MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON HEALTH AND HUMAN SERVICES

Seventy-Third Session
March 2, 2005

The Committee on Health and Human Services was called to order at 1:33 p.m., on Wednesday, March 2, 2005. Chairwoman Sheila Leslie presided in Room 3138 of the Legislative Building, Carson City, Nevada, and, via simultaneous videoconference, in Room 4406 of the Grant Sawyer State Office Building, Las Vegas, Nevada. Exhibit A is the Agenda. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Ms. Sheila Leslie, Chairwoman
Ms. Kathy McClain, Vice Chairwoman
Mrs. Sharron Angle
Ms. Susan Gerhardt
Mr. Joe Hardy
Mr. William Horne
Mrs. Ellen Koivisto
Mr. Garn Mabey
Ms. Bonnie Parnell
Ms. Peggy Pierce
Ms. Valerie Weber

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Genie Ohrenschall, Assembly District No. 12, Clark County

STAFF MEMBERS PRESENT:

Barbara Dimmitt, Committee Analyst
Joe Bushek, Committee Attaché

OTHERS PRESENT:

- Jim Wadhams, Legislative Advocate, representing the Nevada Hospital Association, Reno, Nevada
- Emil Paul DeJan, Bureau Chief, Bureau of Health Planning and Statistics, State Health Division, Nevada Department of Human Resources
- Bobbette Bond, Community Affairs Manager, Culinary Health Fund, Las Vegas, Nevada
- Lynn O'Mara, Health Resource Analyst III, State Health Division, Nevada Department of Human Resources
- Kim Kandt, Patient Safety Officer, University Medical Center, Las Vegas, Nevada

Chairwoman Leslie:
[Meeting called to order and roll taken.] I'd like to open the hearing on Assembly Bill 59, and Assemblywoman Ohrenschall is here.

Assembly Bill 59: Makes certain changes to reporting requirements for sentinel events at medical facilities. (BDR 40-1025)

Assemblywoman Genie Ohrenschall, Assembly District No. 12, Clark County:
[Handed out Exhibit B.] I'm the primary sponsor on A.B. 59. Assembly Bill 59 deals with the need to acquire definitive statistics about hospital-acquired infections. Basically, what the bill talks about is hospital acquired-infections—which, I believe, are called nosocomial infections within the industry—and they're a major health problem in the United States. According to the federal Centers for Disease Control and Prevention (CDC), nosocomial infections account for an estimated 2 million infections, 90,000 deaths, and $4.5 billion in excess health care costs annually.

Common types of infections people acquire in hospitals include infections of the respiratory tract, bloodstream, urinary tract and surgical sites. It is true that hospitals today care for a high proportion of very sick patients with compromised immune systems, something that we didn't have as much of as far as records tell us, say, 30 years ago. It is also true that new strains of antibiotic-resistant bacteria can make the task of infection control more difficult. However, it is also true that there is a lot that can be done to make hospitals safer.

It's estimated that more than half of hospital-acquired infections could be prevented by proper handwashing practices, more careful adherence to well-known antiseptic procedures for catheters, and attending to patients on ventilators. Caring for surgical incisions could prevent additional infections.

Better isolation techniques could prevent the spread of communicable diseases, such as respiratory illnesses, which can lead to severe bronchitis and pneumonia in patients. I've received calls from frightened relatives with loved ones who checked into the hospitals for tests or elective surgery and became ill after being separated only by a curtain from a patient coughing violently from some contagious condition. I'm sure that you've heard of similar accounts, as well as tragic stories of people who have died or nearly died from staph infections and other serious infections contracted during hospital stays that were supposed to be diagnostic or curative.

[Assemblywoman Ohrenschall, continued.] One such instance that I will not read from, but if the Chair will permit I'll provide copies from later, is a *Washington Post* article that appeared February 23, 2005, entitled "Tallying an Unclear Toll" (Exhibit B), talking about the state of Maryland and legislation pending there that may track infections contracted in hospitals. It has a really bad situation in there, where somebody went in with light pneumonia and came out dead due to hospital infections. Now, I understand that this is the extreme and certainly this doesn't happen on a day-to-day basis, but this is the worst.

