MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

FEBRUARY 20, 1985

The meeting of the Public Health, Welfare and Safety Committee was called to order by Chairman Judy Jacobson on Wednesday, February 20, 1985 in Room 410 of the State Capitol at 12:30.

ROLL CALL: All members were present with the exception of Senator Newman, who was excused. Senator Towe arrived late. Karen Renne, staff researcher, was also present.

There were many, many visitors in attendance, also. See attachments.

ACTION ON SENATE BILL 329: Senator Pat Regan of Billings is the sponsor of this bill. The bill is an act revising provisions relating to freedom of choice of medical assistance provided through the Department of Social and Rehabilitation Services.

Karen explained the proposed amendments.

Senator Norman questioned the rule making authority being given to the SRS. He also questioned the freedom of choice. He stated that it appears to him the Department has all of the rule making authority to do all of this already.

Pat Godbout from the Department stated that SB 329 will clarify the intent between the conflicting statutes. She also stated that the Department can contract for physicians at the present time.

Dave Lewis, director of the Department of Social and Rehabilitaiton Services stated that with this bill eye glasses and other medical services could be put out on contract.

Senator Himsl stated that federal statutes give the Department the authority to do this.

Senator Norman asked Pat Godbout, if the bill is really needed. She stated that "yes" the Department does need the bill.

Senator Norman asked who had written the statement of intent. The Department wrote the statement of intent.

A motion was made by Senator Himsl that the Statement of Intent for SB 329 be adopted. Motion carried.

Senator Towe arrived.

A motion was made by Senator Hager that SB 329 DO PASS AS AMENDED. Motion carried. The amendments were adopted at a previous meeting.

DISCUSSION OF SENATE JOINT RESOLUTION 22: Senator Tom Towe of Billings is the sponsor of this resolution which urges the United States Congress to reauthorize the Indian Health Care Improvement Act.

Karen explained the proposed amendments which would designate where the resolution is to be sent.

Senator Himsl asked Senator Towe if he had been able to secure the information which the Committee requested. Senator Towe suggested that we hold this bill until Friday to enable him time to get some more information for the Committee.

CONSIDERATION OF SENATE BILL 286: Senator Tom Hager of Senate District 48 in Billings, the chief sponsor of SB 286, gave a brief resume of the bill. This bill is an act providing for the licensure and regulation of repiratory care practitioners; creating a Board of Respiratory Care; providing for the authority of the board and providing effective date. This bill was requested by the respiratory care practitioners.

Barry Hjort introduced George Lundgren who is a recipient of respiratory care. He stated that this bill would be beneficial to patients to have better trained technicians. Respiratory Care Practitioners should be well trained and licensed. This bill would be the best way of administering the respiratory care practitioners.

Mr. Lundgren had to leave immediately and therefore, the Committee was allowed to ask him questions before his departure.

Senator Stephens asked Mr. Lundgren just what exactly does a respiratory care practitioner do. They administer drugs, check ones heart, pulse, and lungs before and after medication. A therapists will come to either the hospital or ones home.

Barry Hjort, representing the Montana Society of Respiratory Care Practitioners, stood in support of the bill. He stated that this bill would set up a board, call for continuing education, andprovide for effective dates. Mr. Hjort also adressed the fiscal note with the bill.

Leonard Bates, representing the Montana Society of Respiratory Care, stood in support of the bill. Mr. Bates is the president of the society. Respiratory care address life support and life saving measures.

The field of respiratory therapy has grown immensely in the past 15 years, since the administration of oxygen and other therapeutic aerosols. Mr. Bates stated that there will be one level of licensure even though people who have one year of training are usually technicians and those who have upward of two years are therapists. This bill is needed to ensure the highest quality care to the public of the State of Montana for the the public safety.

Several people involved with respiratory care stood and stated their names as proponents of the bill. There were the following: Greg Paulauski, Sally Gavey Reineke, We Bollman, Daryl Dilly, John P. Anderson, Paul Kremer, Jim Roberts, Mike Biggins, Susan Morigeau, JoEllen Bangs.

Jim Roberts, past president of the Montana Society of Respiratory Care, stood in support of the bill. He states that there are 250 respiratory practitioners in the state of Montana. 1/3 are register, 1/3 are certified and 1/3 are not licensed. The people of Montana need to be protected. There is no financial impact of the people of Montana in this bill.

Mike Biggins, a registered respiratory thereapists, stood in support of the bill. He stated that this bill does not necessitate the need for hospitals to hire speciality personnel to provide respiratory care to their patients. Respiratory thereapists and technicians decrease the cost of health care to Montanas through decreasing over utilization over utilization of unnecessary respiratory care procedures and treatments. This bill also does not have any start up costs for the board. Mr. Biggins handed in written testimony to the Committee. See attachments.

W. Bollman of Missoula stood in support of the bill. She stated that she is a student at the vo-tech in Missoula where there is a waiting list of people waiting to recieve training in respirtatory care. The list is some times 100 people long.

Greg Paulauski at respiratory care instructor at the vo tech in Great Falls stood in support of the bill. He stated that those involved with respiratory care need to know what is happening to the patients.

Anna Jones from the American Lung Association stood in support of the bill. She stated that a request for a license for respiratory care is appropriate.

Jerome Loendorf, representing the Montana Medical Association, stood in support of the bill.

With no further proponents, the chairman called on the opponents.

William E. Leary, president of the Montana Hospital Association, stood in opposition to the bill. He handed in written testimony for the Committee to review. See attachments.

Clay Edwards of Dillon stood in opposition to the bill. He stated, however, with some amendments he could support the bill. Mr. Edwards is a home oxygen and home oxygen equipment supplier proposed to amend Section 4, #2 by adding (c) "The delivery, maintainence or administration of oxygen or oxygen equipment to patients is their place of residence, by unlicensed health care personel." This amendment would allow home oxygen companies to employ unlicensed health care personel to deliver and administer oxygen to patients in their homes or nursing homes. This service does not require a licensed Respiratory Care Practitioners and would only result in increased expense to the patients if this bill were strictly enforced. Mr. Edwards handed in written testimony. See attachments.

Chad Smith representing the Montana Hospital Association stood in opposition to the bill. He asked if this bill is really necessary to assure quality care of the patients. He stated that this bill will give status to respiratory care personel and the added status will add to the cost of care. It is a matter of liability.

Mr. Smith asked if anything will really be gained by the public if this bill were to pass.

Dr. Michael Sadaj of Butte stood in opposition to the bill. He stated that there are less than 10 pulmonary specialist in Montana. He addressed some of the definitions in the bill and also stated that on-the-job training is not even addressed in the bill. He urged the Committee to give the bill a Do Not Pass recommendation.

With no further opponents, the meeting was opened to a question and answer period from the Committee.

Senator Lynch asked who can give emergency care when the patients life is at stake.

Senator Stephens asked what kind of training is required. It depends on the hospital. Some hospitals train their own respiratory care pratitioners.

