SENATE BILL REPORT
SB 5236

As Reported by Senate Committee On:
Labor & Commerce, February 7, 2023
Ways & Means, February 24, 2023

Title: An act relating to improving nurse and health care worker safety and patient care by establishing minimum staffing standards in hospitals, requiring hospital staffing committees to develop staffing plans, addressing mandatory overtime and meal and rest breaks, and providing for enforcement.

Brief Description: Concerning hospital staffing standards.

Sponsors: Senators Robinson, Keiser, Conway, Frame, Hunt, Kauffman, Lovelett, Nguyen, Nobles, Pedersen, Shewmake, Stanford, Trudeau, Valdez and Wilson, C..

Brief History:
Committee Activity: Labor & Commerce: 1/17/23, 2/07/23 [DPS-WM, DNP].
Ways & Means: 2/16/23, 2/24/23 [DP2S, DNP, w/oRec].

Brief Summary of Second Substitute Bill

- Requires the Department of Health (DOH) and the Department of Labor and Industries (L&I) to regulate and enforce hospital staffing committees and hospital staffing plans.
- Amends the meal and rest breaks and overtime provisions for health care employees.

SENATE COMMITTEE ON LABOR & COMMERCE

Majority Report: That Substitute Senate Bill No. 5236 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators Keiser, Chair; Conway, Vice Chair; Saldaña, Vice Chair; Robinson and Stanford.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

Minority Report: Do not pass.
Signed by Senators King, Ranking Member; Braun, MacEwen and Schoesler.

Staff: Jarrett Sacks (786-7448)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 5236 be substituted therefor, and the second substitute bill do pass.
Signed by Senators Rolfes, Chair; Robinson, Vice Chair, Operating & Revenue; Mullet, Vice Chair, Capital; Billig, Conway, Dhingra, Hasegawa, Hunt, Keiser, Nguyen, Pedersen, Saldaña and Wellman.

Minority Report: Do not pass.
Signed by Senators Wilson, L., Ranking Member, Operating; Gildon, Assistant Ranking Member, Operating; Schoesler, Ranking Member, Capital; Warnick, Assistant Ranking Member, Capital; Boehnke, Braun, Muzzall, Torres, Van De Wege and Wagoner.

Minority Report: That it be referred without recommendation.
Signed by Senator Rivers, Assistant Ranking Member, Capital.

Staff: Amanda Cecil (786-7460)

Background: Nurse Staffing Committees. Hospitals are required to establish nurse staffing committees whose membership consists of:
- at least one-half who are registered nurses providing direct patient care; and
- up to one-half who are determined by the hospital administration.

The responsibilities of the nurse staffing committee include:
- development and oversight of annual staffing plans;
- review of the staffing plan; and
- review, assessment, and response to staffing variations or concerns presented to the committee.

When developing the annual staffing plan, the committee must consider certain statutory factors, such as patient activity, intensity level, nature of care required, and level of experience of staff.

If the staffing plan is not adopted by the hospital, the chief executive officer must provide reasons why the plan was not adopted and either identify the changes to the plan prior to the hospital's adoption or prepare an alternative staffing plan that the hospital will adopt. Hospitals must submit their nurse staffing plans annually to the Department of Health (DOH).

DOH must investigate complaints related to the failure to establish a staffing committee, submit a nurse staffing plan annually, conduct a semi-annual review of the nurse staffing plan, or follow nursing assignments or shift-to-shift adjustments. There are statutory limitations on when DOH may investigate a complaint of a failure to follow nurse assignments or shift-to-shift adjustments.

After an investigation, if DOH determines there has been a violation, DOH must require the hospital to submit a corrective action plan within 45 days of the presentation of findings from DOH to the hospital. If the hospital fails to submit or follow the corrective action plan, DOH may impose a civil penalty of $100 per day. Various provisions related to the staffing committees, including requirements for DOH to investigate complaints, expire June 1, 2023.

Meal and Rest Breaks. In general, hospitals must provide employees with uninterrupted meal and rest breaks, except for:

- an unforeseeable emergent circumstance; or
- a clinical circumstance that may lead to a significant adverse effect on the patient's condition without the knowledge, specific skill, or ability of the employee on break, or due to an unforeseen or unavoidable event relating to patient care requiring immediate action that could not be planned for by an employer.

