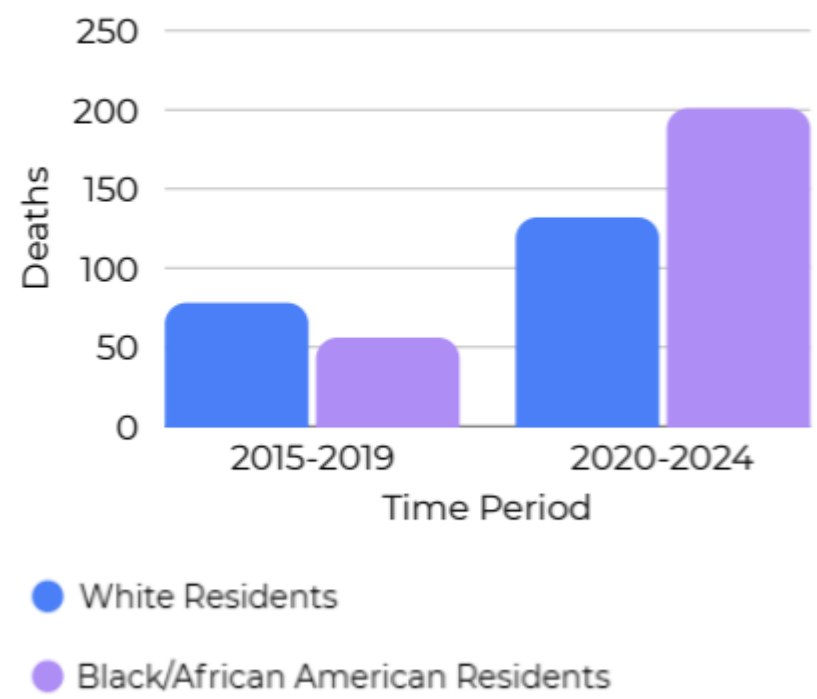
THREE YEARS

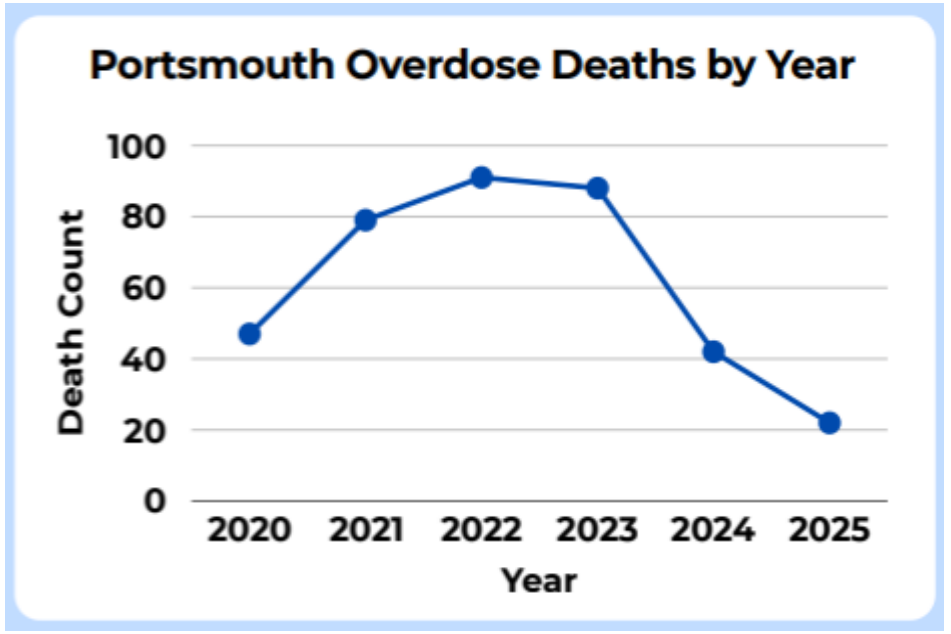
PATH
Portsmouth Access to Harm Reduction

VDH VIRGINIA DEPARTMENT OF HEALTH

Overdose Deaths in Portsmouth, VA

369 Portsmouth residents died from drug overdoses between 2020 and 2024



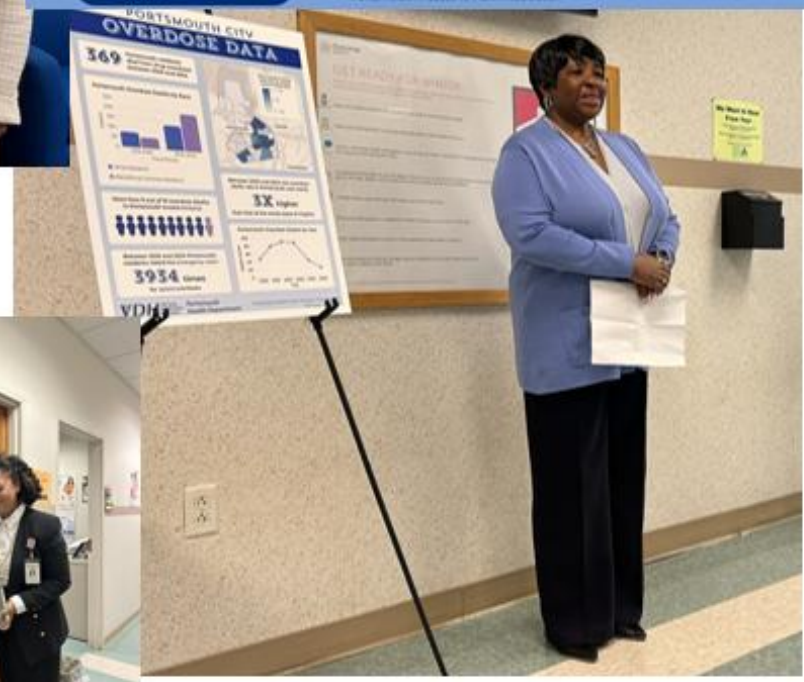


Since 2023:

- PHD has distributed 4,000 naloxone kits
- Overdose deaths dropped by 75%
- 91 lives lost in 2023, 22 lives lost in 2025
- Change in who is most affected

PATH

Grand Opening



VDH VIRGINIA DEPARTMENT OF HEALTH

New River Health District

An Innovative Approach

New River Health District Collaborative Practice Agreement

- New River is only district in VDH with a collaborative agreement for bridge treatment
  - Formal agreement that allows pharmacist, in collaboration with a licensed physician, to provide one-time medication for opioid use disorder (MOUD) to prevent opioid withdrawal until client is seen in treatment or recovery center (“bridge” treatment)
- Low barrier access to treatment when client is ready

How does this Collaborative Practice Agreement work?

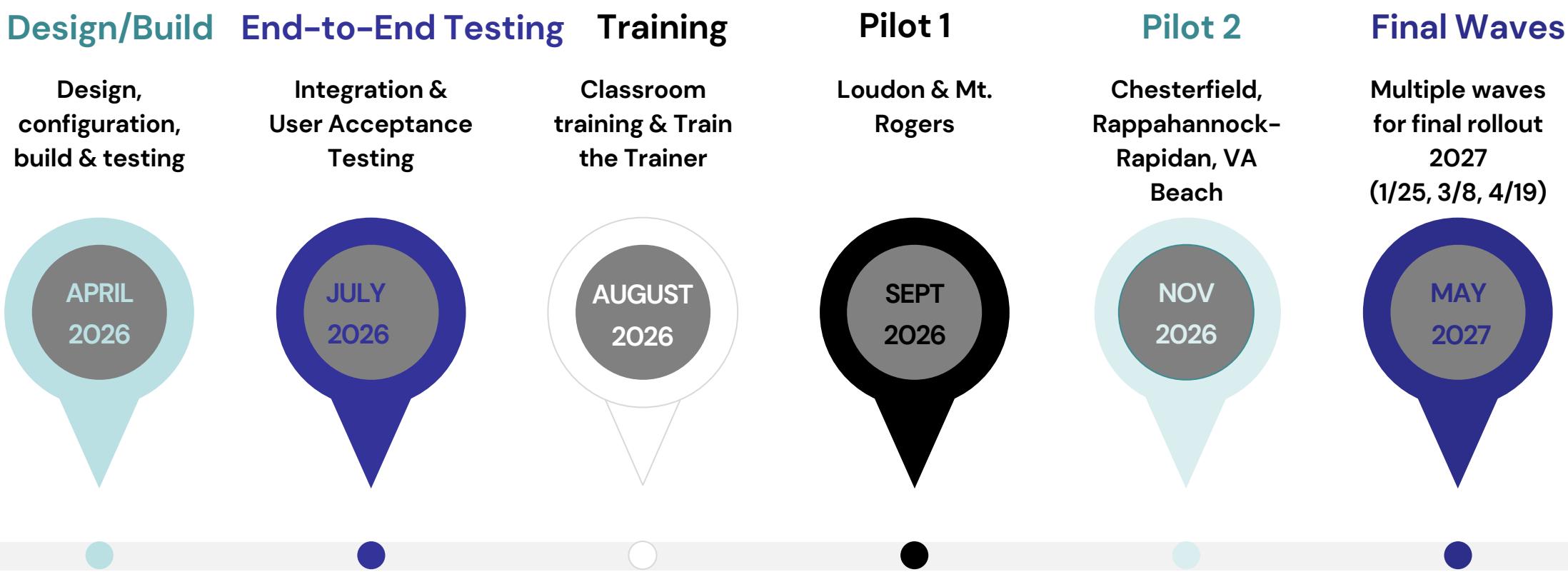
- Clients with know/suspected OUD referred to Rise Above
- Clients seen by pharmacist at Rise Above
- Pharmacist uses American Society of Addiction Medicine (ASAM) criteria for substance use to assess client
- If client meets ASAM criteria, physician District Director renders diagnosis of OUD; gives order for bridge MOUD
- Pharmacist prescribes medications based on orders
- With CHR team, pharmacist develops a treatment plan that includes referrals


PULASKI COUNTY HEALTH


THROUGH LOCAL HEALTH DEPARTMENTS IN:
RADFORD(540)267-8255
THE NEW RIVER VALLEY

EHR Update
June 11, 2026

EHR Timeline



EHR – Key Highlights

01 **200+ staff, 34 of 35 Health Districts actively engaged in EHR initiative**

02 **Funding: $30M ARPA (spend by 12/31/2026)**
GF FY27 $ 8.2M & FY 28 $ 6.8M

03 **Oracle 30% Reduction in Force was well-managed by VDH with minimal disruption**

04 **Integration & User Acceptance Testing underway and scheduled to conclude in August**

Risk-managed Implementation

Pilot 1
Sept 2026
90% of Encounters

Early Detection

Identify gaps, missed workflows and requirements early

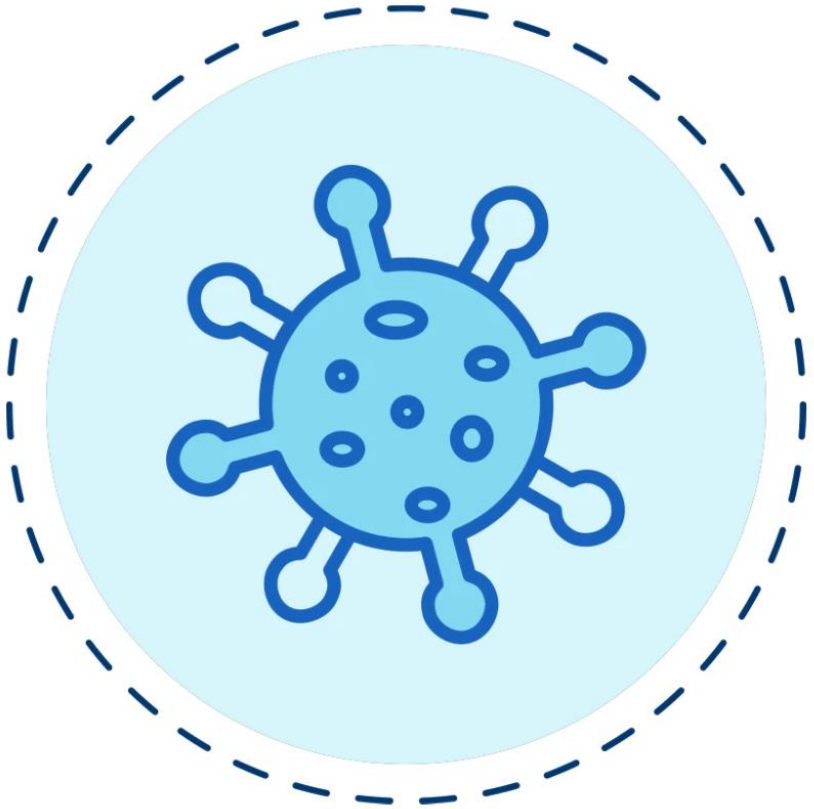
Optimize Resource

Focus on root causes vs incident management

Repeatable Playbook

Learn from mistakes and optimize rollout pro cesses

Pilot 2
Nov 2026
Nearly 100% of Encounters



INFECTIOUS DISEASE UPDATE

Infectious Disease Update – Every Transfer Counts!

VDH, in collaboration with the Virginia Healthcare-Associated Infections Advisory Group, developed a Multidrug-Resistant Organism (MDRO) Communication Guide For Hospitals and Long-Term Care Facilities

Why the guide was developed:

- Timely direct communication of MDRO status is critical
  - Communication breakdowns that occur when patients and residents infected or colonized with MDROs are transferred can lead to silent spread in other facilities
  - Missed communications about MDRO status can have widespread and long-term impact

- Healthcare facilities can learn from each other and adopt best practices

What the guide includes:

Real-life case studies highlighting the consequences that occur when MDRO status is not communicated

Communication essentials detailing information that should be communicated during transfer

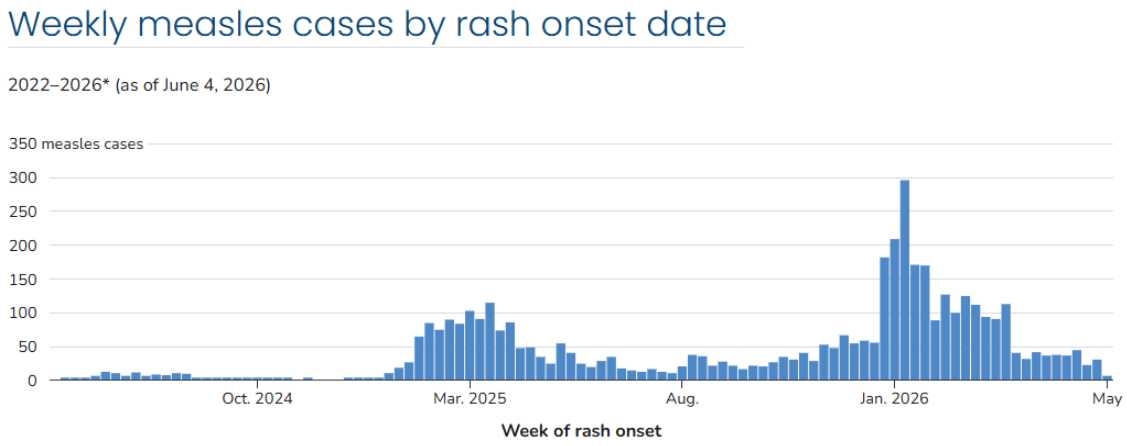
Communication tools from VDH and CDC that facilities can use to review and update current practices

Healthcare facility best practices submitted by Carilion Clinic and Goodwin House Bailey's Crossroads

Every Transfer Counts: Multidrug-Resistant Organism (MDRO) Communication Guide For Hospitals and Long-Term Care Facilities

Infectious Disease Update: Measles

- **Measles activity in the U.S. and in Virginia continues to be increased**
- **In Virginia, 5 measles cases were reported in 2025**
- **2026 (YTD): 106 reported measles cases as of June 9**
  - **78% of cases are associated with an outbreak in Buckingham County announced on May 13, 2026.**
  - **Measles activity in Virginia is expected to rise in the coming months as the outbreak continues and international and domestic travel rates increase.**
  - **VDH measles dashboard launched May 21; includes a county-level map, hospitalization status, and vaccination status.**
- **VDH actively responding to measles cases – initiated IMT on February 10, 2026**
- **https://www.vdh.virginia.gov/measles/**



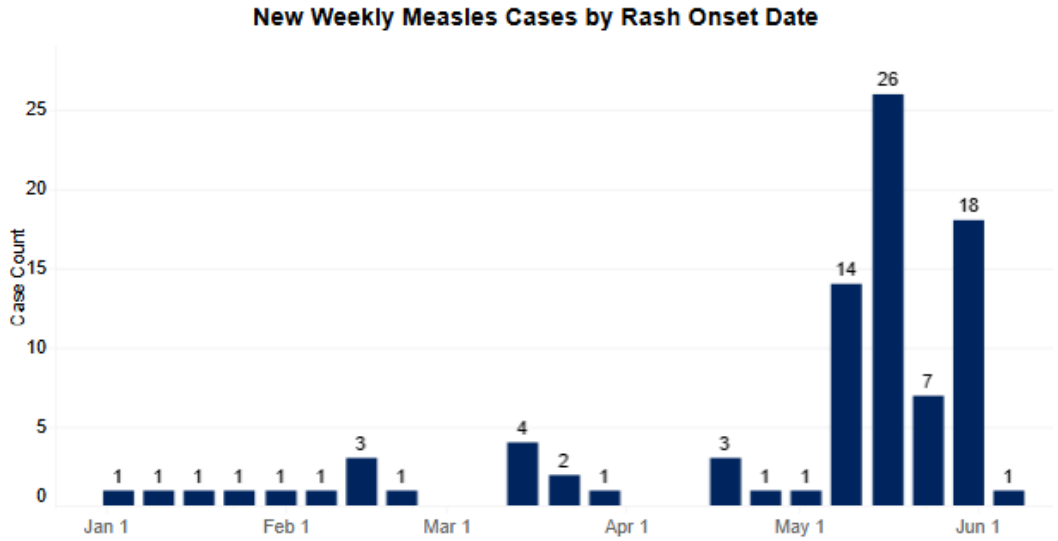
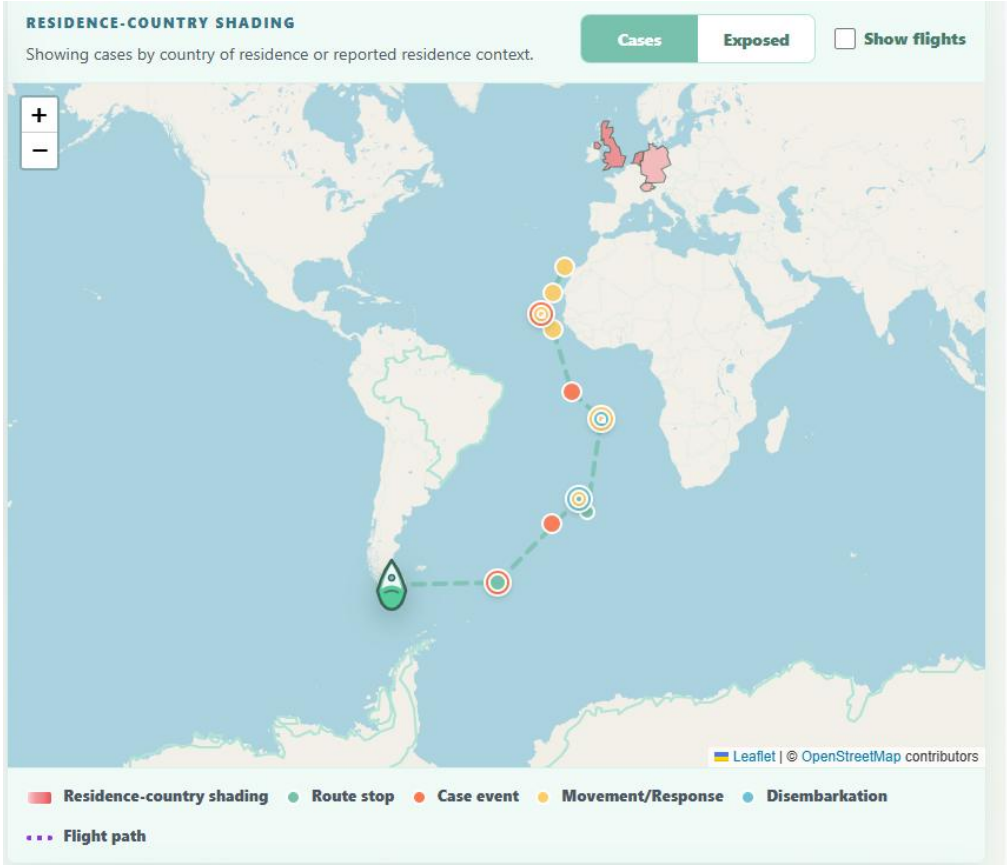