Senator Himsl asked one of the vo tech teachers if their students take the national exam, however, the test is voluntary.. If this bill passes the test for licensure will be the national test, if permissible by the national board.

Senator Himsl asked if the public really needs this bill. He then asked the physical therapists if they would object to putting the respiratory care practitioners on their board. Mr. Edwards stated that their fields are too different for them to be on the same board.

Senator Stephens asked about the correspondence course which some students take.

Senator Towe asked how many people will be affected by this. There are 241 people involved in respiratory care.

Senator Jacobson asked Dr. Sadaj about the on-the-job training which some practitioners and hospitals use. Some hospitals train certain people to do the respiratory care.

Senator Hager closed. He asked the Committee for a favorable consideration of this bill.

ANNOUNCEMENTS: The next meeting of the Public Health, Welfare and Safety Committee will be held on Friday, February 11, 1985 in Room 410 of the State Capitol to consider SB 458 and finish work on the Senate Bills left in Committee.

ADJOURN: With no further business the meeting was adjourned.

Judy Jacobson

SENATOR JUDY JACOBSON
CHAIRMAN

eg

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985 Date 2/26/85

SENATE SEAT #	NAME	PRESENT	ABSENT	EXCUSED
6	SENATOR JUDY JACOBSON, CHAIRMAN	✓		
5	SENATOR J. D. LYNCH, V.CHAIRMAN	✓		
42	SENATOR TOM HAGER	✓		
30	SENATOR MATT HIMSL	✓		
17	SENATOR TED NEWMAN			✓
45	SENATOR BILL NORMAN	✓		
14	SENATOR STAN STEPHENS	✓		
26	SENATOR TOM TOWE	late		

Each day attach to minutes.

DATE 2-20-85

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
Barry Hjort	MT. Resp. Society	286	X	
Paul Kremer	MSRT	286	X	
Jim Roberts	MSRT	286	X	
Anna Jones	ALA of MT	286	X	
Michael Biggins	MSRT	286	✓	
Darryl Dilley	MSRT	286	✓	
Clay Edwards	Dillon Med. Supply	286		X
Greg Paulaconis	MSRT	286	✓	
Sally Gauer Reinecke	MSRT	286	X	
John P. Anderson	MSRT	286	X	
Susan Morigeau	MSRT	286	X	
JOELLEN BANGS	MSRT	286	X	
CHARLOTTE HEATH	MSLPNA	286		
Shirley Davis	MSLPNA	286		
Mary Musil	Self	286		
[illegible]	MT. Hospital Assn	286	✓	
[illegible]	Dept of Commerce	286	No Position	
Ronald A. Unjue	MSRT	286	X	
[illegible]	MHA (Mont Hosp Assn)	SB 286		X
[illegible]	Montana Hospital Assoc.	SB 286		X
David E. [illegible] MD	(MMA/Montana Med. Association Mt Society Resp Therapy and Pulmonol	286	X	
[illegible]	MT Nurses' Assoc.	286		
Nelly Munro	MONTANA	286	no position	
W. Ballman	MSRC	286	X	

STANDING COMMITTEE REPORT

FEBRUARY 20, 19 85

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration SENATE BILL No. 329

FIRST reading copy (WHITE color)

FREEDOM OF CHOICE PROVISIONS FOR MEDICAL ASSISTANCE THROUGH SRS

Respectfully report as follows: That SENATE BILL No. 329

be amended as follows:

1. Page 1, line 25 through Page 2, line 1.
Strike: subsection (b) in its entirety
Renumber: subsequent subsections

AND AS AMENDED

DO PASS

~~DO NOT PASS~~

STATEMENT OF INTENT ATTACHED

SENATOR JUDY JACOBSON Chairman.

FEBRUARY 20, 1985

MR. PRESIDENT:

WE, YOUR COMMITTEE OF PUBLIC HEALTH, WELFARE AND SAFETY HAVING HAD UNDER CONSIDERATION SENATE BILL NO. 329, ATTACH THE FOLLOWING STATEMENT OF INTENT.

STATEMENT OF INTENT

SENATE BILL 329

A statement of intent is required for this bill because it amends 53-6-104 to allow the department of social and rehabilitation services to enact rules in subsection (2). Under present law the department has express rulemaking authority to administer and supervise the state's medical assistance programs under Title 53. The intent of this bill is to clarify that the department has the same options provided under federal freedom of choice statutes to restrict access to and services of health care providers.

Judy Jacobson

SENATOR JUDY JACOBSON
CHAIRMAN

AMENDMENT TO SB 329 (passed by Senate Public Health, Welfare and Safety Committee 2/20/85; bill as amended passed same date; statement of intent, unamended, passed)

1. Page 1, line 25 through Page 2, line 1.
Strike: subsection (b) in its entirety
Renumber: subsequent subsections

PROPOSED AMENDMENT TO SB 329

1. Page 1, line 21 through line 13, page 2.
   Following: "(2)" in line 21
   Strike: remainder of subsection 2
   Insert: "Nothing in this section prevents the department from imposing conditions on medical assistance, under authority provided for in other sections of this chapter."

PROPOSED AMENDMENT TO STATEMENT OF INTENT

1. In the second line of the text, strike: "amends 53-6-104 to allow" and insert: "affects the rulemaking authority of"

2. In the third line of the text, strike: "to enact rules in subsection (2)"

3. In the sixth line of the text, insert: "not to extend this rulemaking authority but" after "The intent of this bill is"

Note: The sentence proposed for insertion in the bill refers to the following sections in Title 53, chapter 6:

53-6-111 - empowers the department to administer and supervise a vendor payment program of medical assistance under the provisions of chapter 2 and the federal Social Security Act, and to adopt rules for applying sanctions to providers who abuse the medical assistance program.

53-6-113 - gives the department the power to adopt rules to administer and supervise medical assistance programs uniformly throughout the state.

53-6-114 - makes the department's rules binding on county welfare departments.

53-6-115 - allows the department to contract for payment of claims and for provision of services.

53-6-141 - allows the department to determine the amount, scope, and duration of assistance to eligible persons.

AMENDMENTS TO SJR 22 (passed by Senate Public Health, Welfare & Safety Committee)

1. Page 3, line 9.
   Following: line 8
   Insert: "(1)"

2. Page 3, line 12.
   Following: line 11
   Insert: "(2) That copies of this resolution be sent to
   (a) the Speaker of the United States House;
   (b) the President of the United States Senate;
   (c) all members of the Montana Congressional delegation; and
   (d) the President of the United States."

RONALD E. BURNAM, M.D., INC.
PULMONARY DISEASES
YELLOWSTONE MEDICAL BLDG., SUITE 300
1145 North 29th Street
Billings, Montana 59101
(406) 256-8600

Testimony for Respiratory Care Bill

February 13, 1985

Senator Judy Jacobson
State Senate
Capital Building
Helena, Montana 59620

R.E. Senate Bill 286
Respiratory Therapy Licensure Act

Dear Senator Jacobson:

Until the date of the hearing had been changed from 13 February until 20 February, I had intended to testify at the hearing concerning the Respiratory Care Licensure Act, but because of conflict of schedule will not be able to testify in person.