In the case of a clinical circumstance, if a rest break is interrupted before ten minutes by the employer, the employee must be given an additional ten minute uninterrupted rest break at the earliest reasonable time during the work period.

An unforeseeable emergent circumstance is:

- any unforeseen declared national, state, or municipal emergency;
- when a health care facility disaster plan is activated; or
- any unforeseen disaster or other catastrophic event which substantially affects or increases the need for health care services.

The meal and rest break provision applies to a health care facility employee who is:

- involved in direct patient care activities or clinical services;
- receiving an hourly wage or covered by a collective bargaining agreement; and
- a licensed practical nurse, registered nurse, surgical technologist, diagnostic radiologic technologist, cardiovascular invasive specialist, respiratory care practitioner, or a nursing assistant-certified.

Health Care Facility Overtime. No employee of a health care facility may be required to work overtime and the acceptance by an employee of overtime is strictly voluntary. The overtime restriction does not apply to overtime work that occurs because of:

- any unforeseeable emergent circumstance;
- prescheduled on-call time, subject to certain limitations;
- when the employer documents it has used reasonable efforts to obtain staffing. An

employer has not used reasonable efforts if overtime work is used to fill vacancies resulting from chronic staff shortages; or
- when an employee must work overtime to complete a patient care procedure.

Health care facilities covered by the overtime restrictions include hospitals, hospices, rural health care facilities, psychiatric hospitals, and facilities owned and operated by the Department of Corrections.

A violation of the overtime provision is a class 1 civil infraction.

Summary of Bill (Second Substitute): Staffing Committees and Staffing Plans. By January 1, 2024, hospitals must establish a hospital staffing committee. The committee membership must be comprised of:
- 50 percent nursing staff, who are non-supervisory and non-managerial; and
- 50 percent members determined by hospital administration, including the chief financial officer, the chief nursing officer, and patient care unit directors or managers.

Additional staffing relief must be provided if necessary for committee members to attend the hospital staffing committee meetings. The committee must adopt a draft of the hospital's annual staffing plan and deliver it to the hospital's chief executive officer (CEO). The CEO must provide written feedback to the staffing committee on a semi-annual basis. Factors that must be addressed by the feedback are specified. The committee must consider the feedback prior to adopting the final staffing plan. Factors considered by the hospital staffing committee when developing the staffing plan are modified. Beginning July 1, 2025, each hospital must submit its final staffing plan to DOH, and annually thereafter.

Each hospital must document when a patient care unit nursing staff assignment is out of compliance with the adopted hospital staffing plan. Out of compliance means the number of patients assigned to the nursing staff exceeds the patient care unit assignment as directed by the nurse staffing plan. Each hospital must report to DOH and L&I on a semiannual basis the percentage of nurse staffing assignments where the assignment in a patient care unit is out of compliance with the adopted nurse staffing plan.

Beginning in 2025, if a hospital is in compliance for less than 80 percent of the nurse staffing assignment in a month, the hospital must report to DOH and L&I regarding lack of compliance with the nurse staffing patient care unit assignments in the hospital staffing plan. The reporting requirements do not apply to critical access care hospitals, certain sole community hospitals, and hospitals with fewer than 25 acute care beds.

A registered nurse, patient care staff, collective bargaining representative, patient, or other individual may make a complaint to the staffing committee on variations of personnel assignments. All complaints submitted to the staffing committee must be reviewed, regardless of what format the complainant uses to submit the complaint.

In the event of an unforeseeable emergent circumstance last more than 15 days, the hospital incident command must report within 30 days to the hospital staffing committee an assessment of the staffing needs arising from the unforeseeable emergent circumstance and the plan to address those needs. After which, the staffing committee must convene and develop a contingency staffing plan. The hospital's deviation from its original staffing plan may not be in effect for more than 90 days without approval of the staffing committee.

An unforeseeable emergent circumstance is:
- any unforeseen declared national, state, or municipal emergency;
- when the hospital disaster plan is activated; or
- any unforeseen disaster or other catastrophic event that substantially affects or increases the need for health care services.

An unforeseeable emergent circumstance does not mean a declared national, state, or municipal emergency or when a hospital disaster plan is activated, if the events persist longer than 90 days.

