

MINUTES

**MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION**

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By CHAIRMAN BILL BOHARSKI, on January 22, 1993,
at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Bill Boharski, Chairman (R)
Rep. Bruce Simon, Vice Chairman (R)
Rep. Stella Jean Hansen, Vice Chairman (D)
Rep. Beverly Barnhart (D)
Rep. Ellen Bergman (R)
Rep. John Bohlinger (R)
Rep. Tim Dowell (D)
Rep. Duane Grimes (R)
Rep. Brad Molnar (R)
Rep. Tom Nelson (R)
Rep. Sheila Rice (D)
Rep. Angela Russell (D)
Rep. Tim Sayles (R)
Rep. Liz Smith (R)
Rep. Carolyn Squires (D)
Rep. Bill Strizich (D)

Members Excused: None

Members Absent: None

Staff Present: David Niss, Legislative Council
Alyce Rice, Committee Secretary

Please Note: These are summary minutes. Testimony and
discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 241, SB 43 con'td., HB 220, HB 211,
HB 238
Executive Action: None

HEARING ON HB 241

Opening Statement by Sponsor:

**REP. BILL STRIZICH, House District 41, Great Falls, said HB 241
seeks to establish minimum standards for clinical laboratory**

practitioners. These include medical technologists, medical specialists, and technicians. There are approximately 900 of these clinical laboratory scientists currently working in Montana. Laboratory scientists perform a range of medical laboratory testing, including cross-matching blood for transfusions, testing for communicable infectious diseases, such as hepatitis and AIDS, evaluating pap smears, and examining blood smears for leukemia. Clinical laboratory practitioners are not currently licensed by the state. There is a direct serious effect of the practice of clinical laboratory science in terms of public health and safety. An error or omission in these tests can result in misdiagnosis in treatment, and could have life and death implications. This compels establishing minimum standards of confidence. This legislation is self-sustained and requires no general fund dollars. There are some amendments which will be explained by the Montana Nurses' Association.

Proponents' Testimony:

Susan Reavis, Medical Technologist, President, Montana Society of Medical Technology (MSMT), said practically every other health care group is licensed. Physicians are relying more and more on the results of laboratory tests for the diagnosis and treatment of their patients. It is imperative that technicians performing laboratory tests are qualified. The public is shocked when they learn that tests are being performed on them and their children by unlicensed technologists with no assurance that they are qualified. **Ms. Reavis** said it is time to protect the public and asked for the committee's support.

Anne Weber, President-Elect, Montana Society of Medical Technology (MSMT), said HB 241 was submitted to the legislative audit committee, under the sunrise law, and received unanimous approval. General fund dollars will not be used for the legislation. License fees will be paid by the licensees. When a person has a serious infection, the clinical laboratory practitioners do the cultures, determine the cause of invasion, and decide which antibiotic drug should be used for treatment. They also perform blood tests for diagnosis of diseases such as AIDS and hepatitis, test blood for transfusions, cholesterol, and evaluate pap smears. The bill defines three levels of practice; the clinical laboratory scientist, clinical laboratory specialist, and clinical laboratory technician. These practitioners would be required to have a license. Pathologists in other positions, licensed professionals who perform critical laboratory tests under their scope of practice, and professionals who perform only waived tests as defined by federal law are exempt. Waived tests are defined as methodologies simple enough to render the likelihood of erroneous results negligible.

Sonja Bennett, St. Vincent Hospital, Billings, supports HB 241.

Brian Sanders, Governmental Relations Liaison, Montana Chapter of the Clinical Laboratory Managers Association (MTCLMA). Written

testimony. **EXHIBITS 1 and 2.**

Karen Searle, Laboratory Manager, Livingston Memorial Hospital, Livingston. Written testimony. **EXHIBIT 3.**

Dr. John Pullman, MD, Butte, said the complexity of testing technology being utilized now is beyond the scope of most physicians who haven't been to medical school in the last few years. HB 241 is a very necessary part of improving health care in Montana.

Dr. Joe Rizza, Pathologist, St. Peter's Hospital, Helena, said he taught medical technologists for four years in Richmond, Virginia. **Dr. Rizza** said although people can be taught to push buttons on a machine, a medical technologist's education, which allows this person to do the tests efficiently, cannot be replaced. Medical technologists' knowledge of medicine allows them to inform the physician whether or not laboratory tests are valid. Medical technologists find many errors in tests done in laboratories by unqualified personnel. **Dr. Rizza** supports HB 241.

Dr. Doug Abbott, Chief, Public Health Laboratory Bureau, Department of Health and Environmental Sciences, said if we want to provide quality laboratory work, we need to make sure that the people doing the testing are adequately trained, and qualified. While most laboratories, like hospital laboratories, have strict personnel requirements, there are still many places where testing can, and is being done by people who are not adequately trained and supervised. Time and again, **Dr. Abbott** has had to redo work on patients who have been misdiagnosed because of false results on tests done by unqualified people in unregulated laboratories. Most of the errors have had minor impact on patients. Some of them have been devastating. **Dr. Abbott** said over the last eight years, his laboratory has tested tens of thousands of patients for infection by the AIDS virus. During that time period they had five patients who were tested in other laboratories, and told that their AIDS test was positive. When **Dr. Abbott's** laboratory tested their specimens, it was determined they did not have AIDS. **Dr. Abbott** told of a family who went through a needless nightmare because their son was misdiagnosed as having AIDS by unqualified laboratory personnel.

Chuck Volf, Medical Technologist, Montana Deaconess Medical Center, Great Falls. Written testimony. **EXHIBIT 4.**

Shannon Knuechel, Medical Technologist, Montana State Hospital, Warm Springs, supports HB 241.

Scott Steinfeldt, President, Medical Reference Laboratory. Written testimony. **EXHIBIT 5.**

Anita Osborne, consumer, passage of HB 241 is important to provide protection for all consumers of health care services in

Montana.

Mary Kaye Bleile, consumer, supports HB 241.

REP. JOHN BOHLINGER, House District, 94, Billings, said medical technology is a profession that has no margin of error because it deals in life and death consequences. It is a high-stress profession that calls for rigid academic standards, and it must be that way in order to protect the public. REP. BOHLINGER urged the committee to pass HB 241.

John DenHerder, Clinical Laboratory Scientist, said he was a laboratory health care surveyor from 1975 to 1985. No erroneous laboratory test results should ever reach the physician and ultimately affect that patient. The product is only as good as the tools one has to work with. The product in this case is accuracy of laboratory testing. The tool is qualified, competent personnel; medical technologists who have integrity.

Barbara Booher, Executive Director, Montana Nurses' Association. Written testimony by Wally Henkelman, Registered Nurse, Montana Nurses' Association. EXHIBIT 6.

Kay Crull, Clinical Laboratory Specialist, Laboratory Director, American Red Cross Blood Services, Missoula. Written testimony. EXHIBIT 7.

Deborah Hanson, Clinical Laboratory Technician, Great Falls. Written testimony. EXHIBIT 8.

Kendra Lamb, Blood Bank Supervisor, St. Patrick Hospital, Missoula. Written testimony. EXHIBIT 9.

Russell Morrison, Montana Chapter President, Clinical Laboratory Management Association, Billings. Written testimony. EXHIBIT 10.

Opponents' Testimony:

Kyle Hopstad, Administrator, Frances Mahon Deaconess, Glasgow, said medical technologists that work in the FMD laboratory spend about 25% of their time testing and retesting to make sure that the tests are meeting requirements dictated by Medicare regulations, and the College of American Technology. HB 241 does not clarify if all personnel must be medical technologists. This would create a concern of cost to hospital laboratories, and put up barriers for recruitment.

Informational Testimony:

None

Questions From Committee Members and Responses:

REP. SIMON asked REP. STRIZICH to explain why HB 241 doesn't address continuing education. REP. STRIZICH replied that in section 7, page nine, line 14 of the bill, there is a requirement for continuing education.

REP. SIMON asked Mr. Sanders how many physicians in the state are qualified to direct a high-complexity laboratory. Mr. Sanders replied approximately 100.

REP. HANSEN asked Ms. Weber if there is presently a system in place for continuing education. Ms. Weber said the Montana Society for Medical Technology has an education program with an education chairperson who manages workshops and seminars statewide.

REP. MOLNAR asked Ms. Reavis how many non-waived tests are currently being performed in physicians' offices. Ms. Reavis said basically every type of test is being performed in physicians' office laboratories. Sometimes physicians will ask nurses or office staff to do laboratory testing. These people have not had sufficient education to perform these tests.

REP. MOLNAR asked Ms. Jamison if enough medical technologists are being trained in Montana to handle the demand so wages don't skyrocket in rural and urban areas. Ms. Jamison said Montana State University and University of Montana have programs that meet the requirements of HB 241. Classes can also be taken at a vocational educational school, but it takes 60 hours to graduate, with six hours in micro-biology and six hours in chemistry. Currently there are 900 people who would come in through the grandfather clause and step into the three different categories, the specialist, technologist, and technician.

CHAIRMAN BOHARSKI asked Ms. Jamison if there is any documentation, such as insurance settlements or lawsuits, based upon inadequate testing. Ms. Jamison said she didn't have it with her but would get it for the committee.

Closing by Sponsor:

REP. STRIZICH cautioned the committee not to confuse what HB 241 is doing with the federal regulations about laboratories. Duplicity of testing has nothing to do with this bill. The intent of this bill is not to regulate physician assistants' practice, it is quality of tests. Don't get confused, confusion kills bills.

HEARING ON SB 43

VICE CHAIRMAN BRUCE SIMON assumed the chair for the duration of SB 43, which is a continuation from a previous meeting. The sponsor's opening statement was during that meeting. Proponents

and opponents who did not receive sufficient notice to be able to testify will be allowed to testify during this hearing.

Opening Statement by Sponsor:

None

Proponents' Testimony:

Gary Kenner, Chief Executive Officer and Administrator, Bozeman Deaconess Hospital, Bozeman. Written testimony. EXHIBIT 11.

Opponents' Testimony:

Rob Hunter, Employee Benefit Management Services, Billings, said sunsetting of the lien is purely in the interest of Blue Cross and Blue Shield. Continuance of the health care lien act is directly opposed to the interest of clients, and will reduce their options.

Dennis McSweeney, Physicians' Management Services, said this is a time when medical cost containment is a paramount concern to both the state and this nation. The passage of this bill could seriously injure some of the cost containment efforts.

Terry Minow, Montana Federation of Teachers, Montana Federation of State Employees, Montana Federation of Health Care Employees, said all three federations are strongly opposed to SB 43. Cost containment is an important part of any health care reform. SB 43 encourages the rise in health care costs.

Revenna Robson, Clinic Administrator, Park Clinic, Livingston, stated Park Clinic opposes SB 43.

Informational Testimony:

Tanya Ask, Blue Cross and Blue Shield of Montana. EXHIBIT 12.

Questions From Committee Members and Responses:

None

Closing by Sponsor:

SEN. DOHERTY closed.

HEARING ON HB 220

Opening Statement by Sponsor:

REP. BRUCE SIMON, House District 91, Billings, said HB 220 requires a health care facility to notify an emergency services provider of exposure to an infectious disease. REP. SIMON asked

the committee members to keep in mind, while listening to testimony, how they would feel if one of their loved ones was an emergency services provider. People who provide emergency services may accidentally be exposed to an infectious disease. Section 2 of the bill requires the health care facility receiving the patient to notify the highest ranking officer of the organization employing the emergency services provider of the exposure. The officer must then notify the exposed individual. Under current law the physician has to believe that the unprotected exposure is capable of transmitting the infectious disease. The current law leaves the judgment up to a physician who wasn't at the site of the exposure, to decide if the exposure was significant. If a provider believes he has been exposed, he can file a request to find out if he has been exposed.

Proponents' Testimony:

Tim Bergstrom, Montana State Council of Professional Fire Fighters, said over the past few years the issue of infectious diseases has taken on a new and urgent meaning with the advent of AIDS, hepatitis, and tuberculosis. The 1991 Death/Injury survey, published by the International Association of Firefighters shows that one in twenty-seven firefighters was exposed to a communicable disease in 1991. The breakdown was 14.7% exposed to tuberculosis, 36.9% exposed to HIV, 17.2% exposed to hepatitis B, and 32.2% exposed to other communicable diseases. Emergency service providers have tried to alleviate risk of exposure by wearing rubber gloves, safety glasses, and other protective garments. Proper disinfectant agents are also used. Training has been given to emergency service providers in universal blood and body precautions, barrier techniques, and other scientifically accepted infection control policies. Fire fighters routinely respond to victims who have been injured and are actively bleeding. Many times the victim may require extrication from a motor vehicle or a poorly accessible building. If the victim is bleeding profusely and needs to be extricated quickly, the emergency service provider may act in haste, without regard for his own safety. All of these factors place the emergency service providers at increased risk of contracting blood borne contagious diseases through a puncture wound, an abrasion or laceration, that can become infected by contaminated blood. There may be broken glass, torn metal or other sharp objects at the scene which are hard to see because lighting is minimal. Many times the victim is combative. An emergency service provider was called to respond to a suicide attempt. The victim had slashed both wrists, and was bleeding profusely. The victim didn't want medical aid and punched the provider in the mouth with a blood-soaked fist. Sometimes victims bite emergency service providers when they are trying to render aid.

The infectious disease status of the victim is almost never known while aid is being given. Many emergency service providers have been immunized against hepatitis B. However, a significant number of providers that are vaccinated don't develop the

antibodies necessary to provide adequate immunization. Many employers have made no provision for follow-up testing to determine the effectiveness of the vaccination. Presently, hepatitis B and C are incurable. There is no serum developed at this time for hepatitis C. Tuberculosis is transmitted by individuals with active infections through air-borne respiratory droplets. These droplets can be produced by coughing and sneezing, but they can also be produced by talking. The droplets can survive for several minutes. The herpes simplex virus is among the most common maladies affecting humans. This virus is responsible for chicken pox and mononucleosis. HB 220 is desperately needed to provide for the well-being of emergency service providers and their families.

Edward Flies, Montana State Council of Professional Fire Fighters, said in Helena, three out of four calls are medical emergencies and they are never in a clean, safe environment. **Mr. Flies** urged the committee's support of HB 220.

Mike Foster, Fire Chief and Exposure Control Officer, Helena Fire Department, said the field is a difficult arena to work in. It is not the sterile environment in which most emergency care providers have in a hospital. There was a recent incident in Helena in which an emergency care provider became exposed. The provider was called to a scene where a man was having respiratory difficulties. In the process of administering aid, the victim developed mucous and blood in his airway which the provider tried to alleviate. The provider suctioned his airway to keep him breathing until he could get to the hospital. During that procedure the victim coughed and blew bloody sputum into the provider's face. Some of the sputum got into the provider's mouth. When the provider returned to the station, after taking all the precautions he could, he filled out the appropriate paperwork and contacted **Mr. Foster**. **Mr. Foster** said he immediately took the paperwork to the hospital. The emergency room nurse refused to accept receipt of the exposure control form which is required by law. The emergency room physician also refused to accept the form and sign a receipt. Without accepting the form and signing a receipt, there is no possible way to find out if the victim had an infectious disease. After a lengthy discussion the physician finally told the nurse to take the form and sign the receipt, but did not notify the department whether or not the victim had an infectious disease. **Mr. Foster** urged the committee to support HB 220.