Image: https://www.cdc.gov/measles/data-research/index.html

2026 Hantavirus Response

- On May 2, WHO notified about severe respiratory illnesses on cruise ship
  - Andes virus identified as cause of outbreak
  - As of May 28: 13 cases, including 3 deaths
- Ongoing investigations to identify source and describe outbreak
- On May 8, VDH activated an Incident Management Team
- Three Virginia residents have been under public health monitoring in Virginia
- On May 11, 18 U.S. citizens who were still on the ship were repatriated to the U.S., including 2 Virginia residents
- Risk of outbreak spreading is very low



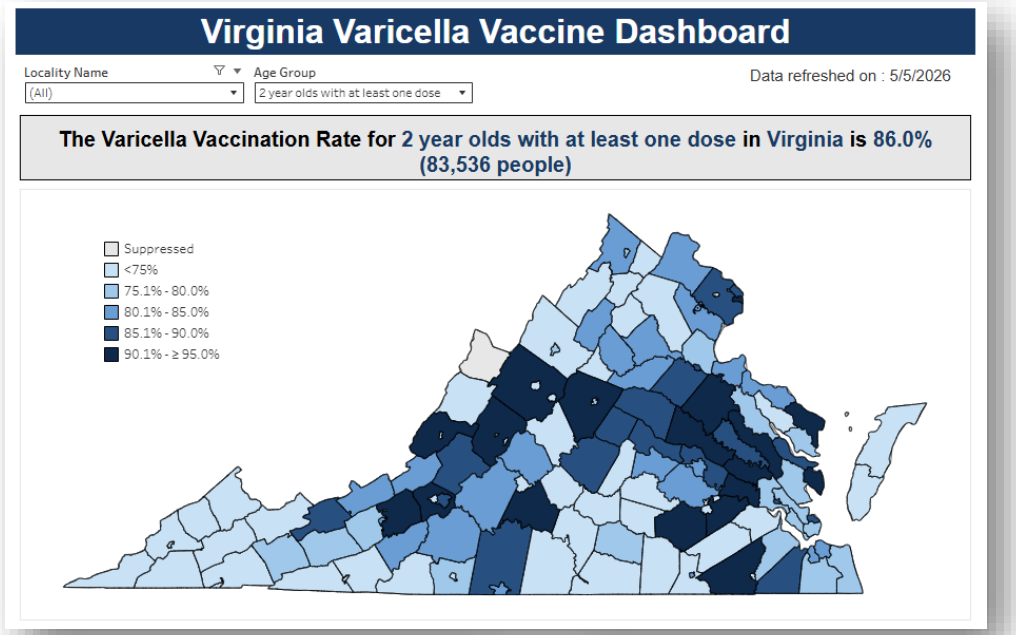
GenomicEpi.com (May 13, 2026)

2026 Hantavirus Strategic Media Response

- **Spokespeople**
  - State Health Commissioner
  - State Epidemiologist
  - Director, Division of Surveillance and Investigation
- **Media coverage**
  - National: CNN, Washington Post, MSN, TIME, Newsweek, USA Today, Politico, ABC News, Reuters, The Hill, and CBS
  - Statewide: WTKR, WWBT, News Leader, WAVY, Fox5DC, WTVR, VA Mercury, and the VA Pilot
- **Key messages**
  - VDH monitoring situation and working with federal partners
  - Confirmed one Virginia travler disembarked and is in good health while under public health monitoring
  - Risk to the general public is low

Immunization

- **AAP et. al., v. Robert F. Kennedy, Jr, et. al.,**
  - **The March 16 Ruling stays ACIP membership changes and votes taken, and January 2026 Memo CDC Childhood Immunization Schedule.**
  - **April 9 ACIP Charter Updated**
  - **April 29 Ruling Appealed.**
  - **Seasonal vaccine recommendations.**
  - **VDH continues to monitor progress and impact.**
- **VDH launched the Childhood Vaccine Dashboards.**
- **VDH partners with ImmunizeVA on outreach and education efforts at community events.**



STI Update

2024-2025 trends

- Early syphilis declined 25.4%
- Cases of syphilis among women increased 3.5%
- Congenital syphilis remained high

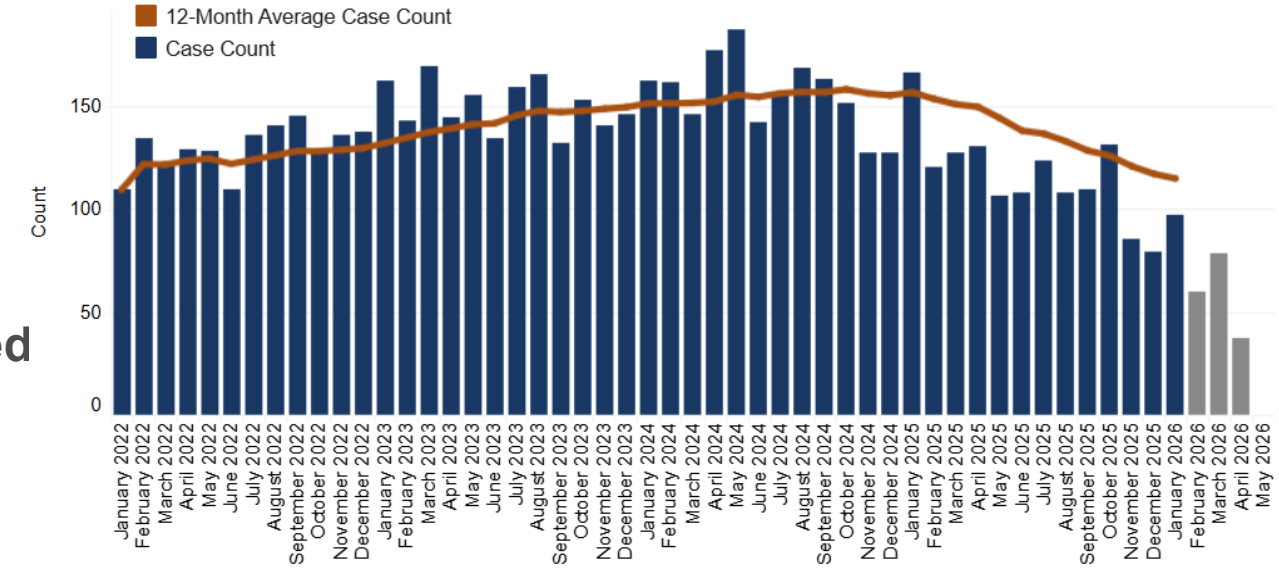
2025-2026 early trends (Jan-Feb)- too early to interpret!

- Early syphilis declined 45%; late syphilis declined 6.4%
- Cases of syphilis among women decreased
- Congenital syphilis cases expected to surpass 2025 totals

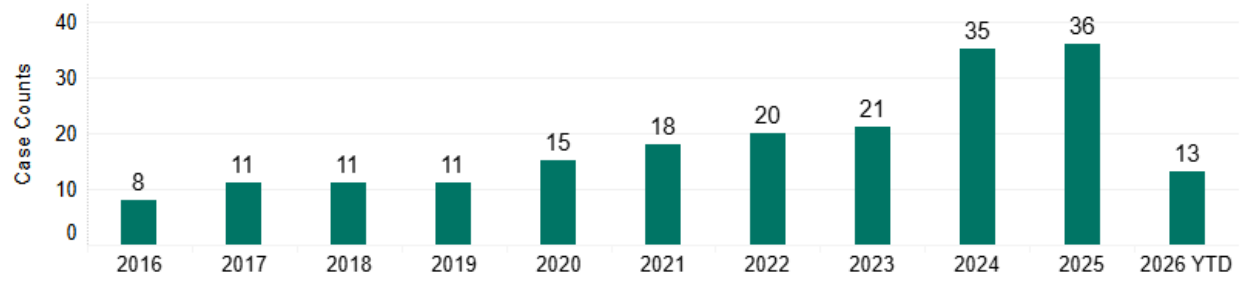
Bicillin national shortage worsens

- Pfizer now lists recovery in Q4 2027
- Next shipment not until October 2026
- VDH is preserving remaining Bicillin doses for pregnant women and infants with congenital syphilis

Early Syphilis- Monthly Diagnoses



Congenital Syphilis



STRATEGIC PRIORITIES

OPERATE WITH EXCELLENCE

RESTORE TRUST IN PUBLIC HEALTH

CENTER HEALTH EQUITY

Strategic Priority – Operate with Excellence

OPERATE WITH EXCELLENCE

- **Deliver operational excellence** — strong financial management, reliable grant execution, modern systems, and clear performance metrics so Virginians can trust their public health agency works.
- **Build structures that support accountability and speed** — defined leadership roles, transparent reporting, and a culture focused on solving today's public health challenges.
- **Maximize every public dollar** — ensure state and federal investments translate into measurable health impact in communities across Virginia.

Strategic Priority – Restore Trust in Public Health

RESTORE TRUST IN PUBLIC HEALTH

Communicate clearly and consistently — share data openly, explain decisions honestly, and lead with evidence.

Be present in communities before there's a crisis — listen, partner, and build relationships that endure beyond emergencies.

Make decision-making inclusive and grounded in real experience — when policies affect families, the people closest to the impact should have a voice in shaping solutions.

VDH 360

Ongoing engagement initiative between Commissioner and VDH staff, built around the following areas:

- **Listening Tour Themes**
  - A place where people thrive
  - Community-driven health and equity
  - One VDH: Strong foundations, lasting outcomes
  - Information that powers impact
  - Access without barriers
- **Commissioner's Strategic Priorities**
  - Operate with excellence
  - Make VDH the best place to work in Virginia government
  - Restore trust in public health
  - Center health equity
- **Workforce Well-Being**
  - Protection from harm
  - Connection and community
  - Work-life harmony
  - Mattering at work
  - Opportunity for growth
  - Worker voice and equity

Strategic Communications & Trust

- **Why It Matters**

  Trust is a critical component of public health preparedness. Virginians are more likely to seek services, follow public health guidance, and partner with VDH during emergencies when they understand who we are, what we do, and how we serve their communities.
- **Our Approach**
  - Elevate the stories and impact of public health work happening every day across Virginia.
  - Strengthen connections between VDH, local health departments, community partners, and the people we serve.
  - Communicate with transparency, consistency, and clarity before, during, and after public health events.
- **Key Initiatives**
  - Increase proactive storytelling that highlights local and statewide public health impact.
  - Expand community-focused communications that showcase available services/resources.
  - Measure and monitor public trust and awareness to inform future engagement efforts.

Strategic Priority – Center Health Equity

CENTER
HEALTH EQUITY

Ensure public health works in every zip code — reduce avoidable gaps in life expectancy and preventable disease by focusing on measurable outcomes.

Prevent illness before it starts — coordinate with healthcare, education, housing, business, and community leaders to address the everyday factors that shape health.

Hold ourselves accountable for progress — set and track clear targets for reducing preventable deaths, improving maternal and child health, expanding access to preventive care, and strengthening local health infrastructure statewide.

Advisory Council on Health Disparity & Health Equity

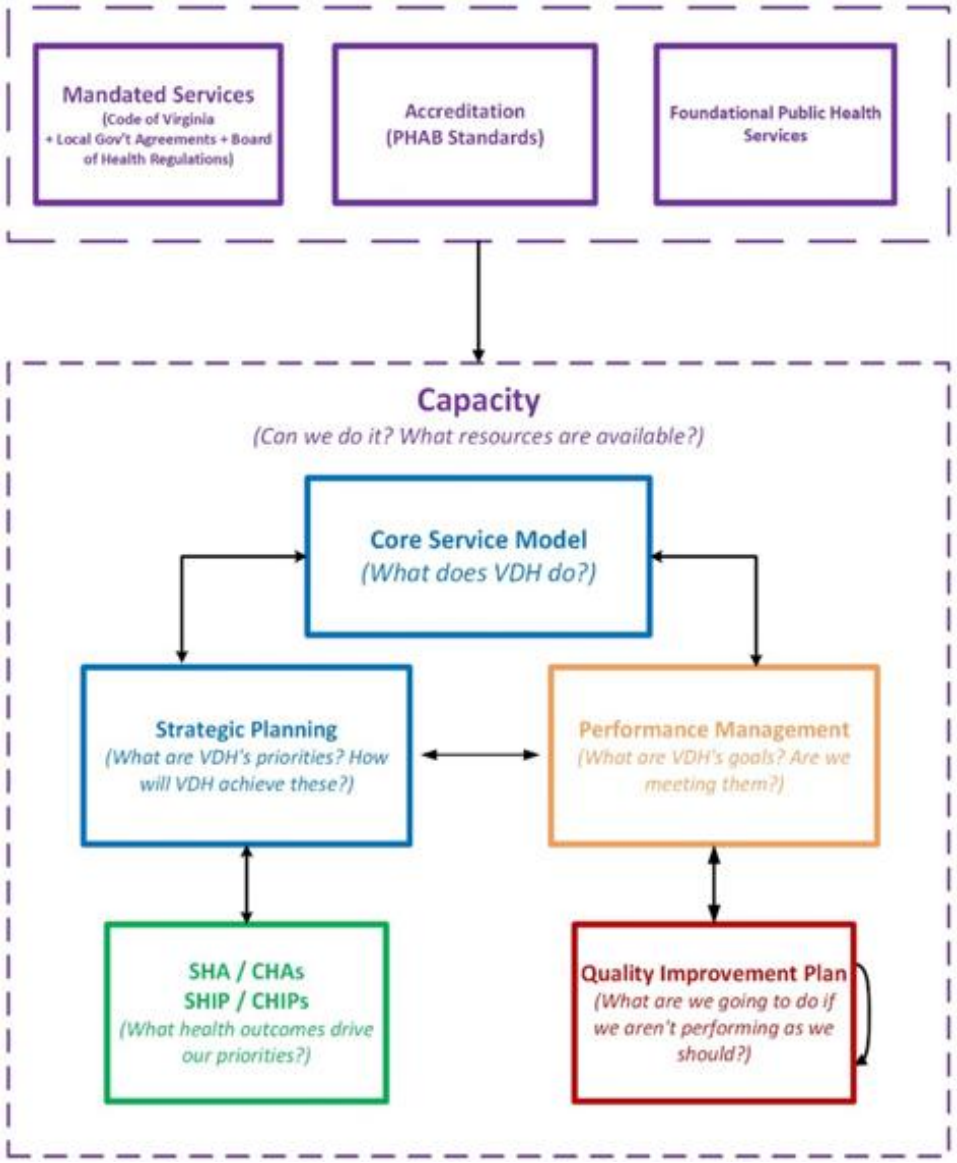
Charged the ACHDHE with the creation of a comprehensive plan to define the future of health equity in Virginia. The plan will be developed through July of 2027. The plan will focus on:

- **Data and measurement**
- **Communications, trust, and community partnership**
- **Healthcare access and quality**
- **Structural and social drivers of health**

The ACHDHE's next meeting is scheduled for July 14, 202

VDH STRATEGIC EFFORTS

Strategic Infrastructure and Capacity Alignment



The VDH Core Service Model and the Strategic Infrastructure and Capacity Initiatives (SICIs):

Guiding External Frameworks:

- Mandated Services
- Accreditation Standards
- Foundational Public Health Services (FPHS)

Core Service Model:

- Using FPHS as a basis, defines the minimum baseline of services that governmental public health in Virginia must provide consistently and uniformly statewide
- Internal guiding framework to align the various SICI

SICIs:

- Strategic Planning
- Performance Management
- Quality Improvement
- Cost and Capacity Assessment
- SHA/SHIP and CHA/CHIPs

Plan for Well Being Implementation

PROGRESS SINCE LAUNCH

Key Activities & Milestones

PHV Advisory Council Membership

Engagement with the Partnering Virginia Advisory Council Council to guide implementation and stakeholder alignment, including expanding membership to the the council

Data Updates

Ongoing updates ensure the latest data is reflected across well-being indicators and metrics.

Equity Measures on “How Virginia Compares” Compares”

Adding equity measures where available to improve improve visibility into health equity across Virginia.

Increased Visits to the Plan Page

Web traffic to the 2025–2029 Plan for Well-Being page has grown since launch, reflecting stronger awareness and engagement.

Alignment with State Initiatives

Reviewing and aligning with related initiatives across Virginia to improve coordination and avoid duplication.

Plan for Well Being Implementation

NEXT STEPS

Implementation Activities

Convene Implementation Partners

Establish Priority-Area Working Groups

Develop Implementation Workplans

Convene Implementation Partners

Bring PHV, VDH programs, local health districts, hospitals, community partners, and state agencies together to confirm roles and expectations and foster a collaborative environment.

Establish Priority-Area Working Groups

Each group will translate plan strategies into concrete action steps, identify existing partner work to reduce duplication, and name lead organizations responsible for execution.

Develop Priority Area Workplans

Develop a detailed workplan including specific activities, assigned owners, clear timelines, required resources, resources, explicit equity considerations, and targets for early wins to build momentum.

VDH Key Implementation Partner Sub-Initiatives

- Innovative Maternal Care
  - “expands rural prenatal and postpartum services…with a focus on supporting mothers with substance use disorders and preventing rural labor and delivery unit closures”

- Community Paramedicine
  - “funds pilots and startup costs for EMS-led treat-in-place care, preventive visits, and telehealth consultations”

STRATEGIC RISKS

Nursing Home Oversight Plan Update

- **Periodic Medical Visits**
- **Resident Assessments and Plans of Care**
- **Steps to:**
  - Improve care quality,
  - Protect residents, and
  - Strengthen oversight and accountability of nursing homes
- **Work with relevant stakeholders to develop and implement a plan to expand workforce capacity in OLC and fill all open MFI positions**
  - Recruitment dashboard
  - Use traditional and non-traditional recruiting measures
- **Dedicated training manager**
- **Work with VITA and ORM to assess use of AI**
- **Annual report to GOV and GA by December 1**

Ryan White Program

Update on Federal Awards for GY26, received (*expected*):

- RW Base: Received: $8,386,807 *($26,031,555)*
- ADAP Emergency Relief Funding: Received: $1,301,133 *($3,165,774)*

HIV Care Services (HCS) team continues to engage with stakeholders to inform program activities:

- Quarterly Contractors' meeting June 3, 2026.
- Case Management Summit in partnership with VCU (April 21-22, 2026).
- Quality Management Advisory Committee (QMAC) quarterly meeting (May 13, 2026).

Upcoming Reports:

- GY25 APR (including Federal Financial Report and Expenditure Report), due June 29, 2026.
- HCS and HIV & Hepatitis Prevention preparing Integrated HIV Care and Prevention Plan (2027-2031) due to CDC and HRSA June 30, 2026.

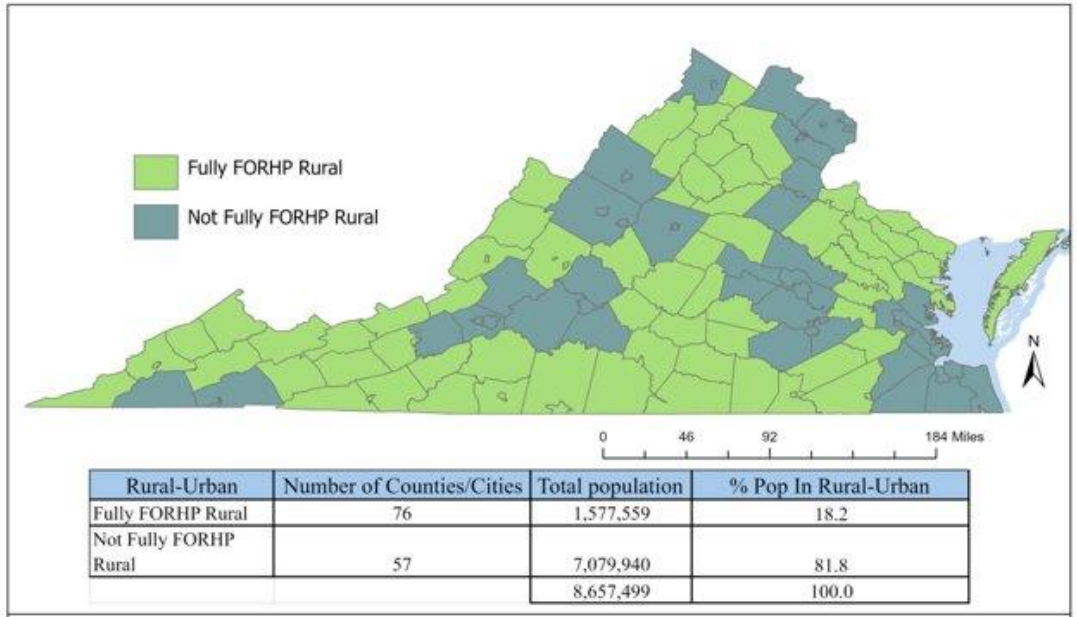
Agency Financial Stability

- VDH is highly dependent upon federal funds (50.2%of the FY2026 budget)
- Federal funding is not as certain as it once was
  - Several major federal public health grants are scheduled to end between in 2027 and 2029.
  - Federal agencies have been piece-mealing out grant awards
    - Awarding VDH several months of funding at a time instead of annual awards
  - Terms and conditions in federal awards continue to change
  - VDH is conceptualizing a budget reduction exercise this summary for grants scheduled to end in the coming 1-2 years to prepare.