Assembly Bill 59 is intended to draw attention to this critical health problem by establishing hospital-acquired infections as a separate category of sentinel event. At the moment, we have legislation on the books that requires the sentinel events be reported to the Health Division. Sentinel events are certain adverse events that hospitals, obstetric centers, surgery centers for ambulatory patients, and independent centers for emergency care currently must report to the Health Division and to the patient involved. Existing law requires facilities to establish patient safety plans and processes. The law also provides for data analysis and reporting of aggregate trend information. Section 1 of A.B. 59 establishes a definition of "hospital-acquired infection" that includes, but is not limited to, the four most common such infections. To make sure that the law will keep up with new developments, subsection 5 authorizes the administrator of the Health Division to add new categories of infection by regulation.

I've been informed that the hospital association has a problem with that section, and I would leave that up to the Committee, who are more learned than I am in the field, but possibly something could be worked out there of putting in a more specific definition of infections and not burdening the administrator with this increased type of discretion. But I would leave that up to the Committee as to which way to go. Section 3 adds "hospital-acquired infection" into the definition of sentinel event, and the rest, Sections 2, 4, 5, 6 and 7, make conforming references to "hospitalized," "hospital-acquired infections," and other provisions governing the collection reporting of sentinel event data.

[Assemblywoman Ohrenschall, continued.] In conclusion, I would like each of you to imagine what an outcry there would be if airline accidents accounted for 90,000 deaths a year. I believe it is well past time to shine the spotlight of fact on the issue of nosocomial infections, to make hospitals and medical facilities safer for all. If hospitals are required to make the separate filing of these things, it will certainly encourage the hospitals to look in their own houses, and to try to prevent as much as possible such infections that can be prevented—for instance, a simple matter, like how you pair two patients who share a room, can have critical results if one of the patients happens to have an immune deficiency and another one happens to have what might not to a reasonably healthy person, be a very threatening disease. These are things that the hospitals can look at. That is basically what Assembly Bill 59 is about. I would like to add the fact that everyone, including the CDC, estimates that as many as 2 million people contract infections from hospitals each year. The deaths that result from such infections could be much higher, or much lower than the 90,000 estimate, but they can't tell because the data is virtually nonexistent. So I think it's important that such matters be reported and that they be reported in a way that keeps them separate from other sentinel event reporting.

Assemblyman Mabey:
On Section 3, how do you know if it's a hospital-acquired infection? Some people go to a hospital and they already have an infection, or they may have one and it's not apparent. How would you decide if somebody really acquired that infection in the hospital? Maybe under your circumstance, maybe a friend came in and coughed on her, and she got influenza in the hospital.

Assemblywoman Ohrenschall:
It's a difficult line to draw, but it's being drawn at the moment because all nosocomial infections are presently being reported to the Health Division. So it's a line that, through regulation, has been defined, and that they seem to be making it work. Now, in Section 1, where we define hospital-acquired infections in the first three subsections, I think it's fairly obvious that those would have to be in the hospital. Obviously, unless there's a surgical site, unless the patient has had surgery, you're not going to have a surgical site infection. If you have a ventilator-associated pneumonia, if the patient hasn't been hospitalized and put on a ventilator, you're not going to have that either. The same thing with central line related bloodstream infections. Small things can become very large. I know what really has had an effect on me is the late Christopher Reeve. After all he went through—falling, fighting paralysis, trying to come back—he finally died because of an infection from a bedsore, and I know under his condition, as long as he was bedridden, it's possible that it could not have been avoided, but the point I'm making is that sometimes these

infections, for as tiny and minute as they appear, can have horrendous outcomes.

Assemblyman Mabey:
Under ventilator-associated pneumonia, perhaps they had pneumonia when they went to the hospital. Often people with urinary tract infections would go to the hospital with that complaint also. It's possible they could acquire that, no doubt about it because of a catheter. To me, it's just going to be hard to decide in some of these whether it was acquired at the hospital, or it was brought to the hospital.

Assemblywoman Ohrenschall:
I definitely understand your concern, and as I say, the only thing I can offer is that these reports are being currently made. There must be some standard by which the hospitals are doing it. I certainly don't mean to in any way minimize them, because those are important concerns.

Chairwoman Leslie:
I think that's an important question. Following up on that, in Section 1, those five things that are listed there, is that what's in regulation?

Assemblywoman Ohrenschall:
The only thing that's not in regulation is catch-all subsection 5, which says "other categories of infection."

Chairwoman Leslie:
"As may be established."