I would like to urge your favorable consideration for forwarding of the Respiratory Care Licensure Act to the entire Legislature for passage as I think it is important in an effort to not only ensure the highest quality respiratory care to the public of Montana, but also will aid in the provision of appropriate respiratory care with the most reasonable outlay of funds.

The field of respiratory therapy has grown immensely in the past 15 years or so since its inception and no longer is it simply the administration of oxygen and therapeutic aerosols. Respiratory therapy is a rapidly expanding field, which is highly technical in nature and in order to be properly administered requires background knowledge in anatomy, physiology and pharmacology that is appropriate to the diseases being treated and the medications being administered. It was in fact the case when I came to Billings that the respiratory therapy department consisted of registered nurses who had been self taught in the field of respiratory therapy and various other persons who had been taught in the department through on the job training. Many of these people had had no formal training in either pharmacology, anatomy or physiology. Since there is nothing to preclude this in the remainder of the state, I assume that this might also be happening at other places in Montana at the present time. I think it is important that the people providing respiratory therapy to patients with respiratory disease have some background and training in appropriate directly or indirectly related fields. We should not permit people to be straight out of high school or other nonrelated training programs who are in a position to apply respiratory therapy without proper training.

A most significant aspect of the bill as presented is that it <u>does not</u> preclude the provision of respiratory care services, all or in part by other health care professionals who have had, if not direct training in respiratory therapy, at least training in anatomy, physiology, and to greater or lesser degrees

pharmacology. I am speaking directly to the fact that registered nurses, registered physical therapists and other duly licensed health care personnel would be able to provide respiratory therapy services in those hospitals who did not wish to or could not afford to hire respiratory therapists because of their own staffing needs. This therefore is not an exclusive practice act other than a needed attempt to exclude people with inadequate or no training from the application of respiratory medicine techniques. This bill as proposed has the support of at least eight of the nine pulmonary physicians who practice in the state of Montana.

Thank you very much for your concerns in this area. If I can be of further help, please do not hesitate to contact me.

Sincerely,

Ronald E. Burnam, M.D., F.C.C.P.

REB/sb

(This sheet to be used by those testifying on a bill.)

NAME: Leonard Bates DATE: 2-20-93

ADDRESS: RR 2254 Great Falls, MT 59405

PHONE: 453-6169

REPRESENTING WHOM? Montana Society for Respiratory Care

APPEARING ON WHICH PROPOSAL: SB 286

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: JIM ROBERTS DATE: 2/20/85

ADDRESS: 3508 GRIZZLY COURT

PHONE: 761-1670

REPRESENTING WHOM? MT SOS FOR RESP CARE

APPEARING ON WHICH PROPOSAL: SB 286

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Michael Biggins DATE: 2-24-85

ADDRESS: 2317 Garland Missoula MT. 59803

PHONE: 251-3159

REPRESENTING WHOM? Montana Society for Respiratory Care

APPEARING ON WHICH PROPOSAL: SB 286

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Missoula Community Hospital

GRANT M. WINN, EXECUTIVE DIRECTOR

Dear Committee Member;

I would like to submit a review of my testimony for the Respiratory Care Practitioner Licsensure Act.

There are three reasons why Licsensure of Respiratory Care Practitioners will not raise the cost of care to Montanans.

1. The bill does not necessitate the need for hospitals to hire specialty personnel to provide respiratory care to their patients.

2. Respiratory Therapists and Technicians decrease the cost of health care to Montanans through decreasing over utilization of unnecessary respiratory care procedures and treatments.

3. Start up cost for a board are not a burden to the people of Montana.

Our bill states that respiratory care can be practiced by only licsensed personnel in Montana, this means RN's, LPN's, Physical Therapists, etc. Their Licsensure Acts or Practice Acts define in their scope of practice that they can provide respiratory care. Thus hospitals in rural Montana will not need to hire additional staff to provide respiratory care. Because of this, cost of additional personnel does not get passed onto patients. The hospitals already have the staff that can provide respiratory care.

The (GAO) in late 1983 released a report that stated respiratory therapy as delivering the lowest percentage (6.1%) of unnecessary care of all ancillary services. The facility I work at, approximately 12% of the procedures and treatments the Respiratory Services Department does are changed from the original order the physician writes. This is not because the physician orders things that are unnecessary, but because qualified practitioners, respiratory therapists and technicians are talking to the physician and making suggestions of other treatment regimes that may be less costly; but yet meet the physicians goals. In other words, there is more than one way to skin a cat. Because of DRGs the respiratory therapists and technicians are well aware of other forms of theraputic modalities that work.

My last point is corroborated by Mrs. Shirley Miller, Department of Commerce, Bureau Chief, Professional Occupation Licsense . The cost of a board is not actually passed onto the people of Montana, but to the practitioners being licsensed.

Sincerely,

Michael Biggins, RRT
Director, Respiratory Services

M|C 2827 FORT MISSOULA ROAD, MISSOULA, MONTANA 59801
M|C MISSOULA COMMUNITY MEDICAL CENTER (406) 728-4100

THOMAS H. SCHIMKE, M.D., P.C.

January 11th, 1985

DIPLOMATE OF THE
AMERICAN BOARD OF
INTERNAL MEDICINE

DIPLOMATE OF THE
SUBSPECIALTY BOARD
OF PULMONARY DISEASE

TO WHOM IT MAY CONCERN:

WHY LICENSURE FOR RESPIRATORY THERAPISTS IS NEEDED NOW IN MONTANA

Respiratory therapy is the only allied health care profession involved in life-saving and life-sustaining measures that is not now licensed by the state of Montana. The formal education programs of the 70's could not keep pace with the growing demand for larger numbers of practitioners. As a result, many people have been thrust into life and death decision-making situations without adequate preparation for that role. Currently no safeguards exist in Montana to assure that a practitioner does not practice beyond his or her education and training.

It is clear that, because of technological advances and innovations in the diagnostic and therapeutic procedures used by respiratory therapists, it is time that Montana mandated that the over 250 respiratory therapists in this state demonstrate that they possess the knowledge necessary to treat patients with cardio-pulmonary impairment. No other group of unregulated allied practitioners has this level of potential for causing injury, or even death, to patients. Implementation of state licensure is in the best interest of the consumers of respiratory care and of the entire health care delivery system.

Although a voluntary national credentialing mechanism does exist, it does not offer a satisfactory solution to the problem. It does not provide a mechanism to deal with unethical, unscrupulous, or incompetent practitioners. And most importantly, it does not provide a legal basis for the practice of respiratory therapy in this state.

During the embryonic stage of the profession, most of the therapist's duties involved the administration of oxygen. Because of new diagnostic and treatment procedures, the role of the respiratory therapist has been expanded to require knowledge of patient airway mechanics, as well as techniques for analyzing blood gases, monitoring pulmonary function and maintaining cardio-pulmonary life support systems.