STRATEGIC OPPORTUNITIES

Rural Health Transformation Goals and Initiatives

- VA Rural Vitality – build a stronger, self-sustaining rural health system
  - CareIQ
  - Homegrown Health Heroes
  - Connected Care, Closer to Home
  - Live Well, Together
- Opportunity to enhance rural health by focusing on innovative models of care delivery



Rural-Urban	Number of Counties/Cities	Total population	% Pop In Rural-Urban
Fully FORHP Rural	76	1,577,559	18.2
Not Fully FORHP Rural	57	7,079,940	81.8
		8,657,499	100.0

Federal Office of Rural Health Policy (FORHP) Definition of Rural and Urban

Rural Health Transformation Update

VDH All Agency Grant Coordination

State Office of Rural Health

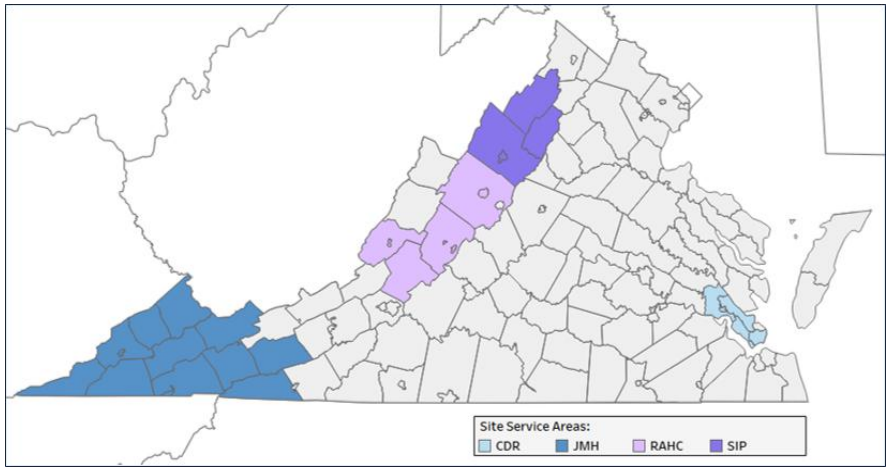
To include grant engagement with other key partners, local health, state health offices, on key rural health requests.

Innovative Maternal Health

Community Paramedicine

Maternal Health Update

- VDH launched the Perinatal Health Hub Pilot Program
  - **Program is made possible by Chapter 725 of the 2025 Virginia Acts of Assembly (Budget Bill, Item #277H): $2.5m general fund**
  - **Goal: The Perinatal Health Hub Pilot Program is designed to improve maternal and infant health outcomes by increasing access to wraparound care and resources during pregnancy and the postpartum period, and by providing care that is rooted in the community it serves.**
  - **Aims: To increase the number of and/or capacity of perinatal health hubs in the state of Virginia and assess the impact on families the hubs serve**
  - **Awardees:**
    - **Category 1 (new):**
      - **Rockbridge Area Health Center (RAHC) - $958,655**
    - **Category 2 (expanding):**
      - **Community Development Resources (CDR) - $679,701**
      - **Johnston Memorial Hospital (JMH) - $360,044**
    - **Category 3 (collaborative):**
      - **Strength in Peers (SIP) - $501,190**



Legislative Mandate HB2446

In 2025, the Virginia General Assembly took decisive, compassionate action to address a silent and often invisible crisis: **perinatal and postpartum depression.**

Through the passage of the Postpartum Depression Education Act (HB2446), the Commonwealth charged the Virginia Department of Health and the Department of Behavioral Health and Developmental Services with developing **a public awareness campaign that reduces stigma, increase recognition of symptoms, and connect families to timely, life-saving resources and support. An online resource hub will also be part of the deliverables.**

Beyond the Blues Awareness Campaign

Launch Date: May 8

The Virginia Department of Health and the Department of Behavioral Health and Developmental Services, led the creation of the *Beyond the Blues* public awareness campaign. The campaign was developed from a mixed-method research approach that aligned community lived experience, clinical realities, statewide data, and community resources into a campaign-ready roadmap to increase awareness, reduce stigma, and improve access to care.

Our learnings made way for a comprehensive and integrated awareness campaign using paid media, earned media, community activation events, and a creative toolkit to provide messaging and asset support to local health districts and support groups across the state.

This approach will maximize impact and support our goals of raising awareness of maternal mental health, reducing stigma, and promoting early treatment and access to support. By shifting how maternal mental health is understood and discussed, the campaign will enable earlier recognition and earlier support, leading to better outcomes for parents and families across Virginia. It will advance health equity, save lives, and fulfill the intent of HB2446 with compassion and impact.

Campaign Milestones

May 8
Campaign Announcement to Media (Earned Media)

May 8
Campaign Launch (VDH Hub & Paid Media)

May 26
Richmond Public Library Community Activation & Earned Media Event

June 30
Paid Campaign Wrap & Reporting

Maternal Health Update

- VDH is the lead agency directed to develop, coordinate, and implement a plan for services for substance-exposed infants, per Code of Virginia §32.1-73.12
- VDH will convene stakeholders at the Virginia Summit on Perinatal Substance Use on June 3-4
  - Provide update on Virginia's Pathways to Coordinated Care Strategic Plan and reengage key partners to implement the plan

Relocation of the Office of Chief Medical Examiner – State Leadership & Central District

- Relocated from its Richmond facility (used since 1995) to a new, state-of-the-art facility in Hanover County.
- Operations relocated April 7, 2026
- Substantial capacity for future growth to support expanding OCME operations over the next 20 years
- Equipped with advanced radiological services, including a CT unit and Lodox full body x-ray system

National Public Health Week

Leadership Visits to Local Health Districts

- **Western Tidewater** – Health of the District
- **Portsmouth** – Staff Town Hall, Harm Reduction Grand Opening
- **Crater** – Maternal Child Health Panel
- **Chickahominy** – Hanover Open House
- **Hampton Peninsula** – CHA Celebration
- **Rappahannock Rapidan** – Legislative Overview
- **Pittsylvania Danville** – Open House
- **Southside** – Open House
- **Virginia Beach** – Staff Recognition

Internal Events

- Public Health Perspectives
  - Healthy Starts
  - Rural Roots, Healthy Futures
  - Baby Care
- Public Health Shelf
- Environmental Health Data Summit
- Bridging the Gap: Community Resource Fair
- Madison Building Staff Connection
- District Staff Recognition and Community Events

National Public Health Week

NPHW Recognition Awards

Changemaker Award
Gary Coggins and Mary Anne Hall

Collaborative Champion Award
Lara Newell and Leanne Knox

Emerging Leadership Award
Rommel Mahon and Gretchen Jackson

Leadership Excellence Award
Darryl Hellams and Lauran Mulryan

Solution Seeker Award
Samantha Pappas and Abi Nimitz

Unsung Hero Award
Patricia Brewer and Adela See

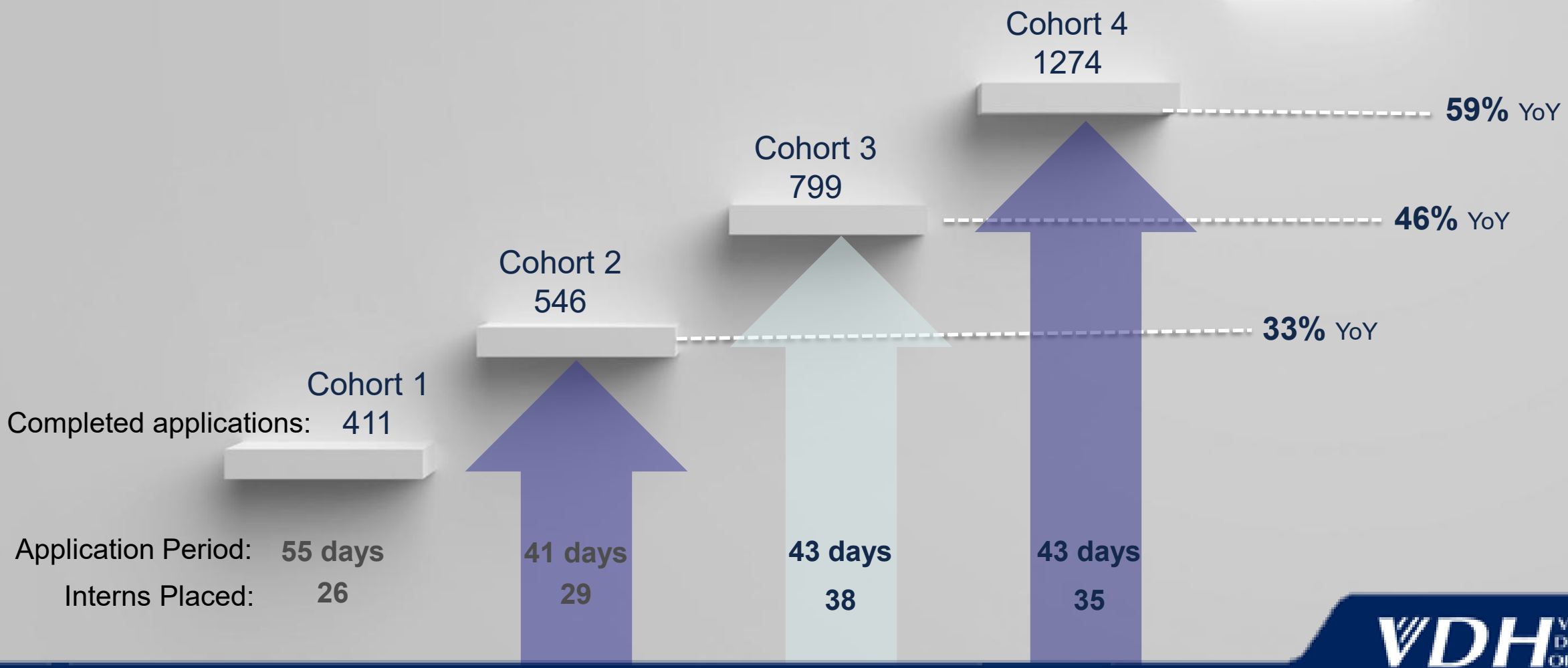
Public Health Student Connections

- 3 Minute Thesis Panel judging
- Meet VDH: Speed Mentoring sessions
- The Power of We: Coalition Building for Emerging Public Health Professionals
- VCU student visit
- Meet VDH: Guest Lectures
- Experiential learning visit with Shellfish team

VIRGINIA DEPARTMENT OF HEALTH

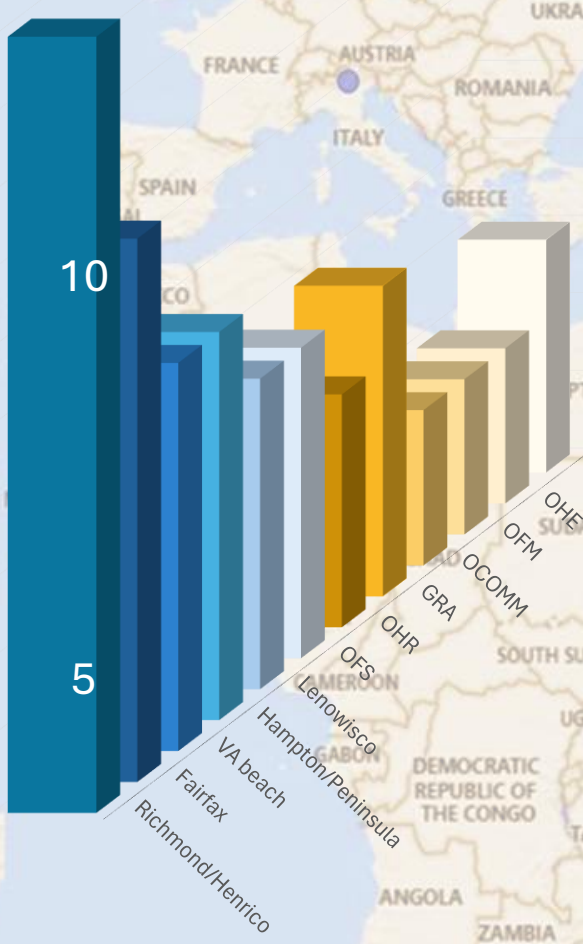
INTERNSHIP ACADEMY

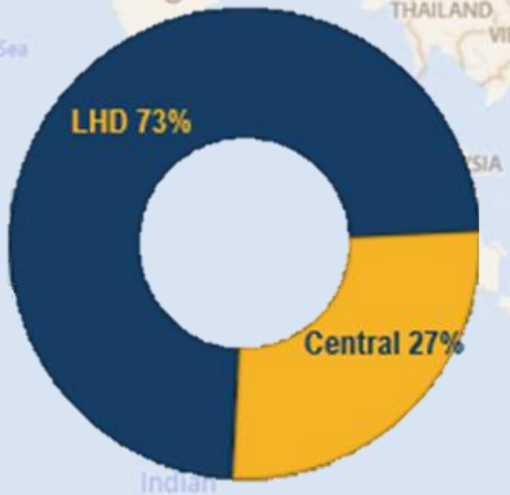
Applications Tripled In four years



VDH VIRGINIA DEPARTMENT OF HEALTH

Host Sites





Submitted Applications 3030

173 Institutions Applied

128 Interns Hosted

52 Hosting Locations


VIRGINIA DEPARTMENT OF HEALTH
INTERNSHIP ACADEMY
VDH
27% Retention rate
52% of applicants Word of Mouth

Questions

REGULATORY ACTION UPDATE

State Board of Health
Regulatory Action Update
June 11, 2026

Overview of Pending Regulatory Actions:

There are 49 regulatory actions under development:

- 10 NOIRA
- 2 Emergency/ NOIRA
- 17 Proposed actions
- 5 Final actions
- 15 Fast Track actions

A spreadsheet containing additional detail concerning each of these actions is attached.

A Notice of Intended Regulatory Action (NOIRA) is the first stage in the standard rulemaking process in Virginia. It describes the nature and scope of the regulatory changes being considered. Should a NOIRA be approved, the next stage in the rulemaking process (the proposed stage) would involve the drafting of actual amending regulatory language for consideration. The proposed stage—if approved—is in turn followed by the final stage. Each of these three stages includes a public comment period.

The Virginia Administrative Process Act (§ 2.2-4000 et. seq. of the Code of Virginia) provides that certain types of regulatory actions are exempt from certain requirements of the state regulatory process. This includes regulatory actions that are:

i. Necessary to conform to changes in Virginia statutory law or the appropriation act where no agency discretion is involved, or
ii. Necessary to meet the requirements of federal law or regulations, provided such regulations do not differ materially from those required by federal law or regulation, and the Registrar has so determined in writing.

The Administrative Process Act also describes a "Fast Track" rulemaking process, which is utilized for regulations that are expected to be noncontroversial. The Fast Track process generally involves an action with a single stage.

Regulatory Actions Taken by the Commissioner on Behalf of the Board pursuant to § 32.1-20 of the Code of Virginia since the March 19, 2026 Board Meeting while the Board was not in Session:

- Approved Final Exempt action for the Waterworks Regulations (12VAC5-590) to comply with federal Consumer Confidence Report Rule revisions.

Non-Regulatory Actions Taken by the Commissioner on Behalf of the Board since the March 19, 2026 Board Meeting while the Board was not in Session:

None

Periodic Review of Regulations

The process for conducting periodic reviews of regulations is governed by the Virginia Administrative Process Act and Executive Order 19 (2022).

All regulations are to be reviewed every four years to determine whether they should be continued without change or be amended or repealed, consistent with the stated objectives of applicable law, to minimize the economic impact on small businesses in a manner consistent with the stated objectives of applicable law.

VDH has 4 periodic reviews in progress:

Chapter		Status
12 VAC 5-125	Regulations for Bedding and Upholstered Furniture Inspection Program	Intend to issue result after current action becomes effective.
12 VAC 5-371	Regulations for the Licensure of Nursing Facilities	Issued with NOIRA, Result will be published with Proposed stage.
12 VAC 5-381	Home Care Organization Regulations	Issued with NOIRA, Result will be published with Proposed stage.
12 VAC 5-620	Regulations Governing Application Fees for Construction Permits for Onsite Sewage Disposal Systems and Private Wells	Intend to issue result after current action becomes effective.

Executive Branch Review activity completed since the March 19, 2026 Board Meeting:

The Office of the Attorney General certified:

- Proposed amendments to the Rules and Regulations Governing the Construction of Migrant Labor Camps (12VAC5-501)
- Final amendments to the Prescription Drug Price Transparency Regulation(12VAC5-219)
- Final Exempt amendments to the Waterworks Regulations (12VAC5-590)

The Secretary of Health and Human Resources completed the review of:

- Fast Track amendments to the Food Regulations (12VAC5-421)
- NOIRA for the Regulations Governing Tourist Establishment Swimming Pools and Other Public Pools (12VAC5-460)
- NOIRA for the Rabies Regulations (12VAC5-105)
- NOIRA for the Food Regulations (12VAC5-421)
- Fast Track amendments to the Regulations for the Licensure of Nursing Homes (12VAC5-371)

The Governor approved:

- Final Exempt amendments to the Regulations for the Immunization of School Children (12VAC5-110)
- Fast Track amendments to the Food Regulations (12VAC5-421)
- NOIRA for the Rabies Regulations (12VAC5-105)
- Fast-track amendments to the Virginia Immunization Information System Regulations (12VAC5-115)
- NOIRA for the Food Regulations (12VAC5-421)

PUBLIC COMMENT PERIOD

Public Comment Period

- There is a two minute time limit for each person to speak.
- We will be calling from the list in the room.
- After the 2 minute public comment limit is reached we will let you complete the sentence and move on to the next attendee.
- We will call the name of the person on list and also the name of the person is next on the list.

LUNCH PRESENTATION

Office of Environmental Health Services & Three Rivers Health District Program Highlights

June 11 , 2026

June 2026 Virginia Board of Health
Virginia Institute of Marine Sciences (VIMS)

Agenda

- Staff Introductions
- Three Rivers Health District
  - Administration
  - Epidemiology
  - Emergency Preparedness & Response
  - Environmental Health
  - Clinical and Community Health

Staff Introductions

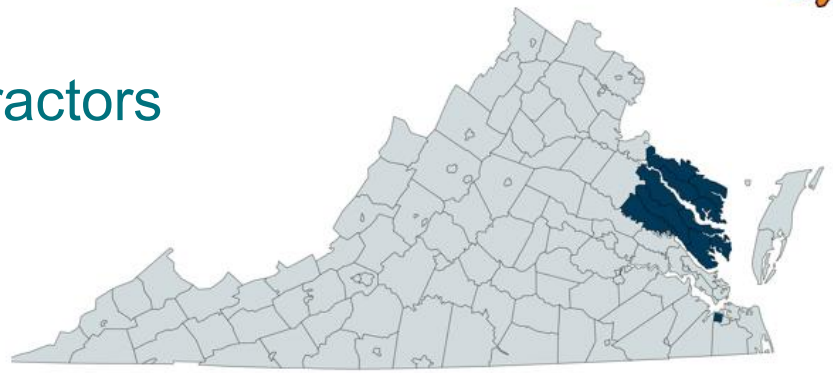
- Krystal Reagan, Business Manager, Three Rivers Health District
- Holly Balderson, Nurse Manager, Three Rivers Health District
- David Fridley, Environmental Health Manager, Three Rivers Health District
- Brenden Rivenbark, District Director, Three Rivers Health District

Three Rivers Health District Program Highlights

- *District Overview*
- *Administration*
- *Epidemiology*
- *Emergency Preparedness*
- *Environmental Health*
- *Clinical & Community Health*

Three Rivers Health District Overview

- The Three Rivers Health District supports the 10 counties of the Northern Neck and Middle Peninsula.
  - 2,000 square miles between the waters of the Potomac, Rappahannock, and York Rivers and borders the Chesapeake Bay on the east.
  - Population of ~145,000 with much fluctuation during the summer season
  - 4 Native American Tribes (Mattaponi, Upper Mattaponi, Rappahannock, Pamunkey)
  - 9 Incorporated Towns
  - 3 Hospitals (Riverside Walter Reed, Bon Secours Rappahannock General, VCU Tappahannock)
- 10 Local Health Departments
- 88 Full-Time Staff, 4 Wage Staff, 6 Contractors



Three Rivers Health District Administration

- *TRHD Administration is led by the District Director, Business Manager C, Business Manager A, District Human Resources Analyst, 5 fiscal staff, 2 Office Services Specialists Supervisors, 1 Program Support Tech, and 18 Office Services Specialists.*
- *Administration develops and executes the budget, procures supplies, collects revenues, recruits and retains staff, pays invoices, responds to FOIA requests, schedules clinics, maintains patient and client files, issues vital records, and assures the day-to-day operations of the Health District.*
  - *~$12,000,000 budget*
  - *Issue ~3,000 vital records*
  - *Execute over 1,000 family planning, STI, WIC, & Ryan White clinics*
  - *Respond to ~2,700 FOIA requests annually*
  - *Process ~ 4,000 septic, well, and food permits annually*
  - *Support day-to-day clinic and environmental health capabilities.*
  - *Lead facility safety and maintenance*