Assemblywoman Ohrenschall:
Yes.

Chairwoman Leslie:
So it looks like we're codifying the regulation in the statute.

Assemblywoman Ohrenschall:
Basically, that's what we're doing. The other categories of infection, although it is a catch-all, there are other things that are being reported now which are not included within the first four that are listed. As I said, it would be possible if the discretion in that were the sticking point in getting this bill to pass, to look at the things that are presently being reported that are not within subsection 1, 2, 3 and 4, and perhaps just list those.

Chairwoman Leslie:
If the objection is to "other"?

Assemblywoman Ohrenschall:
Yes.

Assemblywoman Weber:
Can you tell me, the definition itself, where that definition originates? Is it a CDC definition?

Assemblywoman Ohrenschall:
I'm not certain. I believe it's currently used; certainly there is a bill that's been floating around, pushed by the Consumers Union, that has a definition that is a bit broader than this, but goes on those topics, but I think mostly it's common sense. I went down to LCB [Legislative Counsel Bureau], and we tried to hash out what is there now, what's being put in. We tried to make it not quite as draconian as the one being proposed by Consumers Union, and also tried to make it so that it would follow what was being reported now.

Assemblywoman Weber:
Is there a way we can get what the CDC considers a hospital-acquired infection? Would that be possible?

Chairwoman Leslie:
Yes, we can request that.

Assemblywoman Weber:
I'm sure some of the items are incorporated.

Assemblywoman Ohrenschall:
It's possible that somewhere in my file I have that. I will certainly try to look for it, too, and I know the Committee will also.

Chairwoman Leslie:
We can request that our Research staff find that.

Assemblyman Hardy:
Observations from the clinical practice of medicine. If you put a catheter in for whatever reason, a urinary catheter, and you do a culture a week later, you're going to have a positive culture. So some people say, "Okay, now you've got an infection." If we treat that infection as an infection, if we treat the positive culture as an infection, we select out the bad bugs.

[Assemblyman Hardy, continued.] So in the practice of medicine, if you're a urologist, and your patients have catheters all the time, they do not treat positive urinary cultures unless the person develops what they call a clinical infection, fever, chills, et cetera. So the definition of a hospital-acquired infection hinges on, "what is an infection?" So you can have a positive culture and not have a "clinically important" infection. So it's not an easy clinical decision, let alone a definition. I understand the difficulty that you're dealing with, and then I would also ask about the sentinel event. What is the definition of a "sentinel event"? From the physician's perspective, a sentinel event is usually an, "I see one, I know what it is" kind of thing. A urinary tract infection from a catheter is not a sentinel event. So the definitions become very interesting and problematic in how this is going to "change behavior," so if you're going to get information, is it going to be used in such a way to change behavior? We did a study and we found out if you wash your hands, you don't spread infection as much. So it comes down to that kind of simplicity. The latest study, that is kind of fun. If you wear a tie, your tie can carry infection. It's not just the hands with bugs on them.

Assemblywoman Ohrenschall:
All I can suggest to you now again, this is going back to Assemblywoman Weber, that a sentinel event, of course, has a definition that's picked up in my bill from NRS [*Nevada Revised Statutes*] 439.830, and again, and to you, Dr. Hardy, it's an unexpected occurrence involving hospital-acquired infection, death, serious physical or psychological injury or risk thereof, or any process variation which could carry a significant chance of a serious adverse outcome. So again, I understand these are qualitative decisions that have to be made within the definition, but I'm just trying to point out that the definition that is currently in the statute and in the regulations does take that into account. On the hospital-acquired infection, I think that if you look at it carefully with the Nevada State Health Division's "Sentinel Event Report Guide" and the regulations, you'll find that using the fancier terminology, "nosocomial infection," that the two definitions are not very far apart.

The Guide defines a nosocomial infection as "a localized or systematic condition that results from adverse reaction to presence of an infectious agent or toxin that was not present or incubating at the time of the admission of the medical facility." They're gathering this evidence now for that. For most bacterial nosocomial infections, that means that the infection usually becomes evident 48 hours, typical incubation time, or more, after admission. It goes on and says here, and I'm reading as a layperson: "However, because the incubation period varies with the various types of pathogen, and to some extent with the patient's underlying condition, each infection must be assessed for evidence

that links it to the hospitalization." So that part has been used, and I would assume the same thing would continue.