Although many practitioners have recognized the need for adequate education to enable them to function safely and effectively during this era of sophisticated technology, there is no mechanism in Montana requiring practitioners to demonstrate even minimal competence before treating patients. The Montana Society of Respiratory Therapy feels that it is imperative that a program requiring state licensure of respiratory therapist be enacted in Montana. Only in this manner can we be certain that minimum standards for education and competence will be maintained as respiratory therapy continues to play an important role in the health care provided to the citizens of Montana.

Sincerely,

Thomas H. Schimke, M.D.

601 WEST SPRUCE MISSOULA, MONTANA 59802 TELEPHONE 728-1970

PAUL LOEHNEN, M.D., P.C.
OMATE OF THE AMERICAN BOARD OF
IAL MEDICINE AND PULMONARY DISEASE.

601 West Spruce
Missoula, Montana 59802
(406) 728-5324

January 30, 1985

TO WHOM IT MAY CONCERN:

I believe that licensure for respiratory therapists is needed now in Montana. The following are my reasons:

Respiratory therapy is the only allied health care profession involved in life-saving and life-sustaining measures that is not now licensed by the state of Montana. The formal education programs of the 70's could not keep pace with the growing demand for larger number of practitioners. As a result, many people have been thrust into life and death decision-making situations without adequate preparation for that role. Currently no safeguards exist in Montana to assure that a practitioner does not practice beyond his or her education and training.

It is clear that, because of technological advances and innovations in the diagnostic and therapeutic procedures used by respiratory therapists, it is time that Montana mandated that the over 250 respiratory therapists in this state demonstrate that they possess the knowledge necessary to treat patients with cardio-pulmonary impairment. No other group of unregulated allied practitioners has this level of potential for causing injury, or even death, to patients. Implementation of state licensure is in the best interest of the consumers of respiratory care and of the entire health care delivery system.

Although a voluntary national credentialing mechanism does exist, it does not offer a satisfactory solution to the problem. It does not provide a mechanism to deal with unethical, unscrupulous, or incompetent practitioners. And most importantly, it does not provide a legal basis for the practice of respiratory therapy in this state.

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C. Paul Loehnen, M.D.

CPL:bp

(This sheet to be used by those testifying on a bill.)

NAME: Anna Jones DATE: 2-20-85

ADDRESS: 538 Highland, Helena

PHONE: #442-6556 (443-6317)

REPRESENTING WHOM? American Lung Assn. of MT

APPEARING ON WHICH PROPOSAL: SB 286

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Jerome T. Loendorf DATE: 2-20-85

ADDRESS: Helena, Mt

PHONE: 442-6350

REPRESENTING WHOM? Mt. Medical Assn

APPEARING ON WHICH PROPOSAL: SJ 86

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: David E. Anderson MD DATE: 2/20/85

ADDRESS: 901 Buena, Great Falls, MT.

PHONE: 454-2171

REPRESENTING WHOM? myself + the Pulmonary physicians in Montana

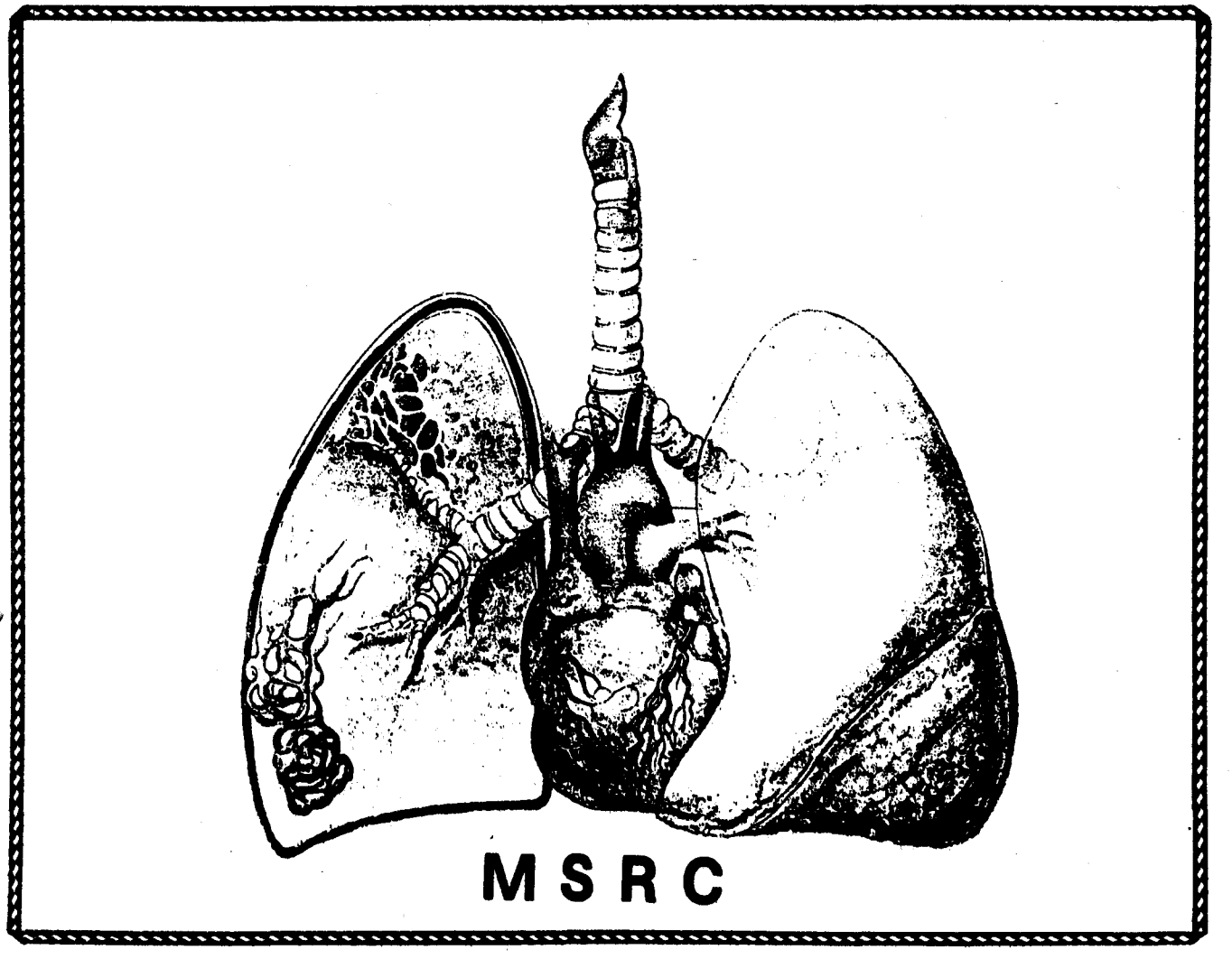
APPEARING ON WHICH PROPOSAL: SB 286

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Montana Society for Respiratory Care



Introduction

For most of us, breathing is effortless. But for thousands of patients in Montana hospitals and nursing homes, respiration is a constant struggle. Newborn babies, the elderly, victims of heart attacks, accidents and near-drownings — all are vulnerable to interruption of the respiratory process.