Vern Erickson, Montana State Firemen's Association, urged the committee to support HB 220.

Jim Ahrens, President, Montana Hospital Association (MHA), said MHA supports HB 220.

REP. SAYLES, House District 61, Missoula, said he has been a volunteer fireman for twenty-one years, an emergency medical technician for thirteen years, and supports HB 220.

Opponents' Testimony:

None

Questions From Committee Members and Responses:

REP. MOLNAR said he supports HB 220, but is concerned that someone might challenge the confidentiality rights of a victim, who is the only one being transported to the hospital at the time. REP. MOLNAR told Mr. Bergstrom that part of the bill should be edited to clearly ensure the victim's confidentiality. Mr. Bergstrom said that was a good point and he would be willing to work with the committee to clarify it.

REP. SAYLES asked Mr. Erickson if it was true that under the Montana confidentiality Act, records cannot be released from the fire department. Mr. Bergstrom said that is true. If any type of confidentiality breach is suspected, the records are filed in a locked case, and not even the news media has access to them.

Closing by Sponsor:

REP. SIMON said emergency service providers are extraordinary people who are willing to put their lives on the line to protect others. He asked the committee to support HB 220.

HEARING ON HB 211

Opening Statement by Sponsor:

REP. VIVIAN BROOKE, House District 56, Missoula, said HB 211 provides licensure for residential and inpatient hospice facilities. In this age of rising health care costs, restricted access to appropriate health care facilities, and an increasing population of terminally ill citizens, this bill is an important and necessary piece of legislation. There are nineteen hospice organizations in Montana. EXHIBIT 13.

Proponents' Testimony:

Bonnie Adee, Manager, Hospice of St. Peter's, Helena, Montana Hospice Organization Legislative Committee. Written testimony. EXHIBIT 14.

REP. LIZ SMITH, House District 48, Deer Lodge, said she has been the Nurse Director for Hospice of Powell County for ten years. She asked the committee to support HB 211.

John Flink, Vice President, Montana Hospital Association (MHA), Helena. MHA supports HB 211.

Mike Craig, Bureau Chief, Licensure Bureau, Department of Health and Environmental Sciences. Written testimony. EXHIBIT 15.

Russell Meech, Assistant Administrator, Horizon Health Care Corporation, Great Falls. Written testimony. EXHIBIT 16.

Bernice Bjertness, Director, Big Sky Hospice, President, Montana Hospice Organization Billings. Written testimony. EXHIBIT 17.

Dallas Rychener, Executive Director, Partners in Home Care, Inc., Missoula. Written testimony. EXHIBIT 18

Ira Byock, Medical Director, Mountain West Hospice, Missoula. Written testimony. EXHIBIT 19

The following individuals from Big Sky Hospice, Billings, presented written testimony:

Patricia Peters, R.N. EXHIBIT 20

Mary Van Zandt, R.N. EXHIBIT 21

Beth Emard, R.N. EXHIBIT 22

Mary Dyrud, R.N. EXHIBIT 23

Roxanne Allen, R.N. EXHIBIT 24

Pam Feldman, R.N. EXHIBIT 25

Shirley Ratcliff, R.N. EXHIBIT 26

Kathy Wendeln, R.N. EXHIBIT 27

Loretta Foley, R.N. EXHIBIT 28

Johnna Brumit, R.N. EXHIBIT 29

Cindy Enderson, R.N. EXHIBIT 30

Marianne Fisher, R.N. EXHIBIT 31

Marjorie Hansen, R.N. EXHIBIT 32

Cathy Miller, R.N. EXHIBIT 33

Julie Jardine, R.N., Manager, Gateway Hospice, Livingston. Written testimony. EXHIBIT 34.

Peter Kozisek, M.D., Helena Family Physicians, Helena. Written testimony. EXHIBIT 35.

Thomas Warr, M.D., Northwest Medical Offices, Great Falls. Written testimony. EXHIBIT 36.

Kathryn Ravenscraft, Hospice Coordinator, Fallon Medical Complex, Baker. Written testimony. EXHIBIT 37.

Opponents' Testimony: None

Questions From Committee Members and Responses:

REP. SIMON asked Mike Craig if the department could establish fees to recover costs in the process of licensure. Mr. Craig said existing law allows the department to establish fees. REP. SIMON asked Mr. Craig if hospice facilities would have to go through the certificate of need process. Mr. Craig replied hospice facilities do not have to go through the certificate of need process.

CHAIRMAN BOHARSKI asked Mr. Craig why the department can't provide licensure to hospice facilities without the bill. Mr. Craig said the department believes it needs the legislature's direction to develop licensure standards. CHAIRMAN BOHARSKI asked Mr. Craig if residential hospice facilities are eligible for Medicaid or Medicare reimbursement. Mr. Craig said these facilities would not be eligible. CHAIRMAN BOHARSKI asked Mr. Craig how the department is going to administer more rules in light of the budget cuts. Mr. Craig said rulemaking does have a cost attached to it and the department does not budget for rulemaking when it goes through the appropriations process. The department will do the best it can within its given resources, probably taking longer to accommodate the intent of the bill.

Closing by Sponsor:

REP. BROOKE said this is an important piece of legislation for all of us because we will all be there some day.

HEARING ON HB 238

Opening Statement by Sponsor:

REP. LIZ SMITH, House District 48, Deer Lodge said Montana has had statutes since 1974 which allow the state to investigate a parent's ability to help pay the cost of their child's care, when placed outside the family home. These statutes, however, did not give the state adequate authority to require a contribution toward the cost of care or a means to collect any amount owed. Last session the statutes were amended to require the court to make a finding regarding the parent's ability to contribute to the cost of care while the child is committed to the custody of the Department of Family Services. The statutes now provide that the Child Support Enforcement Division of Social and Rehabilitation Services, will collect any amount owed by parents pursuant to court order. The amount owed is to be calculated by the court, according to the child support guidelines currently used. HB 238 allows inquiry into the financial resources of a parent or guardian during an investigation of alleged abuse or neglect of a child for the purpose of determining eligibility for federal program funding or parental contribution for the cost of

out-of-home care for the child.

Proponents' Testimony:

Ann Gilkey, Legal Counsel, Department of Family Services.
Written testimony. EXHIBIT 38 and 39.

Opponents' Testimony:

None

Questions From Committee Members and Responses:

REP. SAYLES asked **Ms. Gilkey** in what part of the bill she planned to insert the amendment she presented. **Ms. Gilkey** said the amendment would become section 2, and the present section 2 would become section 3.

REP. GRIMES asked **Ms. Gilkey** to give an example of parents who are able to support a child in foster care but don't, and address what happens to the lower income parents who may not be able to contribute. **Ms. Gilkey** said there are some parents who are very affluent, who do not pay for the care of their child while in foster care, including bankers, doctors, and lawyers. The bill will help the department obtain funding for services to the low income parents who would be eligible for federal assistance programs.

Closing by Sponsor:

REP. SMITH closed.

ADJOURNMENT

Adjournment: The meeting adjourned at 6:36 p.m.

Wm E Boharski

WILLIAM BOHARSKI, Chair

Alyce Rice

ALYCE RICE, Secretary

WB/ar

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING

COMMITTEE

ROLL CALL

DATE

1/22/93

NAME	PRESENT	ABSENT	EXCUSED
REP. BILL BOHARSKI, CHAIRMAN	✓		
REP. BRUCE SIMON, VICE CHAIRMAN	✓		
REP. STELLA JEAN HANSEN, V. CHAIR	✓		
REP. BEVERLY BARNHART	✓		
REP. ELLEN BERGMAN	✓		
REP. JOHN BOHLINGER	✓		
REP. TIM DOWELL	✓		
REP. DUANE GRIMES	✓		
REP. BRAD MOLNAR	✓		
REP. TOM NELSON	✓		
REP. SHEILA RICE	✓		
REP. ANGELA RUSSELL	✓		
REP. TIM SAYLES	✓		
REP. LIZ SMITH	✓		
REP. CAROLYN SQUIRES	✓		
REP. BILL STRIZICH	✓		

EXHIBIT 1
DATE 1-22-93
HB 241

January 21st, 1993

J. Brian Sanders
Director of Special Projects
1400 29th Street South
Great Falls, MT 59405
406-454-2171 ext. 398

Members of the House Health Services Committee
Montana State Legislature
Helena, MT

RE: HB241 - Clinical Laboratory Science Practice Act

Honorable Members of the House:

My name is Brian Sanders and I am the Governmental Relations Liaison for the Montana Chapter of the Clinical Laboratory Management Association. I am also the Director of Special Projects for Medical Reference Laboratories with duties that include the management of five laboratories in Montana and act as a laboratory consultant with physician office laboratories and hospital laboratories throughout Montana, Wyoming and the Dakota's. The membership of the Montana Chapter of CLMA, will be on the front line in the day-to-day administration of this legislation. Through our consensus process, we have voted overwhelmingly in favor of this bill. I am here today to introduce you to sections 6 & 7 of this bill which cover the composition and duties of the Clinical Laboratory Science Board as defined in Section 3.

The major purpose behind the Board is to administer, promulgate and enforce the rules and regulations that will be used to establish specific criteria for qualification of licensure, renewal, and to set fees, establish investigatory procedures, establish continuing education requirements, and disciplinary requirements. All of these items will be decided by the board using the framework established in other sections of this bill.

The Board will be composed of five (5) members. One of those members will be a licensed physician who also qualifies as a director of a high complexity lab as set forth under Federal regulations known as the CLIA regulations. This for all practical purposes will most likely be a Board Certified Pathologist. Three members will be clinical laboratory science practitioners who are qualified under section 7 of this bill. The last member of the Board will be a private citizen who previously was not associated with or financially interested in the practice of clinical laboratory science.

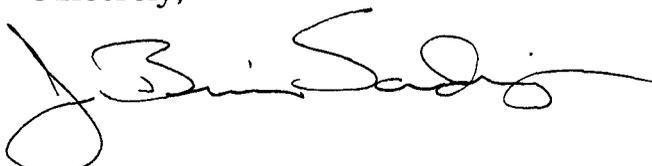
The members of the Board will serve terms of four years. The initial appointments will be in a staggered fashion such that three members will be serving four year terms and two will be serving two year terms. No member shall serve more than two consecutive terms.

The philosophy behind the Board's composition is as follows... The physician member can offer a global perspective to the operation of laboratories in light of the total health care delivery system. The three clinical laboratory science practitioners bring a specific level of expertise in the day today operation of clinical laboratories. The private citizen will act as a controlling influence and offer a non-medical perspective.

The duties prescribed in these sections follow, in a very similar nature, the duties of Boards that administer other licensed professionals in the State of Montana. Board members will meet at a minimum of once per year and at other times as required under this act to perform those duties. The Board members are also entitled to compensation and travel expenses as provided by law.

I will make myself available to you at any time should you have questions regarding these sections and any other concerns you may have concerning this legislation. I thank you for your time.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Brian Sanders". The signature is fluid and cursive, with a large initial "J" and "S".

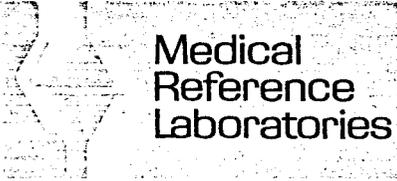
J. Brian Sanders MT(ASCP)

Governmental Relations Liaison
Montana Chapter of CLMA

Director of Special Projects
Medical Reference Laboratories

EXHIBIT 2
DATE 1-22-93
HB 241

January 18th, 1993



J. Brian Sanders
Director of Special Projects
1400 29th Street South
Great Falls, MT 59405
406-454-2171 ext 398

Members of the House Health Services Committee
Montana State Legislature
Helena, MT

RE: Clinical Laboratory Science Practice Act

Honorable Members of the House:

My name is Brian Sanders and I am here as the Governmental Relations Liaison of the Montana Chapter of the Clinical Laboratory Management Association. I am also Director of Special Projects for Medical Reference Laboratories. My responsibilities include the management of the Great Falls Clinic Laboratory & Satellite Lab, the Central Montana Medical Center Laboratory, and Medical Reference Laboratory's Butte facility. In addition, I act as a technical laboratory consultant for other rural hospitals and physician office labs throughout Montana, Wyoming and South Dakota. I feel that these positions uniquely qualify me to speak toward the effect personnel licensure will have on the management and operation of clinical laboratories in Montana. The Montana Chapter of CLMA has, through its consensus process, voted overwhelmingly in favor of this licensure bill. As a representative of the professional organization who's members will be responsible for the day to day implementation of this legislation, we can say that the people of the State of Montana will be better served by this bill than without it.

Over the past years, I have had the opportunity to visit, inspect and consult with many rural hospital labs and physician office laboratories. Those facilities success or failure invariably has related directly to the quality of personnel in those facilities. Those laboratories with qualified technologists have had little problem in meeting the new Federal CLIA requirements. Those laboratories with unqualified personnel have no concept of what is expected of them under the new regulations. Common laboratory practices such as the statistical analysis of quality control material, quality assurance plans, proficiency testing, OSHA chemical & bloodborne pathogen safety policies etc., all have come as something new to them.

The future ability of the State of Montana to continue to provide quality laboratory service to all of its citizens will be determined by the quality of its

laboratory personnel. One criticism of this legislation is that the cost of hiring qualified personnel as described in this bill will drive facilities out of business and thus reduce the access to care. I am here to testify before you today that just the opposite will be the case. The ability of unqualified personnel to maintain their laboratories up to the standards described under the CLIA amendments and avoid sanctions, is much less than from those facilities operated by qualified personnel. In addition, the risk of closure due to malpractice suits and poor operational management is much greater in the poorly staffed laboratory than in the well staffed one.

Included with my testimony today is a letter from Karen Searle. She is the manager of the laboratory at the Livingston Memorial Hospital. Included in that letter is a personal experience of her late Uncle with a hospital in this state. Unqualified laboratory personnel incorrectly processed a unit of blood and transfused this blood into her Uncle. What is known as a hemolytic transfusion reaction followed that was contributory to her Uncle's death. This hospital is now closed. I'm convinced that the kind of laboratory services Karen's uncle received was related to this hospital's closure. The community is now having to reduce their expectations as to the level of health care available to them. If this licensure bill had been law then, this unfortunate set of circumstances could very well have been avoided.

From a purely economic standpoint alone, the clinical laboratory is better off being run by someone fully conversant in all aspects of clinical laboratory science than by someone trained 'on the job'. Hidden costs such as calibration intervals, proficiency testing, troubleshooting and outdating, to mention just a few, can quickly take an otherwise solvent institution to one which could financially cripple a hospital or medical practice. Some unscrupulous vendors are trying to sell small laboratories in this state, test systems, that have tremendously high hidden operating costs. Without a complete knowledge of appropriate test volume, test menu, proficiency testing costs, calibration intervals, repeat rate etc., these analyzers will soon financially ruin these small labs. In the next few years, as the inevitable restructuring of our country's medical delivery system takes shape, only those laboratories managed by competent, well trained individuals will be able to continue to provide the kinds of services the people of Montana have come to expect. This licensure bill is not designed to create a kind of guild, but to help Montana protect itself from the regulatory and financial pitfalls that are just around the corner.