By January 1, 2025, the hospital staffing committee must file with DOH a charter that must include:
- roles, responsibilities, and processes by which the hospital staffing committee functions;
- meeting schedules;
- processes for reviewing, investigating, and resolving complaints;
- processes for reviewing staff turnover and workforce development plans;
- policies for the approving and retaining meeting documentation; and
- processes for the hospital to provide the staffing committee with information regarding certain patient complaints made to the hospital.

L&I and DOH must provide technical assistance to hospital staffing committees to assist in compliance with the bill. Technical assistance may not be provided during an inspection or during the time between when an investigation of a psychiatric hospital has been initiated and when such investigation is resolved.

Beginning January 1, 2027, DOH must review all non-compliance reports required by the bill and L&I must require corrective action plans.

DOH must review hospital staffing plans to ensure they are received by the appropriate deadline and in the correct format. DOH must post staffing plans, charters, and violations on its website. The appropriate agency may take administrative action with penalties up to $10,000 per month for failing to submit a staffing plan, charter, or corrective action plan. L&I may assess a penalty of $50,000 per month for failing to follow a corrective action plan.

Additionally, L&I and DOH must investigate complaints for failure to:
- form or establish a hospital staffing committee;
- conduct a semi-annual review of a staffing plan;
- submit an annual staffing plan and any updates; or
- follow the requirements for personnel assignments and shift-to-shift adjustments in the nurse staffing committee law.

The provision limiting investigations to complaints with evidence of a continuing pattern of unresolved violations is removed.

A hospital will not be found in violation of the nurse staffing committee and staffing plan requirements if an investigation determines that:
- there were unforeseen emergent circumstances and the process for handling emergent circumstances established in law was followed; or
- the hospital, after consultation with the hospital staffing committee, documents that the hospital has made reasonable efforts to obtain and retain staffing to meet required personnel assignments but has been unable to do so.

Reasonable efforts means that the employer exhausts and documents all of the following but is unable to obtain staffing coverage:
- seeks individuals to consent to work additional time from all available qualified staff who are working;
- contacts qualified employees who have made themselves available to work additional time;
- seeks the use of per diem staff; and
- seeks personnel from a contracted temporary agency when such staffing is permitted by law or an applicable collective bargaining agreement, and when the employer regularly uses a contracted temporary agency.

Reasonable efforts does not mean circumstances when an employer is chronically short staffed with vacancies that persist longer than 90 days or have frequently recurring absences.

L&I must investigate complaints alleging violations of the bill and issue a notice of assessment or a closure letter with 90 days of receiving the complaint. The penalty for violations of the bill, unless a different penalty is specified, is $1,000 for each violation up to three violations. The penalty is $2,500 for a fourth violation and $5,000 for each subsequent violation. Citations and notices of assessment may be appealed.

L&I may investigate and take enforcement action without a complaint if the department discovers information suggesting a violation of the staffing committee and staffing plan statute, or a violation of the minimum staffing standards established under the bill.

L&I and DOH must establish a formal agreement that identifies the roles of each agency

with respect to oversight and enforcement of the bill and, to the extent feasible, provide for enforcement by a single agency and to avoid multiple citations for the same violation.

Advisory Committee. DOH and L&I must establish an advisory committee on hospital staffing by September 1, 2023. The committee must include the following members:

- six members representing hospitals and hospital systems and their alternates, selected from a list of nominees submitted by the Washington State Hospital Association;
- six members representing frontline hospital patient care staff and their alternates, selected from a list of nominees submitted by collective bargaining representatives of frontline hospital nursing staff, and
- up to four non-voting ex oficio members.

The advisory committee on hospital staffing shall advise DOH on its development of the uniform hospital staffing plan form. At the discretion of L&I, the advisory committee on hospital staffing may advise on any rule-making undertaken by DOH. .

By December 1, 2023, WSIPP must survey hospitals and report to the advisory committee on hospital staffing on Washington hospitals' existing use of innovative hospital staffing and care delivery models.

Meal and Rest Breaks. Combining meal and rest breaks is allowed for any work period in which an employee is entitled to one or more meal periods and more than one rest period. Provisions that allowed certain clinical circumstances to exempt hospitals from meal and rest break requirements are amended. The requirement to provide uninterrupted meal and rest breaks does not apply when there is a clinical circumstance, as determined by the employee that may lead to a significant adverse effect on the patient's condition, unless the employer determines that the patient may suffer life-threatening adverse effects.