Today, virtually every patient in a life-threatening situation benefits from emergency respiratory care and is assisted on the road to recovery by the services of an experienced and dedicated respiratory therapist.

Respiratory therapists are members of the health care team who provide respiratory care for patients with heart and lung disorders. The scope of practice of the respiratory therapist includes:

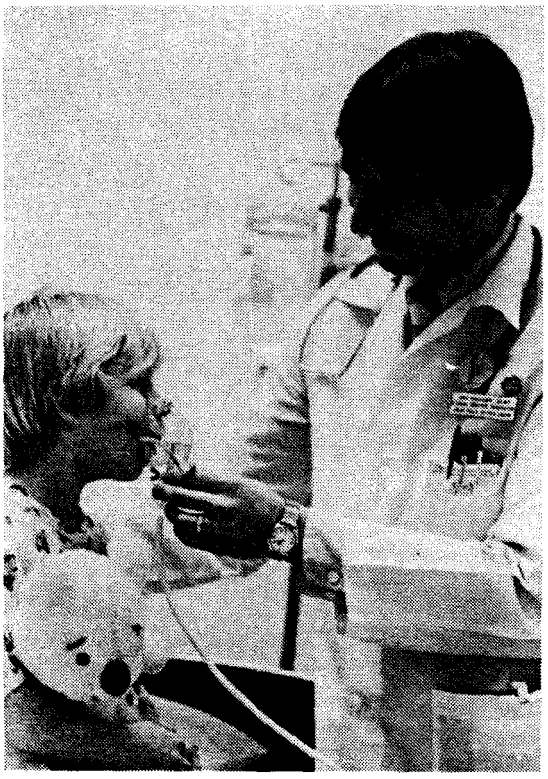
- General Care
- Neonatal Monitoring
- Pediatric Critical Care
- Diagnostic Testing
- Adult Trauma Care
- Rehabilitation and Home Care
- Education and Research

Patients with both acute and chronic cardiopulmonary problems are cared for by therapists in a variety of settings: in hospitals, in out-patient facilities, and in the patient's home.

Pediatric Critical Care

Respiratory therapists are responsible for providing direct care to our most fragile, acutely ill children and are integral members of the health care teams that staff pediatric intensive units.

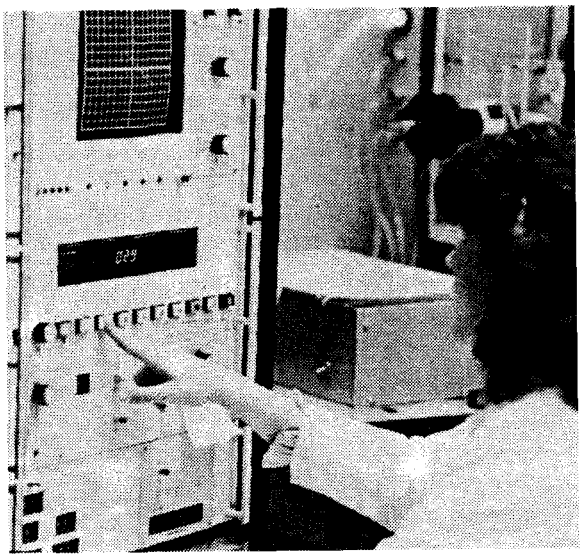
In aiding critically ill infants and children to breathe, these practitioners administer oxygen therapy, provide mechanical ventilatory support for those in cardiopulmonary failure, administer bronchopulmonary hygiene therapy to clear the lungs of excessive mucus, expand collapsed lungs and administer cardiopulmonary resuscitation (CPR).



Diagnostic Testing

Laboratories that perform extensive pulmonary function testing are frequently staffed by respiratory therapists. This type of testing is performed to help assess the extent and nature of lung disease a person may have. Coal miners and asbestos workers are examples of people at risk for lung disease because of the irritants they are exposed to in their jobs. Respiratory therapists participate in screening these workers, along with others, for lung disease.

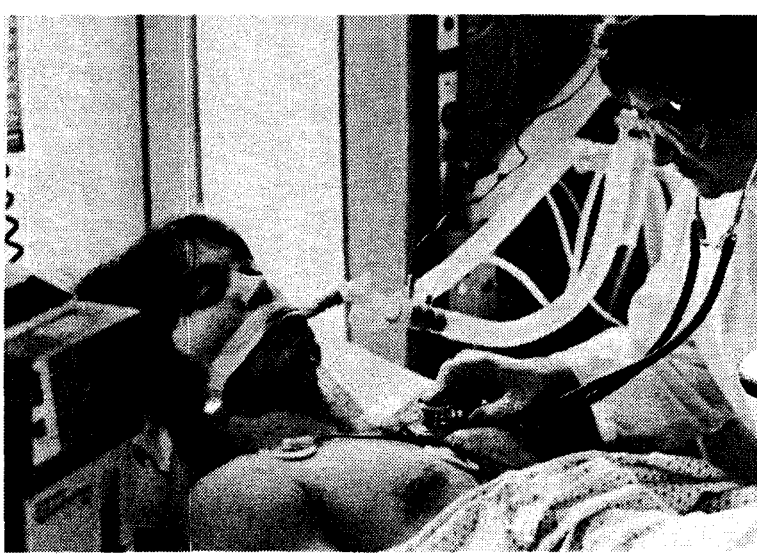
Blood sampling and analysis for blood gases may also be performed by respiratory therapists. This is a critical test used to assess cardiopulmonary function and appropriate treatment. Respiratory secretions are also collected and analyzed by therapists to assist physicians in diagnosing a specific pulmonary disease.



Critical Care

The respiratory therapists who work in trauma/emergency room units or in adult intensive care units perform a variety of functions for patients who have suffered heart attacks, drug overdoses, and accidents. They administer oxygen therapy and provide mechanical ventilatory support to those patients in cardiopulmonary failure. They may also perform cardiopulmonary resuscitation (CPR), expand collapsed lungs, and establish and maintain a patient's airway. The respiratory therapist is a vital member of the emergency cardiopulmonary arrest team which responds to "Code Blue" in the hospital—a code that signifies that a life or death situation exists for a patient.

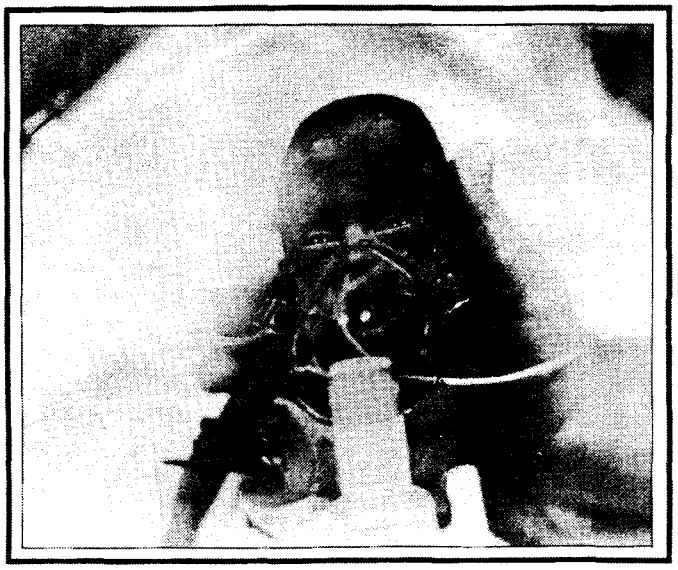
Many of the most unstable, critically ill patients in our trauma units and ICU's require care by respiratory therapists.