Much has been said regarding the advances in technology available to the modern clinical laboratory. Manufacturers are often telling us how 'foolproof' and easy to use their kits or instruments are. My twenty years of experience in the laboratory field tells me that no instrument is 'foolproof'. In fact, the more technically sophisticated the system is, the more subtle the errors are. What does it matter that the instrument delivers numbers when the operator of that instrument has no idea what those numbers mean or even if they are appropriate to the patient in question?

Not long ago I was the technical supervisor of a chemistry department and had the unfortunate experience of having to recall reports on 75 patients run the night before. The technician running the analyzer, who was an 'on the job' trained employee had turned out all 75 patients with one of the tests having the exact same number. Every single one of those 75 patients had a test result value of 54! When questioned as to how this could happen, his reply was that he had run the controls and they were fine. Unfortunately, shortly after those controls were run, the particular test reagent in question became contaminated. His lack of understanding of this test, the functioning of the instrument and the clinical implications of this test, gave him a false sense of security. While the error was caught in time for most patients, several patients had already been contacted by their physicians for follow-up testing. The resulting confusion and re-testing at this facility cost the laboratory alone over \$3,000.00. Any formally educated technologist would never had let those results go out to the physicians. As a result of this error, the facility had a severe credibility gap with regard to both its client physicians and the patients themselves. This facility was soon forced to modify its hiring policies such that only certified technicians or technologists would be performing laboratory tests. Again, State Licensure would have prevented this incident.

The technical requirements of a modern clinical laboratory require cutting edge technology. A good example is the testing for levels of the drug digoxin. This medication is used by many Montanans to control irregular heartbeats. The drug is highly toxic and must be carefully monitored by the patients physician. This drug is effective at a concentration of 0.5 to 2.0 nanograms per milliliter. What's a nanogram? It is the equivalent of one shot of whiskey in six miles of railroad tanker cars! For a test system to accurately and reliably find that small a quantity, everything must work perfectly! I could list for you over thirty different things that could go wrong with this assay that could dramatically effect the results. Yet this assay could be performed by an individual who's only qualifications are a high school diploma and has been told by the manufacturer that this assay system is easy to use and 'foolproof'.

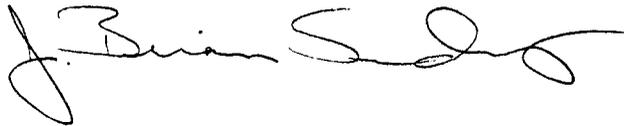
I was at a conference of laboratory managers in Washington D.C. a couple of years back where a Congressional Representative told this audience that he was assured by instrument representatives that there were foolproof instruments already on the market. This Congressional Representative was almost laughed off the podium. Yes, the technology is sophisticated, yes, it is often very easy to use. ...but foolproof? It just isn't so. Yet, hospital administrators all over this country are being sold just such a myth. A tremendous misunderstanding of the complex nature surrounding clinical laboratories is creating an image of a laboratory where anyone off the street could come in and function adequately.

Montana cannot afford to be taken in by the Myth of the easy, foolproof laboratory test. State licensure of clinical laboratory practitioners is very important to the State of Montana. As a manager and consultant to clinical laboratories of all sizes, I can tell you without reservation, that the use of

SEARCHED _____
SERIALIZED 1/22/93
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FILED _____

qualified, licensed personnel is the best way for Montana to assure its citizens of continued quality laboratory service in the future .

Sincerely,

A handwritten signature in black ink, appearing to read "J. Brian Sanders". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

J. Brian Sanders MT(ASCP)

Director of Special Projects
Medical Reference Laboratories

Governmental Relations Liason
Montana Chapter of Clinical Laboratory Management Association

Possible Digoxin Errors

Instrument

1. Voltage
2. Temperature of reaction area
3. Optic calibration
4. Optic maintenance (cleanliness)
4. Syringe maintenance
5. Probe positions
6. Cuvette condition
7. Pipet calibration
8. Pipet maintenance

Controls

9. Outdating
10. Matrix effects
11. Storage Temperature
12. Working Temperature
13. Trend analysis
14. Suitability of values to clinical values

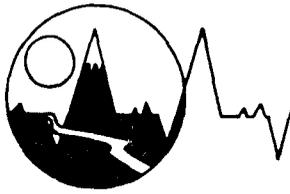
Reagents

15. Reagent dating
16. Calibrator dating
17. Analysis temperature
18. Storage temperature
19. Shipped temperature
20. Exposure to air
21. Exposure to light
22. Humidity (desiccation or condensation)

Sample

23. Collection procedure
24. Specimen processing
25. Specimen storage
26. Specimen temperature at time of analysis
27. Specimen identification
28. Time of last dose
29. Other medications
30. Age

HB 241
1/22/93



**LIVINGSTON
MEMORIAL
HOSPITAL**

EXHIBIT 3
DATE 1-22-93
HB 241

Livingston Memorial Hospital
504 South 13th Street
Livingston, Montana 59047
December 11, 1992

Brian Sanders
Government Relations Liaison
Great Falls Clinic
1400 29th Street S
Great Falls, MT 59405

Dear Mr. Sanders,

It is my intention to testify during the January hearings for the Personnel Licensure Bill. In the event that these hearings are scheduled during the CLMA mid-year meeting in San Antonio, then I will be unavailable and I want you to present this information.

I do not believe that it should be entirely a matter of scaring ourselves into the idea of personnel licensure. Somewhere "right reason" should prevail. I've included a copy of the ASCP Clinical Laboratory Levels of Practice and the companion book developed by the Competence Assurance Council of ASMT titled Model Criteria For Peer Review. I would ask the legislators to please review this material to get a sense of the volumes of technical information that we are taking about when we refer to the work that a laboratory technician does on a day to day basis. It is lengthy and it is detailed, but by no means comprehensive. Not something that a high school graduate can readily assimilate.

On the other hand, if it is "war stories" that you want, I can tell a few that will point to the seriousness of the matter of licensure. One situation that impacted my family very dramatically occurred a few years ago. My uncle became anemic and required blood transfusions. He was given the wrong type of blood as a result of testing by an unqualified laboratory worker. This person typed my uncle incorrectly. Not a matter of making a clerical error as you might expect to be the cause of an ABO Incompatibility. The result was a hemolytic transfusion reaction that then was not even recognized by the laboratory worker. Now when a person is given ABO incompatible blood, a hemolytic transfusion reaction results. That means his body hemolyzed the transfused cells and they plugged his kidneys. Without functioning kidneys you die. This was but a factor in my uncle's death as there were comorbidities.

Again, this was not a case that you heard about in the papers because my aunt chose not to sue, she did not want to press action that would financially impair the hospital. Not surprisingly, that hospital recently closed its doors.

Testing errors do not always result in fatalities. Errors or negligence may result in serious consequences for patients, disruption of hospital operations or serious financial loss. The cost of unwarranted follow up testing is a wasted resource. For example if liver enzymes are reported as abnormal, the patient may be scheduled for an unnecessary nuclear scan costing hundreds of dollars. (This has happened.) Patients being helicoptered to regional centers for treatment of a myocardial infarction only to find that the referral diagnosis was incorrect. (This has happened.) Costly mistakes.

Ignorance of the technical issues surrounding testing can result in false negatives. I'm referring specifically to a clinic in a neighboring town who could not seem to understand the importance of CO2 enrichment for culturing of Neisseria. The patients were being charged, and they were getting results that were "Negative for GC". The only thing worse than having venereal disease is having it and being told that you are clear.

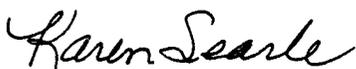
This same clinic lab (staffed with unregistered personnel) repeatedly draws the wrong vacutainer tubes for certain tests. Because they never developed an understanding of specimen requirements, they submit specimens that do not produce valid test results for specific testing methodologies.

Take the most common blood test that a diabetic requires: glucose. Here you are striving for accuracy of testing because good control of diabetes prolongs life. Again, it may not be a matter of an individual glucose result contributing to demise, however, over time, the patient develops symptoms of poorly controlled diabetes (loss of vision, loss of circulation, etc) and poor quality of life.

What about the drug store cholesterol story relayed to me by a coworker. The results were 165, 165, 165, 165, patient after patient only to find that this was an error code for the machine. Again, lack of basic understanding of the technology. Easy to learn how to push the button. Hard to learn what to do with the information that is generated. To determine the clinical relevance of test results and balance that quality control data?

In conclusion, errors or negligence by laboratory workers may result in serious consequences for patients, disruption of hospital operations or serious financial loss. Please urge the legislators to facilitate adoption of this licensure bill to ensure that qualified licensed workers perform laboratory testing.

Sincerely,



Karen Searle
Laboratory Manager
Livingston Memorial Hospital

Ladies and Gentlemen of the House Human Services Committee

My name is Chuck Volf. I am a Medical Technologist and have worked in the laboratory at Montana Deaconess Medical Center in Great Falls for the past 16 1/2 years. I feel it is my honor and privilege to stand before you today and ask for your support of HB 241 which recommends state licensure of Clinical Laboratory Practitioners.

As stated through previous testimony, the main purpose of the bill is to provide for the continued public safety our state now enjoys, but due to the passage of CLIA 88 by our federal government and the laboratory personnel standards that are being implemented, this experience of public safety may deteriorate.

We are virtually the only allied health profession which reports medical data to the attending physicians without interpretation by a specialist physician, but we are also one of the only professions without state standards for practice. Does this make sense?

I am privileged to share with you four cases of instances that occurred in our laboratory in the past year that I hope will illustrate the necessity of properly educated people in our profession.

Case #1: A patient was admitted to our hospital for surgery. The patient stated he had antibodies in his blood and gave a list of these antibodies to the Medical Technologist drawing the blood sample. Upon testing, the patients' antibody screen in our Blood Bank, some antibodies were found, but not all that were stated by the patient. Our technologist then called a Denver hospital where his previous surgery was done and confirmed the patient's story. So were we wrong by not finding all the antibodies? No. Antibodies weaken over time and some cannot be detected after only 48 hours. However, our Blood Bank must screen units for all antigens to make sure the patients' antibodies (even the undetected ones) do not get restimulated. So, if the Technologist doing the Blood Banking that day was not aware of the technical implications of antigen-antibody responses, this problem would have gone unnoticed and the patient would have been given blood to which he would have had a reaction and possibly would have died from an acute transfusion reaction.

Case #2: A patient who recently had a kidney and pancreas transplant was regularly having tests done to monitor the organs and to prevent organ rejection. Upon testing, the Technologist noticed the patients' serum was icteric. This usually indicates a liver problem. No liver studies were ordered, so the Technologist did a liver panel and found some enzymes to be 10 times normal. Upon reporting this to the patients' doctor, subsequent testing was done and it was found that the patient was

a carrier of Hepatitis C and was having liver complications due to the disease state. This patient could have died from an illness unrelated to the organ transplant if our Technologist hadn't discovered the icteric serum.

Case #3: A patient came in as an outpatient to have his cholesterol checked. Upon testing, the patient had a cholesterol of 795 mg/dl (4 times normal). His serum was also very lipemic. Because of the lipemia, our Chemistry Technologist did a triglyceride on the serum and received a value of 2,878 (20 times normal). These findings were presented to the doctor and through proper medication and patient diet and exercise, immediate heart problems were averted.

Case #4: Approximately 10 years ago, an uncertified technician was performing screenings of cervical pap smears in a laboratory within our state. This person reported out a "negative" result for a patient that previously had three reports for stage IV cervical cancer. The attending physician inquired into the matter with the pathologist whom verified that the malignancy did appear on the smears.

We hope these experiences will help you to understand the importance of having qualified and properly educated clinicians working in our state wide laboratories. We do not feel this will continue if this bill is not passed. Please help us by recommending passage of HB241.

EXHIBIT 5
DATE 1-22-93
HB 241SENATE COMMITTEE TESTIMONY--CLS PRACTICE ACT
SCOTT STEINFELDT, MEDICAL REFERENCE LABORATORIES, INC.
JANUARY 22, 1993

GOOD MORNING. MY NAME IS SCOTT STEINFELDT. I AM PRESIDENT AND C-E-O OF MEDICAL REFERENCE LABORATORIES, INCORPORATED, A FULL SERVICE, PRIVATELY OWNED AND OPERATED LABORATORY BASED IN MONTANA. I'M HERE TODAY TO TESTIFY IN FAVOR OF HOUSE BILL 241--THE C-L-S PRACTICE ACT.

MEDICAL REFERENCE LABORATORIES, INCORPORATED IS THE LARGEST INDEPENDENTLY OWNED AND OPERATED REFERENCE LABORATORY IN MONTANA, WITH FORTY PERCENT OF THE MARKET SHARE. OUR SERVICE AREA INCLUDES NOT ONLY MONTANA, BUT WYOMING AND PARTS OF SOUTH DAKOTA AND IDAHO AS WELL. WE EMPLOY 65 PEOPLE AND, THROUGH CONTRACT ARRANGEMENTS, ARE INDIRECTLY RESPONSIBLE FOR 150 OTHERS.

AS ADMINISTRATOR FOR MEDICAL REFERENCE LABORATORIES, QUALITY OF SERVICE IS MY NUMBER ONE PRIORITY. FOR THIS REASON, I SUPPORT PASSAGE OF HOUSE BILL 241. I BELIEVE THAT LICENSURE OF CLINICAL LABORATORY SCIENTISTS IS CRUCIAL IN MAINTAINING THE QUALITY OF LAB SERVICES PROVIDED THROUGHOUT THE STATE.

ALTHOUGH THIS BILL WOULD HELP GUARANTEE THAT QUALITY, IT SHOULD ALSO BE NOTED THAT THE BILL WOULD HAVE NO ADVERSE ECONOMIC IMPACT ON OUR BUSINESS OR OUR ABILITY TO PROVIDE COST-EFFECTIVE LABORATORY DATA. THIS IS ESPECIALLY IMPORTANT DURING THESE TIMES OF ECONOMIC CHALLENGES IN OUR STATE.

I WOULD ALSO LIKE TO EMPHASIZE THAT MEDICAL REFERENCE LABORATORIES IS A PRIVATE PROVIDER AND IS NOT AFFILIATED WITH ANY HOSPITAL OR OTHER ORGANIZATION. STILL, WE BELIEVE THAT THE SMALL EXTRA EFFORT REQUIRED FOR C-L-S LICENSURE WILL PAY BIG DIVIDENDS IN THE LONG RUN FOR ALL MONTANANS.