The definition of employee is broadened, applying the meal and rest break provisions to an employee who is employed by a hospital; is involved in direct patient care activities or clinical services; and receives an hourly wage or is covered by a collective bargaining agreement.

Mandatory Overtime. The definition of employee is modified similarly to the change in the meal and rest breaks statute.

The definition of overtime is modified to mean hours worked in excess of:

- an agreed upon, predetermined, regularly scheduled shift;
- 12 hours in a 24-hour period; or
- 80 hours in a consecutive 14-day period.

For the purposes of exemptions to the overtime restrictions the prescheduled on-call time must not exceed more than 60 hours per month; and the health care facility's reasonable efforts to obtain staffing are not reasonable if overtime is used to fill vacancies from chronic

staff shortages that persist longer than three months or for frequently reoccurring staff shortages. Mandatory prescheduled on-call time may not be used when an employer schedules a nonemergent patient procedure that is expected to exceed the employee's regular scheduled hours or work.

WSIPP Study. WSIPP must conduct a study on hospital staffing standards for direct care registered nurses and direct care nursing assistants. WSIPP must review current and historical staffing plans filed with DOH and describe:

- timeliness and completeness of filed forms;
- format of filed forms;
- staffing ratios related to the maximum number of patients to which a direct care nursing or nursing assistant may be assigned;
- descriptive statistics on submissions by hospital unit type;
- trends over time, if any;
- legal minimum staffing standards for registered nurses and nursing assistants in other jurisdictions; and
- relevant professional association guidance, recommendations, or best practices.

WSIPP must provide the report to L&I and the Legislature by June 30, 2024.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Second Substitute):

Removes provisions requiring L&I to adopt rules establishing minimum staffing standards and removes related provisions, including requiring the creation of a negotiated rulemaking committee to propose rules. Requires DOH, in addition to L&I, to establish the advisory committee. Requires the advisory committee to consider innovative hospital staffing and care delivery models. Requires L&I and DOH to provide notifications of corrective action plans and adherence to those plans to the advisory committee.

Removes the daily penalties for the failure to adopt a staffing plan. Modifies the terminology around nursing and patient care staff and adds definitions for nursing assistant-certified, patient care staff, and registered nurse. Modifies the definition of unforeseeable emergent circumstance to include any unforeseen disaster or other catastrophic event that substantially affects or increases the need for health care services. Requires an unforeseeable emergent circumstance to last more than 15 days prior to the hospital incident command being required to report to the hospital staffing committee. Requires 50-percent of the voting members of the hospital staffing committee to be nursing staff, rather than nursing and patient care staff. Requires 50-percent of the members on a staffing committee to be determined by hospital administration, rather than up to 50 percent. Requires staffing plans to be delivered to the hospital's CEO and requires the CEO to provide written feedback to the staffing committee on a semi-annual basis, including a status report on implementation of the staffing plan.

Requires staffing plans and charters to be submitted to DOH, rather than L&I. Requires hospitals to document when a patient care unit nurse staffing assignment is out of compliance with the staffing plan and, beginning January 31, 2026, report to DOH and L&I the percentage of nurse staffing assignments where the assignment in a patient care unit is out of compliance with the adopted nurse staffing plan. Requires, beginning in 2025, a hospital to report to DOH and L&I if its compliance rate is less than 80 percent of the nurse staffing assignments in a month. Excludes critical access care hospitals, hospitals with fewer than 25 acute care licensed beds, and certain sole community hospitals from the reporting requirements. Requires DOH, beginning January 1, 2027, to review the reporting of compliance rates below 80 percent. Requires L&I, beginning January 1, 2027, to require corrective action plans within 45 days of the required report to DOH and L&I. Requires hospitals to post corrective action plans required by the bill in a public place on each patient care unit.