Epidemiology

- TRHD Epidemiology team collaborates with public health nurses, environmental health specialists, VDH staff, and community partners to actively monitor communicable diseases across the community.
- TRHD promptly investigates the sources and implements strategies to contain the spread. This includes educational initiatives, guidance on infection control, recommendations for post-exposure prophylaxis, community surveillance, and vaccination efforts.
  - *Receive ~2,200 communicable disease reports annually*
  - *Close ~50 disease outbreaks annually*
  - *Consistently provides outreach and education to provide guidance on diseases of concern.*

Emergency Preparedness & Response

- *Trainings*
- *MRC*
- *Mass Care Coordination*
- *Public AED*
- *Public Health Emergency Coordination*
- *POD Exercise*
- *Resources & Assets*

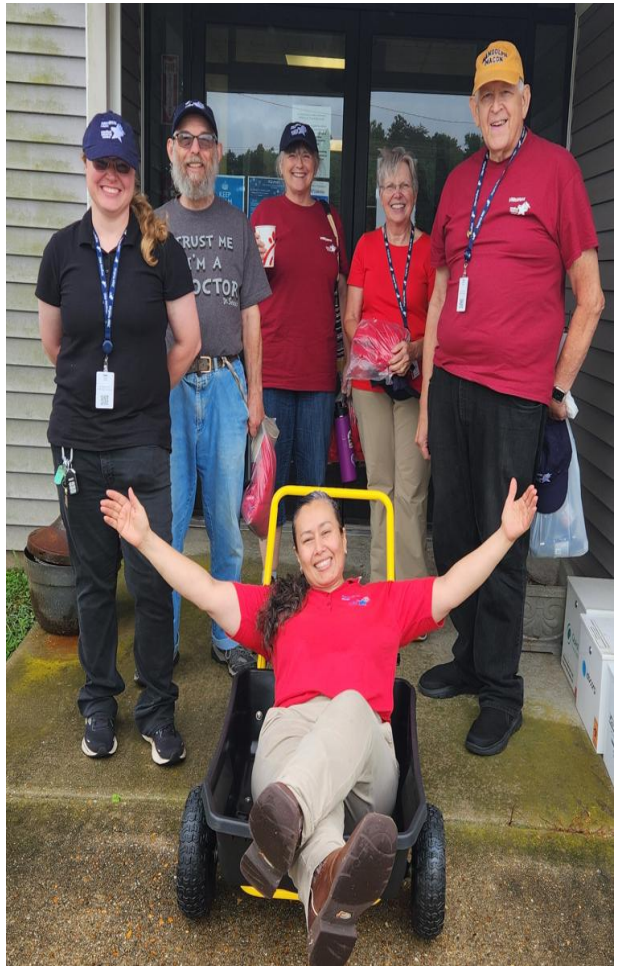
Emergency Preparedness & Response

Trainings		
Name	**Audience**	**Dates**
American Heart Association Basic Life Support	Clinical Staff Community Health Staff	November 24th 2025 January 20th, 2026
Stroke Smart Train the Trainer	Staff Community Leader MRC Volunteers	September 2nd, 2025 October 7th, 2025 January 27th, 2026
Family Emergency Preparedness	Clinical Staff	October 3rd
Active Violence Immediate Response Training (AVIRT)	Community Health Staff Admin Staff EHP Staff	February 3rd, 2026
Workers Safety	Office Managers	September 26th, 2025
Shock and compress	Office Managers	March 27th, 2026

Emergency Preparedness & Response

Medical Reserve Corp (MRC)

240 volunteers	
82 non-medical shifts	250 hours
44 medical shifts	202 hours
172 training courses taken	336 training hours
Gloucester Mathews Care Clinic Support	57 shifts
First Aid Support	12 shifts
POD Exercise	23 Volunteers
Activities	
Community training offered ✓ Compress & Shock ✓ Stroke Smart ✓ Stop The Bleed	District Programs Support ✓ Back to School Vaccination ✓ Flu Vaccination ✓ Emergency Communications: HAM Radio ✓ Health District Administrative Support ✓ Food Distribution Support (Corner Stone Community Development Center)
$16,724 workforce savings	



Emergency Preparedness & Response

Mass Care Coordination Activities	
Objective	Pulling together all Mass Care partners to network and collaborate/coordination roles, responsibilities, gaps, and opportunities to build and strengthen local Mass Care operations within 3RHD
Trainings	Community G108 Mass Care Management Course, Mass Care Symposium

County	Date
King William County/Town of West Point	November 3rd, 2025
Gloucester County	December 11th, 2025
Essex Cunty	February 5th, 2026
Lancaster County	March 9th, 2026
Northumberland	March 12th, 2026
Essex High School Walkthrough	April 13th, 2026

Emergency Preparedness & Response
Public AED

Three Rivers secured funding in 2023 to deploy 10 publicly accessible automated external defibrillators (AEDs) across the Middle Peninsula & Northern Neck. These assets are managed by our local Emergency Management partners.

Emergency Preparedness & Response

Public Health Emergency Coordination	
State Level ✓ Public Health Emergency Preparedness (PHEP) Coordination Meeting- **Monthly** ✓ Sovereign Nations of Virginia Conference-**Annual** ✓ **Translation**	**Regional Level** ✓ Eastern Region Emergency Coordination Meeting-**Monthly** ✓ EVH Eastern Virgina Health care Coalition Meeting - **Monthly**
District Level ✓ Urbana Oyster Fest planning and after-action meetings-**Annual** ✓ Local Emergency Planning Committee Meetings (KW and Gloucester) **Quarterly**	**Exercises/Planning** ✓ Shelter Operations Exercise & After-Action Meeting Gloucester 2025 ✓ EVHC Medical Response and Surge Exercise (MRSE) 2025 ✓ Northumberland Emergency Planning Meeting December 8th, 2025 ✓ Public Health Preparedness Summit March 24th and 25th, 2026
Tribes: ✓ Upper Mattaponi Tribe Emergency Coordination Meeting September 11th, 2025 ✓ Mattaponi Indian Tribe Emergency Coordination Meeting February 25th, 2026	**Hospitals:** ✓ VCU Tappahannock Hospital Emergency Coordination Meeting November 20th, 2025 ✓ Walter RED/ Riverside Health Emergency Coordination Meeting, February 10th, 2026 ✓ Bon Secours Rappahannock General Hospital Emergency Coordination Meeting March 4th, 2026

Emergency Preparedness & Response

POD EXERCISE

Exercise Synopsys

Exercise Name	Requisite Cardinal 2026/ 3RHD POD Exercise
Exercise Date	**May 1st, 2026**
Scope	This exercise is a full-scale exercise planned for: The Rappahannock Community College (RCC) campus at Warsaw and Glens on Friday May1st, 2026. Exercise play is limited to 3RHD, RCC, Richmond and Gloucester County Officials, Local hospitals, tribes, Department of Social Services (DSS), Middle Peninsula Northen Neck Behavioral Health (MPNNBH) and district wide Emergency Management Organizations.
Focus Area(s)	Public Heath Response
Capabilities	Emergency operations Coordination (3), Information sharing (6), Medical Countermeasures Dispensing and Administration (8), Medical Material Management and Distribution (9), Surveillance and Epidemiological Investigation (13), Volunteer Management (15)
Objectives	The intent of this exercise is to evaluate 3RHD and its response partners ability to respond to a large-scale biological event. Evaluate the ability to dispense and administrate Medical Countermeasures during a public health emergency. Evaluate the ability to receive, manage and distribute medical materials. Evaluate the ability to manage volunteers. Evaluate the ability to collaborate with local agencies
Threat/Hazard	H5N9 Influenza outbreak
Scenario	In 2025, the U.S. reported a novel strain of H9N5 Highly-Pathogenic Avian Influenza (HPAI) in bird species. As of early 2026, H9N5 virus was confirmed in mammal species including cattle, goats, cats, and peridomestic wildlife. VDH has reported multiple cases and identified several exposure locations so far in 2026. Zoonotic infections are linked to exposure to goats, however an increasing number of cases report no contact with animals, suggesting person-person transmission. VDH formed an Incident Management Team (IMT) in March to coordinate preparedness and response efforts in support of the Governor's declaration of emergency and activation of the Virginia Emergency Support Team (VEST). VDH to begin scaling PPE and antiviral drug distribution through open and closed PODs to high-risk individuals, first responders, hospitals, and other healthcare providers starting next week.
Sponsor	**Three Rivers Health District**
Participating Organizations	3RHD, RCC, Richmond and Gloucester County Officials, Local hospitals, tribes, Department of Social Services (DSS), Middle Peninsula Northen Neck Behavioral Health (MPNNBH) and district wide Emergency Management Organizations

Emergency Preparedness & Response

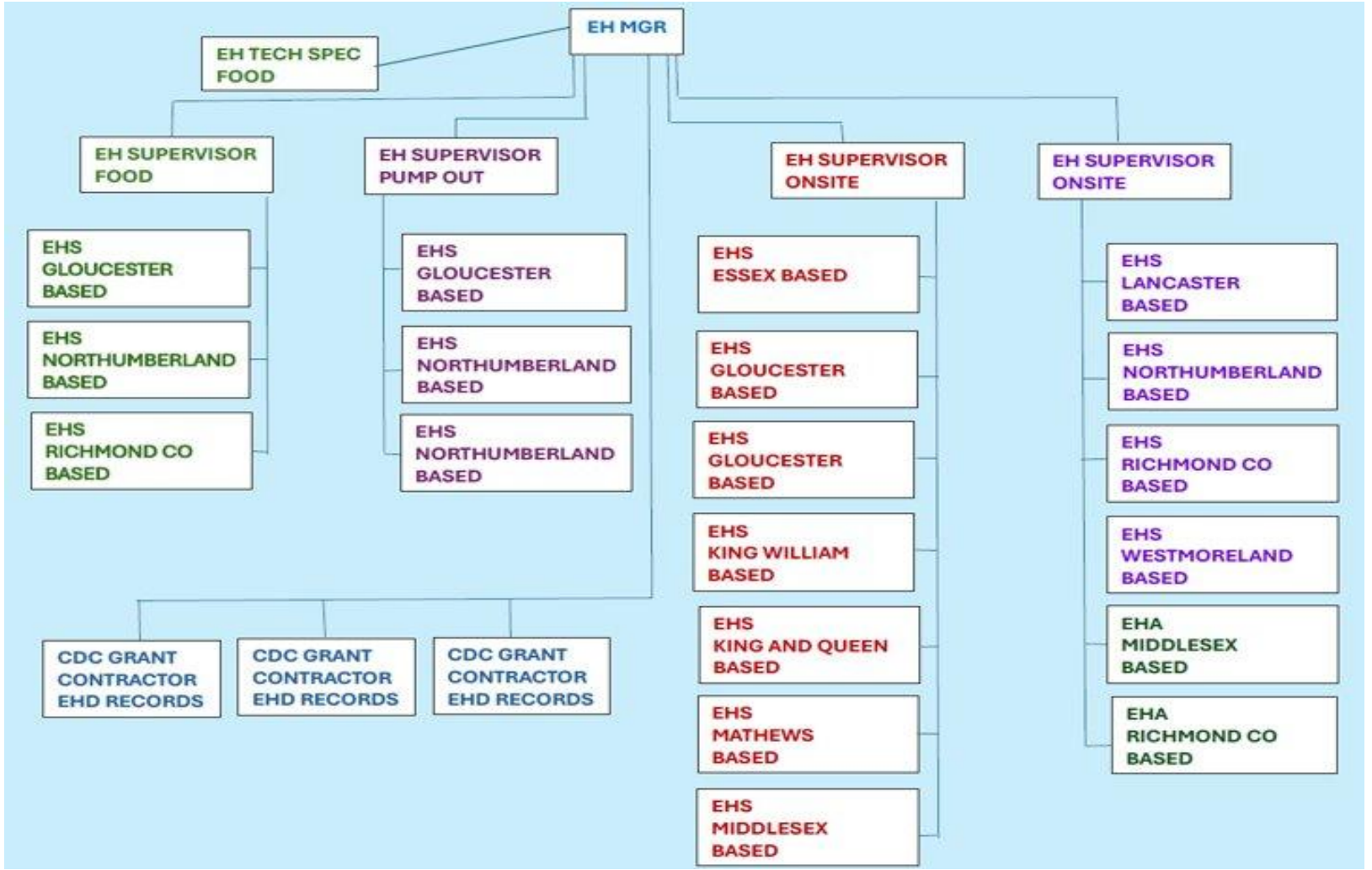
POD EXERCISE

Emergency Preparedness & Response

Resources & Assets

- 1 Shelter Support Operations Trailer: Cots, Blankets, Pillows, Sanitary kits, generator, chairs, PPE for MRC and Staff supporting shelters.
- 2 POD trailers with HAM Radio communication capabilities: Tens, Chairs, cones, signs, trash cans, PPE, Admin Boxes, Tables, Generators.
- CPR, Stop The Bleed, Compress and Shock and AVIRT high fidelity training materials.

Overview of VDH Environmental Health Programs: Prevent, Protect, Promote



Overview of VDH Environmental Health Programs: Prevent, Protect, Promote

Food Safety—Foodborne illness causes up to 48 million illnesses and 3,000 deaths each year in the US, per CDC.

Five inspector staff evaluate the food risks posed by roughly 500 facilities in Three Rivers and schedule regular safety inspections based on the hazards posed—menu, food handling process, service to highly susceptible populations (schools, nursing homes, hospitals, day care).

Educating food operators and the public is a key element to this program's success.

Partnerships with the CDC and VDACS help respond to illness outbreaks, recalls, and investigations.

Partnerships with the FDA, NACCHO, and NEHA help align Three Rivers with federal standards for an effective food safety program with measurable results and public health advances.

Overview of VDH Environmental Health Programs: Prevent, Protect, Promote

Private Drinking Water—most of Three Rivers' residents get drinking water from a private water well located on their own property, for which they are entirely responsible to maintain and operate.

Environmental health staff permit approximately 900 new water well locations annually, and inspect each well after it is drilled and sampled for coliform bacteria.

Three Rivers partners with Virginia Tech and OEHS to promote water well sampling, collect water quality information, and map hot spots of potential hazards to safe drinking water in the District.

Overview of VDH Environmental Health Programs: Prevent, Protect, Promote

Private Septic Systems—on-lot wastewater drainfields serve most of Three River's service area. Like water wells, each owner is responsible for their maintenance and upkeep. We estimate 80,000 onsite systems exist in the district and our staff permits approximately 1,500 sewage construction permits per year.

Protecting groundwater (the source of our drinking water) and surface waters for shellfish harvests and recreation requires careful siting and design for septic systems, more and more of which use small household-sized treatment plants to meet increasingly better informed water quality standards.

Overview of VDH Environmental Health Programs: Prevent, Protect, Promote

Chesapeake Bay Preservation Act, Septic Pump Out Program—the General Assembly transferred implementation authority for this program in Three Rivers and the Eastern Shore from county governments to these two health districts as of 2023.

Three Rivers has hired staff working to create a full electronic inventory of our septic systems, know who has pumped out and maintained them as the Code requires, and identify and problem-solve local infrastructure needs with our licensed septic pumpers and approved disposal sites.

Our pump out staff promote septic safety at public events, collaboration with local resource groups, and through targeted mailings to thousands of property owners annually.

Overview of VDH Environmental Health Programs: Prevent, Protect, Promote

The Rest of the Story—our environmental health team rounds out their public health work with a variety of disease and sanitation regulation:

- 400-plus rabies exposure investigations annually
- Sanitation at approximately 300 marina facilities
- Annual health inspections for migrant labor camps, hotels and motels, campgrounds, and establishments regulated by the Department of Social Services.

Clinical & Community Health

- ***PHNs***
  - *8 PHNs (including 3 PHN Srs), 1 PHN Epi, 2 Nurse Supervisors, 1 LPN, 1 NP, down 2 positions*
  - *Our Nurses travel across the district to provide all services*
  - *Our Nurses manage all clinical programs*
  - *Perform LTSS (550 Adults/75 Pediatrics in 2025), Animal Bite Investigations, Communicable Disease Investigations, including screening, testing, and treatment for LTBI and TB disease, in addition to FP/STI/Immz clinics, RW Lab clinics*
- ***Family Planning/STI***
  - *Blended Clinics in all 10 counties with 1 NP, offering Women's Health services, such as pap smears, breast exams, pregnancy planning & birth control, STI testing & treatment. We also see men*
  - *275+ clients in 2025*
- ***Immunizations***
  - *Providing vaccines for children and adults*
  - *Provided in clinics, schools and community settings*
  - *Gave over 1600 vaccines in 2025*
- ***WIC – Women Infants Children***
  - *A Federal Assistance program that helps with the health and nutrition of low income pregnant women, postpartum and breastfeeding mothers, and infants and children under the age of 5. Provides access to nutritious foods, personalized nutrition education, breastfeeding support and referrals to medical and social services*
  - *8 staff (including 1 Nutritionist)*
  - *Serving over 1900 participants*
  - *Breastfeeding Peer Counselor – trained to provide guidance, encouragement, and practical tips to help new and expectant mothers with breastfeeding*
- ***Public Blood Pressure Screenings***
  - *Facilitated almost 13,000 blood pressure screenings to the community via 12 mobile screening devices deployed in local libraries, YMCAs, and health departments.*
- *K-12 Education & Outreach*
  - *Reached almost 400 students in handwashing training.*

Clinical & Community Health Services cont'd.

- ***DIS - Disease Intervention Specialist***
  - *1 staff, mostly Syphilis and STI investigations*
  - *Completes investigations and helps clients and their contacts receive treatments*

- ***Ryan White***
  - *2.5 staff (MCM & NMCM)*
  - *MCM's focus on improving health outcomes in the support of the HIV care continuum by providing assessments of need, develops comprehensive individualized service plans, coordinates services, & monitors clients*
  - *NMCM provides a range of client-centered activities focused on improving access to and retention in needed core medical and support services, including eligibility for services, referrals, and support.*
  - *Usually have around 80 clients*
  - *Partner with Riverside to provide Medical services & our staff go to the clinic each month to provide services to clients while they are being seen by the MD*
  - *Virginia Medication Assistance Services (VAMAP) Services, in addition to Case Management*
  - *For the past 5+ years out clients have maintained a Viral Load Suppression in the 90th percentile, above the state and national levels of 70 – 80th percentile*
  - *After the loss of RW Part B funding earlier this year, our program has had over 250 referrals for VAMAP services*
  - *Our Unified Eligibility Assessment error rate was 2.6% in FY25, which is well below the contractual goal of 10% and the state goal of 5%*
  - *Our NMCM, Aimee Conklin, was awarded the NMCM of the Year award this year!*

Clinical & Community Health Services cont'd.

- ***MCH/RM - Maternal Child Health/Resource Mothers***
  - *The Resource Mother's program is a mentoring program for pregnant & parenting teens. Usually, the RM was a teen mom themselves and can provide encouragement and support based on what they experienced.*
  - *Follow the Growing Great Kids Curriculum, which is designed to enhance the Parent-Child relationship by providing child development activities and handouts that integrate health, wellness, and parenting skills*
  - *1 Resource Mother providing mentoring, community resources, education and transportation for ~24 pregnant and parenting teens*
  - *Three Rivers is a maternal dessert. There are no birthing facilities within the 10 counties. The Maternal Child Health program is focused on supporting our pregnant and postpartum clients.*
  - *2 CHWs providing individualized Maternal & Child Health Services, including connecting families to community resources such as WIC, housing assistance, food support, women's shelters, pediatric care, mental health services, and transportation,*
  - We also provide education on breastfeeding, maternal health, family planning, and safe sleep, while also guiding clients through the complexities of the healthcare system, like appointment scheduling, transportation challenges, insurance issues, and access to care.
  - Through outreach and active coalition participation, our CHWs have established strong relationships with community organizations, including Bay Aging, It Takes a Village, Early Impact, and The Haven, further fostering partnerships that enhance our ability to serve families and strengthen our network of support.
  - *All Certified to teach Safe Sleep Classes and will be taking Car Seat certification classes later this year*
  - *Both CHWs currently enrolled in a certification class*
  - *Working towards holding a Community Baby Shower in late June*

Clinical & Community Health Services Team

WRAP UP / CLOSING

-

Thank you!

PROPOSED AMENDMENTS: REGULATIONS FOR THE LICENSURE OF NURSING FACILITIES (12VAC5-371)

April Dovel, MSW, MBA
Director, Office of Licensure and Certification

COMMONWEALTH of VIRGINIA

Department of Health

B. Cameron Webb, MD, JD
State Health Commissioner

P O BOX 2448
RICHMOND, VA 23218

TTY 7-1-1 OR
1-800-828-1120

MEMORANDUM

DATE: May 15, 2026

TO: State Board of Health

FROM: April Dovel
Director, Office of Licensure and Certification

SUBJECT: Amend Regulation after Enactment of Chapters 166 and 180 of the 2025 Acts of Assembly

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Enclosed for your review and approval is a Proposed regulatory action to amend the Regulations for the Licensure of Nursing Facilities (12VAC5-371) to enact the provisions of Chapters 166 and 180 of the 2025 Acts of Assembly. The proposed amendments are necessary to comply with §§ 32.1-127.01, 32.1-134.1, 32.1-134.4, and 32.1-135 of the Code of Virginia. As such, VDH recommends that the Board approve the proposed amendments to the Regulations for the Licensure of Nursing Facilities.