[Assemblywoman Ohrenschall, continued.] I did speak with the Health Division, their sentinel events people, and they informed me that as far as they're concerned, they're neutral on this piece of legislation because they feel they're already picking up most of the information, so it's not going to cost them any more or require any very significant change of procedure within their department.

Jim Wadhams, Legislative Advocate, representing the Nevada Hospital Association, Reno, Nevada:
[Handed out a proposed amendment, Exhibit C.] I want to apologize personally to the sponsor of this bill. I've not had an opportunity to show her the language yet. We in fact just came up with this within the last hour or so, and it's simply designed to accomplish what I think the testimony has suggested, a codification of the regulation. As some in the room will recall, we spent one summer dealing with a bill called Assembly Bill 1 of the 18th Special Session, and the Chair was personally involved, dealing with exactly this language of sentinel events. We think what came out of that was a very positive piece of legislation, which the Executive Branch agency has worked to further refine. As the sponsor testified, the language does include a reporting of hospital-acquired infections. I've marked the box that I'm appearing neutral, and that's really only because I think that this technical change to bring the wording to pick up what is in regulation makes the bill work a little easier.

Assemblywoman Ohrenschall:
In the course of circulating the bill and so on, I had intended today to ask Assemblywoman Koivisto to be one of the sponsors too; somehow, glitches happened. At any rate, I checked with the Speaker's office. They stated I could make a motion here to the Committee to add her name as one of the primary cosponsors, and I would really like the Committee to consider that if it could.

Chairwoman Leslie:
We can certainly put that in the work session document to amend the bill to add Mrs. Koivisto's name. That won't be a problem.

Assemblywoman Ohrenschall:
Thank you very much. You both have worked so hard in these areas that it's important to have you both leading the way.

Chairwoman Leslie:
We appreciate that consideration. Mr. Wadhams, "urinary tract infections" is already in the regulation?

Jim Wadhams:
Yes, it is.

Chairwoman Leslie:
I thought that was a good point.

Jim Wadhams:
The definition of nosocomial, I am told by those who are health professionals, that it does include that.

The amendment slightly adjusts the wording to bring the language that was previously in Section 3 into Section 1. In kind of a rough sense, what we have tried to present here in rough bill drafting style, "hospital-acquired infection" means "a localized or systemic condition," and these are the new words, "which results in a sentinel event from an adverse reaction."

The language that's currently in Section 3 becomes unnecessary. I think bill drafters would technically just delete that section to leave the law as it is and then add the language that I have described into Section 1. As the Chair will probably quickly recognize, I didn't do this, and I apologize, but the phrase "hospital-acquired," to conform to existing Nevada law, should be "facility-acquired." The application of the sentinel event law applies beyond hospitals. There are four facilities that are identified in that statute, and so I think the proper reference would be "facility-acquired infection" as opposed to simply "hospital." I'd be happy to answer the questions. I think, with the changes, this would be the codification of the existing regulation. I think I should also compliment the Executive Branch agency on working through with the bill, Assembly Bill 1 of the 18th Special Session, to accomplish what has been supported by the sponsor of this bill.

Emil Paul DeJan, Bureau Chief, Bureau of Health Planning and Statistics, Nevada Department of Human Resources:
The Bureau is responsible for the Repository for Health Care Quality Assurance created by NRS 439.850, which includes the sentinel event registry for mandatory reporting of sentinel events pursuant to the NRS 439.800 to 439.890. First, this bill creates no fiscal impact for the Health Division; and second, based on the definition of sentinel events in NRS 439.830, we believe the hospital-acquired infections, or nosocomial infections, are already required to be reported. Basically, that's our position. We're neutral on the bill.

Assemblywoman Weber:
I just wanted to find out: within your regulations, what is the definition of "hospital-acquired infection"? Is that already in your regulations? My point of asking is I want to make sure if we put it in statute it matches what you do.

Emil DeJan:
"Nosocomial" is in our training guides for filling out the reporting forms. We don't use the words "hospital-acquired infections." We use the more medical term.

Vice Chairwoman McClain:
So does it match?

Emil DeJan:
It's generally accepted to mean the same thing.

Assemblywoman Gerhardt:
I do have a couple of questions about the reporting. What exactly is reported? How often is it reported? How does all that come together?