WHEN THE PUBLIC AND OTHERS CONTACT A HEALTH CARE SERVICE ORGANIZATION SUCH AS OURS, THEY EXPECT TO RECEIVE THE BEST QUALITY OF SERVICE AVAILABLE. IT IS POSSIBLE THAT DURING MY TIME AS CHIEF EXECUTIVE OF MRL, SOME OF YOUR FRIENDS AND FAMILY MEMBERS MAY REQUIRE OUR SERVICES. THROUGH A LICENSING PROCESS--SUCH AS THE ONE PROPOSED BY THE C-L-S PRACTICE ACT--I WILL BE ABLE TO GUARANTEE THAT THE PROFESSIONALS IN OUR BUSINESS WHO PROVIDE

THESE SERVICES ARE TRULY CAPABLE AND
COMPETENT IN THEIR SPECIALTY.

EXHIBIT 5
DATE 1/22/93
HB 241

C-L-S PERSONNEL STATEWIDE ARE HIGHLY SCHOOLED
PROFESSIONALS WHO WILL NOT HESITATE TO
UNDERGO A LICENSING PROCESS TO VERIFY THEIR
COMPETENCY AND QUALIFICATIONS. THESE PEOPLE
HAVE ALREADY SUCCESSFULLY COMPLETED A FOUR OR
FIVE YEAR EDUCATION PROGRAM IN THE BIOLOGICAL
SCIENCES AND HAVE FULFILLED A LABORATORY
INTERNSHIP. THEY HAVE ALSO RECEIVED NATIONAL
CERTIFICATION.

FROM AN ADMINISTRATIVE STANDPOINT, THESE ARE
THE PEOPLE I WANT WORKING IN MY LABORATORIES.
I TRUST THEIR ABILITY TO NOT ONLY GATHER
IMPORTANT LABORATORY DATA, BUT TO CORRELATE
THIS DATA WITH A PATIENT'S HISTORY AND OTHER
DATA. WHEN THE PROCESS IS COMPLETE, IT'S
REASONABLE FOR ME TO ASSUME THAT EVERYTHING
HAS BEEN DONE CORRECTLY.

THE ONLY ONES THIS BILL COULD IMPACT WILL BE
THOSE WHOSE QUALIFICATIONS MAY NOT BE
ACCEPTABLE OR VERIFIABLE FOR THE SERVICES
THEY PROVIDE. WITHOUT THE EDUCATION AND

TRAINING REQUIRED BY THE C-L-S PRACTICE ACT,
THESE PEOPLE SIMPLY LACK THE KNOWLEDGE AND
HANDS-ON EXPERIENCE REQUIRED FOR COMPETENCE
IN THIS EXACTING PROFESSION.

5
DATE 1/22/93
HB 241

AS CALLS FOR HEALTH CARE REFORM INCREASE, AN
IMPORTANT ISSUE ARISES CONCERNING "COST" AND
"QUALITY OF SERVICE." SOME BELIEVE THAT AS WE
LOOK FOR WAYS TO KEEP COSTS DOWN, QUALITY OF
SERVICES PROVIDED WILL BE SACRIFICED. HOUSE
BILL 241 WILL GO A LONG WAY TO INSURE THAT--
REGARDLESS OF ANY HEALTH CARE REFORM PLANS--
QUALITY IS NOT SACRIFICED IN THE MONTANA
LABORATORY INDUSTRY.

AS A C-L-S PROFESSIONAL AND ADMINISTRATOR
MYSELF, I CAN ASSURE YOU THAT THIS BILL IS IN
THE BEST INTERESTS OF THE LABORATORY INDUSTRY
AND OF THOSE THE INDUSTRY SERVES. RECOGNIZING
THE IMPORTANCE OF C-L-S LICENSING, BOTH THE
MONTANA SOCIETY OF MEDICAL TECHNICIANS AND
THE CLINICAL LABORATORY MANAGEMENT
ASSOCIATION OF MONTANA HAVE COME OUT IN FAVOR
OF HOUSE BILL 241. I ALSO URGE YOUR SUPPORT
OF THIS IMPORTANT MEASURE.



Montana Nurses' Association

P.O. Box 5718 • Helena, Montana 59604 • 442-6710

EXHIBIT 6
DATE 1-22-93
HB 241

TESTIMONY ON HB 241 (LC142) Before House Human Services Committee
"An act providing for the licensure of clinical laboratory science practitioners; and providing an immediate effective date."

By: Wally Henkelman, RN, Montana Nurses Association

Position: Support

Since the Montana Nurses Association actively supports the provision of quality health care for all the people of Montana, and since clinical laboratory services are essential to the provision of that health care, we support efforts to ensure or enhance the quality of such services. Licensure of clinical laboratory science practitioners and the establishment of a regulatory board for oversight of those practitioners will allow for the implementation of standards for entry into practice, including educational requirements, and for monitoring of practitioners on the basis of competency and ethics.

Montanans seeking health care can already expect that care will be provided by persons who are competent and that, among other things, laboratory results will be as accurate as possible to avoid misdiagnoses which could result in unnecessary or incorrect medical treatment and associated suffering or expenses. This act will provide an additional method of ensuring that those expectations are likely to be met.

Further, based on experience in other states which have established such legislation, we support an amendment to Section 5, paragraph 2, subparagraph a, to delete the word "authorizes" and substitute the phrase, "as defined by that profession's regulatory board, allows". Experience has shown that, regardless of the intent of regulatory legislation, failure to clearly define which agency has regulatory powers over each profession can lead to future "turf battles" over various aspects of practice. This language should help avoid such problems.

lb/Testimony on HB241

EXHIBIT 7
DATE 1-22-93
HB 241

Testimony in Support of HB 241
for Clinical Laboratory Personnel Licensure
January 22, 1993

Thank you for the opportunity of addressing you to express my support for House Bill 241 for Clinical Laboratory Personnel Licensure. My name is Kay Crull. I am a Clinical Laboratory Specialist and have worked in laboratories in Montana since 1979. I currently am employed as the Lab Director at the American Red Cross Blood Services in Missoula. I also hold the volunteer position of Continuing Education Coordinator for the Montana Society for Medical Technology - the professional society for laboratory staff in Montana.

My purpose today is to emphasize two main points in this bill. First, I want to firmly state that this bill ensures that all laboratory personnel that have worked fulltime at least one year of the last three will be issued a license to continue to work in their current capacity. No one would lose their job, and the status of health care in the facilities of Montana would not be affected. Only new practitioners would have to qualify for a license under the provisions of this bill.

The second area I would like to stress that is unstated in the bill is the commitment of our profession to continuing education. The requirements for continuing education that will be adopted by the board will ensure that all laboratory personnel in the state stay abreast of the latest technologies. The medical field changes and improves constantly; thus it is vital that laboratorians keep informed of these changes. This allows us to provide the best service to our physicians and patients. Health care is best provided by an informed clinical laboratory scientist.

Continuing education is available from numerous sources in Montana for laboratorians. The Montana Society for Medical Technology will also expand its current offerings to meet the needs of the profession.

Thank you for the opportunity to address you. Please consider carefully how the quality of health care will be improved by a well-trained, educated laboratory staff. Then, I urge you to recommend a "Do Pass" on this HB241.

Kay Crull, MT(ASCP)
3216 Park Street
Missoula MT 59801

To: Anne Weber

From: Kay Crull

Roads terrible, Judy and I had to turn back at Drummond. Here is testimony. - I'm really sorry -

Kay

January 22, 1993

Testimony for HB 241, Licensure for Clinical Laboratory Practitioners

Mr. Chairman, members of the committee;

I regret that I am not able to be with you today and appreciate the opportunity to give testimony "in absentia". I have been a practicing Clinical Laboratorian for over 16 years. I have worked in a group practice physician laboratory, hospitals and blood banks. I have worked with bachelor deegreed, fully credentialed staff as well as on-the-job-trained people.

While the professional training gives people the ability to question and evaluate the tests they are doing and the results they are reporting, anyone can "push buttons." I would be surprised if a group does not come forward saying that modern technology has made professional level training obsolete.... push button technology means that a high school education is adequate for laboratory work. An integral part of that theory is that the clinical practitioner or physician evaluates each result as to its accuracy based on the clinical picture of the patient.

In reality, modern medicine has become so complex, that no clinician can hope to keep up with all aspects of healthcare. They rely on the expertise of those performing laboratory tests as well as fulfilling prescriptions; administering medications; taking X-rays; giving respiratory, physical or occupational therapy to utilize their educations and be a part of the healthcare team to safeguard those receiving treatment.

While I was working at a hospital, which shall be nameless, a request came for a simple hemoglobin/hematocrit on a patient. This test measures how much of a person's blood is red cells able to carry oxygen to the tissues and is even a waived test according to the government. The sample was drawn, tested and reported. On the basis of the result: 27 percent, which is low; two units of blood were administered to the patient. After transfusion, the test was again ordered and the result was 54 percent. As it is not possible for two units of blood to have that profound of an impact, my investigation revealed that the actual result of the first specimen was 48 percent, high normal. The patient was exposed to two units of blood unnecessarily with the associated risk of disease transmission, was charged over \$200 each for the administration of blood which was not needed, additional venipuncture and testing was done unnecessarily and the clinician never questioned the result. He relied on the person who performed that simple "button pushing", no-brain-required test.

Please help us dedicated laboratory professionals protect the lives of fellow Montanans by recommending a "do pass" on this bill. By assuring that the people performing a test have the training necessary to evaluate it appropriately, you will be adding a safeguard to the practice of medicine in Montana and assisting physicians in the appropriate treatment of their patients.

Thank you for "listening" to me.

Deborah Hanson MBA, MT(ASCP)SBB
Great Falls

A handwritten signature in cursive script that reads "Deborah Hanson". The signature is written in black ink and is positioned below the typed name and address.

EXHIBIT
DATE 1-22-93
HB 241

Kendra Lamb MT (ASCP)
514 4th st. N
Great Falls, MT 59401

1-12-93

re: licensure.

When I was blood bank supervisor at St. Patrick Hospital in Missoula I was asked to give a blood bank "refresher" course to a noncredentialed Medical Technician. This person was working as the only Tech. on a shift at a small rural hospital and was performing crossmatches when necessary. I began reviewing with him at what I thought was a basic level. I could tell by the expression on his face that I was talking at a level over his head. I began quizing him so that I could assess his knowledge and discovered that he didn't even have a grasp of what reverse grouping was.

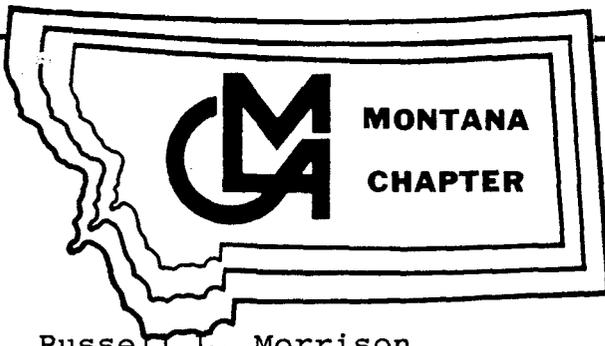
Needless to say; this person did not need a refresher but should have had a year worth of training. The frightening thought about all of this is that this person is currently working in another rural lab and occasionally calls me with crossmatch problems (scary questions!). I actually fear getting into an accident in this area.

I also had experience with another noncredentialed Tech. who had to be removed from the blood bank because he consistently did not perform the required QC testing and misidentified an antibody due to the inability to interpret weak reactions on the antigram.

Sincerely,



KENDRA LAMB



Russell L. Morrison
Montana Chapter President
Clinical Laboratory Management Association
% 1233 North 30th St.
Billings, MT 59101

January 17, 1993

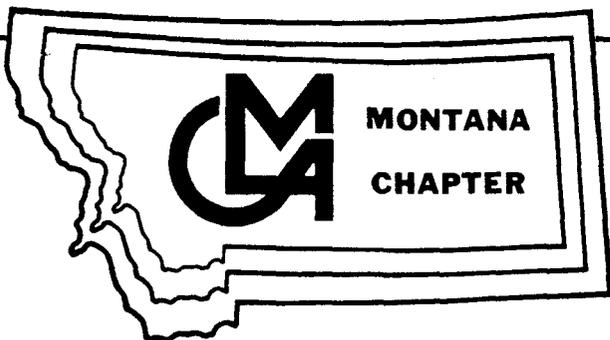
Honorable Members of the House
Montana State Legislature
Helena, Montana

Honorable Members of the House:

I write in support of the House Bill currently known as the "Clinical Laboratory Science Practice Act". The following paragraphs summarize my position.

I currently hold the position of Manager of Laboratory Services for Saint Vincent Hospital and Health Center in Billings, Montana. I was raised in western Oklahoma and received a bachelor of science from the University of Texas (Medical Technology) in 1975. (I mention the rural background because it is important that we all understand the challenge of providing quality health care to outlying regions separated from sophisticated medical centers.) In 1990, I was granted a Masters of Business Administration, MBA, by the University of Cincinnati. I have practiced clinical laboratory science for 19 years.

First, a state with fewer people per square mile deserves the same quality from the health care system as in more densely populated areas. Scientific investigation has shown that persons performing laboratory tests who are certified (ie: trained in the profession and certified by a certifying agency) perform better on proficiency testing challenges than those who do not have such training. Much of the testing performed in a laboratory is complex with many procedural steps. Screening slide preparations for malignant cells, determining the maturity of fetal lungs and selecting appropriate products for blood transfusion are only a few of the tasks delegated to the laboratory professional. A level of sophistication with scientific technique, safety and data analysis is required. Many of the results are used as a basis for diagnosis and treatment of disease. Both short and long term outcome of patient care depends, at least partly, on the ability of the physician to receive accurate data to describe human biological health.



Second, this bill is not overly restrictive. It allows all persons currently performing laboratory tests to continue to do so. It also does not apply to any other health care professionals who are currently authorized to perform human tests.

Third, the bill does not endanger the lives of patients. "Waived Tests" allow methods most commonly required for emergency treatment of patients to be performed simply and reliably by untrained individuals. Waived tests are approved for such use by the United States Food and Drug Administration.

Fourth, the bill does not prohibit tests approved for use in the home. These products are also approved by the United States Food and Drug Administration.

The intent of the proposed legislation was not to limit access to care, but to ensure that quality data are delivered. This bill will require providers of tests used in human health care management to select individuals who are trained competent professionals or to limit the scope of practice to those tests authorized by the FDA. The choice is left in the hands of the provider.

Finally, on behalf of the Montana Chapter of the Clinical Laboratory Management Association, I urge you to support this legislation and to guarantee quality laboratory data for all Montanans.

Sincerely,

Russell L. Morrison
(406) 657-7143

President, Montana Chapter
Clinical Laboratory Management Assn.

Manager, Laboratory Services
Saint Vincent Hospital & Health Ctr.

HOUSE HUMAN SERVICES AND AGING COMMITTEE

JANUARY 22, 1993

HEARING ON SB43

Mr. Chairman and Members of the Committee:

My name is Gary Kenner. I am Chief Executive Officer and Administrator for Bozeman Deaconess Hospital. I am appearing today to express support for SB43, a bill introduced by Senator Doherty to repeal the sunset on the Hospital Lien Act (HB405), enacted in 1991.