Neonatal Monitoring

Many times an infant, before it is born, is classified as "high risk," meaning that it is possible that the newborn will have breathing problems from birth. In these cases, when the mother is ready to deliver, a respiratory therapist stands ready to perform resuscitation if necessary.

Respiratory therapists also participate in the emergency transport of a sickly newborn from a community hospital to the nearest tertiary care neonatal intensive care unit. Their role within the intensive care unit includes monitoring, assessing and responding to clinical signs and symptoms.



Rehabilitation/Home Care

Respiratory therapists play a vital role in educating patients in rehabilitation and home care settings. Teaching breathing exercises and training patients in the proper modes of respiration and cardiopulmonary rehabilitation procedures are part of the respiratory therapist's responsibilities in treating patients in hospitals, chronic-care facilities and in the home.

Home care provided by respiratory therapists may include a range of services from administration of oxygen therapy, to monitoring infants at risk for sudden infant death syndrome, to support of chronic ventilator patients.

General Care

Respiratory therapists work in various areas of the hospital providing therapy to inpatients with both acute and non-critical cardiopulmonary problems. Types of care delivered by respiratory therapists in the general care area of the hospital include:

- Oxygen Therapy
- Chronic Mechanical Ventilatory Support
- Bronchopulmonary Hygiene Therapy
- Blood and Respiration Secretion Sampling and Analysis
- Bedside Pulmonary Function Testing
- Airway Establishment and Maintenance
- Delivery of Aerosolized Medications

Licensure for Respiratory Therapists
Why it is Needed Now

What is Respiratory Care?

Respiratory care is a young, dynamic, growing health specialty. Respiratory therapists employ a wide variety of sophisticated techniques and equipment in evaluating and assisting patients with impaired heart and lung functions.

Respiratory therapists work both in and out of hospitals providing diagnostic and therapeutic services to patients in need of pulmonary care. Diagnostic activities include obtaining blood samples in order to determine acid-base status and blood gas values, and measuring pulmonary function. Therapeutic services provided by these health care professionals include the delivery and monitoring of:

1. Oxygen therapy
2. Pulmonary ventilation
3. Artificial airway care
4. Bronchial hygiene therapy
5. Cardiopulmonary resuscitation
6. Respiratory rehabilitation

What do Respiratory Therapists do?

Simply put, respiratory therapy personnel help people breathe. They are the specialists who monitor and treat patients with cardiopulmonary dysfunction. By performing various tests to evaluate heart and lung functions and by administering gases and medication to help correct breathing problems, respiratory therapists serve a wide variety of patients.

Infants, the elderly, postoperative patients, and persons with chronic respiratory ailments benefit from the respiratory therapist's training and expertise.

What Kind of Patients do Respiratory Therapists Treat?

Patients who suddenly stop breathing or who cannot breathe adequately without continued assistance need respiratory support. These problems require that an open passage to the lungs be maintained so that it can be inflated with the proper volume of air and oxygen. Since the brain requires a constant supply of oxygen and can begin to suffer permanent damage within minutes after this supply is interrupted, there is very little margin for error, so the respiratory therapy clinician's role is critical.

Some patients need life-sustaining support therapy over extended periods of time. The respiratory therapist who cares for these patients must master the operation of complex treatment and monitoring apparatus, and have an advanced understanding of heart and lung functions to care for these patients. In addition, the clinician must understand associated function of other organ systems, such as brain and kidneys, in order to assist in the assessment of the patient's response to therapy and in the selection of appropriate modifications of treatment.

Since the heart and lungs are vital organs and can be affected by a wide variety of diseases, respiratory therapists treat patients

of all ages and a broad spectrum of illnesses. Some of the more common include:

- Infants with premature lungs
- Children with crippling lung diseases such as asthma and cystic fibrosis
- Adults with chronic (long-term) lung disease such as bronchitis and emphysema
- Surgical patients
- Traumatic injury patients
- Patients with pneumonia
- Patients with drug overdose
- Patients with acute (sudden) cardiorespiratory failure
- Near drowning patients
- Patients who have suffered heart attacks

How Has the Practice of Respiratory Therapy Evolved?

Respiratory therapy evolved as an allied health care profession in response to many factors; however, the increasing incidence of lung disease and the technological advances in medicine and health care are the most important factors resulting in the field's growth and development. The oxygen orderly of a few years ago is no longer capable of handling the complex medical equipment and life support instrumentation that can be found in the modern respiratory therapy department. No longer can on-the-job training provide the theory and technical knowledge necessary for the safe clinical application of patient respiratory care.

Because of new diagnostic and treatment procedures, the role of the respiratory therapist has been expanded to require knowledge of patient airway mechanics, as well as techniques for analyzing blood gases, monitoring pulmonary function and maintaining cardiopulmonary life support systems.

Does the Respiratory Therapist Practice Independently?

Respiratory therapists operate as an adjunct to the physician in his provision of the best care of his patient. These practitioners become an extension of the health care team and provide highly technical care. During the administration of respiratory therapy, which is ordered by the physician, it is the duty of the therapist to make evaluations and judgments to determine the effectiveness of the therapy and communicate that information to the physician. This is especially true in a nursing home or home care setting where there is no physician present during the administration and monitoring of respiratory therapy care. And because of the cost-effective aspect in the provision of out-patient services, delivery of respiratory therapy in these settings is increasing rapidly.

What Kind of Training Does Respiratory Therapy Care Require?

During the embryonic stage of the profession, most of the therapist's duties involved the administration of oxygen. Throughout the 50's and 60's, respiratory therapy did not require evaluative skills of an understanding of human anatomy and physiology. Today's sophisticated therapeutic techniques mandate these skills and knowledge.

In the 70's, however, an explosive growth of the profession occurred. The state of the art changed very rapidly as new and beneficial techniques were discovered. High technology was applied to all areas of medical practice, and this involved additional responsibilities for respiratory therapists.

Although many respiratory therapists have recognized the need for adequate education to enable them to function safely and effectively during this era of sophisticated technology, there is no mechanism in Montana to require practitioners to demonstrate even minimal competence before treating patients.

Why is Licensure of Respiratory Therapists Needed?

The formal education programs which proliferated in the 70's could not keep pace with the growing demand for larger numbers of respiratory therapists. As a result, many people have been thrust into life and death decision-making situations without adequate preparation for that role. Currently no safeguards exist in Montana to assure that a practitioner does not practice beyond his or her education and training.