Emil DeJan:
When a sentinel event occurs within a hospital they have 13 days after discovering to report the initial event to the Health Division, and then 45 days to report after they've done their intensive root-cause analysis reviews. The list of sentinel events is long; I could show you a copy. There are several different categories.

Assemblywoman Gerhardt:
So once it's reported, this information is put together and it goes to the Health Division?

Emil DeJan:
That's correct. We've been receiving ongoing reports since the initiation day of January 1, 2005. To date, we have received 15 reports for February and January, and 9 retroactive reports. The Hospital Association and its members agreed to report retroactively back to July 1, 2003, the date of the initial bill enactment.

We expect to receive considerably more retroactive reports. The 15 reports to date, when compared with the 16 reports that were made to JCAHO [Joint Commission on Accreditation of Healthcare Organizations] over an eight-year period, I think is an indication that the hospitals, medical facilities, are reporting.

Assemblywoman Gerhardt:
Then what's done with all that information?

Emil DeJan:
Right now, the information is being logged into our registry database, and at present we have the information in the database. There are strict laws in Assembly Bill 1 of the 18th Special Session about the discoverability, so the information will stay there until there's a report prepared on the information.

Assemblywoman Parnell:
I'm just curious. If and when that information becomes public, and if it does, how does that process happen?

Emil DeJan:
Right now, one of the parts of the features of the bill that wasn't funded was to have the quality improvement organization, which would probably have been Health Insight for the state of Nevada, be a reporting mechanism for the data that is in the sentinel events registry. Currently, we will compile the data probably at the end of a period of time where we have significant information, which will probably be a year. Hopefully we'll have retroactive data to add to that. We could, at that time, provide a report if requested. In the law itself it features aggregate reporting, so it wouldn't be institution- or provider-specific. Again, we were talking about fairly small-sized numbers at this point.

Assemblywoman Pierce:
Could you tell me what was not funded that you just described?

Emil DeJan:
There's part of the bill that was funding a quality improvement organization, to take the data that was gathered by the registry and do trending and other types of analytical work. Monies for that section of the bill were not funded.

Assemblywoman Pierce:
Has it been funded in the Governor's budget this year?

Emil DeJan:
It has not been.

Bobbette Bond, Community Affairs Manager, Culinary Health Fund, Las Vegas, Nevada:
I'm here speaking today in support of the idea these conversations about sentinel events, what they are, and what should continue to be reported. I'm appreciative of Assemblywoman Ohrenschall bringing the bill forward. I think when we talk about nosocomial infections, the one issue that I see in the reporting that's going on now is, it would be nice to understand when they say in the actual statute that they will be reviewed. There's text here that they'll review to determine whether they're hospital-based, and they'll have to provide a pretty substantial link that they were hospital-based. I think it would be nice if there were some clear definition of what that means, or some understanding from the hospitals about how they do that when the reports go out. I think that would be useful.

Other than that, I'm really happy to see from our concern about watching what the hospitals are doing and watching what kind of quality care is being initiated. It's really nice to see this sentinel project get off the ground, and it's nice to see the reporting beginning. As I understand it, it's just been within the last couple of weeks that the website has been up and running and you can track what's going on.

The lack of funding was going to be my other point. It's great for them to collect all this data. Now we need to get a way to get it back into the community and be able to work with it some. If you can't trend it, then it's just left to organizations like ours to be able to get the data and do something with it. Actually getting the data brought forward in a way that people can pay attention to—and specifically on nosocomial infections, understanding exactly how the hospital would assess whether it's nosocomial or not—because I think Assemblywoman Ohrenschall's definition is the crux of what's left of the problem, figuring out what nosocomial is. So thank you for the time.

Lynn O'Mara, Health Resource Analyst III, Nevada State Health Division, Nevada Department of Human Resources, Carson City, Nevada:
On the Health Division website via the link to the Health Planning and Statistics is the sentinel registry website, <health2k.state.nv.us>. We've had it up since June, providing information about what was going on. Also available are the forms and the training guide, as well as the training presentation that we use. So it has all the information as to what we're collecting right now.

Assemblywoman Pierce:
I am not sure who can answer this, but about the funding, what parts of Assembly Bill 1 of the 18th Special Session weren't funded? Is this the only

part of Assembly Bill 1 of the 18th Special Session that wasn't funded, this part where it goes into a report and demonstrates trending and that sort of thing?