Chapters 166 and 180 of the 2025 Acts of Assembly authorize the State Health Commissioner to impose additional intermediate sanctions on nursing homes licensed in Virginia, and require the Board of Health to promulgate regulations specifying (i) the criteria for when sanctions are appropriate, (ii) criteria for the imposition of sanctions, (iii) a schedule of civil penalties, (iv) procedures for the imposition of sanctions, and (v) provisions for the notification of the Department of Medical Assistance Services when a licensure is revoked or suspended.

The Board of Health is requested to approve these proposed amendments to 12VAC5-371. Should the Board approve the proposed amendments, they will be submitted for Executive Branch Review and, upon approval by the Governor, published in the Virginia Register of Regulations. Following publication in the Virginia Register of Regulations, a 60-day public comment period will begin, and the agency will hold a public hearing. The agency will then consider comments in the preparation of final amendments.

townhall.virginia.gov

Proposed Regulation
Agency Background Document

Agency name	State Board of Health
Virginia Administrative Code (VAC) Chapter citation(s)	12 VAC 5-371
VAC Chapter title(s)	Regulations for the Licensure of Nursing Facilities
Action title	Amend Regulation after Enactment of Chapters 166 and 180 of the 2025 Acts of Assembly
Date this document prepared	5/15/2026

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Order 19 (2022) (EO 19), any instructions or procedures issued by the Office of Regulatory Management (ORM) or the Department of Planning and Budget (DPB) pursuant to EO 19, the Regulations for Filing and Publishing Agency Regulations (1 VAC 7-10), and the *Form and Style Requirements for the Virginia Register of Regulations and Virginia Administrative Code*.

Brief Summary

Provide a brief summary (preferably no more than 2 or 3 paragraphs) of this regulatory change (i.e., new regulation, amendments to an existing regulation, or repeal of an existing regulation). Alert the reader to all substantive matters. If applicable, generally describe the existing regulation.

Chapters 166 and 180 of the 2025 Acts of Assembly authorize the State Health Commissioner to impose sanctions on nursing homes licensed in Virginia pursuant to the laws regulating medical care facilities and services. The Board of Health is required by Chapters 166 and 180 of the 2025 Acts of Assembly to promulgate regulations implementing the provisions of the act.

Chapters 166 and 180 of the 2025 Acts of Assembly specify additional, intermediate sanctions that the Commissioner may impose, the nursing home's continued responsibility for persons under its care, the use of funds remunerated in accordance with such sanctions, the criteria necessary for the commissioner to impose such sanctions, and additional provisions for the revocation of nursing facility licenses. These proposed regulatory amendments specify that certain sanctions shall not be imposed on a nursing facility for the same conduct that is sanctioned by the Centers for Medicare and Medicaid Services (CMS) and

that certain sanctions may not be imposed for violations deemed more severe than CMS Level 2 violations.

Acronyms and Definitions

Define all acronyms used in this form, and any technical terms that are not also defined in the "Definitions" section of the regulation.

"APA" means the Virginia Administrative Process Act, § 2.2-4000 et seq. of the Code of Virginia.

"Board" means the Virginia State Board of Health.

"Chapters 166 and 180" means Chapters 166 and 180 of the 2025 Acts of Assembly.

"CMS" means the Centers for Medicare and Medicaid Services.

"Commissioner" means the State Health Commissioner.

"VDH" means the Virginia Department of Health.

Mandate and Impetus

Identify the mandate for this regulatory change and any other impetus that specifically prompted its initiation (e.g., new or modified mandate, petition for rulemaking, periodic review, or board decision). For purposes of executive branch review, "mandate" has the same meaning as defined in the ORM procedures, "a directive from the General Assembly, the federal government, or a court that requires that a regulation be promulgated, amended, or repealed in whole or part."

The State Board of Health is mandated by the provisions of Chapters 166 and 180 of the 2025 Acts of Assembly. The impetus for this change is Chapters 166 and 180 of the 2025 Acts of Assembly.

Legal Basis

Identify (1) the promulgating agency, and (2) the state and/or federal legal authority for the regulatory change, including the most relevant citations to the Code of Virginia and Acts of Assembly chapter number(s), if applicable. Your citation must include a specific provision, if any, authorizing the promulgating agency to regulate this specific subject or program, as well as a reference to the agency's overall regulatory authority.

This regulation is promulgated under the authority of §§ 32.1-12 of the Code of Virginia and Chapters 166 and 180 of the 2025 Acts of Assembly.

§ 32.1-12 of the Code of Virginia grants the Board the legal authority "to make, adopt, promulgate, and enforce such regulations…as may be necessary to carry out the provisions of this title and other laws of the Commonwealth administered by it, the Commissioner, or the Department."

Chapters 166 and 180 of the 2025 Acts of Assembly (§ 32.1-27.3) direct the Board of Health to promulgate regulations to implement the provisions of this act.

Purpose

Explain the need for the regulatory change, including a description of: (1) the rationale or justification, (2) the specific reasons the regulatory change is essential to protect the health, safety or welfare of citizens, and (3) the goals of the regulatory change and the problems it is intended to solve.

The Board has determined that the regulations are essential to protect the health, safety, and welfare of citizens because the General Assembly enacted Chapters 166 and 180 requiring the Board to adopt regulations for establishing procedures for the implementation of sanctions on licensed nursing homes. The Board may address other potential issues as the regulation is developed and as can be raised during the public comment period.

Substance

Briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both. A more detailed discussion is provided in the "Detail of Changes" section below.

This regulatory action contains additional provisions for the Commissioner to impose sanctions on nursing facilities in the Commonwealth. The intention of the Board is to establish procedures for the implementation of sanctions by the Commissioner on any nursing home that is licensed pursuant to the laws regulating nursing facilities and services. This action and the provisions of the proposed regulations may be revised based on public comments received.

Issues

Identify the issues associated with the regulatory change, including: 1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions; 2) the primary advantages and disadvantages to the agency or the Commonwealth; and 3) other pertinent matters of interest to the regulated community, government officials, and the public. If there are no disadvantages to the public or the Commonwealth, include a specific statement to that effect.

1) The primary advantages of this proposed regulation to the public are the improvement in overall care quality for vulnerable residents in long term care facilities in the Commonwealth. There are no primary disadvantages to the public.
2) The primary advantages of this proposed regulation to agency and Commonwealth is additional authority by the agency and Commonwealth in holding long term care facilities that violate the Code of Virgina and the Virginia Administrative Code accountable. There are no primary disadvantages to the agency and the Commonwealth.
3) Primary advantages to the regulated community, government officials, and the public is the availability of intermediate sanctions to compel compliance that may be less severe than the Commissioner's existing sanction authority. There are no primary disadvantages to other pertinent matters of interest to the regulated community, government officials, and the public.

Requirements More Restrictive than Federal

Identify and describe any requirement of the regulatory change which is more restrictive than applicable federal requirements. Include a specific citation for each applicable federal requirement, and a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements, or no requirements that exceed applicable federal requirements, include a specific statement to that effect.

Nothing in this proposed regulation exceeds federal requirements.

Agencies, Localities, and Other Entities Particularly Affected

Consistent with § 2.2-4007.04 of the Code of Virginia, identify any other state agencies, localities, or other entities particularly affected by the regulatory change. Other entities could include local partners such as tribal governments, school boards, community services boards, and similar regional organizations. "Particularly affected" are those that are likely to bear any identified disproportionate material impact which would not be experienced by other agencies, localities, or entities. "Locality" can refer to either local governments or the locations in the Commonwealth where the activities relevant to the regulation or regulatory change are most likely to occur. If no agency, locality, or entity is particularly affected, include a specific statement to that effect.

Other State Agencies Particularly Affected

The Department of Medical Assistance Services (DMAS) is to be reported to following the Commissioner's revocation or suspension of a license of any facility with an applicable Medicaid provider agreement.

Localities Particularly Affected

None

Other Entities Particularly Affected

Nursing facilities and industry organizations that represent the aforementioned facilities.

Economic Impact

Consistent with § 2.2-4007.04 of the Code of Virginia, identify all specific economic impacts (costs and/or benefits) anticipated to result from the regulatory change. When describing a particular economic impact, specify which new requirement or change in requirement creates the anticipated economic impact. Keep in mind that this is the proposed change versus the status quo.

Impact on State Agencies

For your agency: projected costs, savings, fees, or revenues resulting from the regulatory change, including: a) fund source / fund detail; b) delineation of one-time versus on-going expenditures; and c) whether any costs or revenue loss can be absorbed within existing resources.	None
For other state agencies: projected costs, savings, fees, or revenues resulting from the regulatory change, including a delineation of one-time versus on-going expenditures.	None
For all agencies: Benefits the regulatory change is designed to produce.	None

Impact on Localities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a or 2) on which it was reported. Information provided on that form need not be repeated here.

Projected costs, savings, fees, or revenues resulting from the regulatory change.	None
Benefits the regulatory change is designed to produce.	None

Impact on Other Entities

If this analysis has been reported on the ORM Economic Impact form, indicate the tables (1a, 3, or 4) on which it was reported. Information provided on that form need not be repeated here.

Description of the individuals, businesses, or other entities likely to be affected by the regulatory change. If no other entities will be affected, include a specific statement to that effect.	None
Agency's best estimate of the number of such entities that will be affected. Include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that: a) is independently owned and operated, and; b) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	None
All projected costs for affected individuals, businesses, or other entities resulting from the regulatory change. Be specific and include all costs including, but not limited to: a) projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses; b) specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the regulatory change; c) fees; d) purchases of equipment or services; and e) time required to comply with the requirements.	None
Benefits the regulatory change is designed to produce.	None

Alternatives to Regulation

Describe any viable alternatives to the regulatory change that were considered, and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the regulatory change. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in § 2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulatory change.

No alternative was considered because the General Assembly required the Board to adopt regulations establishing procedures for the implementation of sanctions on nursing homes pursuant to Chapters 166 and 180 of the 2025 Acts of Assembly.

Regulatory Flexibility Analysis

Consistent with § 2.2-4007.1 B of the Code of Virginia, describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) establishing less stringent compliance or reporting requirements; 2) establishing less stringent schedules or deadlines for compliance or reporting requirements; 3) consolidation or simplification of compliance or reporting requirements; 4) establishing performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the regulatory change.

No alternative regulatory methods or options have been identified.

Periodic Review and Small Business Impact Review Report of Findings

If you are using this form to report the result of a periodic review/small business impact review that is being conducted as part of this regulatory action, and was announced during the NOIRA stage, indicate whether the regulatory change meets the criteria set out in EO 19 and the ORM procedures, e.g., is necessary for the protection of public health, safety, and welfare; minimizes the economic impact on small businesses consistent with the stated objectives of applicable law; and is clearly written and easily understandable. In addition, as required by § 2.2-4007.1 E and F of the Code of Virginia, discuss the agency's consideration of: (1) the continued need for the regulation; (2) the nature of complaints or comments received concerning the regulation; (3) the complexity of the regulation; (4) the extent to the which the regulation overlaps, duplicates, or conflicts with federal or state law or regulation; and (5) the length of time since the regulation has been evaluated or the degree to which technology, economic conditions, or other factors have changed in the area affected by the regulation. Also, discuss why the agency's decision, consistent with applicable law, will minimize the economic impact of regulations on small businesses.

This Proposed Regulation is not being used to announce a periodic review or a small business impact review.

Public Comment

Summarize all comments received during the public comment period following the publication of the previous stage, and provide the agency's response. Include all comments submitted: including those received on Town Hall, in a public hearing, or submitted directly to the agency. If no comment was received, enter a specific statement to that effect.

No comments were received during the Notice of Intended Regulatory Action public comment period ending 12/31/2025.

Public Participation

Indicate how the public should contact the agency to submit comments on this regulation, and whether a public hearing will be held, by completing the text below.

The State Board of Health is providing an opportunity for comments on this regulatory proposal, including but not limited to (i) the costs and benefits of the regulatory proposal, (ii) any alternative approaches, (iii) the potential impacts of the regulation, and (iv) the agency's regulatory flexibility analysis stated in that section of this background document.

Anyone wishing to submit written comments for the public comment file may do so through the Public Comment Forums feature of the Virginia Regulatory Town Hall web site at: https://townhall.virginia.gov. Comments may also be submitted by mail, email or fax to Geoff Garner, 9960 Mayland Drive, Suite 401 Henrico, VA, 23233, 804-367-2157, geoff.garner@vdh.virginia.gov. In order to be considered, comments must be received by 11:59 pm on the last day of the public comment period.

A public hearing will be held following the publication of this stage, and notice of the hearing will be posted on the Virginia Regulatory Town Hall website (https://townhall.virginia.gov) and on the Commonwealth Calendar website (https://commonwealthcalendar.virginia.gov/). Both oral and written comments may be submitted at that time.

Detail of Changes

List all regulatory changes and the consequences of the changes. Explain the new requirements and what they mean rather than merely quoting the text of the regulation. For example, describe the intent of the language and the expected impact. Describe the difference between existing requirement(s) and/or agency practice(s) and what is being proposed in this regulatory change. Use all tables that apply, but delete inapplicable tables.

If an existing VAC Chapter(s) is being amended or repealed, use Table 1 to describe the changes between the existing VAC Chapter(s) and the proposed regulation. If the existing VAC Chapter(s) or sections are being repealed and replaced, ensure Table 1 clearly shows both the current number and the new number for each repealed section and the replacement section.

Table 1: Changes to Existing VAC Chapter(s)

Current chapter-section number	New chapter-section number, if applicable	Current requirements in VAC	Change, intent, rationale, and likely impact of new requirements
12VAC5-371-90		Administrative sanctions	**Change:** 1. Changing the catchline of the section from “Administrative Sanctions” to “Sanctions”. 2. Stylistic changes throughout including changing “department” to “commissioner” to maintain consistency in the regulations. 3. Addition of DMAS notification and licensure reinstatement requirements provided by Chapters 166 and 180 following (B) (3). 4. Removal of reasons

			that may be considered for the imposition of administrative sanctions. 5. Addition of newly authorized sanctions, including a civil monetary penalty of $500 per violation per day and license probation. 6. Addition of provisions restricting the Commissioner's ability to impose civil monetary penalties and probation. 7. Addition of provision clarifying that a nursing facility sanctioned under this section shall retain responsibility for the health, safety, and welfare of persons in their care. **Intent:** 1. Broaden the section catchline. 2. Comply with the requirements of the *Virginia Register of Regulations Form, Style, and Procedure Manual for the Publication of Virginia Regulations*. 3. Include code requirement that the Commissioner notify DMAS in the event of a relevant nursing home license suspension or revocation. 4. Move existing criteria for existing sanctions to a newly created section within Chapter 371 for consistency and clarity of the regulations. 5. Add the new sanctions, including the schedule of civil monetary penalties ($500 per violation per day) and license probation to comply with requirements of Chapters 166 and 180. 6. Adding restrictions to comply with the requirements of Chapters 166 and 180. 7. Adding clarifying provision about nursing facility responsibility to comply with Chapters 166 and 180. **Rationale:** 1. The addition of new sanctions broadens the scope of the Section, which necessitates a broader title. 2. Compliance with the *Virginia Register of Regulations Form, Style, and Procedure Manual for the Publication of Virginia Regulations* is necessary for the clarity and uniformity of the regulations and required by the APA. 3. Chapters 166 and 180 include provisions that the Board promulgate regulations that include DMAS notification of certain license suspensions or revocations, which is required by these regulations within 48 of the revocation or suspension of such license. 4. This regulation creates a new Section (12VAC5-371-91) to provide for the criteria in which sanctions may be imposed. These

			existing criteria for existing sanctions were moved to the new section for clarity and readability. 5. Specifically including the sanctions available to the commissioner authorized by Chapters 166 and 180, and adding conditions in which the new sanctions may be considered, as well as including the schedule of civil monetary penalties as $500 per violation per day, not to exceed $10,000 satisfies the requirements of Chapters 166 and 180. 6. Restating specific provisions included in Chapters 166 and 180 helps ensure compliance with the Code of Virginia. 7. Restating specific provisions included in Chapters 166 and 180 helps to ensure compliance with the Code of Virginia. **Likely Impact:** The agency believes that the changes outlined above will likely result in increased compliance from nursing facilities in the Commonwealth subject to these regulations, increased clarity and readability of the regulations, and regulatory compliance with the requirements of Chapters 166 and 180.

If a new VAC Chapter(s) is being promulgated and is not replacing an existing Chapter(s), use Table 2.

Table 2: Promulgating New VAC Chapter(s) without Repeal and Replace

New chapter-section number	New requirements to be added to VAC	Other regulations and laws that apply	Change, intent, rationale, and likely impact of new requirements
12VAC5-371-91	Criteria for the imposition of sanctions	None	**Change:** This new section provides the criteria necessary for the Commissioner to impose sanctions outlined in 12VAC5-371-90. **Intent:** The intent is to provide clear instruction on which nursing facility violations may result in the commissioner imposing specific types of sanctions. **Rationale:** By clearly indicating types of noncompliance and the sanctions that may be imposed as a result of such noncompliance, the agency and regulants are instructed as to which disciplinary actions

			may be taken in compliance with the regulations and the Code of Virginia. **Likely Impact:** The agency believes that the addition of this section will likely result in increased compliance from nursing facilities in the Commonwealth subject to these regulations, increased clarity and readability of the regulations, and regulatory compliance with the requirements of Chapters 166 and 180.
12VAC5-371-92	Administrative procedures for sanctions.	None	**Change:** Establishing procedures for the Commissioner to follow when imposing civil penalties on nursing homes as required by Chapters 166 and 180, which includes requirements to be satisfied before new sanctions may be imposed including provisions for a plan of correction and a letter of intent from the Commissioner to a nursing facility. This section also includes additional remedies that the Commissioner and a nursing facility may pursue, including informal fact finding conferences. **Intent:** Providing the Commissioner and regulants with procedural direction when imposing sanctions on nursing homes pursuant proposed regulation. **Rationale:** By clearly indicating administrative procedures for sanctions, the agency and regulants are instructed of the administrative procedures that must be taken in compliance with the regulations and the Code of Virginia or that are available. **Likely Impact:** The agency believes that the addition of this section will likely result in

			increased compliance from nursing facilities in the Commonwealth subject to these regulations, increased clarity and readability of the regulations, and regulatory compliance with the requirements of Chapters 166 and 180.

*If the regulatory change is replacing an **emergency regulation**, and the proposed regulation is identical to the emergency regulation, complete Table 1 and/or Table 2, as described above.*

*If the regulatory change is replacing an **emergency regulation**, but changes have been made since the emergency regulation became effective, also complete Table 3 to describe the changes made since the emergency regulation.*

Table 3: Changes to the Emergency Regulation

Emergency chapter-section number	New chapter-section number, if applicable	Current emergency requirement	Change, intent, rationale, and likely impact of new or changed requirements since emergency stage

Project 8523 - Proposed

Department of Health

Amend Regulation after Enactment of Chapters 166 and 180 of the 2025 Acts of Assembly

12VAC5-371-90. ~~Administrative sanctions~~ Sanctions.

A. Nothing in this part shall prohibit the ~~department~~ commissioner from exercising ~~its~~ his responsibility and authority to enforce the regulation, including proceeding directly to imposition of administrative sanctions, when the quality of care or the quality of life has been severely compromised.

B. The commissioner may impose ~~such administrative~~ the following sanctions or take such actions as are appropriate for violation of any of the standards or statutes or for abuse or neglect of persons in care~~. Such sanctions include~~:

1. Restricting or prohibiting new admissions to ~~any~~ a nursing facility;

2. Petitioning the court to impose a civil penalty or to appoint a receiver, or both; or

3. Revoking or suspending the license of a nursing facility.

a. The commissioner shall notify the Department of Medical Assistance Services within 48 hours when any license issued pursuant to Chapter 5 of Title 32.1 of the Code of Virginia (§ 32.1-123 et seq.) is revoked or suspended.

b. If a license of any nursing facility issued pursuant to Chapter 5 (§ 32.1-123 et seq.) is revoked, the commissioner may issue a new license after (i) satisfactory evidence is submitted to the commissioner that the conditions upon which revocation was based have been corrected; and (ii) proper inspection has been made and

compliance with all provisions of Chapter 5 (§ 32.1-123 et seq.) and applicable state and federal laws and regulations has been obtained.

~~C. The following reasons may be considered by the department for the imposition of administrative sanctions or the imposition of civil penalties:~~

~~1. Failure to demonstrate or maintain compliance with applicable standards or for violations of the provisions of the Code of Virginia;~~

~~2. Permitting, aiding, or abetting the commission of any illegal act in the nursing facility; or~~

~~3. Deviating significantly from the program or services for which a license was issued without obtaining prior written approval from the OLC, or failure to correct such deviations within a specified time.~~

~~D.~~C. Violations which in the judgment of the ~~OLC~~ commissioner jeopardize the health and safety of residents shall be sufficient cause for immediate imposition of subsection B of this section.