Respiratory therapy is the only allied health care profession involved in **life-saving** and **life-sustaining** measures that is not now licensed by this state.

It is clear that, because of technological advances and innovations in the diagnostic and therapeutic procedures used by respiratory therapists, it is time that Montana mandated that the over 250 respiratory therapists in this state demonstrate that they posses the knowledge necessary to treat patients with cardiopulmonary impairment. No other group of unregulated allied medical practitioners has this level of potential for causing injury, or even death, to patients. Implementation of state legal credentialing is in the best interest of the consumers of respiratory care and of the entire health care delivery system.

Although a voluntary national credentialing mechanism does exist, it does not offer a satisfactory solution to the problem. Only one-half of the respiratory therapy practitioners in Montana have voluntarily become credentialed. It does not provide a mechanism to deal with unethical, unscrupulous or incompetent practitioners. And most importantly, it does not provide a legal basis to the practice of respiratory therapy in this state. For these reasons, the Montana Society for Respiratory Care feels that it is imperative that a program requiring state legal credentialing of respiratory therapists be enacted in Montana. Only in this manner can we be certain that minimum standards for education and competence will be maintained as respiratory therapy continues to play an important role in the health care provided to the citizens of Montana.

The enclosed materials regarding respiratory care are provided by:

The Montana Society for Respiratory Care
2100 16th Avenue South
Great Falls, Montana 59405

INTERNAL MEDICINE
F. J. ALLAIRE, M.D.
D. E. ANDERSON, M.D.
R. D. BLEVINS, M.D.
PULMONARY DISEASE
A. BUFFINGTON, M.D.
NEPHROLOGY
S. J. EFFERTZ, M.D.
RHEUMATOLOGY
J. D. EIDSON, M.D.
K. A. GUTER, M.D.
ONCOLOGY
T. J. LENZ, M.D.
W. N. MILLER, M.D.
GASTROENTEROLOGY
W. N. PERSON, M.D.
T. W. ROSENBAUM, M.D.
NEPHROLOGY
J. D. WATSON, M.D.
CARDIOLOGY

ɪTETRICS AND GYNECOLOGY
R. E. ASMUSSEN, M.D.
P. L. BURLEIGH, M.D.
F. J. HANDWERK, M.D.
R. L. MCCLURE, M.D.
G. K. PHILLIPS, M.D.

NEURO-SCIENCES
D. E. ENGSTROM, M.D.
PSYCHIATRY
W. H. LABUNETZ, M.D.
NEUROLOGY—EEG
E. E SHUBAT, PH. D.
PSYCHOLOGY

PEDIATRICS
J. A. CURTIS, M.D.
J. M. EICHNER, M.D.
N. C. GERRITY, M.D.
J. R. HALSETH, M.D.
J. P. HINZ, M.D.

SURGERY
W. P. HORST, M.D.
UROLOGY
R. E. LAURITZEN, M.D.
GENERAL AND VASCULAR
J. E. MUNGAS, M D.
VASCULAR SURGERY
L. M. TAYLOR, M.D.
GENERAL AND THORACIC
W. C. VASHAW, M.D.
GENERAL AND VASCULAR

ADMINISTRATION
W. D. TAYLOR
M. D. MISSIMER

GREAT FALLS CLINIC
P. O. BOX 5012
1400 TWENTY-NINTH STREET SOUTH
GREAT FALLS, MONTANA 59403
PHONE (406) 454-2171

January 28, 1985

To whom it may concern:

This letter is in support of the Montana Respiratory Care Practice Act.

I have practiced as a chest physician in Montana for the past two and a half years. During that time I have come to rely quite heavily on the respiratory care practitioner at Deaconess and Columbus Hospitals in Great Falls. These practitioners are very well trained in the physiology of normal lung function, as well as the pathophysiology of lung diseases. They are capable of providing respiratory care services under the auspices of a physician and not infrequently provide helpful suggestions for more effective care of the respiratory patients.

Respiratory care is rapidly changing field and I enthusiastically support the Respiratory Care Practice Act, which is currently before legislature. I believe it is important to recognize the respiratory care practitioner for the important member of the health care team that he is. I feel that licensure as provided by the Respiratory Care Practice Act will insure that well qualified respiratory care practitioners are recognized by the State of Montana and hospitals requiring their services. I urge your support for this Act.

Sincerely,

RICHARD D. BLEVINS, M.D.

RDB/lb

February 20, 1985

TESTIMONY - SENATE BILL 286

Licensure and Regulation of Respiratory Care Practitioners

by

William E. Leary, President
Montana Hospital Association

Madame Chair, Members of the Senate Public Health Committee, the Montana Hospital Association must rise in opposition to the passage of Senate Bill 286 and in doing so, must state that it is not because of the sponsor of the bill, Senator Hager, who we respect as a supporter of quality health care for the people of Montana, nor are we critical of the quality of respiratory care procedures as provided in our Montana hospitals by the very capable respiratory care technologists, both certified and non-certified. We rise in opposition for several reasons, the major of which is since 1976, the national dialogue relative to the licensure of health care personnel still recognizes the need to foster the growth and contributions of the various allied health personnel, the need to insure high quality patient care and safety through careful employee preparation and performance, and the need for employers to be able to use manpower flexibly. It is therefore our contention that licensing of additional health care occupations will fractionalize further the provision of health services, impede job advancement for employees, and hinder management in utilizing new knowledge and technological advances. Licensure of and by itself does not guarantee the provision of high quality health services to the patients in the most cost effective manner possible.

Before getting into the bill itslf, I must comment on the fiscal note which is made a part of this presentation and calls for the expenditure of a minimal sum of $29,000 for the biennium. More importantly, I question the projected revenue of $30,000 for the biennium which is based upon approximately 250 licensees.

My question is predicated on where are the 250 respiratory care practitioners now employed. How many are employed in Montana hospitals, how many in nursing homes, how many in home health agencies, and how many in freestanding respiratory care clinics.

It is important to know if the hospitals are employing respiratory care therapists who are certified by their national organization - the National Board for Respiratory Care, Inc. I would state that in general, the larger hospitals in the state do employ certified respiratory care therapists who in turn train and supervise a small number of respiratory care technicians. Certainly the twelve large hospitals in the state do not employ anywhere near the 250 respiratory care practitioners called for in the fiscal note.

In general, the small and medium size hospitals give special training to a number of registered nurses so they are able to give the minimum respiratory care called for in the small communities. This raises another question in that will all registered nurses need to have a new licensure under this bill, one from the State Board of Nursing and another from the State Board of Respiratory Care Practitioners? If not, does this then cut the 250 down to only those in the larger hospitals, including the certified respiratory care practitioners. If so, this would require a significant increase in the licensure and annual fee paid by the respiratory care practitioners remaining under the control of this legislation.

I refer you to page 9, section 16, which is the proponents efforts to establish a self-sustaining board. I congratulate them on their foresight. However, I feel the numbers are just not valid enough to assure this legislature that this board would be self-sustaining by the end of 1987.