Two years ago I testified in favor of HB405, that was offered by my representative, Representative Norm Wallin.

I learned from Representative Wallin that there was considerable confusion for the Committee in the hearing last Wednesday on SB43. It is my belief that much of the confusion about the bill arises from the fact that the Committee did not have before it all of the relevant information concerning the 1991 amendments, and the underlying law of hospital liens.

Accordingly, I am presenting to the Committee today a six page report which supplies to the Committee members the documents necessary to form a judgment on the validity of the 1991 bill.

I will refer briefly to each of the pages, which are numbered by hand at the bottom of each page. As the documents are being distributed to the Committee, let me just take a moment to describe what is on each page.

- Page one presents the legislation that is before the Committee today, SB43, which is reprinted at the bottom of page one. At the top of page one appears HB405, which was enacted into law in 1991.

- Page two presents part eleven of Title 71, which is commonly called the Hospital Lien Act. Also at the bottom right hand corner of page two are two definitions from the Montana Insurance Code, which was the subject of some discussion in Wednesday's hearing.

- Page three presents a page from the annotation of Montana Code Annotated, describing the reasons why the 1991 bill, HB405 was introduced.

- Page four is a simple schematic showing how a hospital lien is filed and what its impacts are.

- And finally, on pages five and six are reprinted a summary of all of the liens under Montana law, which appear in Title 33, Chapter 3, followed by fifteen parts: part eleven of which deals with hospital liens.

An Explanation of the Legislation - - Now if the Committee would turn its attention to the bottom of page one, which shows that SB43 has one simple purpose: to repeal section four of the 1991 laws. That repealer applies to Section four of HB405. In both cases, the number three is noted to the side, which indicates that this was the third amendment added by HB405.

If SB43 is successful (as was the case last week in the Senate when only five Senators voted against it on 2nd reading, and four on 3rd reading) then all that is left in the Montana law books for the Hospital Lien Act are amendments number one and number two, noted by hand, on HB405.

To get a better idea of exactly what amendments one and two did, I urge the Committee to turn to page two and look at the existing hospital lien law, which appears, beginning on page 1059 of Volume 9 of the Montana Code Annotated, which has the technical numbering of Title 1, Chapter 3, Sections 1111 - 1118.

Highlighted (in green) are the two amendments which correspond to the amendments on page one. Amendment number one simply states that the term insurer includes a health service corporation. I would urge the Committee to look at the bottom right hand page and where the year 1987 is noted, signifying that in 1987, the Montana legislature amended the insurance code to make it clear that the term "insurer" included health service corporations. The only health service corporation in the State of Montana is Blue Cross - Blue Shield.

Paragraph two explained the significance of the 1987 amendment, I would ask the Committee to turn briefly to page three of my handout, which is a reprint from the annotations of the Montana Code Annotated, published by the Montana Legislative Council. You will note that marked in green is a note which states that "in 1987 the legislature amended the insurance code to include health service corporations." This was the provision I just pointed out to you at the bottom right hand corner of page two. The reason for the 1991 amendment to the lien act is explained by the annotation which notes that

"the Supreme Court [held] that the legislature did not specifically state that it was subjecting health service corporations to the lien statutes."

If the Committee would then turn back to page two of my handout, you will note that the Supreme Court decision prompted the legislature to amend the lien act to coincide with the rest of Montana law in that Blue Cross would be considered a health insurer both under the insurance code and the lien act.

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I would also note that the 1987 decision was prompted by an appeal by Blue Cross Blue Shield to the Montana Supreme Court.

Disability Insurance - - Now I would like to turn the Committee's attention to amendment two of the 1991 bill. To understand amendment two, one must understand for what purpose the Hospital Lien Act exists. I would urge the Committee to look at the middle of the page on page two, where under subsection two, it states that

"if a person is an insured . . . in the event of injury or disease, a . . . hospital . . . has a lien for the value of services rendered on all proceeds or payments . . . by the insurer."

This provision simply states that the Hospital Lien Act authorizes hospitals to file a lien on health insurance.

However, a complication arose from the 1987 lawsuit, wherein Blue Cross asserted that health insurance was not subject to the Hospital Lien Act. The portion of the lien act that Blue Cross focused its attention on was subsection three in the right hand column of page two, wherein it states that disability insurance is not subject to a hospital lien. Blue Cross contended that disability insurance, as defined under the insurance code, includes health insurance. The precise definition of disability appears at the bottom of the page, in section 33-1-207, highlighted in pink.

Any reasonable person reading the Hospital Lien Act in 1987 would conclude that the Hospital Lien Act was intended to cover health insurance. However, to avoid the cost of additional litigation in interpreting that provision, the Montana Hospital Association sought a clarifying provision, which was amendment two of HB405, and which appears in green at the top right hand corner of page two, wherein an exception is stated that disability insurance does not include health insurance for the purpose of the lien act.

Blue Cross suggests that the purpose of that 2nd amendment was to subject all health insurers to the lien act. That was not the intention. All health insurers, but Blue Cross, were subject to the lien act prior to the 1991 legislature. However, to make certain that Blue Cross would not take its case to the Supreme Court, it argued that health insurance was exempt from the lien act, this clarifying provision was added.

The reason that I bring this to the Committee's attention is that a number of non-Blue Cross insurance related entities testified before the Committee on Wednesday that they were somehow not subject to the lien act. As you can see from the material in front of you, they are subject to the lien act. Prior to 1991, the only insured not subject was Blue Cross-Blue

Shield. After April 1991, all health insurers were subject to the lien act.

The last three pages of my handout I will refer to only briefly. Page four simply presents a simple schematic explaining how the Hospital Lien Act works. Pages five and six list all of the liens currently that exist under Montana law. If any Committee members have questions about hospital liens or any other liens, I would urge that they discuss them with the legal counsel for the Committee.

I thank the Committee for taking the time to take this testimony. I would be happy to answer any questions on this. Additionally, I have asked MHA's legal counsel, Steve Browning, to be here in the audience to answer any questions the Committee might have.

I urge your support for SB43. Thank you.

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January 22, 1993

SUBJECT: HKS&A NO. 8-3
PHYSICIAN'S LIEN ACT

Tanya Ask
Blue Cross and Blue Shield of Montana
404 Fuller Avenue
Helena, MT 59601

Dear Tanya::

You have asked me to outline for you the fascinating history behind the amendments to the Physician's Lien Act, and explain why no health insurer was subject to the Lien Act prior to the 1991 amendments. Although the insurance code is a fairly technical area of the law, I think you will find the following explanation to be sufficient.

Montana has had a physician lien statute since 1931. Prior to a test case instituted by some Missoula doctors in 1988, no one had ever contended that the lien act applies, or should apply, to Blue Cross and Blue Shield of Montana, or any other disability insurer. (Montana law defines a provider of health insurance as a "disability insurer," § 33-1-207, MCA.) The doctors' test case failed when a unanimous Montana Supreme Court ruled that the Physician's Lien Act did not apply to Blue Cross and Blue Shield of Montana, *Anesthesiology P.C. v. Blue Cross and Blue Shield of Montana*, 47 St.Rep. 2015. It was unnecessary for the Montana Supreme Court to reach the broader question of whether the Physician's Lien Act applied to any disability insurer.

The original Physician's Lien Act was intended to apply in cases where the health care provider's patient was receiving treatment was a result of a personal injury. The title of the Act is instructive:

Liens of physicians, nurses, physical therapists, occupational therapists, chiropractors, dentists, and hospitals in personal injury claims.

Tanya Ask
January 22, 1993

Page 2

In 1979, the Montana Hospital Association spearheaded a major rewrite of the Lien Act. Included in their bill was current subsection 71-3-1114(2):

If a person is an insured or beneficiary under insurance which provides coverage in the event of injury or disease, a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital, upon giving the required notice of lien, has a lien for the value of services rendered on all proceeds or payments, except payments for property damages, payable by the insurer.

The addition of the underlined language, "or disease," suggested a major change in the application of the Lien Act. Yet, in hearings on the bill, the Montana Hospital Association specifically represented to the Legislature that the provisions of the bill were to apply only to casualty insurers, the insurance companies which would be involved in a personal injury case, March 13, 1979 Minutes of the Senate Judiciary Committee:

Senator Anderson questioned if this goes on life insurance benefits. Mr. Smith answered no, just on casualty. Senator Turnage said that a major change was disease and he said that was a substantial change and did they see any problems with health insurance benefits and he wondered what kind of problems are we raising by slipping disease in. He said that the old statute simply stated injury.

The Legislature took the Montana Hospital Association at its word, amending the bill by adding what is now subsection 71-3-1118(3):

This part does not apply to any benefits payable under a policy of life insurance or group life insurance, a contract of disability insurance, or an annuity contract or to pension benefits payable under a qualified pension plan.

The State Commissioner of Insurance has applied the exemption to all disability insurance coverage, even the medical payment provision of a policy of casualty insurance. (See attached correspondence between the Commissioner of Insurance and the Montana Deaconess Hospital.)

As I mentioned earlier, dealing with the definitions in the Insurance Code is a fairly technical matter. In the District Court litigation which preceded our successful Montana Supreme Court appeal, my partner made the same mistake currently being made by the Montana Hospital Association. It is flatly wrong to suggest that all health insurance companies, except Blue Cross and Blue Shield of Montana, were subject to the

Tanya Ask
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Page 3

Physician's Lien Act prior to the 1991 amendments. No health insurance company was subject to the Lien Act prior to the 1991 amendments.

Sincerely,


John Alke

ks:BCBS.Ask

Enclosure

EXHIBIT 12
DATE 1/22/93
SP 43

June 18, 1986

Mr. Michael L. McPherson, General Counsel
Montana Deaconess Medical Center
1101 Twenty-sixth Street South
Great Falls, MT 59405-5193

RE: Health care provider lien

Dear Mr. McPherson:

Thank you for your May 23, 1986, letter. In your letter, you indicate that one may interpret an entire automobile policy under casualty insurance (Section 33-1-206, MCA) without calling the med pay provision "disability insurance". You stated further that even if the med pay provision of an automobile policy were defined as disability insurance, it is not a "contract of disability insurance" but is merely one paragraph of disability-type insurance in a casualty insurance contract. While I agree that the med pay provision of an automobile policy may come within the definition of "casualty insurance", I disagree with your conclusion that an automobile policy is not disability insurance.

The Montana Insurance Code contemplates that insurance coverages may come within the definitions of two or more kinds of insurance, and provides that the "inclusion of such coverage within one definition shall not exclude it as to any other kind of insurance within the definition of which such coverage may likewise be reasonably included." Section 33-1-205, MCA. Because the coverage offered in an automobile policy may reasonably be included within the definition of disability

Michael McPherson
Great Falls, MT

page 2

insurance, it falls within the exception to the lien act, and health care providers may not file a lien on such a policy. I consequently believe that my staff has applied the proper interpretation to the statutory language in analyzing the problem. I again offer my staff's assistance in correcting the statutory lien language of section 71-3-118(3), MCA, of the Physicians, Nurses, and Hospital Lien Act of 1979.

With best personal regards, I am

Very truly yours,

Andrea "Andy" Bennett
State Auditor and
Commissioner of Insurance

AAB/KMI/vf(107)

71-3-1118(3)

71-3-1106 through 71-3-1110 reserved.

71-3-1111. Short title. This part may be cited as the "Physician, Nurse, Hospital Therapist, Occupational Therapist, Chiropractor, Dentist, and Hospital Lien Act".

History: En. Sec. 1, Ch. 532, L. 1979; amd. Sec. 1, Ch. 85, L. 1987.

71-3-1112. Purpose. The purpose of this part is to establish lien rights for physicians, nurses, physical therapists, occupational therapists, chiropractors, persons practicing dentistry, and hospitals when a person receiving medical treatment:

- (1) is injured through the fault or neglect of another; or
- (2) is either insured or a beneficiary under insurance.

History: En. Sec. 2, Ch. 532, L. 1979; amd. Sec. 2, Ch. 496, L. 1983; amd. Sec. 2, Ch. 85, L. 1987.

71-3-1113. (Temporary) Definitions. As used in this part, the following definitions apply:

- (1) "Beneficiary" means a person entitled to insurance benefits.
- (2) "Insurance" means a contract whereby a person, the insurer, undertakes to indemnify another, the insured, or pay or provide a determinable amount or benefit upon determinable contingencies. The term "insurer" includes a health service corporation.
- (3) "Person" means an individual, a corporation, an organization, or other legal entity. (*Terminates April 17, 1993—sec. 4, Ch. 469, L. 1991.*)

71-3-1113. (Effective April 17, 1993) Definitions. As used in this part, the following definitions apply:

- (1) "Beneficiary" means a person entitled to insurance benefits.
- (2) "Insurance" means a contract whereby a person, the insurer, undertakes to indemnify another, the insured, or pay or provide a determinable amount or benefit upon determinable contingencies.
- (3) "Person" means an individual, a corporation, an organization, or other legal entity.

History: En. Sec. 3, Ch. 532, L. 1979; amd. Sec. 1, Ch. 469, L. 1991.

Compiler's Comments

1991 Amendment: In definition of insurance inserted second sentence to include a health service corporation. Amendment effective April 17, 1991.

Termination Date: Section 4, Ch. 469, L. 1991, provided: "[This act] terminates [2 years after the effective date of this act]." Effective April 17, 1991, and terminates April 17, 1993.

71-3-1114. Liens of physicians, nurses, physical therapists, occupational therapists, chiropractors, nurses, persons practicing dentistry, and hospitals. (1) Whenever a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital renders services to a person injured through the fault or neglect of another, the physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital, upon giving the required notice of lien, has a lien for the value of services rendered on:

- (a) any claim or cause of action the injured person, his estate, or successors may have for injury, disease, or death;

71-3-1011. Notice to purchaser of oil and gas. Anything in this part to the contrary notwithstanding, any lien claimed by virtue of this part insofar as it may extend to oil or gas or the proceeds of the sale of oil or gas shall not be effective against any purchaser of such oil or gas until written notice of such claim has been delivered to such purchaser at his residence or principal place of business. Such notice shall state the name of the claimant, his address, the amount for which the lien is claimed, and a description of the interest upon which the lien is claimed. Such notice shall be delivered personally to the purchaser or by registered or certified letter deposited in the United States mail. Until such notice is delivered as above provided, no such purchaser shall be liable to the claimant for any oil or gas produced from the interest upon which the lien is claimed or the proceeds thereof, except to the extent of such part of the purchase price of such oil or gas or the proceeds thereof as may be owing by such purchaser at the time of delivery of such written notice. Such purchaser shall withhold payments for such oil or gas runs to the extent of the lien amount claimed until delivery of notice in writing that the claim has been paid.

History: En. 45-1010 by Sec. 10, Ch. 143, L. 1957; R.C.M. 1947, 45-1010.