Emil DeJan:
The only major part of the bill that wasn't funded was approximately $150,000, depending on which version of funding; there were three versions. Most of the other parts of the bill were funded. They were funded in different degrees in the three options that were presented. The smaller option of the three was the one that was funded with the least amount in each category. That one amount for the quality improvement organization was not included in option three; it was in option one and option two.

Kim Kandt, Patient Safety Officer, University Medical Center, Las Vegas, Nevada:
One of the things that comes with my job description is doing root-cause analysis in sentinel event reporting. I looked at this bill, and I just want to know if there's a differentiation between—it's already in there that nosocomial infections will be reported, but the way the bill reads, it says every nosocomial infection doesn't necessarily tie it to being a sentinel event. So I need to know if there's some differentiation there, because nosocomial infection, any infection that's found after 48 hours in a hospital. At this time, we don't test every patient for every kind of infection when they're admitted. I want to make sure there's differentiation there, because I think there's a fiscal impact if we're expected to report every single infection that occurs after 48 hours as a nosocomial infection.

Vice Chairwoman McClain:
I think if you would see the amendment that was offered, it basically says an infectious agent that becomes a sentinel event. So you wouldn't have to do any testing until it actually happened, right? That's the way I understand it.

Kim Kandt:
In that sentinel event reporting, actually, you're a person that wanted the definition. It's actually in the "Sentinel Report Guide" that a nosocomial infection is a localized systemic condition that causes harm. I wanted to make sure that the "causes harm" thing that we report for sentinel events is not a problem. But some of them, like the one the doctor said, there are urinary tract infections they had when they came that were not nosocomial infections.

Vice Chairwoman McClain:
We'll make sure staff understands.

Assemblywoman Weber:
I'm not sure who this question might go to, but since patients now stay less time in hospitals, we get them in, get them out, and they were to go home, and after they've left the hospital they've discovered something happened or is there, if they should return to the place where they had the surgical event or whatever, is that considered at that time to be a sentinel event? Is there a linkage to get that information back from the patient, or when they leave the hospital there's a way for them to report that?

Assemblywoman Ohrenschall:
That's a good question. I'm not sure I fully understand exactly what you're saying. If somebody goes home they think they feel feverish, and they come back to the hospital because of that?

Assemblywoman Weber:
Is it picked up as under the category of a sentinel event and reported as a nosocomial or a facility, hospital-acquired infection?

Assemblywoman Ohrenschall:
I imagine that would be up to the patient to alert the hospital that, in fact, the patient had begun suffering from that on the prior hospitalization. I don't think we're asking the hospitals to have a crystal ball going either backward or forward.

Assemblywoman Weber:
My point is, if they come home and come back, will it be recognized and possibly be recognized as a sentinel event as a nosocomial infection?

Vice Chairwoman McClain:
Maybe one of our doctors can answer that.

Assemblyman Mabey:
I will answer what may happen. I can't tell you exactly. If the patient's discharged, and a patient calls me and I take care of it outside the hospital, there's no way the hospital would ever know. And that would never be reported. If they return to the same hospital within a certain amount of time, I think that does trigger an event, and I'm not exactly sure what happens, but that would be recorded. If they go to a different facility, I don't think that would be detected.

Assemblywoman Ohrenschall:
I think we were expecting at least some responsibility and action on the part of the patient, too, to make sure that when he comes back in he makes the people

in the hospital that he is coming back into aware of the history of where something started. That is the best answer I can give you at the moment. It may be something else that needs to be looked at in work session.

Vice Chairwoman McClain:
I'll call this hearing to a close on Assembly Bill 59. And if there's nothing else to come before the committee, we're adjourned [at 2:20 p.m.].

RESPECTFULLY SUBMITTED:

_____
Joe Bushek
Committee Attaché

APPROVED BY:

_____
Assemblywoman Sheila Leslie, Chairman

DATE: _____

EXHIBITS

Committee Name: Health and Human Services

Date: 3/2/05 Time of Meeting: 1:30 p.m.

Bill #	Exhibit ID	Witness	Dept.	Description
	A			Agenda
59	B	Assemblywoman Genie Ohrenschall		News article from the Washington Post entitled "Tallying an Unclear Toll"
59	C	Jim Wadhams		Proposed amendment to A.B. 59