Now to the specifics of Senate Bill 286. We in the hospital and nursing home field recognize that respiratory care is a valuable service, especially to asthmatics and persons with pulmonary diseases, however, we doubt that it should be given the full status of a health care profession, which is stated on page 2, section 3, line 15. We know one reason it is defined as a health care profession in this bill is to give the practitioners certified, as well as all others licensed under this bill, status which will set up the future introduction of legislation to force insurance companies to stipulate that the benefits must cover respiratory care services conducted outside a health care facility, i.e. in the freestanding respiratory care practitioner offices (page 4, section 5, line 10-11) that I predict will spring up over Montana in but a few short years. I believe this legislature could look forward in 1987 to a bill which would force the Medicaid program to provide reimbursement, even permissible, to respiratory care services if given by a licensed respiratory care practitioner. Evnidence of this can be found in House Bill 595 which now stipulates that Medicaid has

permission to reimburse services by licensed social workers.

Of course the pulmonary physicians will support this bill as they are giving medical direction at least in the hospital setting, the physician's office and the home health care, however, I question how much medical direction would be adhered to in the freestanding respiratory care practitioners office.

I refer you to page 3, section 3, lines 1-2, and stipulate that in the hospital setting, we have policies and standards as to the respiratory technologist use of pharmacology and diagnostic and therapeutic agents. Guidelines and well worked out protocols have been developed to prevent overlapping responsibilities of the hospital pharmacist, the physicians, the registered nurses, who are all technically trained and legally authorized to either compound, and certainly to dispense pharmaceuticals. We have no such guarantees that those same protocols would be adhered to in the freestanding respiratory care practitioners office.

We have a problem on page 4, section 6, lines 20-23, which raises the question as to what effect the adoption of this section would have on those registered nurses who give a minimal amount of respiratory care treatments in the small rural hospitals.

On page 8, section 15, lines 18-25, we see what is commonly referred to as the reciprocity clause which is generally acceptable in licensure bills of this nature. However, I would point out that currently only four states, Arkansas, California, Florida and New Mexico have laws to license respiratory care technologists. While it is true that similar legislation has been introduced in 27 other states, including Montana, I maintain that it would be far better to kill this bill in this session and let more states which do not have the small rural hospital problem that we in Montana have, lead the way towards licensure of a significant number of respiratory care practitioners. This would then make the reciprocity clause more meaningful.

Page 11, section 19, carries the grandfather provision and while I recognize the efforts of the proponents towards a grandfather provision, this particular provision will really not work in Montana for the following reasons. The large hospitals, the big twelve, provide the major portion of the specialized respiratory care services and in general these services are being performed by practitioners certified by the national board. Since the large hospitals have the kinds of services which require a certified RCP and since all employees of the hospitals are covered under the hospitals' malpractice insurance policies, the hospital is the controlling agent in what that person can or cannot do. Chad Smith, attorney

for the Montana Hospital Association, will explain in greater detail the complexity of this issue.

We recognize the employment in the larger hospitals of the certified technologist, however, the small rural hospital does not have that capability as their market for provision of these services is somewhat limited.

Passage of Senate Bill 286 will not help to contain the rise in health care costs which is the ultimate goal of every hospital in the state. It will actually have the reverse effect as it will require several of our medium and smaller hospitals, as well as the respective nursing homes, to employ licensed respiratory care practitioners as a replacement for the already adequately trained RN in order for us to legally provide respiratory care services to all those in need. We cannot, nor do we want to, take away from the registered nurses any part of their role in the delivery of health care services for which they have been trained in the hospital or the skilled nursing facility. The provision of health care services as carried out by registered nurses is vital to the care and wellbeing of the patients. Thus, certain hospitals may be saddled with two professions, both adequately trained to provide the service, but without enough patients to make the service pay for itself. When this happens, the medical practitioners, the physicians, have a tendency to over-order or over-utilize the service in order to make certain there will be sufficient revenue to maintain the service the physicians feel is important for their patients. This will further increase hospital costs as well as hospital charges and is but one additional problem the hospital administration will have in trying to contain rising health care costs. It is obvious the proponents of this bill have the well being of the citizens of the state in their minds, but have no concept of the problems all hospitals are having in meeting the dictates of the citizens for significant health care cost containment.

I respectfully request that you vote Senate Bill 286 as Do Not Pass.

(This sheet to be used by those testifying on a bill.)

NAME: Clay Edwards R.P.T. DATE: 2/20/85

ADDRESS: 502 S. Idaho ST. Dillon MT

PHONE: Bus 683-2324 Home 683-5790

REPRESENTING WHOM? Dillon Medical Supply & Home Oxygen Supply Company

APPEARING ON WHICH PROPOSAL: Senate Bill 286

DO YOU: SUPPORT? _____ AMEND? X OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

DILLON MEDICAL SUPPLY
24 HOUR HOME OXYGEN SERVICE

Clay Edwards
February 20, 1985

Committee Members
Senate Public Health, Welfare and Safety Committee

RE: Senate Bill #280 Respiratory Care Practitioners Act
Proposed Amendment

Madam Chairman and committee members:

I am Clay Edwards from Dillon and owner of Dillon Medical Supply, a home oxygen and home oxygen equipment supplier.

I propose to amend Senate Bill #280, Section 4. Exemptions. #(2), by adding (c) "The delivery, maintenance or administration of oxygen or oxygen equipment to patients in their place of residence, by unlicensed health care personel."

This amendment would allow home oxygen companies to continue to employ unlicensed health care personel to deliver and administer oxygen to patients in their homes or nursing homes. This service does not require a licensed Respiratory Care Practitioner and would only result in increased expense to the patient if this bill were strictly enforced.

I have been assured by the originators of this bill that the intention is not to limit home oxygen supply companies. However, the wording is sufficiently unclear that this amendment is necessary to clarify the status of unlicensed employees of home oxygen companies.

I have also been told by one of the key originators of this bill that they would not be opposed to this amendment, but did not want to include it prior to this committee hearing as the proposed bill was already quite long.

If this bill passes this committee I urge that it do so only with this amendment. Thank you for your consideration.

Sincerely,

Clay Edwards

Clay Edwards
Owner, Dillon Medical Supply

502 SOUTH IDAHO STREET, BOX 526 DILLON, MONTANA 59725 TELEPHONE (406) 683-6848

(This sheet to be used by those testifying on a bill.)

NAME: J. MICHAEL SADAJ MD DATE: 20 FEB 85

ADDRESS: 3465 QUINCY ST. BUTTE MT

PHONE: 406-723-4022 (OFC) 494-6661 - home

REPRESENTING WHOM? SELF — MEDICAL DIRECTOR OF RESPIRATORY CARE DEPARTMENT

APPEARING ON WHICH PROPOSAL: SENATE BILL 286 LICENSURE RESPIRATORY CARE PRACTITIONERS

DO YOU: SUPPORT? _____ AMEND? OR OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.