71-3-1012. Effect on interest which is less than fee interest. If a lien provided for in this part attaches to an estate less than the fee, forfeiture of such estate shall not impair any lien as to material, appurtenances, and fixtures located thereon and to which said lien has attached prior to forfeiture. If a lien provided for in this part attaches to an equitable interest or to a legal interest contingent upon the happening of a condition subsequent, failure of such interest to ripen into legal title or such condition subsequent to be fulfilled shall not impair any lien as to material, appurtenances, and fixtures located thereon and to which said lien attached prior to such failure.

History: En. 45-1011 by Sec. 11, Ch. 143, L. 1957; R.C.M. 1947, 45-1011(part).

Part 11

Liens of Physicians, Nurses, Physical Therapists, Occupational Therapists, Chiropractors, Dentists, and Hospitals in Personal Injury Claims

Part Cross-References

Assignment of right to periodic installments for certain future damages, 25-9-405.

Acknowledgment of lien satisfaction — penalty, 71-3-131.

71-3-1101 through 71-3-1105. Repealed. Sec. 9, Ch. 532, L. 1979. 8395.1 through 8395.5, R.C.M. 1935; R.C.M. 1947, 45-1201 through 45-1205.

Compiler's Comments

History of Repealed Sections: 71-3-1101 through 71-3-1105. En. Sec. 1 through 5, Ch. 57, L. 1931; re-en. Sec.

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(b) any judgment the injured person, his estate, or successors may obtain for injury, disease, or death; and
 (c) all money paid in satisfaction of such judgment or in settlement of the claim or cause of action.

(2) If a person is an insured or a beneficiary under insurance which provides coverage in the event of injury or disease, a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital, upon giving the required notice of lien, has a lien for the value of services rendered on all proceeds or payments, except payments for property damage, payable by the insurer.

(3) The lien is subject to the lien of an attorney provided in 37-61-420.
 History: En. Sec. 4, Ch. 532, L. 1979; amd. Sec. 3, Ch. 85, L. 1987.

71-3-1115. Notice of lien. (1) A physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital claiming a lien shall serve written notice upon the person and upon his insurer, if any, against whom liability for injury, disease, or death is asserted, stating the nature of the services, for whom and when rendered, the value of the services, and that a lien is claimed.

(2) A physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital claiming a lien upon proceeds or payments payable by an insurer shall serve written notice upon the insurer against whom the lien is asserted, stating the nature of the services, for whom and when rendered, the value of the services, and that a lien is claimed.
 History: En. Sec. 5, Ch. 532, L. 1979; amd. Sec. 4, Ch. 85, L. 1987.

71-3-1116. Notice of lien — filing with clerk of court. If an action is commenced for recovery for injury, disease, or death, a copy of the notice of lien may be filed in the office of the clerk of court in which the action is pending, and the filing is notice to all parties to the action.

History: En. Sec. 6, Ch. 532, L. 1979.

71-3-1117. Liability for failure to recognize lien. If any insurer or person, after receiving notice of lien, makes payment on account of injury, disease, or death and the amount of the lien claimed by any physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital has not been paid, the insurer or person is liable to the physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital for the reasonable value of the services.
 History: En. Sec. 7, Ch. 532, L. 1979; amd. Sec. 5, Ch. 85, L. 1987.

71-3-1118. (Temporary) Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act or the Occupational Disease Act of Montana.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under a policy of life insurance or group life insurance; a contract of disability insurance, except benefits payable in reimbursement for services rendered by a physician, nurse, physical therapist, occupational therapist, chiropractor, person practicing dentistry, or hospital; or an annuity contract or to pension benefits payable under a qualified pension plan. (*Terminates April 17, 1993—sec. 4, Ch. 469, L. 1991.*)

71-3-1118. (Effective April 17, 1993) Applicability. (1) Except as provided in subsection (2), this part does not apply to compensation awarded to workers for injury, disease, or death pursuant to the Workers' Compensation Act or the Occupational Disease Act of Montana.

(2) This part applies to all payments awarded for medical, therapy, chiropractic, dentistry, and hospital services pursuant to the acts referred to in subsection (1).

(3) This part does not apply to any benefits payable under a policy of life insurance or group life insurance, a contract of disability insurance, or an annuity contract or to pension benefits payable under a qualified pension plan.
 History: En. Sec. 8, Ch. 532, L. 1979; amd. Sec. 1, Ch. 496, L. 1983; amd. Sec. 6, Ch. 85, L. 1987; amd. Sec. 2, Ch. 469, L. 1991.

Compiler's Comments

1991 Amendment: In (3), near middle after "disability insurance", inserted exception clause. Amendment effective April 17, 1991.

Termination Date: Section 4, Ch. 469, L. 1991, provided: "This act terminates [2 years after the effective date of this act]. Effective April 17, 1991, and terminates April 17, 1993.

Cross-References

Workers' Compensation Act, Title 39, ch. 1991, provided: "This act terminates [2 years

71.

Occupational Disease Act, Title 39, ch. 72.

Part 12

Agisters' Liens and Liens for Service

Part Cross-References

Bailment, Title 70, ch. 6.

Acknowledgment of lien satisfaction — penalty, 71-3-131.

71-3-1201. Who may have lien. (1) If there is an express or implied contract for keeping, feeding, herding, pasturing, or ranching stock, a ranchman, farmer, agister, herder, hotelkeeper, livery, or stablekeeper to whom any horses, mules, cattle, sheep, hogs, or other stock are entrusted has a lien upon such stock for the amount due for keeping, feeding, herding, pasturing, or ranching the stock and may retain possession thereof until the sum due is paid.

(2) Every person who, while lawfully in possession of an article of personal property, renders any service to the owner or lawful claimant thereof by labor or skill employed for the making, repairing, protection, improvement, safekeeping, or carriage thereof has a special lien thereon, dependent on possession, for the compensation, if any, that is due to him from the owner or

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Senate Judiciary Committee
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Lory stated this was to address a problem that is the result of modern technology.

Dan MacDonald, representing St. Peters Hospital, gave an example of an individual who moved to Kallispeil, owing \$22,000.00 and the hospital realized nothing.

Dennis Ryan, representing St. Peters Hospital, gave a statement in support of this bill.

Bill Wagner, representing St. Patricks Hospital, gave a statment in support.

Chad Smith, representing the Montana Hospital Association, stated that he has had experience working with the present lien laws over the years and said there are some problems. He said that the companies doing business in the state of Montana have been very cooperative and he said that there are a number of companies that do not do business in Montana and that is where the problem basically lies. He stated that this is an improvement of the law and he would endorse it.

There were no further proponents and no opponents.

Senator Anderson questioned if this goes on life insurance benefits. Mr. Smith answered no, just on casualty. Senator Turnage said that a major change was disease and he said that was a substantial change and did they see any problems with health insurance benefits and he wondered what kind of problems are we raising by slipping disease in. He said that the old statute simply stated injury.

Senator Galt wondered how this is going to affect the insurance involved where a policy pays \$50.00 a day and call it compensation and he wondered if they were getting into that too. It was answered that they wanted to make this as broad as possible and as it stands, it states "which provides coverage as result of disease." He said that if they are getting \$50.00 to \$100.00 a day, the way he reads it, they will be able to claim it.

Senator Lensink questioned if they interpret this as proceeds for disability insurance and he stated that

APPENDIX A

March 13

19 79

MR. President

We, your committee on Judiciary

having had under consideration House Bill No. 783

Lory (Anderson)

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Respectfully report as follows: That House Bill No. 783,

third reading bill, be amended as follows:

1. Page 2, lines 21 through 23.
Strike: subsection (3) in its entirety
Renumber: subsequent subsection

2. Page 4, line 1.
Following: "applicable."
Insert: "(1)"

3. Page 4.
Following: line 4
Insert: "(2)" [This act] does not apply to any benefits payable under a policy of life insurance or group life insurance, a contract of disability insurance, or an annuity contract or to pension benefits payable under a qualified pension plan."

And, as so amended,
BE CONCURRED IN

2225X

(Handwritten initials)

HOSPICES OF MONTANA JANUARY 1993

CERTIFICATION BUREAU

LICENSURE BUREAU

LICENSED AND CERTIFIED

- ANACONDA - Anaconda Pintler Hospice of Community Hospital of Anaconda
- BAKER - Fallon Medical Complex, Inc. - Hospice
- BILLINGS - Big Sky Hospice
- BOZEMAN - Gallatin Hospice
- BUTTE - Highlands Hospice
- GREAT FALLS - Gift of Life Hospice - Columbus Hospital Corporation
- HAMILTON - Marcus Daly Memorial - Hospice of the Bitter Root
- HELENA - Hospice of Saint Peter's Community Hospital
- KALISPELL - Flathead Valley Hospice
- LEWISTOWN - Hospice of Central Montana
- LIVINGSTON - Gateway Hospice
- MISSOULA - Mountain West Home Health and Hospice, Inc. -

LICENSED ONLY

- BIG TIMBER - Hearts and Hands Hospice
- COLUMBUS - Stillwater Convalescent Center Hospice
- CONRAD - Pondera Hospice
- DEER LODGE - Hospice of Powell County
- DILLON - Dillon Hospice
- LIBBY - Kootenai Volunteer Hospice
- ROUNDUP - Helping Hands Hospice

Testimony before the House Human Services and Aging Committee on
H.R. 211. on January 22, 1993, from Bonnie Adee, Manager of Hospice
of St. Peter's in Helena, Montana and member of Montana Hospice
Organization Legislative committee.

Why Does Montana Need This Legislation?

The state of Montana has licensed hospice programs since 1983.
We hospice providers requested this licensure to assure minimum
standards for hospice programs which also made sense in a rural
state. Without state licensure, the recognized standards for
hospice would be the federal ones specified by Medicare. As you
can see in your packet from Representative Brook, seven programs in
our state are not certified. Hospice licensure assures the public
quality care from these programs as well.

In the federal regulations for Medicare certifications, there are
standards for an in-patient hospice facility. HR 211 will
recognize those standards as one option for an inpatient hospice
facility (p.7 lines 8-11).

However, HR 211 would give Montanans a second option for a hospice
facility, something called a hospice residential facility (p.7
lines 12-14). This facility could be managed by a licensed
hospice, and would have different standards than those required by
Medicare.

Hospice is asking the legislature to give clear authority to the
Department of Health and Environmental Sciences to establish the
standards for a hospice residence (p.13 lines 8 & 9). In addition

we ask that the Department have authority to enforce the federal standards for a hospice inpatient facility through licensure (p. 13 lines 9-15).

There are no inpatient hospice facilities in Montana today. We hospice providers believe we are being responsible in coming here today to ask for licensure before someone builds or opens a facility. We'd like to know what the rules are before any of us gets started.

What will it cost?

There is no fiscal note with this bill. We are not asking you to fund hospice facilities. Each of us, as we evaluate the feasibility of a hospice facility in our own community must determine how it will be funded. In other states, hospice facilities receive reimbursement from a variety of sources, including Medicare, Medicaid, private insurance, self-pay, and donations from foundations and the community.

The cost to Medicare and Medicaid would not increase because these payors pay for hospice care based on established daily rates governed by specific criteria and subject to retrospective review. The inpatient rate will only be paid when the patient's condition warrants it. Otherwise, the home care rate is paid, regardless of whether the patient is at home, in a nursing home, or in a hospice residence.

Hospice providers have told the Department of Health we are willing to pay higher fees for licensure to off-set the cost of the survey.

We estimate that over the next bienium only one to three hospices are likely to request licensure for a facility.

Can someone other than an existing hospice own or develop a hospice facility under this proposed legislation?

Yes. The language is intended to assure quality, but not exclude other providers. The owner of an existing facility who can meet the standards developed for a hospice facility has two options to apply for this type of licensure.

One option is to develop a management contract with the existing hospice in that community, promoting the kind of cooperation in health care we all hope to see more of. If no hospice program operates in that community, or the provider chooses not to work with the existing hospice, a second option is to develop a hospice program and apply for that licensure as well. Certificate of need does not currently apply to hospice.

I urge your support of HR 211. This is important and needed legislation which may become a model for other states to follow.

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HB 211

TESTIMONY ON HOUSE BILL 211 (BROOKE)
January 22, 1993
House Human Services & Aging Committee
by Mike Craig, Licensure Bureau

Chairman Boharski, members of the committee, good afternoon. I am Mike Craig, Bureau Chief of the Licensure Bureau in the Department of Health and Environmental Sciences. The Department wishes to extend its support to House Bill 211.

The Licensure Bureau is responsible for state defined regulatory oversight over many health care facilities and services in Montana. The chart I have provided shows the current number of hospices in the state. (Brief explanation.)

The bill directs the Department to exercise existing rulemaking authority to modify state standards for hospice care by authorizing two new types of hospice programs. Both new types are facility-based. Currently, hospice services are primarily provided in a person's home.

The inpatient hospice component of the bill would authorize a type of facility that the federal government will certify under Medicare. The building standards would also have to meet federal inpatient requirements, which would likely limit the number of these facilities because of the costs necessary to meet those standards.

The residential hospice would not be a service recognized under Medicare. Therefore, the Department would have primary regulatory jurisdiction over this level of care. We believe the need for residential hospices exists for individuals who have no primary caregiver in their own homes, or for persons who really have no place to call home except possibly a nursing home or some other type of congregate living arrangement. This is also the model which would most benefit individuals who are in advanced stages of HIV-related illnesses and who are infected with the AIDS virus. This is also an option that some terminally ill individuals would potentially like to have so that they can place themselves in a situation where they believe they are less of a burden to their families.

The structural standards would be less rigorous to meet under the residential hospice program. Our comfort in supporting this new type of residential health facility is based on the requirement that it is managed by a licensed hospice service.

EXHIBIT 19
DATE 1-22-93
HB 211



HORIZON HEALTHCARE CORPORATION

1130 17th Ave. South
Great Falls, Mt. 59405

January 15, 1993

Representative Vivian Brooke
Capitol Station
Helena, Mt. 59620

Dear Representative Brooke,

I am writing in support for a bill entitled "An Act to Create Licensure For Residential and Inpatient Hospice Facilities" which you are soon to introduce in the House.

As an operator of a skilled nursing facility, I am interested in promoting quality care in Montana. This act would create a rule to enable terminal patients to be cared for in residential homes as well as inpatient facilities. This is in keeping with current trends in terminal care.

As I understand it, this act would in no way prohibit a personal care operator from applying for their own hospice license. The bill would ensure that dying patients and their families be cared for in a safe and quality manner.

Sincerely,

Russell Meech
Assistant Administrator

rm/mc



EXHIBIT 17
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
c/o House of Representatives
State Capitol
Helena, MT 59601

RE: House Bill 211

Dear Representative Brooks:

On behalf of the Montana Hospice Organization and Big Sky Hospice I wish to extend our appreciation to you for sponsoring HB 211. In addition, I would like my support for the bill to be known by the House Human Services and Aging Committee.

HB 221 establishes licensing standards for residential hospice and inpatient hospice facilities. I believe licensure is needed to ensure that facilities which provide terminal care to dying patients meet standards established by the National Hospice Organization and the Federal regulating agencies.