Requires DOH, in addition to L&I, to provide technical assistance, but prohibits providing technical assistance during inspections and during certain investigations. Establishes a penalty of $10,000 per month for failing to timely file a staffing plan, charter, or corrective action plan. Modifies the penalty for failing to follow a corrective action plan to $50,000 per month. Removes requirement that the penalties apply until the corrective action plan is followed for 90 days, and instead applies the penalties until the hospital begins to follow the corrective action plan. Requires DOH, rather than L&I, to post violations on its website. Requires DOH and L&I to establish a formal agreement identifying the roles of each agency in enforcing the bill, and requires, to the extent feasible, to provide for enforcement by a single agency and include measures to avoid multiple citations for the same violation.

EFFECT OF CHANGES MADE BY LABOR & COMMERCE COMMITTEE (First Substitute):

Requires the hospital staffing charter to be filed with L&I by January 1, 2025 and modifies provisions for what the charter must include. Requires L&I to provide technical assistance to staffing committees to assist in compliance with the staffing committee statutes. Provides that the hospital staffing plan must be adopted by a 50-percent-plus-one vote of the staffing committee, rather than a consensus of the staffing committee. Modifies the anti-retaliation provision of the staffing committee statute to prohibit retaliation, intimidation, or taking an adverse action against an employee performing hospital staffing committee duties or voicing staffing concerns.

Allows L&I to investigate violations of the nurse staffing committee statutes and minimum staffing standards without a complaint if it discovers information suggesting a violation occurred. Modifies the definition of "unforeseeable emergent circumstance" to exclude a declared national, state, or municipal emergency or when a health care facility disaster plan is activated if the events persist more than 90 days.

Requires L&I to engage in negotiated rulemaking to establish the minimum staffing

standards for nurses and nursing assistants. Requires L&I to convene a negotiated rulemaking committee (NRC) that includes representatives of:

- the hospitals and hospital systems;
- frontline hospital patient care staff;
- L&I;
- DOH; and
- WSIPP.

Adds requirements around the NRC's processes for reaching consensus, voting, and recommending rules to L&I.

Requires L&I to establish an advisory committee on hospital staffing by September 1, 2023 to advise L&I on the development of the uniform hospital staffing plan form and any rulemaking not covered by the NRC, and to review and make recommendations on variances or innovative hospital staffing models. Requires WSIPP to survey hospitals and report to the advisory committee on hospital staffing and existing uses of innovative hospital staffing models by December 1, 2023. Allows L&I to grant variances from the minimum staffing standards for innovative staff and care delivery models.

Changes the definition of overtime to mean any of the following: (a) hours worked in excess of an agreed upon, predetermined, regularly scheduled shift; (b) hours worked in excess of 12 hours in a 24-hour period; or (c) hours worked in excess of 80 hours in a consecutive 14- day period. Changes the effective date of most of the bill from January 1, 2024 to July 1, 2024. Requires WSIPP to conduct a study on hospital staffing standards for direct care registered nurses and direct care nursing assistants.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: The bill contains several effective dates. Please refer to the bill.

Staff Summary of Public Testimony on Original Bill (Labor & Commerce): *The committee recommended a different version of the bill than what was heard.* PRO: This bill is just part of the discussion around how we staff health care and providing support for health care workers. Inadequate staffing leads to worse patient outcomes. It also leads to seasoned nurses leaving. The current staffing crisis has lead to many nurses being burned out and leaving and there are not enough new nurses to replace them. There is not a shortage of nurses, there is a shortage of safe work environments. Hospitals are not short on money and some have larger reserves now than they did before the pandemic due to investments and federal aid. Current staffing plans are not adhered to, and the current law has no teeth. Ensuring nurses do not have excessive patient load ensures patients receive the

care they need. Hospitals are understaffed by design.

CON: Hospitals are already closing various units and stopped performing certain procedures and the bill will only make that worse. Hospitals will have to close because they cannot find more nurses or pay the fines. L&I does not have the expertise to implement the bill. Unlike other industries hospitals cannot limit demand for their services and they cannot stop treating admitted patients. The cap on prescheduled on- call nurses will cause units to close. Ratios will stifle innovative staffing models. Hospitals cannot fill current staffing plans with enough nurses even with hiring expensive traveling nurses. California has ratios and the highest pay in the country and still has a nursing shortage. It also has the fewest nurses per capita in the country. Instead, we need legislation to train and develop new nurses. EMS and fire departments already have to wait to transfer patients and the bill will make that worse, now is not the time to pass the bill.