D. The commissioner may impose the following sanctions in response to findings made during a state licensure inspection conducted within the previous 24 months and for which such findings have been communicated to the nursing facility within 14 business days of the survey end date:

1. Imposing a civil monetary penalty of $500 per violation per day.

a. A civil monetary penalty shall not exceed $10,000 for a series of related incidents of noncompliance.

b. Civil penalties collected pursuant to this subdivision shall be paid to the Nursing Scholarship and Loan Repayment Fund established pursuant to § 54.1-3011.2 of the Code of Virginia; and

2. Placing on probation any license issued pursuant to Chapter 5 of Title 32.1 of the Code of Virginia (§ 32.1-123 et seq.).

E. ~~The licensee will receive a notice of the department's intent to impose sanctions. The notice shall describe the reasons for imposing the sanction.~~ The commissioner may not impose sanctions pursuant to subsection D of this section:

1. For violations deemed more severe than a level 2 deficiency under the Centers for Medicare and Medicaid Services deficiency severity definitions under federal law; or

2. If a nursing facility has been sanctioned by the Centers for Medicare and Medicaid Services for conduct that also subjects the nursing facility to sanctions pursuant to subsection D of this section.

a. If the Centers for Medicare and Medicaid Services fails to issue a sanction to a nursing facility in the Commonwealth for conduct described in subsection D of this section within 60 days, the commissioner may issue a sanction under subsection D of this section if the commissioner determines that issuing such sanction is necessary to protect the public health and welfare or the health and safety of residents of the nursing facility.

b. In the event the Centers for Medicare and Medicaid Services issues a sanction on a violation for which the commissioner has issued a sanction pursuant to this section, the sanction issued by the commissioner shall be nullified with any civil penalty imposed refunded to the nursing facility within 60 days.

F. ~~Upon receipt of the notice to impose a sanction, the licensee has the right and the opportunity to appeal according to the Administrative Process Act (§ 2.2-4000 et seq. of the Code of Virginia). The procedures for filing an appeal shall be outlined in the notice.~~ A nursing facility sanctioned by the commissioner pursuant to this section shall retain responsibility for the health, safety, and welfare of any person under the nursing facility's care, including the timely transfer or relocation of any persons under the nursing facility's care.

12VAC5-371-91. Criteria for the imposition of sanctions.

A. The commissioner may impose civil monetary penalties pursuant to 12VAC5-371-90 D 1 on a nursing facility for repeat or patterned noncompliance with any provision of Chapter 5 of Title 32.1 of the Code of Virginia (§ 32.1-123 et seq.) or of any applicable regulation promulgated pursuant to the Regulations for the Licensure of Nursing Facilities (12VAC5-371) which includes:

1. Repeat deficiency on two consecutive licensure inspections;

2. Three or more violations of any one section of this chapter; or

3. Permitting, aiding, or abetting the commission of any illegal act during the provision of health care services delivered by such nursing facility.

B. The commissioner may place on probation the license of a nursing facility pursuant to 12VAC5-371-90 D 2 for persistent or escalating noncompliance with any provision of Chapter 5 of Title 32.1 of the Code of Virginia (§ 32.1-123 et seq.) or of any applicable regulation promulgated pursuant to the Regulations for the Licensure of Nursing Facilities (12VAC5-371), which includes:

1. Repeat deficiency on three consecutive licensure inspections;

2. Three or more violations of two or more sections of this chapter; or

3. Permitting, aiding, or abetting the commission of any illegal act during the provision of health care services delivered by such nursing facility.

C. The commissioner may impose on a nursing facility sanctions pursuant to 12VAC5-371-90 B for systemic noncompliance which includes:

1. Violations of the provisions of the Regulations for the Licensure of Nursing Facilities (12VAC5-371) or violations of the provisions of the Code of Virginia;

2. Deviating significantly from the program or services for which a license was issued without obtaining prior written approval from the commissioner or failure to correct such deviations within a specified time; or

3. Permitting, aiding, or abetting the commission of any illegal act in the nursing facility.

12VAC5-371-92. Administrative procedures for sanctions.

A. Before imposing sanctions pursuant to 12VAC5-371-90 D, the commissioner shall require the nursing facility subject to disciplinary action to submit to the commissioner, and comply with, a plan of correction within 90 days.

1. If the commissioner concludes that a lack of training has led directly to noncompliance, the plan of correction shall include mandated training for the nursing facility's employees at the expense of the nursing facility.

2. Upon expiration of the initial plan of correction, the commissioner may extend the time period for the plan of correction or may impose sanctions pursuant to 12VAC5-371-90 D.

B. The commissioner may not impose a sanction on a nursing facility before the commissioner provides the nursing facility with reasonable notice of imposition of sanctions, which shall describe the reasons for imposing the sanction. The facility shall be provided an

opportunity to be heard within no fewer than 30 days from the day of such notice by the commissioner's presiding officer in accordance with § 2.2-4019 of the Code of Virginia.

1. All requests for an opportunity to be heard following a notice of the imposition of such sanction shall be received in writing within 15 days of the date of receipt of such notice.

2. All administrative proceedings pursuant to subsection D of 12VAC5-371-90 shall be separate from the Office of Licensure and Certification. The Commissioner shall appoint an individual to serve as a presiding officer.

a. The presiding officer shall make decisions regarding the conduct of the conference, regulate the procedures at the conference, review all information presented, and recommend a case decision to the commissioner.

b. The presiding officer may require the exchange of documents before the informal conference.

c. The presiding officer shall contact the facility within five business days of the being appointed to schedule the informal conference and to ascertain whether legal counsel shall represent the facility at the conference.

d. The presiding officer shall schedule the conference no later than 90 days after being appointed, unless all parties jointly agree to a later date.

C. Upon issuance of a letter of intent, the facility has 15 days to appeal the letter of intent and request an informal proceeding conference pursuant to the Administrative Process Act (§ 2.2-4000 et seq of the Code of Virginia). Upon receiving a written appeal, the commissioner shall convene an informal fact finding conference to determine the facts for its decision. At an informal fact finding conference, both parties may present all relevant information to support their cases and narrow and simplify issues in dispute.

1. The respondent has the following rights at an informal fact finding conference:

a. Reasonable notice of the conference;

b. Appearance in person and representation by counsel;

c. Receipt of notice of adverse facts or information upon which the department may rely in making its determination; and

d. Written notice of the factual or procedural basis for an adverse decision.

2. The commissioner shall appoint an individual to serve as presiding officer.

a. The presiding officer shall make decisions regarding the conduct of the conference, regulate the procedures at the conference, review all information presented, and recommend a case decision to the commissioner.

b. The presiding officer may require the exchange of documents before the informal conference.

c. The presiding officer shall contact the facility within five business days of the being appointed to schedule the informal conference and to ascertain whether legal counsel shall represent the facility at the conference.

d. The presiding officer shall schedule the conference no later than 60 days after being appointed, unless all parties jointly agree to a later date.

e. Based on the information presented at the conference, the presiding officer shall prepare a written report and recommendation for the commissioner's consideration. The presiding officer's written report and recommendation shall be submitted to the commissioner within 14 business days of the date of the conference.

3. After the informal conference, the adjudication officer shall provide a recommendation to the commissioner, including findings of fact, conclusions, and appropriate disciplinary action.

4. The commissioner may affirm, modify, or reverse such recommendation and shall issue a final case decision.

5. A nursing facility sanctioned by the commissioner shall retain responsibility for the health, safety, and welfare of any person under such nursing facility's care, including the timely transfer or relocation of any persons under such nursing facility's care as may be deemed necessary by the commissioner. Upon expiration of the initial plan of correction, the commissioner may extend the time period for the plan of correction or may impose sanctions.

6. Any person aggrieved by the final case decision of the Commissioner to impose disciplinary action is entitled to judicial review in accordance with the provisions of the Administrative Process Act (§ 2.2-4000 et seq.).

DECISION MEMO: TRAUMA DESIGNATION ADOPTION OF THE AMERICAN COLLEGE OF SURGEONS (ACS) VERIFICATION MODEL FOR VIRGINIA TRAUMA CENTER DESIGNATION

Ashley Camper

Trauma and Critical Care Program Manager, Office of Emergency Medical Services

Paula A. Ferrada, MD

Chair, State Emergency Medical Services Advisory Board

COMMONWEALTH of VIRGINIA
Department of Health
B. Cameron Webb, MD, JD
State Health Commissioner
P O BOX 2448
RICHMOND, VA 23218
TTY 7-1-1 OR
1-800-828-1120

May 27, 2026

DECISION MEMORANDUM

TO: State Board of Health

FROM: Dr. Cameron Webb
State Health Commissioner

SUBJECT: Adoption of the American College of Surgeons Verification Model for Virginia Trauma Center Designation

I. PURPOSE

The Virginia Department of Health's (VDH) Office of Emergency Medical Services (OEMS) is seeking State Board of Health approval to transition the state designation and verification model to an American College of Surgeons (ACS) recognition verification framework as part of the Commonwealth's trauma center designation process. Under the proposed framework, OEMS would recognize ACS verification findings as the primary verification methodology for trauma center designation decisions while preserving the Commonwealth's authority for trauma center designation, oversight, enforcement, and statewide trauma system accountability.

II. BACKGROUND

Pursuant to Code of Virginia § 32.1-111.3(A)(10), the State Board of Health is responsible for "establishing and maintaining a process for designation of appropriate hospitals as trauma centers, certified stroke centers, and specialty care centers based on an applicable national evaluation system."

Virginia currently operates a state-administered trauma center verification and designation system through the Virginia OEMS, utilizing state-led verification reviews, designation standards, and ongoing compliance oversight informed by nationally recognized frameworks established by the ACS.

Over time, the operational complexity and resource demands associated with maintaining a fully state-administered trauma verification system have increased significantly. Current operational responsibilities include:

Reviewer recruitment and coordination;

- Site review scheduling and travel administration;
- Trauma designation oversight activities;
- Maintenance and modernization of designation standards;
- Administrative management of trauma verification activities; and
- Ongoing alignment with evolving national trauma standards and practices.

Multiple Virginia trauma centers currently participate in ACS trauma quality improvement and verification programs in addition to maintaining state trauma center designation requirements. However, because Virginia does not currently recognize ACS as an official trauma verification entity for state designation purposes, participating trauma centers must separately complete the Commonwealth's state-verification process to obtain or maintain trauma center designation. Nationally, many states operate under frameworks in which the state retains trauma center designation authority while formally recognizing ACS verification findings as part of the state designation and oversight process.

The State EMS Advisory Board reviewed trauma designation sustainability considerations through stakeholder engagement that included trauma system leadership, trauma program representatives, and hospital stakeholders. Following those discussions, in November 2025, a unanimous agreement was reached amongst EMS Advisory Board Members to recommend to the State Board of Health the adoption of a state designation model that recognizes ACS trauma center verification through a phased five-year transition and implementation process.

III. JUSTIFICATION

The Commonwealth's current trauma designation framework provides critical oversight to ensure adherence to established trauma center designation criteria and maintain statewide trauma system quality, accountability, and coordination. However, increasing operational demands, fiscal limitations, and evolving national trauma verification practices warrant evaluation of long-term sustainability strategies.

Beginning in July 2025, OEMS established a budget-neutral operating position following significant agency-wide fiscal stabilization efforts. As part of this restructuring, Trauma Program staffing was reduced from four positions to one, creating substantial operational challenges in maintaining a fully state-operated trauma center designation program. Current estimates indicate that administration of an independent state trauma designation system costs approximately $550,000 annually, excluding indirect administrative, personnel, and support costs. In addition, external trauma site review activities alone are estimated to cost between $70,000 and $110,000 annually.

These operational and fiscal realities support continued evaluation of nationally recognized trauma verification frameworks, including potential alignment with the ACS verification model, while preserving Virginia's statutory authority over trauma center designation. Such evaluation

is intended to assess opportunities for long-term sustainability, consistency with national best practices, reduction of fiscal burden, and continued assurance of high-quality trauma system oversight across the Commonwealth.

Evaluation of an ACS-recognition verification framework provides operational benefits including:

- Improved alignment with nationally recognized trauma verification standards;
- Reduced duplication of verification activities for participating trauma centers;
- Improved access to established national trauma review infrastructure; and
- Enhanced consistency with national trauma data quality improvement practices.

Trauma verification activities and associated costs, currently funded by the Commonwealth, would transition to the individual trauma centers through their ACS verification process.

Under an ACS-recognition framework, the Commonwealth would retain authority for trauma center designation, oversight, recognition of the review process, and trauma system quality assurance activities. This framework would not eliminate state designation authority or the role of the Virginia OEMS. Rather, it would recognize ACS verification as the trauma verification model and utilize ACS verification findings as the basis for granting, denying, maintaining, or revising state trauma center designation status.

IV. RECOMMENDATION

VDH OEMS recommends that the State Board of Health authorizes the transition to an ACS verification model as the basis for state trauma center designation, as described above. The proposed implementation date for the transition would begin on January 1, 2027.

V. APPROVAL:

☐ Recommend ☐ Recommend with Modification ☐ Deny

_____

Dr. Cameron Webb Date

VDH VIRGINIA DEPARTMENT OF HEALTH

STATE VS. ACS TRAUMA CENTER DESIGNATION

Office of Emergency Medical Services
Board of Health Trauma Designation Briefing

What is the Virginia Code Requirement?

ESTABLISHING AND MAINTAINING A PROCESS FOR DESIGNATION OF APPROPRIATE HOSPITALS AS TRAUMA CENTERS, CERTIFIED STROKE CENTERS, AND SPECIALTY CARE CENTERS BASED ON AN APPLICABLE NATIONAL EVALUATION SYSTEM.

"2024 CODE OF VIRGINIA
TITLE 32.1 - HEALTH
CHAPTER 4 - HEALTH CARE PLANNING
§ 32.1-111.3. STATEWIDE EMERGENCY MEDICAL SERVICES PLAN; TRAUMA TRIAGE PLAN; STROKE TRIAGE PLAN"

Current State of Trauma Designation:

- Currently, all trauma hospitals are required to have a state designation, facilitated by VDH OEMS. Additionally, trauma centers can seek their own separate ACS designation.
- Designation and verification are currently provided at no direct cost to trauma centers.
- VA standards have long mirrored ACS, with input from TPM groups and trauma committees. However, current Virginia standards are not fully aligned with evolving national practices due to delays in the release of updated criteria.
- The program relies on providers and nurses from other trauma centers to conduct peer reviews.
- The current process relies exclusively on in-person site reviews.

Cost to the Stat:

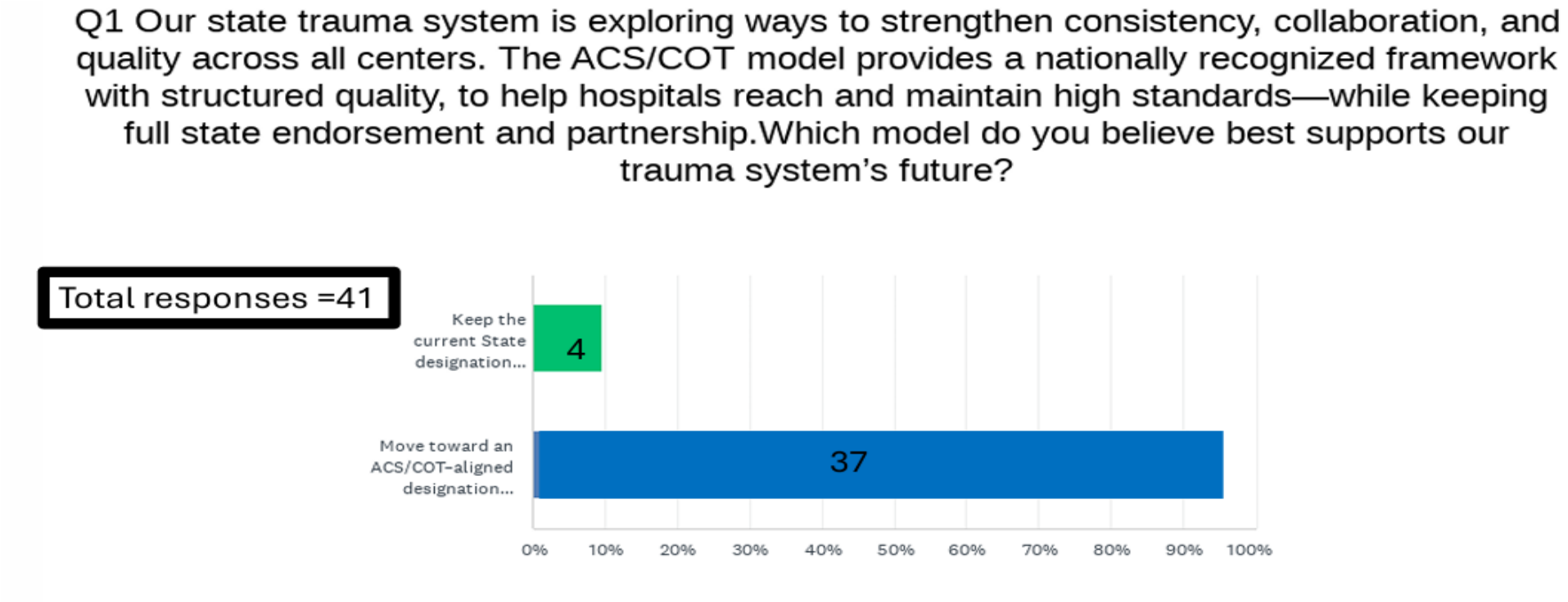
- Due to OEMS establishing a budget-neutral stance last July 2025, several staff cuts occurred. The Trauma program went from a staff of 4 to1.
- The total yearly cost to run a state's internal Trauma Designation system is $550,000.
- Cost of Site Review Teams alone ($70,000-110,000 annually)

EMS Advisory Board Involvement:

- In November 2024, the Governor's advisory board requested the Chair of the Trauma Administration and Government research whether the state should remain a state-administered trauma system (with costs borne by the state) or pursue national verification through a partnership with ACS.

Survey of trauma centers in Virginia:

- The following survey was conducted, and a motion was approved during the November 2025 EMS advisory board to move forward with consideration of Virginia becoming an ACS-verified state.



ACS Overview:

- ACS is the national standard for trauma center verification. This verification spans both adult and pediatric trauma programs.

- Centers must undergo a process similar to the current state process, including submitting letters of intent and applications, obtaining verification, and maintaining good standing through recurring three-year review cycles.

- ACS utilizes a remote-access review process.

- ACS standards are more rigorous than the state standards:
  -More requirements for specialty call schedules for level II
  -Mandatory for level I to have a residency program

Trauma Quality Program (TQP) Fees

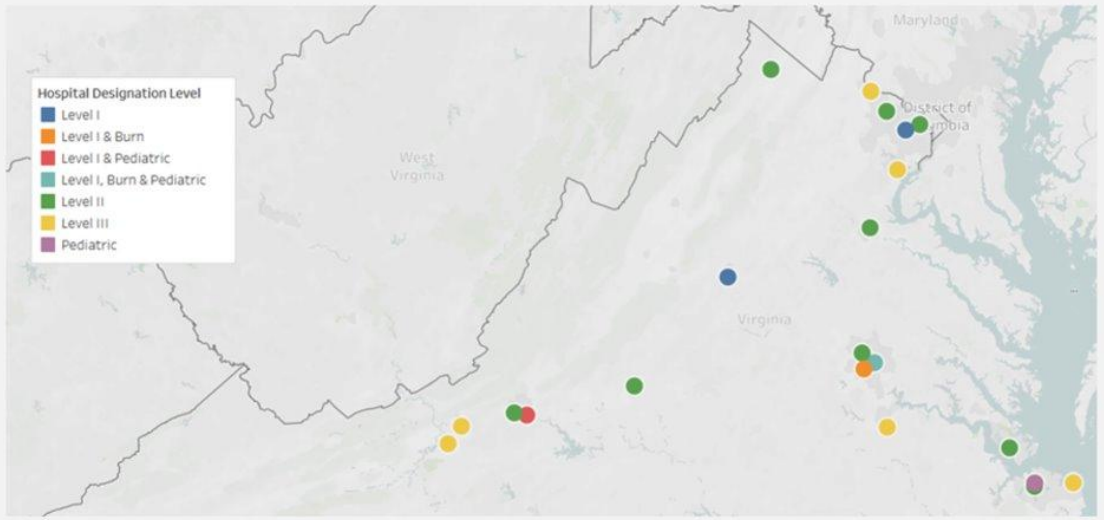
Annual Fees

- The annual *TQIP Only* fee covers TQIP
- The annual *Trauma Quality Program* fee covers participation in both the VRC program and TQIP

Program Type	Beginning 7/1/2024	Beginning 7/1/2025	Beginning 7/1/2026
Adult Level I & II TQIP	$15,217	$15,826	$16,459
Pediatric TQIP	$15,217	$15,826	$16,459
Adult Level III TQIP	$8,954	$9,312	$9,684
Adult Level I and II Quality Program	$22,240	$23,130	$24,055
Pediatric Level I Quality Program	$22,240	$23,130	$24,055
Adult Level III Quality Program	$16,909	$17,585	$18,288
Adult Level I or II with Pediatric Level II Quality Program	$39,213	$40,781	$42,412
Adult Level I with Pediatric Level I Quality Program*	$44,480	$46,260	$48,110
Hospital Administered TQIP Collaborative	$520	$541	$562

*Hospitals that participate in both the full Adult Quality Program and the full Pediatric Quality Program will be billed the respective Trauma Quality Program fees as two different line items.