The hospice philosophy of care encompasses a hospice-trained, interdisciplinary team which provides care to patients in a variety of settings, offers a full array of services, involves the patient and family as a unit of care and offers bereavement care to the family during the first year following a patient's death. The standards required by hospice licensure and Medicare certification require this. I believe that the standards are minimum requirements that any consumer of hospice care should be able to expect.

If a terminally ill person lives alone a plan must be in place for how the person will be cared for during the final stage. A residential facility which offers care to dying patients for the last few weeks or months would be an excellent place for an individual to live with others. Such a residence should offer the same standard of care that hospice offers to patients in their home. Without licensure anyone wanting to offer terminal care can do so. Licensure seeks to ensure that terminally ill persons

*Big Sky Hospice strives to ensure comfort, dignity and choice
for the dying person and grieving family.*

residing in a hospice residential facility or free-standing inpatient unit will receive the best possible terminal care from a competent and caring staff which meets the hospice standards of care.

As a provider of hospice care I ask you to please support the passage of HB 211.

Sincerely,

Bernice Bjertness

Bernice Bjertness, RN, MN
Director, Big Sky Hospice
President, Montana Hospice Organization

EXHIBIT 18
DATE 1-22-93
HB 211

Partners In Home Care, Inc.

Bringing Health Care Home

Vivian Brooks
C/O House of Representatives
State Capital
Helena, MT 59601

Dear Representative Brooks:

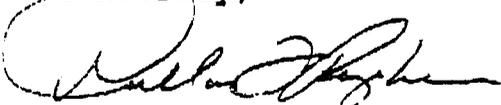
I am writing to thank you for introducing House Bill No. 211 for the licensure of residential and inpatient hospice facilities. We strongly support the bill and hope it will be endorsed by the Human Services and Aging Committee.

There is a definite need for facility-based hospice services in Missoula to supplement the in-home hospice services currently provided by our Hospice program. In collaboration with St. Patrick Hospital and Community Medical Center, we are currently exploring the development of a residential and inpatient facility that would enable us to serve individuals who are not able to remain in their own home. In some cases, the lack of a family support system makes it impossible for the individual to be maintained at home. In other cases, the level of the patient's need is simply too high for family members to cope. In those cases, a residential or inpatient hospice facility would improve a much needed option to traditional institutional care.

The need for this type of facility is apparent in Missoula and other parts of Montana. We believe the facilities will be developed with or without licensure requirements. For the safety and well-being of the patient and family, we believe these facilities need to be licensed and held accountable to standards of hospice care and management.

Thank you for your support. Please feel free to call on us for further information.

Sincerely,



Dallas L. Rychener
Executive Director

Palliative Care Consultation Service

Ira R. Byock, MD, FACEP

341 University Avenue Missoula, MT 59801 (406) 728-8643 Pager 329-6604

Honorable Vivian Brooke
Human Services and Aging Committee
House of Representatives
State Capitol
Helena, MT 59601

January 19, 1993

To the 1993 Montana Legislature.

It is a pleasure to write a letter of support for HB 211. I have been active in hospice within Montana for the past 10 years, in Livingston, in Billings and, during the past nearly 6 years in Missoula, where I have the privilege of serving as medical director of Mountain West Hospice.

Hospice provides comprehensive medical care and case management for people at the end of life. For hospice the unit of care is the patient **with** his or her family. For most patients and families, after all reasonable curative therapies have been exhausted, remaining comfortable, at home, surrounded by loved ones is a major goal. Hospice programs go to great lengths to help people achieve that goal. However, despite our best intentions and efforts, remaining at home is not always possible. At times, factors such as the complexity of care, the frailty of the family member who is providing primary care, the distances between home and other family or friends, or pre-existing social problems make it impossible to continue providing for adequate attention in a private residence. The result is admission to a hospital or nursing home.

I know first-hand the anguish of the families who are unable to maintain their loved one at home, often despite their deep desire and a longstanding promise to do so. Patients in this situation may feel that they have become a burden and, although feeling somewhat abandoned, may find themselves too ill and dependent to complain.

Creation of a hospice facility represents a wonderful alternative to institutionalization. In such a facility families can remain deeply involved, providing as much direct care they are able but with the active support of medical professional and trained hospice caregivers. Drawing from the experience of Great Britain and a number of communities across the United States, hospice residential and inpatient facilities can provide a genuinely homelike environment for those terminally ill persons who require intensive, "high-touch" care.

HB 211 addresses development of this important clinical resource from a uniquely Montana perspective. Acknowledging that many Montana communities have hospice programs that are small and financially challenged, the proposed legislation would create two licensure categories - hospice residential facility and hospice inpatient facility - allowing local communities the flexibility to develop the type of site-based hospice that best fits their particular needs and capabilities.

I strongly feel that this proposed legislation represents an innovative, cost-effective means of helping to address the need of improving care of patients and families at the end of life.

Sincerely,

Ira R. Byock, MD



EXHIBIT 20
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

As a Hospice nurse I am deeply concerned about maintaining the standard of care for Hospice patients in residential Hospice facilities. I do appreciate your sponsoring HB 211. Please inform the House Human Services and Aging Committee of my support of this bill.

As a Hospice trained team member it is important to maintain a high level of care for our terminally ill patients. This takes an interdisciplinary team approach of professionals to provide the care needed for someone whose life is ending. This same quality of care needs to be provided in a residential hospice facility and should meet all the regulatory standards required by National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Patricia R. Peters, RN
Patient Care Coordinator



EXHIBIT 21
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
& House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would like to extend my appreciation to you for sponsoring HB 211. Would you please inform the House Human Services and Aging Committee of my support of this bill.

Hospice care is an interdisciplinary team approach to care. This is done in a variety of settings and should include residential Hospice facilities. It is very important that Hospice patients and families are provided the highest quality of care possible. This can be assured by licensure of the facilities that meet the standards as set by the National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

A handwritten signature in cursive script that reads "Mary Van Zandt".

Mary Van Zandt, RNC



EXHIBIT 22
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

As a Hospice nurse I am deeply concerned about maintaining the standard of care for Hospice patients in residential Hospice facilities. I do appreciate your sponsoring HB 211. Please inform the House Human Services and Aging Committee of my support of this bill.

As a Hospice trained team member it is important to maintain a high level of care for our terminally ill patients. This takes an interdisciplinary team approach of professionals to provide the care needed for someone whose life is ending. This same quality of care needs to be provided in a residential hospice facility and should meet all the regulatory standards required by National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Beth Emard

Beth Emard, RN



EXHIBIT 23
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
& House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would like to extend my appreciation to you for sponsoring HB 211. Would you please inform the House Human Services and Aging Committee of my support of this bill.

Hospice care is an interdisciplinary team approach to care. This is done in a variety of settings and should include residential Hospice facilities. It is very important that Hospice patients and families are provided the highest quality of care possible. This can be assured by licensure of the facilities that meet the standards as set by the National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Mary Dyrud RN

Mary Dyrud, RN



EXHIBIT 24
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
& House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

As a Hospice nurse I am deeply concerned about maintaining the standard of care for Hospice patients in residential Hospice facilities. I do appreciate your sponsoring HB 211. Please inform the House Human Services and Aging Committee of my support of this bill.

As a Hospice trained team member it is important to maintain a high level of care for our terminally ill patients. This takes an interdisciplinary team approach of professionals to provide the care needed for someone whose life is ending. This same quality of care needs to be provided in a residential hospice facility and should meet all the regulatory standards required by National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Roxanne W. Allen RN

Roxanne W. Allen, RN



EXHIBIT 25
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

As a Hospice nurse I am deeply concerned about maintaining the standard of care for Hospice patients in residential Hospice facilities. I do appreciate your sponsoring HB 211. Please inform the House Human Services and Aging Committee of my support of this bill.

As a Hospice trained team member it is important to maintain a high level of care for our terminally ill patients. This takes an interdisciplinary team approach of professionals to provide the care needed for someone whose life is ending. This same quality of care needs to be provided in a residential hospice facility and should meet all the regulatory standards required by National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Pam Feldman, R.N.C.

Pam Feldman, RNC



EXHIBIT 26
DATE 1-22-93
HB 241

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would like to extend my appreciation to you for sponsoring HB 211. Would you please inform the House Human Services and Aging Committee of my support of this bill.

Hospice care is an interdisciplinary team approach to care. This is done in a variety of settings and should include residential Hospice facilities. It is very important that Hospice patients and families are provided the highest quality of care possible. This can be assured by licensure of the facilities that meet the standards as set by the National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Shirley E. Ratcliff, RN

Shirley E. Ratcliff, RN



EXHIBIT 21 HOUSE FILE
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would like to extend my appreciation to you for sponsoring HB 211. Would you please inform the House Human Services and Aging Committee of my support of this bill.

Hospice care is an interdisciplinary team approach to care. This is done in a variety of settings and should include residential Hospice facilities. It is very important that Hospice patients and families are provided the highest quality of care possible. This can be assured by licensure of the facilities that meet the standards as set by the National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

A handwritten signature in cursive script that reads "Kathy Wendeln, RN".

Kathy Wendeln, RN



EXHIBIT 28
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would personally like to thank you for sponsoring HB Bill 211. On behalf of Big Sky Hospice I would like to add my support for this bill and ask that you inform the House Human Services and Aging Committee of this support.

Residential facilities will be an important part of continued Hospice care in our state. It is very important that licensure include Hospice standards and philosophy of care as established by the Nation Hospice Organization and Federal regulatory agencies.

Terminally ill patients and families deserve the guarantee they will receive the same standard of care in a residential Hospice facility as they would if they remained in their own home.

As a Hospice nurse I ask your support in passage of HB 211.

Sincerely,

A handwritten signature in cursive script that reads "Loretta Foley RN".

Loretta Foley; RN



DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
* House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would personally like to thank you for sponsoring HB Bill 211. On behalf of Big Sky Hospice I would like to add my support for this bill and ask that you inform the House Human Services and Aging Committee of this support.

Residential facilities will be an important part of continued Hospice care in our state. It is very important that licensure include Hospice standards and philosophy of care as established by the Nation Hospice Organization and Federal regulatory agencies.

Terminally ill patients and families deserve the guarantee they will receive the same standard of care in a residential Hospice facility as they would if they remained in their own home.

As a Hospice nurse I ask your support in passage of HB 211.

Sincerely,

Johnna Brumit R.N.C.

Johnna Brumit, RNC



EXHIBIT 2
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
* House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would personally like to thank you for sponsoring HB Bill 211. On behalf of Big Sky Hospice I would like to add my support for this bill and ask that you inform the House Human Services and Aging Committee of this support.

Residential facilities will be an important part of continued Hospice care in our state. It is very important that licensure include Hospice standards and philosophy of care as established by the Nation Hospice Organization and Federal regulatory agencies.

Terminally ill patients and families deserve the guarantee they will receive the same standard of care in a residential Hospice facility as they would if they remained in their own home.

As a Hospice nurse I ask your support in passage of HB 211.

Sincerely,

Cindy Enderson R.N.

Cindy Enderson, RN



EXHIBIT 31
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
% House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would like to extend my appreciation to you for sponsoring HB 211. Would you please inform the House Human Services and Aging Committee of my support of this bill.

Hospice care is an interdisciplinary team approach to care. This is done in a variety of settings and should include residential Hospice facilities. It is very important that Hospice patients and families are provided the highest quality of care possible. This can be assured by licensure of the facilities that meet the standards as set by the National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Marianne Fisher, RN

Marianne Fisher, RN



EXHIBIT 32
DATE 1-22-93
HB 241

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
& House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

As a Hospice nurse I am deeply concerned about maintaining the standard of care for Hospice patients in residential Hospice facilities. I do appreciate your sponsoring HB 211. Please inform the House Human Services and Aging Committee of my support of this bill.

As a Hospice trained team member it is important to maintain a high level of care for our terminally ill patients. This takes an interdisciplinary team approach of professionals to provide the care needed for someone whose life is ending. This same quality of care needs to be provided in a residential hospice facility and should meet all the regulatory standards required by National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,



Marjorie Hansen, RN



EXHIBIT 33
DATE 1-22-93
HB 211

1041 North 29th • Billings, MT 59101 • (406) 248-7442

January 20, 1993

Representative Vivian Brooks
& House of Representatives
State Capitol
Helena, MT 59601

Re: House Bill 211

Dear Representative Brooks:

I would like to extend my appreciation to you for sponsoring HB 211. Would you please inform the House Human Services and Aging Committee of my support of this bill.

Hospice care is an interdisciplinary team approach to care. This is done in a variety of settings and should include residential Hospice facilities. It is very important that Hospice patients and families are provided the highest quality of care possible. This can be assured by licensure of the facilities that meet the standards as set by the National Hospice Organization and Federal regulatory agencies.

As a provider of Hospice care I ask you to please support the passage of HB 211.

Sincerely,

Cathy Miller, RN

Cathy Miller, RN

1 st brand fax transmittal memo 7671 # of pages 2	
To: Bonnie Adee	From: Julie Jardine
ospice of St. Peter's	Co. Gateway Hospice
447-2540	Phone # 222-3541
	Fax # 222-0540

EXHIBIT 34
DATE 1-22-93
HB 211

TESTIMONY BEFORE HOUSE HUMAN SERVICES AND AGING COMMITTEE 1/22/93
RE: HOUSE BILL #211, TO LICENSE HOSPICE FACILITIES
PRESENTED BY: JULIE JARDINE, RN, GATEWAY HOSPICE DEPARTMENT MANAGER AND MONTANA
HOSPICE ORGANIZATION LEGISLATIVE COMMITTEE CHAIR

I am Julie Jardine, a Registered Nurse, the Manager of Gateway Hospice, a state licensed and Medicare Certified Hospice program in Livingston, MT; and the Chair of the Montana Hospice Organization's Legislative Committee. I have been providing hospice care in Montana for 9 years.

Historically, hospices began in England in the 1960's as inpatient units to provide institutional care to terminal patients. As hospice came to the United States in the 1970's, some care was provided in inpatient facilities, but most programs began as grass-roots, community based, home care programs. In Montana today, whether it be hospital-based, home health agency based, or a volunteer community program, the home care model is the type of terminal care all hospices provide. We utilize round-the clock nursing care at home or hospital inpatient beds when our patients require acute 24 hour care; and nursing home beds when the family requires a break or are unable to care for the patient at home.

All hospice providers in Montana and the country have been dealing in more recent years with an increasing number of terminal patients without adequate primary caregivers to keep them in their home setting for a variety of reasons: increased longevity, our mobile society and break up of the nuclear family, diseases which alienate the patient from their potential caregivers, and more women in the work force who are unavailable for home care. Whatever the reason, this is becoming more of a reality on a daily basis.

We are aware of interest, both outside of our hospice circles and within our own group, in developing either residential or acute inpatient facilities to deal with this growing need. Our purpose in proposing this legislation is to ensure that these facilities are constrained to a certain standard of care, that we, as licensed or Medicare Certified hospice programs provide to our terminal clients. We see this as an issue of protection to the consumer. Hospice prides itself on an excellent reputation of providing quality care to our patients, on utilizing an interdisciplinary team approach, on "state of the art" symptom management, and on including patients and their families as the central directors of their care. If residential and acute inpatient facilities are calling themselves "hospice" we want to ensure that the public can continue to expect that same quality care.