OTHER: To implement, L&I will need time to gather expertise and increase staff for the bill. The bill will also require an update to IT systems.

Persons Testifying (Labor & Commerce): PRO: Senator June Robinson, Prime Sponsor; Jennifer Gordon; Collin Greer, SEIU Healthcare 1199NW/Certified Nursing Assistant; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Nonie Kingma, Washington State Nurses Association; Nich Gullickson, South King County Professional Firefighters; Anna Nepomuceno, NAMI Washington; Kelli Johnson, UFCW 3000; Sam Hatzenbeler, Economic Opportunity Institute; Melissa Swetland, 1199 NW; Jim Freeburg, Patient Coalition of Washington; Zane Zuchowski.

CON: Darcy Jaffe, RN, Washington State Hospital Association; June Altaras, RN, MultiCare; Elizabeth Wako, MD, RN, Providence Swedish; Susan Scott, RN, Providence Holy Family Hospital; Mike Martinoli, RN, Ferry County Memorial Hospital; Beth Goetz, RN, Direct Care Nurse; Lisa Thatcher, Washington State Hospital Association; Matt Cowan, Shoreline Fire Department; Jeff Faucett, South Kitsap Fire & Rescue.

OTHER: Tammy Fellin, Labor & Industries.

Persons Signed In To Testify But Not Testifying (Labor & Commerce): PRO: Lisa Winchell; Kelsay Irby; Kainui Rapaport; Sara Gering; Evan Riley.

CON: Alyssa Odegaard, LeadingAge Washington; CHARLOTTE MORRIS, Trilogy; John Bramhall, Washington State Medical Association; Onora Lien, Northwest Healthcare Response Network; Laci Johnson, Forks Comunity Hospital; William Johnson; Mike Battis, Washington Ambulance Association; Heidi Anderson, Forks Community Hospital; Licett Garbe, Greater Spokane Valley Chamber of Commerce; Carlton Heine, WA ACEP.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: Hospitals are not doing their best to solve the current nursing crisis. Carrots have been

ineffective for too long, so it is time for the stick. Lots of new grads are being hired to replace the experienced nurses leaving in droves, which is not an equal replacement. Nursing turnover is expensive and dangerous. This bill will help rebuild trust in the healthcare system in a fiscally responsible way. Safe staffing ratios will allow nurses to deliver higher quality care and save patients from preventable death. If hospitals can afford to pay their CEOs millions, they can afford to improve standards for nurses.

CON: This bill introduces a rigid and authoritarian structure to staffing which is unsafe, as nurse placement needs to be flexible. This will lead to delays in access to care and will close hospitals in rural areas which will be devastating. The lack of prenatal care is associated with an increased likelihood that a woman will die of a pregnancy-related death by 3-4 times. These ratios will not work, as they have not worked in California. There are only about 3000 nurses who are unemployed in Washington, and there are more than 6000 unfilled positions. There are not enough nurses. This bill will not create more nurses, it will only increase costs and reduce the ability to respond to dynamic conditions and situations.

Persons Testifying (Ways & Means): PRO: Jennifer Gordon; Kainui Rapaport; Annika Hoogestraat, N/a; Evan Riley; Sara Gering RN BSN CCRN-CMC; Katy Roth RN; Natalie Fincher RN; Anita Dalton RN; Heidi Debauge RN; Sarah Gwin RN; Kathryn Lewandowsky, BSN, RN; James Harrigan; Lindsey Grad, 1199NW; Stephanie Simpson, Bleeding Disorder Foundation of Washington; Sam Hatzenbeler, Economic Opportunity Institute; Laura Zaske; Nicole Johnson.

CON: John Bramhall, MD, Washington State Medical Association; Michael Moran, Confederated Tribes of the Colville Reservation; Jennifer Graham, RN, MultiCare Health System; Heidi Anderson, RN, Forks Community Hospital; Lisa Thatcher, Washington State Hospital Association; Jeff Faucett, Washington Fire Chiefs Association; Norma Sanchez, Confederated Tribes of the Colville Reservation; Bob Battles, Association of Washington Business (AWB); Kim Williams, Camano Island Fire and Rescure; Jeff Gombosky, Washington Health Care Association and LeadingAge Washington; Onora Lien, Northwest Healthcare Response Network.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.