Current Center Status:



VIRGINIA TRAUMA CENTERS

- 22 Designated Centers
- 6 Level I
- 9 Level II
- 6 Level III
- 3 Burn Centers
- 3 Pediatric Centers

Level I Trauma Centers:

FACILITY & LEVEL
Level I Adult
HCA Chippenham ACS Level II
Inova Fairfax Hospital ACS Level I
Sentara Norfolk General ACS app submitted
Carilion Roanoke Memorial ACS Level I
UVA ACS Level I
VCUH ACS Level I

Level II Trauma Centers:

Level II Adult
HCA Henrico Doctors ACS Level II
Centra Lynchburg General Not ACS
Mary Washington Hospital Not ACS
Reston Hospital Center ACS Level II
Riverside Regional Medical Center Not ACS
Virginia Hospital Center Not ACS
Lewis Gale Medical Center Not ACS
Winchester Not ACS
Naval Portsmouth ACS app submitted

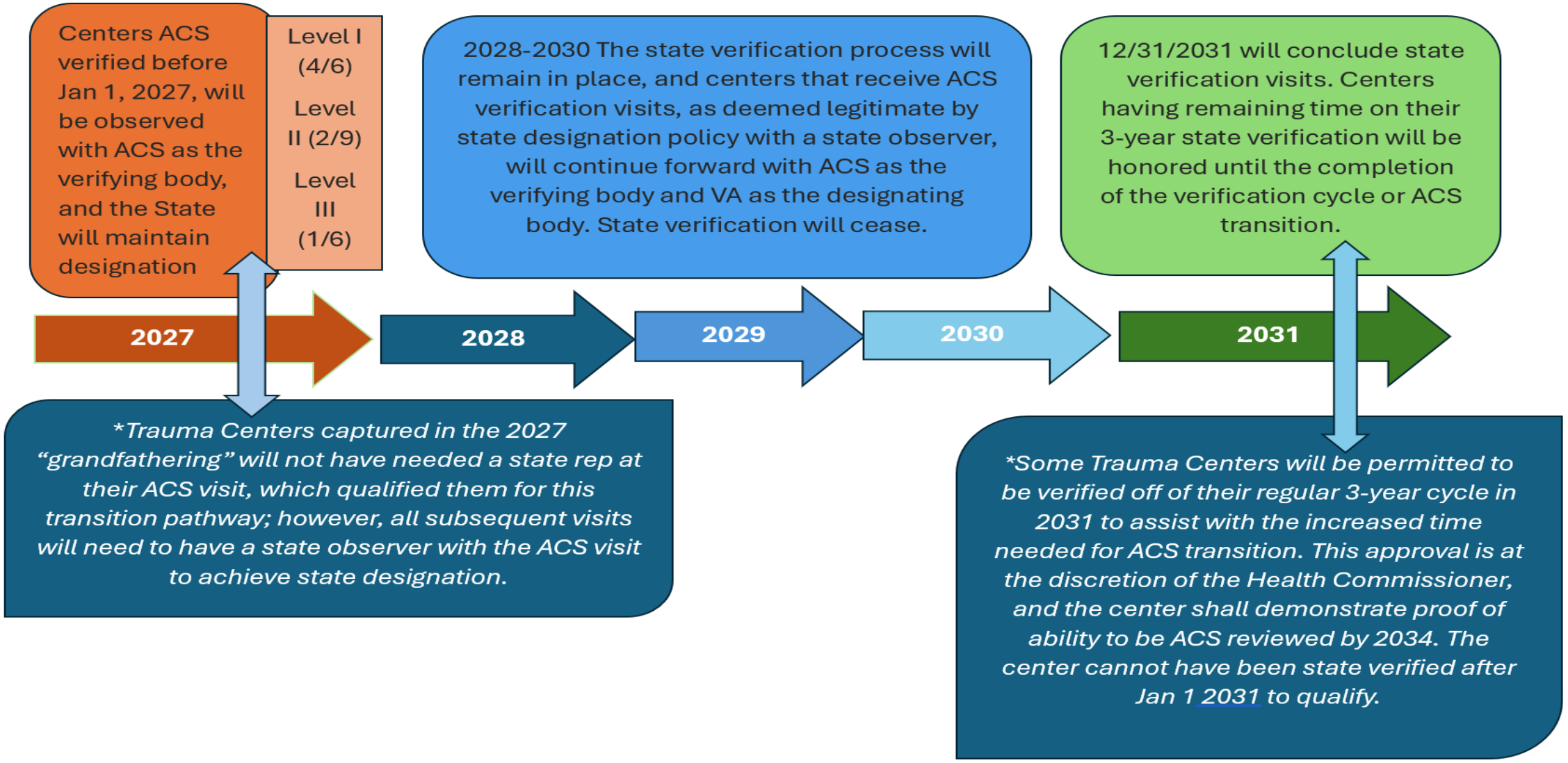
Level III Centers

Level III Adult
Lewis Gale- Montgomery Not ACS
Inova Loudoun Hospital Not ACS
Carilion New River Valley Not ACS
Northern Virginia Medical Center ACS Level III
Southside Regional (Bon Secours) Not ACS
Sentara Virginia Beach General Not ACS

Pediatric Centers:

FACILITY & LEVEL	
Pediatric	
VCU Medical Center	Pediatric centers will be recommended to proceed along the same timeline as the adult designation transition on the following slide.
Children's Hospital of the King's Daughters	
Carillion Roanoke Memorial Hospital	

ACS Timeline



ACS Pathway:

- It is important to note that a center would not simultaneously maintain equivalent ACS and state verification status.
- When a center is verified by ACS, the state ceases its verification status and instead institutes a Memorandum of Agreement (MOA) with ACS findings, and grants state designation based on whether the center successfully passed ACS verification.
- Requirements regarding ACS application materials, verification documentation, and items due to the state trauma program will be outlined in the state MOA and designation manual.

ACS Factors to consider

- The state will no longer be responsible for maintaining a criteria manual, website, or reviewer scheduling/payments.
- This pathway would also allow for the future development of Level IV trauma centers within the Commonwealth.
- Level II centers may experience increased competition for ACS application and review scheduling. It may take several years to obtain approval for an application and complete a successful site visit.
- There are minimal differences between the current Virginia Level III criteria and the ACS Level III criteria.

BOH Action

- The EMS Advisory Board recommends that the State Board of Health transition to the American College of Surgeons as the verification body for adult and pediatric trauma centers in the Commonwealth.

JCHC PHARMACY PRESENTATION

Access to Pharmacy Services in Virginia

Jen Piver-Renna, PhD

Deputy Director, Joint Commission on Health Care

Purpose of the JCHC

- Code of Virginia; § 30-168: *"The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services."*
- JCHC is supported by a professional staff of health policy analysts
- JCHC furthers its purpose by developing recommendations for legislative action

Study purpose

The JCHC directed staff to:

- Describe how access to pharmacy services has changed in Virginia over time and the impact of those changes
- Identify areas and populations in Virginia impacted by pharmacy deserts
- Identify factors that impact access to pharmacy services in Virginia
- Describe strategies to ensure access to pharmacy services
- Recommend policy options through which Virginia may ensure access to pharmacy services

Agenda

Access to community pharmacies in Virginia

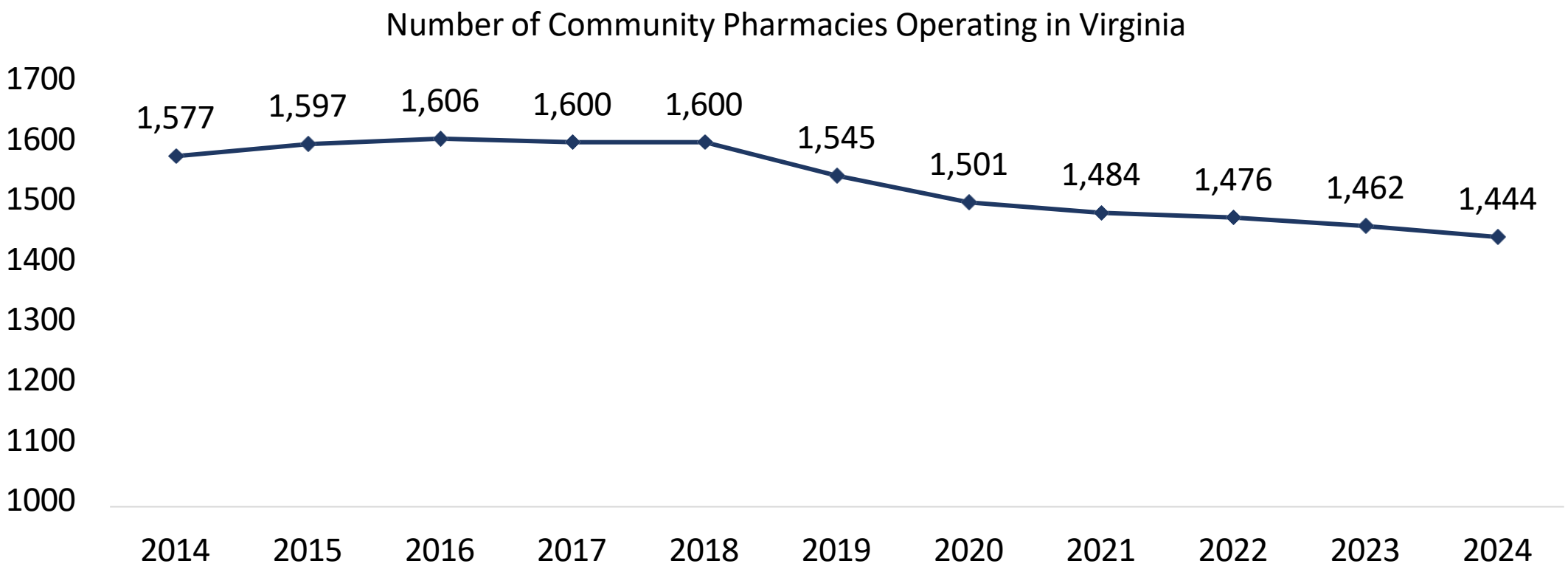
Pharmacy expenses and revenue sources

JCHC recommendations and outcomes of the 2026 General Assembly session

Community pharmacies are a critical access point for health care services

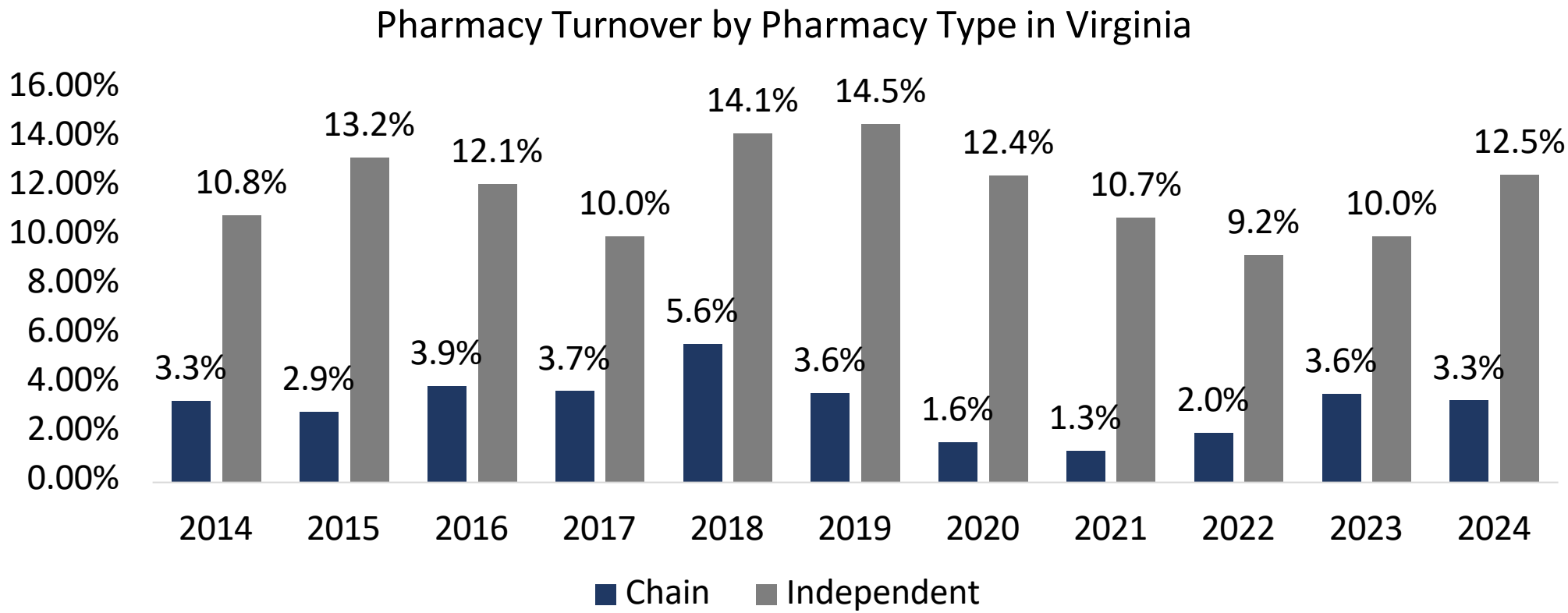
- Community pharmacies dispense medications and provide health services to all members of the public
- Access to community pharmacies improves medication adherence, individual health, and public health outcomes
- Closure of community pharmacies reduces medication adherence and vaccination rates, and strains remaining pharmacies that must serve additional patients

Community pharmacies are declining in Virginia



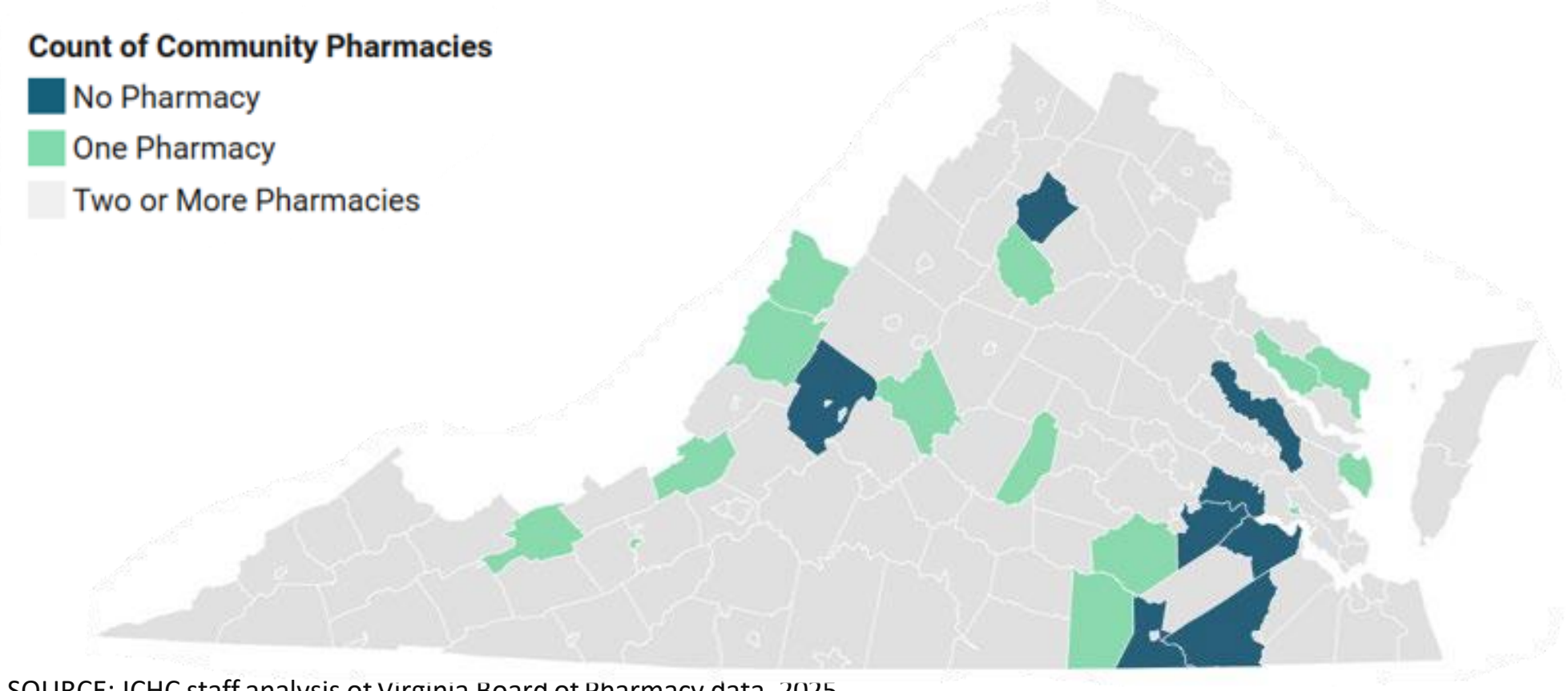
SOURCE: JCHC analysis of Virginia Board of Pharmacy data, 2025.

Independent pharmacies turnover more frequently than chains



SOURCE: JCHC staff analysis of Virginia Board of Pharmacy, 2025.

22 localities in Virginia have limited or no access to a community pharmacy



SOURCE: JCHC staff analysis of Virginia Board of Pharmacy data, 2025

Agenda

Access to community pharmacies in Virginia

Pharmacy expenses and revenue sources

JCHC recommendations and outcomes of the 2026 General Assembly session

Revenue is not keeping pace with the costs of pharmacy operation

- Pharmacy operating expenses are increasing
- Reimbursement fees for dispensing are the primary source of revenue for pharmacies, but fees fall below costs of acquiring and dispensing drugs
- Pharmacists must make tough decisions about their business viability, particularly in communities with independent pharmacies, low dispensing volume, or a larger number of patients covered by plans with lower reimbursement fees

Virginia could set a reimbursement floor for the Medicaid program

- General Assembly has previous considered minimum reimbursement fees in the 2019, 2024, and 2025 state budgets
- *Save the Local Pharmacies Act* directs DMAS to select a single PBM to administer pharmacy benefits
  - Does not explicitly require increased reimbursement fees
  - Enforceable minimum reimbursement fees must be built into contracts with managed care organizations

JCHC Recommendation

- Set a reimbursement fee floor for drug ingredient costs and professional dispensing fees paid to community pharmacies for all medications dispensed to Medicaid members.

- Budget Item 291 #44h (Wachsmann) was left in Committee

Incentives can maintain or re-establish pharmacies in low access communities

- Pharmacies require greater support to survive in low access communities
  - Typically rural, with smaller population and lower sales volume
  - High rates of Medicaid enrollment with low reimbursement
- States have implemented incentive programs targeting pharmacies in rural areas
  - Maryland's small rural pharmacy grants program
  - Oregon's rural health care income tax credit program

JCHC Recommendation

- Introduce legislation and submit a budget amendment to establish an incentive program to provide funding for pharmacies operating in localities with low access to community pharmacies.

- HB335 (Anthony): Establishes the Independent Pharmacy Access and Resilience Pilot Program; left in Appropriations

Government-funded pharmacy services could support areas with no access

- Health safety net providers provide health care and pharmacy services to underserved communities and individuals who cannot afford health services
- VAFCC and VCHA receive state funding to provide some pharmacy services to low-income, uninsured patients

VAFCC = Virginia Association of Free and Charitable Clinics; VCHA = Virginia Community Healthcare Association

JCHC Recommendation

- Submit a budget amendment to increase funding to expand access to pharmacy services provided by existing clinics and community health centers to localities with no operating community pharmacies.