I'd like to describe to you an example of this interest in residential hospice facilities. A few years ago the manager of a small Personal Care Home in Livingston expressed an interest in trying to develop a wing of her facility as what she described as a "hospice house" for terminal patients. While we applauded her interest and innovation in such an idea; we had a concern that she was not at all familiar with what hospice care was all about. We requested that she begin working with us when she had a terminal patient in her facility and that she and members of her staff attend our hospice training. She did so, and by her own admission, realized that she was not aware of the comprehensive approach we take to caring for the terminally ill, nor of the body of knowledge required to provide the symptom management which is so paramount in hospice care. This woman has since closed her facility and left the area, but it left us feeling very concerned that another facility could choose to do this without

involving hospice and misrepresent their ability to provide what we consider to be comprehensive hospice care by trained staff and volunteers.

This proposed legislation ensures a minimum standard of quality hospice care, consistent with the hospice approach to care and current trends in hospice care, by requiring that these facilities be directly managed by a state licensed hospice (for residential facilities) or a Medicare Certified hospice (for inpatient facilities). We recognize that the provider could choose to seek their own licensure or certification as a hospice program rather than affiliating with an existing hospice. This would be appropriate because they would then be required to provide the same standards of care which we do.

In summary, the Montana Hospice Organization did not want to sit back and see hospice residential and inpatient care defined by non-hospice providers, in a well-intentioned attempt to meet this growing need. We wanted to be pro-active in defining who can provide this type of care, and to assure that any hospice facility is delivering the same quality care which Hospices in Montana have been proud of providing in the home setting for years.

Respectfully Submitted,



Julia Jardine, RN
Gateway Hospice Department Manager &
Montana Hospice Organization Legislative Chair

GATEWAY HOSPICE

A Service of
Livingston Memorial Hospital
504 South Thirteenth Street
Livingston, MT 59047
(406) 222-3541

EXHIBIT 35
DATE 1-22-93
211



HELENA FAMILY PHYSICIANS
820 North Montana • Helena, MT 59601

W. Crichton, M.D.
J. Maher, M.D.
P. Kozisek, M.D.
Telephone:
406-442-3570
406-443-7067

January 21, 1992

Honorable Vivian Brook
House of Representative
State Capitol
Helena, MT 59603

Dear Representative Brook:

I am writing in support of legislation establishing licensure for residential and inpatient hospice facilities.

As a practicing family physician and part-time hospice medical director, I frequently encounter circumstances where terminally ill patient are admitted to hospitals for symptom control when such symptoms could be readily addressed in a more appropriate setting. While these patients require more intense and continuous care than could be provided in a nursing home, a specialized hospice facility would be a cost effective and medically appropriate setting for these patients.

Experience in other states and countries has shown that such facilities work well and compliment existing health care structures. However, because they do not fit the strict definition of a hospital or nursing home, specific legislation is necessary to establish licensure requirements.

Thank you for your thoughtful consideration of this important issue.

Sincerely,

Peter B. Kozisek
Peter B. Kozisek, M.D.

cc: Bonnie Adee
Hospice of St. Peter's Hospital

HB 211

THOMAS A. WARR, M.D.

Member, American Board of Internal Medicine
Internal Medicine
Hematology
Medical Oncology

NORTHWEST MEDICAL OFFICES
401 - 15th AVENUE SOUTH, #201
GREAT FALLS, MONTANA 59405
(406) 727-1770

January 17, 1993

State Representative Vivian Brooke
Capitol Station
Helena, Montana 59620

Dear Ms. Brooke:

I am writing to support legislation that is pending before the State Legislature supporting a requirement that would establish rules requiring licensure for "residential Hospice organizations" and for "inpatient Hospice organizations".

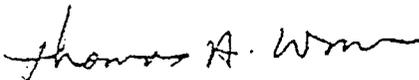
I am the Medical Director of the Gift of Life Hospice, Medicare certified Hospice in North Central Montana. I am aware through my experience with this organization of the many different types of care that can be given to dying patients. Apparently residential Hospice organizations also care for their patients, with very little in place to monitor the quality of care provided. In this regard, sometimes the care that is provided is quite inadequate.

With this in mind, requirement for licensure of these organizations would be reasonable and certainly I would be in favor of an approach that would require these organizations to become affiliated with the local Hospice organization.

Medicare certified Hospices are required to meet certain training requirements of all staff including volunteers who have between 20 and 30 hours of active training and full licensure status of all employed professionals.

A requirement for licensure and affiliation with a Hospice program I think would go far towards insuring adequate care of patients in this circumstance. Please note that these patients are quite vulnerable to those who would otherwise not be fully adept or scrupulous with regards to these unfortunate patients care.

Sincerely,



Thomas A. Warr, M. D.

TAW/rml

cc: Bonnie Spade

FALLON MEDICAL COMPLEX

320 Hospital Drive, L 820

Baker, Montana 59313

Hospital (406) 778-3331 • Clinic (406) 778-2833 • FAX (406) 778-2488

FALLON MEMORIAL HOSPITAL
MEMORIAL NURSING HOME
HOME CARE SERVICES
COMMUNITY CLINIC
PARKVIEW RETIREMENT CENTER

EXHIBIT 37
DATE 1-22-93
HB 211

January 21, 1993

Ms. Vivian Brooks
c/o House of Representatives
State Capitol
Helena, MT 59601

Dear Ms. Brooks,

I am writing in support of House Bill Number 211, for which a hearing will be held on Friday, January 22, 1993. The bill as drafted is supported by the Montana Hospice Organization and would enable hospice programs to provide care for a previously underserved portion of Montana residents.

In our service area, the ability to establish an inpatient unit as provided for in this bill would enable us to serve patients that currently are not within the realm of feasibility. These patients cannot be served because of a lack of a primary caregiver for the hospice to work with in providing care, because of extreme distances to patient homes which prohibit timely response in person by hospice personnel, or the need for closer monitoring in a time of crisis for those patients who live a great distance away, yet whose condition does not merit hospitalization. Although the primary focus for patient care would be in the home, the inpatient unit would be available as needed. This flexibility would allow us to provide care in a more cost-effective manner.

House Bill number 211 defines hospice inpatient units, with restrictions which will maintain quality care without imposing an undue burden upon hospices which would be establishing such units or upon the state in regulating those units.

Thank you for your support of this Bill.

Sincerely,

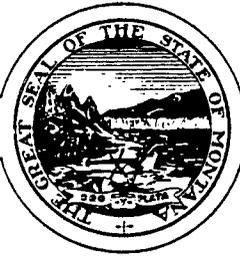


Kathryn Ravenscraft
Hospice Coordinator

cc: Bonnie Adee

DEPARTMENT OF FAMILY SERVICES

EXHIBIT 38
DATE 1-22-93
HB 238



MARC RACICOT, GOVERNOR

(406) 444-5900
FAX (406) 444-5956

STATE OF MONTANA

HANK HUDSON, DIRECTOR
JESSE MUNRO, DEPUTY DIRECTOR

PO BOX 8005
HELENA, MONTANA 59604-8005

January 22, 1993

DEPARTMENT OF FAMILY SERVICES TESTIMONY IN SUPPORT OF HB 238

Submitted by Ann Gilkey, Legal Counsel

This bill has two purposes. The first is to increase federal participation available to the Department of Family Services to provide services to our clients. This will be accomplished by allowing the department to inquire into the financial resources of a family for the purpose of determining the family's eligibility for federal emergency assistance programs. Examples of such emergency assistance may include support services delivered to the home of an abused or neglected child, or child at risk of being abused or neglected, in an attempt to eliminate the need for protective services, prevent the need for an out-of-home placement, or expedite the early return of the child to the family home. Substitute care on a temporary basis may also be provided with this funding source. Without the language requested in HB 238 and attached amendment, there will be no way to determine a family's eligibility for federally funded emergency assistance prior to court action requesting temporary custody of a youth.

The second purpose of HB 238 is to clean up conflicting language in the statutes. Last session the Department of Family Services requested legislation that bolstered the agency's ability to receive contributions from parents of youth who need to be removed from their homes. When a child is committed to the temporary custody of the department, the current statutes require the court to make a finding regarding a parent's ability to contribute to the cost of their child's out-of-home care, and order the parents to make a contribution as calculated by the Child Support Enforcement Guidelines. The CSED of SRS has the authority to collect the amount ordered by the court through its established process and turn the funds over to DFS to be used to abate the cost of that child's care.

The conflict arises in Section 41-3-202 and 41-3-401 which prohibit a social worker from inquiring into the financial resources of a family during an investigation of alleged child abuse or neglect, or prior to the adjudicatory hearing regarding temporary custody although 41-3-403(2)(f) allows the court to make a determination regarding the parent's ability to contribute to the cost of care during the earlier stages of state involvement with the family.

HB 238 simply removes the conflicting language, thereby clarifying that the social worker may inquire into the financial resources of a family to comply with the provisions of 41-3-406. This means that the department will be allowed to provide information to the court to assess a family's ability to contribute to the cost of their child's care.

The Department of Family Services urges your support of HB 238.

1. Title, line 10.
Following: "41-3-202"
Insert: "and 41-3-401"

2. Page 3.
Following: line 9
Insert: "Section 2. Section 41-3-401, MCA, is amended to read:

41-3-401. Abuse, neglect, and dependency petitions. (1) The county attorney, attorney general, or an attorney hired by the county welfare department or office of human services shall be responsible for filing all petitions alleging abuse, neglect, or dependency. The county attorney or attorney general, or an attorney hired by the county welfare department or office of human services with the written consent of the county attorney or attorney general, may require all state, county, and municipal agencies, including law enforcement agencies, to conduct such investigations and furnish such reports as may be necessary. ~~Investigations as to financial status may not be made prior to the adjudicatory hearing provided for in 41-3-404.~~

(2) Upon receipt of a petition, the court shall set a date for an adjudicatory hearing on the petition. Such petitions shall be given preference by the court in setting hearing dates.

(3) A petition alleging abuse, neglect, or dependency is a civil action brought in the name of the state of Montana. The rules of civil procedure shall apply except as herein modified. Proceedings under a petition are not a bar to criminal prosecution.

(4) The parents or parent, guardian, or other person or agency having legal custody of the youth named in the petition, if residing in the state, shall be served personally with a copy of the petition and summons at least 5 days prior to the date set for hearing. If such person or agency cannot be served personally, the person or agency may be served by publication in the manner provided by the Montana Rules of Civil Procedure for other types of proceedings.

(5) In the event personal service cannot be made upon the parents or parent, guardian, or other person or agency having legal custody, the court shall appoint an attorney to represent the unavailable party where in the opinion of the court the interests of justice require.

(6) If a parent of the child is a minor, notice shall be given to the minor parent's parents or guardian, and if there is no guardian the court shall appoint one.

(7) Any person interested in any cause under this chapter has the right to appear.

(8) Except where the proceeding is instituted or commenced at the request of the department of family services, a citation shall be issued and served upon a representative of the department prior to the court hearing.

(9) The petition shall:

(a) state the nature of the alleged abuse, neglect, or

dependency;

(b) state the full name, age, and address of the youth and the name and address of his parents or guardian or person having legal custody of the youth;

(c) state the names, addresses, and relationship to the youth of all persons who are necessary parties to the action.

(10) The petition may ask for the following relief:

(a) temporary investigative authority and protective services;

(b) temporary legal custody;

(c) termination of the parent-child legal relationship and permanent legal custody with the right to consent to adoption;

(d) any combination of the above or such other relief as may be required for the best interest of the youth.

(11) The petition may be modified for different relief at any time within the discretion of the court.

(12) The court may at any time on its own motion or the motion of any party appoint counsel for any indigent party. "

Renumber: subsequent sections

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. HB 241
DATE 4/22/93 SPONSOR(S) Rep. Strick
PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
John M. Dunderder	Self.	X	
Chuck Valf	Med Tech Great Falls Mt. Deaconess Med Ctr	X	
Susan Lewis	Montana Society of Medical Technology	X	
Shannon Kuehel	Warm Springs State Hosp. M.S.M.T	X	
DOUG ABBOTT	MYSELF	X	
Rynn Williamson	Columbus Hospital Great Falls	X	
Jeff Staple	Med. Ref. LAB	X	
Allyn Christensen	Columbus Hospital Great Falls	X	
Downa Gollehon	Bozeman MT	X	
Rhonda Crauer	Bozeman MT	X	
Mary Kaye Bleile	Consumer	X	
Sonja Bennett	St Vincent Hospital Billings	X	
Anne Weber	MS MT	X	
Anta Dierne	Consumer	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. AB241

DATE 1/22/95 SPONSOR(S) Rep. Strizich

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
J. Brian Sanders	MT CLMA	X	
Jeanne Strizich Great Falls	Mont. Deac. Mod Center	X	
John Pullman MD	self	X	
Susie Zanto, Helena	self	X	
MMA Jamison	MT CLMA	X	
Steve Meloy	Commune (MGA)		
Doree Doohew	MT. Nurses Assoc.	X	
BEV JAVORNIK	Self	X	
RON JAVORNIK	"	X	
Joyce ZABAWA	SELF	X	
Jamie Zabawa	self	X	
Mark Javornik	"	X	
Vicki Rice	self	X	
RANDY Spear	MAPA		X

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HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services

COMMITTEE

BILL NO. SB 43

DATE 1/22/93

SPONSOR(S) Senator Roberts

Continuation

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GARY KAWNER - Bozeman	Bozeman Hosp Dent.	X	
Jim Boquette - Billings	SAINT VINCENT HOSPITAL	+	
Rob Hunter - Billings	Employee Benefit Management Services		X
Damb Doohan	Mt. Nurses Assoc.	X	
Reverna Robson	PARK CLINIC		X
Dennis M. Sweeney	Physicians Mgmt Services		X
Bill Olson	AARP		X
Terry Miron	MT Fed Teachers		X
John alk	BCBS		X

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HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. HB220
DATE 1/22/93 SPONSOR(S) Rep. Simon

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NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
TIM BERGSTRÖM	MT. STATE COUNCIL OF PROFESSIONAL FIRE FIGHTERS	X	
EDWARD L FLIES	MT STATE COUNCIL OF Prof. Fire Fgts	X	
MIKE FOSTER	HELENA FIRE DEPT.	X	
DON HUBNI	CITY OF HELENA	X	
DAN BOOHER	MT. NURSES ASSOC	X	
W. E. ...	MT St. Terrence's	X	

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HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services

COMMITTEE

BILL NO.

HB 211

DATE 1/22/93

SPONSOR(S)

Rep. Drake

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Bomb Becker	Mt. Nurses Assoc.	X	
Bonnie Adee	Mt. Hospice Organization	X	
Mike Gaig	DHES	X	
BEV JAVORNIK	Self	X	
Pana Meeds	Self Helena Med. LAB	X	
Debby Thorpe	Helena Medical LAB	X	
Liz Smith	HB # 48	X	
Steve Browning	ITB MHA	X	
Johy Flink	MHA		

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