- Budget Item 282 #2h (Willett) was left in Committee

Questions and Discussion

DMAS PHARMACY PRESENTATION

Virginia Department of Medical Assistance Services (DMAS)

Medicaid Single Pharmacy Benefit Manager Study

Virginia Board of Health Meeting

June 11, 2026

Virginia Pharmacy Access

PROGRAM SCALE

- **Virginia Medicaid serves more than 1.7 million members — approximately 90% enrolled in Cardinal Care managed care. The remaining approximately 10% are served through the FFS delivery system, most temporarily enrolled prior to MCO transition.**
- **Members in Virginia fill over 20 million perscriptions annually with total expenditures over $1 billion**

PHARMACY DESERT STATISTICS

- **160 Virginia zip codes (17.7% of all zip codes) are classified as pharmacy deserts for Medicaid members.**
- **14.2% of Medicaid members — approximately 261,624 individuals — live in zip codes with no pharmacy whatsoever.**
- **Pharmacy deserts are a systemic community-level problem, not a Medicaid-specific shortfall. The percentage of residents living in zip codes without pharmacies is nearly identical for Medicaid and non-Medicaid populations**
- **Mail order is not a universal solution.**

The Statutory Mandate

CORE REQUIREMENTS

- **DMAS must select and contract with a single third-party administrator to serve as the State PBM to administer ALL Medicaid pharmacy benefits.**
- **Each Cardinal Care MCO contract shall require the MCO to contract with and utilize the DMAS-contracted single PBM to administer all pharmacy benefits for its enrolled members.**

MANDATORY PBM CONTRACT TERMS (HB 2610)

- **Establish the State PBM's fiduciary duty owed to DMAS**
- **Require the use of pass-through pricing (already in place)**
- **Require use of a common formulary, reimbursement methodologies, and dispensing fees negotiated by DMAS**
- **Require full transparency in drug costs, rebates collected and paid, dispensing fees, administrative fees, and all other charges and holdbacks**

What Current Legislation Does Not Address

- Pharmacy Reimbursement Changes
- Dispensing Fee Alignment
- Reimbursement Methodology Including Pricing Benchmarks
- Potential Effects on Capitation Payments to MCOs
- MCO Competitive Differentiation

Current Model Themes
Strengths and Weaknesses

Strengths

- MCO-PBM Operational Integration
- Common Core Formulary Customization
- MCO-level utilization management strategies
- Member-facing infrastructure
- Actuarially sound capitation rates
- Independent rebate negotiation

Weaknesses

- Administrative Fragmentation / Duplication
- Dispensing Fee Misalignment
- Rebate Collection
- Independent Pharmacy Burden: Transparency Deficit
- Coverage Inconsistencies

Single PBM Contracting Models

Option	Model	Party that Procures Single PBM Contract	Source of Funds for Single PBM Remuneration	Who Compensates the Single PBM?	MCO Agreement with Single PBM?
1	MCO At-Risk	State	Capitation rate	MCO	Yes
2	MCO Non-Risk	State	State (provides MCOs with administrative fee funds)	MCO (passes through funds received from State)	Yes
3	Carve-Out Pre-Paid Ambulatory Health Plan (PAHP)	State	State (capitation rate or non-risk-based payment)	State	Yes
4	Pharmacy Carve-Out	State	State	State	No contract

Single PBM Contract Design: Key Decision Points

01 PHARMACY NETWORK

Who builds and manages the network? Defines responsibility for provider outreach, education, and enrollment support.

02 SERVICE AUTHORIZATION

How will PA functions transition from five MCO PBMs? How are in-flight PAs grandfathered at go-live?

03 PREFERRED DRUG LIST

Single PBM manages the PDL under DMAS direction. Retain a Common Core Formulary vs. move to a Universal PDL?

04 MEMBER-FACING FUNCTIONS

Which services — appeals, grievances, pharmacy lock-in, MTM — stay with MCOs vs. centralized?

05 DATA EXCHANGE

How will MCOs receive real-time pharmacy claims data for care coordination, DUR escalations, and regulatory reporting?

06 REBATE ADMINISTRATION

Who manages P&T Committee and PDL? Who participates in SSDC negotiations? What are MCO roles in supplemental rebates?

07 RELATED-PARTY RESTRICTIONS

What PBM disclosure requirements for affiliated pharmacy relationships and prohibit preferential treatment will be required for the RFP?.

08 SERVICE LEVEL AGREEMENTS

What comprehensive performance standards, SLAs, corrective action plans, and enforceable penalty structures need to be updated?

Single PBM — MCO At-Risk

- **STRUCTURE:** State enters a zero-dollar contract with the single PBM. MCOs are contractually required to contract with the PBM and pay for PBM services out of their capitation. MCOs remain at full financial risk for pharmacy claims.
- **HOW IT WORKS:** State procures and sets terms with the PBM. PBM contracts with each MCO separately. MCOs pay the PBM — invoiced for the total cost of processed pharmacy claims plus administrative fees. PBM reimburses pharmacies. DMAS retains oversight and penalty authority.
- **MCO IMPLICATIONS:** MCOs lose PBM selection authority and contract terms control. MCOs retain financial risk for pharmacy spend. MCOs retain member-facing functions (care coordination, lock-in programs, member communications, case management). MCO capitation rates adjusted to reflect any changes in pharmacy cost structure.
- **STRENGTHS:** Least structural disruption to MCO risk architecture. Most closely mirrors current arrangement without changing MCO financial exposure.
- **RISKS:** MCOs responsible for PBM payment on a schedule they don't set. Requires detailed service agreement between each MCO and the PBM. MCO oversight of PBM performance is limited to what DMAS delegates.
- **KENTUCKY EXPERIENCE:** Total pharmacy PMPM decreased 8.6% in CY2021 following implementation. Spread pricing eliminated. Provider enrollment simplified. Prior authorization streamlined.

Single PBM: MCO No Risk Options

OPTION 2: SINGLE PBM — MCO NON-RISK

- **State contracts with single PBM and pays it directly, using funds passed through from MCO capitation as an administrative fee passthrough. MCO is contractually required to use the PBM but is insulated from direct pharmacy financial risk.**
- **MCO IMPLICATION: MCO retains member-facing functions but loses both PBM selection authority AND financial pharmacy risk. Capitation rates adjusted to extract pharmacy administrative cost component.**

OPTION 4: MANAGED CARE CARVE-OUT

- **Pharmacy is removed from managed care entirely. DMAS administers the pharmacy benefit directly via a single PBM as a standalone program. MCOs have no contractual relationship with the PBM.**
- **MCO IMPLICATION: Pharmacy responsibility eliminated from MCO scope. MCO capitation rates adjusted to remove pharmacy benefit entirely. Greatest structural disruption to MCO operations.**
- **Analogous to New York (NYRx program) and West Virginia carve-out models.**

Single PBM: Prepaid Ambulatory Health Plan

OPTION 3: CARVE-OUT PRE-PAID AMBULATORY HEALTH PLAN (PAHP)

- **Pharmacy is carved out of MCO responsibility into a separate PAHP structure. State contracts with and pays the PAHP/PBM directly via capitation or non-risk payment. MCO has no direct PBM contract.**
- **REQUIRES: A 1915(b) waiver from CMS — CMS must issue a decision within 90 days of a complete application submission. This adds significant timeline and regulatory complexity.**
- **MCO IMPLICATION: Pharmacy benefit exits MCO operational scope entirely. MCO retains all other managed care responsibilities. Real-time pharmacy data exchange for MCO care coordination must be designed explicitly into the contract.**
- **RISK: Most complex data architecture challenge — MCO loses native pharmacy claims visibility that currently informs care coordination, case management, and DUR activities.**

Implementation Risk Factors and Competing DMAS Priorities

- **FAS CORE MODULE (Fiscal Agent Services — Medicaid Enterprise System): The FAS implementation is DMAS's largest current technology initiative.**

- **H.R. 1 (ONE BIG BEAUTIFUL BILL ACT): Federal legislation with significant Medicaid program changes. CMS guidance on implementation requirements is forthcoming and the timeline and programmatic scope are in flux.**

- **NEW MEDICAID MANAGED CARE RULE: Ongoing implementation of CMS managed care rule requirements continues to demand DMAS and MCO policy and operational resources.**

- **STAFFING: DMAS will require 7–8 additional FTE to manage single PBM implementation and ongoing oversight (3–4 pharmacists, 2 data analysts, 1 appeals coordinator, 1 rebate manager).**

Fiscal Impact Summary

Period	Description	Estimated Fiscal Impact
Year 0	6-month procurement + 6 months implementation activities	Initial cost of $6.2M – $9.6M
Year 1	6 months continued implementation + 6 months single PBM contract operations	Potential cost of $6.1M to savings of $1.6M
Years 2+	Full 12-month periods of single PBM operations	Potential savings of $10.2M – $22.1M annually

- **The range in these estimates largely represents unknowns related to: (1) model design decisions DMAS must still make, (2) results of the procurement process and vendor pricing, and (3) how the model is operationalized.**
- **States that implemented single PBM models report widely varying savings outcomes based off starting conditions, model design choices, and vendor contracts differ significantly.**

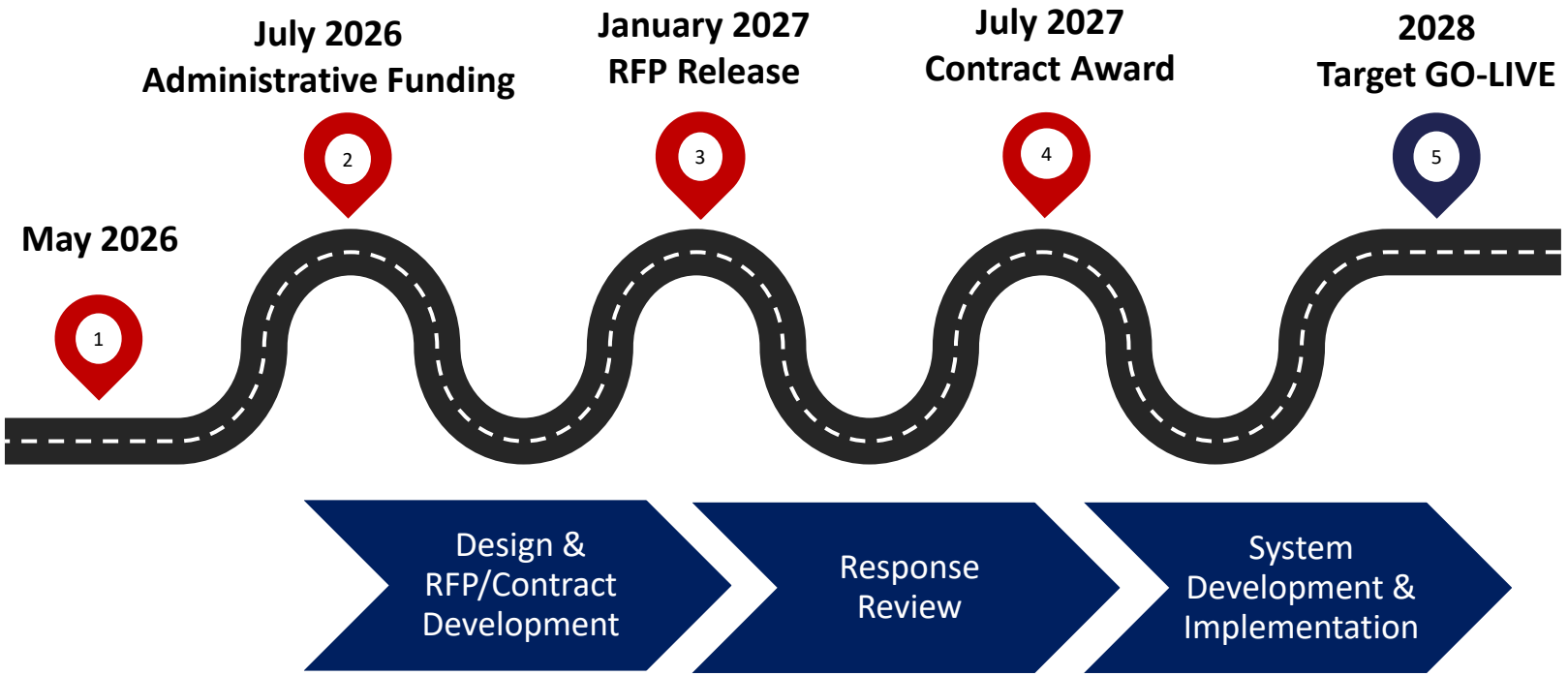
Anticipated Cost

Cost Item	Description	Estimated Impact
Single PBM Administrative Fee	PBM fees for both FFS and MCO populations; based on peer state pricing	$16.4M – $20.5M annual (ongoing)
Single PBM Implementation Fee (DDI)	One-time design, development, implementation — system config and testing	$1.5M – $2.5M one-time
DMAS Permanent FTE Staff	3–4 pharmacists, 2 data analysts, 1 appeals coordinator, 1 rebate manager	$925K – $1.1M annual (ongoing)
Temporary DMAS Implementation Staff	5–6 temporary FTEs for 24 months — integration, financial, business consultants	$1.8M – $2.5M/year (first 2 years)
External Implementation Consultants	PM, RFP development, readiness reviews, post-go-live stabilization (24 months)	$1.8M – $2.1M/year (first 2 years)
System Integration (MMIS and MES)	Interfaces, testing, reporting	$3.4M – $5.9M one-time (2 years)
MCO Supplemental Rebate Revenue Loss	Loss of MCO-retained rebates currently in capitation; only 15–20% recoverable	$21.8M annual

Anticipated Savings

Savings Item	Description	Estimated Impact
MCO PBM Administrative Fees Eliminated	Total MCO PBM admin fees currently paid by MCOs — eliminated when MCOs no longer contract with their own PBMs	$31.1M annual savings (after single PBM implemented)
FFS PBM Administrative Fees Eliminated	Current DMAS FFS PBM admin fees — eliminated when single PBM takes over	$6.1M annual savings (after single PBM implemented)
Supplemental Rebate Savings (Unified PDL)	Increased supplemental rebate revenue from single preferred drug list	$3.3M – $4.4M annual (starting Year 2)
Utilization Management Cost Offset	Admin savings from consistent UM criteria; reduced duplicative MCO pharmacy ops;	$6.6M – $9.9M savings in Year 1; $13.2M – $19.7M annual

Best Case Scenario Single PMB Implementation Timeline (contingent on funding/integration with other IT procurements)



Virginia Department of Medical Assistance Services (DMAS)

Cost of Dispensing Survey

Virginia Board of Health Meeting

June 11, 2026

Why This Study Exists

Legal Mandate

Required under 12VAC30-80 and 42 CFR § 447.518

Fee changes must be supported by cost-based data — not market rates

CMS Reinforced

CMS-2434-F (Sept. 2024) just-finalized rule reinforces this requirement

PBM rates alone do not qualify as cost justification

Access Protection

Below-cost fees drive pharmacy exits

206 Virginia-licensed pharmacies not enrolled in Medicaid — a leading indicator

What It Costs to Fill a Prescription

$13.70

Medicaid-Weighted Mean (All Pharmacies)

$12.72

Medicaid-Weighted Mean (Non-Specialty)

67%

of cost is labor ($7.98 of $12.72)

Survey Basis

- **1,781 pharmacies surveyed; 434 usable responses (24.6% response rate)**
- **All costs inflated to June 30, 2024 via BLS Employment Cost Index**
- **70% of pharmacies: costs fall between $6 – $17 per prescription**
- **Every dollar in the fee is a documented, CMS-compliant operating expense (margins excluded)**

The 20–30% Cost Increase

THE INFLATION NARRATIVE

2010–2020

Little to no cost increase nationally — volume efficiencies offset rising labor and overhead

Post-COVID

20–30% increase depending on measure — overhead AND labor rose simultaneously

Today

Virginia's current fee still reflects a pre-COVID cost environment

Labor = 67% of cost — fastest-rising post-COVID component

The Dispensing Fee Options

Option 1

$13.70

BASIS

All pharmacies, including specialty

TRADE-OFF

Highest cost; simplest to administer; above national single-fee range

Option 2

$12.72

BASIS

Non-specialty pharmacies only

TRADE-OFF

Within national range; specialty pharmacy not separately addressed

Option 3

Tiered

BASIS

Non-specialty, 3 volume bands

TRADE-OFF

Best equity for rural/low-volume pharmacies; most administrative complexity

National single-fee range: $8.96 (RI) to $12.46 (ND) — Virginia's documented costs exceed this range. That's a feature of Virginia's labor market, not a discrepancy.

Managed Care & PBM Context

FFS (Fee-for-Service)

~280,000 Rx/yr

~$2.4M in dispensing fees
Full DMAS visibility

2% of VA Medicaid Rx volume

VS

Managed Care (5 MCOs)

~20 million Rx/yr

Fees often <$1.00
Near-zero DMAS visibility

98% of VA Medicaid Rx volume

SPBM HORIZON: KY, LA, MS adopted; OH implementing; TX considering. Virginia is aware of the trend.

Questions

ELECTRONIC MEETING POLICY

TITLE: Procedures for Electronic Participation in Board of Health Meetings and All-Virtual Meetings

EFFECTIVE DATE: 7/1/26

AUTHORITY: § 2.2-3708.3 of the Code of Virginia

DEFINITIONS:

The following definitions shall apply to the words used in this policy unless otherwise noted:

"Participate electronically" means participating in an in-person meeting through electronic communication from a location that is not the location advertised in the public meeting notice.

"Electronic communication" means the use of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities to transmit or receive information.

"In-person meeting" refers to a meeting that has not been approved as an all-virtual meeting pursuant to this policy. All in-person meetings must have a quorum assembled in one physical location.

"All-virtual meeting" refers to a meeting that has been approved as an all-virtual meeting pursuant to this policy. During an all-virtual meeting, all members, staff, and the public may participate through electronic communication. No more than two members may be assembled in one physical location that is not open to the public.

PARTICIPATING ELECTRONICALLY DURING IN-PERSON MEETINGS:

<u>Process for making requests</u>

Each individual member shall request approval to participate electronically from the Board of Health (Board) Chair, and Board staff. Each request shall state a specific reason for electronic participation. Electronic participation is limited to the following reasons:

1. A member is unable to attend the meeting because of a temporary or permanent disability or other medical condition that prevents their ability to physically attend such meeting,
2. A medical condition of a family member of a member requires the member to provide care that prevents their physical attendance,
3. A member's principal residence is more than 60 miles from the location of the meeting, or
4. A member is unable to attend due to an emergency or personal matter – the specific nature of which shall be shared with the Chair and staff.

If a member is requesting to participate electronically pursuant to reasons 1, 2, or 3, they must make their request 10 business days before the meeting. The Chair may make exceptions to this rule in his or her discretion.

If a member is requesting to participate electronically pursuant to reason 4, they may make their request up to 24 hours before the scheduled start time of the meeting. The Chair may make exceptions to this rule in his or her discretion.

Other requirements

Whenever an individual member is to participate electronically, the following conditions must be present:

1. A quorum of the Board must be physically assembled at the primary or central meeting location.
2. There must be arrangements for the voice of the remote participant to be heard by all persons at the primary or central meeting location.

If a member is participating electronically, the minutes shall reflect which of the four reasons the member has given. Members participating virtually due to caregiver duties (reason 2) are considered present for the physical quorum.

If a member is participating electronically pursuant to reason 4 (above), the minutes shall also include the specific nature of the personal matter cited by the member. Furthermore, such electronic participation by any one member is limited to by law to two of the Board's meetings or 25% of the meetings per year, whichever is greater. There is no limit to the number of times a member may participate electronically due to other allowable reasons.

Automatic approval; vote required if challenged

Individual electronic participation from a remote location shall be approved unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act. If a member's participation from a remote location is challenged by one or more members, then the Board shall vote whether to allow such participation and the results of such vote shall be recorded in the minutes with specificity.

If a member is approved to participate electronically the meeting minutes shall reflect the remote location from which the member participated; however, the remote location need not be open to the public and may be identified by a general description.

ALL-VIRTUAL MEETINGS:

The Board of Health may convene all-virtual meetings in accordance with the Virginia Freedom of Information Act. An indication of whether a meeting will be in-person or all-virtual will be included in the meeting notice. The type of meeting will not be changed once the notice is published unless the Board provides a new notice in accordance with the Virginia Freedom of Information Act.

At the third regular meeting of the calendar year, the Board shall discuss potential dates for all-virtual meetings during the following calendar year based on the planned work load of the Board and the schedules of the members. The members may then, by consensus, suggest two meetings that may be held as all-virtual meetings.

At least 15 business days prior to any regular or special meeting, the Chair of the Board shall confirm with staff whether a meeting will be an in-person meeting or an all-virtual meeting. Staff will then communicate the type of meeting to the other members and the public. There is a strong

preference to follow the suggested schedule created each calendar year. However, the Chair may, to the extent allowed by law, change a scheduled in- person meeting to an all-virtual meeting in extenuating circumstances. The Chair may also change a scheduled all-virtual meeting to an in-person meeting at the request of other members and/or Board staff.

The Board may not convene an all-virtual public meeting (i) more than two times per calendar year or 50 percent of its meetings held per calendar year rounded up to the next whole number, whichever is greater, or (ii) consecutively with another all-virtual public meeting.

During all-virtual public meetings, members will be considered absent for portions of the meeting where their video or audio connection fail or are disconnected.

CLARIFICATIONS:

The limits on electronic participation from a remote location due to emergencies or personal matters (reason 4) are separate from the limits on all-virtual meetings and will be counted separately. If a member's request to participate electronically is disapproved, said member may still continue to monitor the meeting from the remote location, but may not participate and may not be counted as present for the meeting.

Three or more members may be gathered in one location during an all-virtual meeting so long as that location is open to the public.

The Board shall review and certify this policy annually by recorded vote.

REPORT OF NOMINATING COMMITTEE

OTHER BUSINESS

ADJOURN