MINUTES

MONTANA HOUSE OF REPRESENTATIVES
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES AND AGING

Call to Order: By Stella Jean Hansen, on February 3, 1989, at 3:00 p.m.

ROLL CALL

Members Present: All

Members Excused: None

Members Absent: None

Staff Present: Mary McCue, Legislative Council

Announcements/Discussion: None

HEARING ON HB 389

Presentation and Opening Statement by Sponsor: Rep. Campbell stated that this bill was an act clarifying the definition of the practice of practical nursing.

List of Testifying Proponents and What Group They Represent:

Ken Dunham, Montana Licensed Practical Nurses Association
Rep. Carolyn Squires

List of Testifying Opponents and What Group They Represent:

Cathy Caniporali, Montana Nurses Association
Barbara Booher, Montana Nurses Association
Donna Small, Montana Nurses Association
Jan Cronguest, Montana Nurses Association

Testimony:

Ken Dunham, supports this legislation and states that LPN's are an important part of the nursing profession and this change in the definition will allow them to do more of what they have been trained to do, to allow R.N.'s and physicians to make better use of the LPN's, and help alleviate some of the nursing shortage we hear

so much about. Montana LPN's would hope that this small change would be made in nursing law to help that all happen. Exhibit 1.

Rep. Carolyn Squires supports this bill and states that she would testify on behalf of herself and Carol Jazinski from Havre and stated that they had worked for a long period of time to resend this particular portion of the nurse practice act as they felt it was prohibitive to the job performance. Predictable outcome has been a constraint in many ways in some of the activities that LPN's performed within the hospital but at yet at other times, when it is necessary for the LPN to function within the hospital it is okey for LPN's to perform.

Cathy Caniporali opposes this bill and states that the definition in statute of practical nursing allows for the performance of services requiring basis knowledge of the biological, physical behavioral, psychological and sociological sciences and of nursing procedures. These duties are all done under the supervision of an R.N. or physician or dentist, et al. There is nothing in the educational preparation of an LPN which would prepare them to safely determine the use of standardized procedures in the situation which has unpredictable outcome. R.N.'s utilize the parameters of predictable and unpredictable outcomes to decide which health care team member can provide the safest care to the client. An LPN is not asked to perform procedures for which they are not prepared in their education. This leads to a wide variety of procedures which LPN's can safely perform, utilizing the expertise of the LPN in performance of standardized procedures with predictable outcomes also allows the R.N. to provide bedside care to clients who may have problems which have unpredictable outcomes.

Barb Booher opposes this bill and states that she would read the testimony into the record from Gretchen Fitzgerald. Exhibit 2.

Donna Small opposes this bill and states that she would supply testimony into the record from Laura Fields and from Elaine Watkins.

Jan Cronquest stated that she was not opposing this bill rather a deferring of the bill is her hope. The phrase in question has been a key to the differences between the roles of registered nurses and licensed practical nurses based on their educational level.

Maura Fields and Elaine Watkins also supplied written

opposition to this bill. Exhibit 3.

Questions from the Committee: Rep. Lee stated that there were 48 states which did not contain this language in their statutes and asked Mr. Dunham if he was aware if there were any other mechanisms, training, or criteria that addressed the areas of concern that the opponents have raised and Mr. Dunham stated that he was not aware of any. Rep. Lee then asked Mr. Dunham if the removal of the words that were selected, that perhaps there are others compensatory things in these other states that are in statute that would preclude them having to contain these words. Mr. Dunham said there were not. Rep. Lee asked the same question of Ms. Small and she stated that the concern is very definitely that wording. After three years of study by a task force when the whole nurse practice act was written, that was the language that came out of that task force to unilaterally remove that wording without comparing what it does to the rest of the wording, changes the scope of practice that they were seeking. Rep. Lee then asked Ms. Small about the scope and practice that is envisioned in the change and would it be any different in the practice of the other states. Ms. Small said that she had not studied the other states statutes on this.

Rep. Strizich asked Mr. Dunham if he could give the committee an example that could describe the difference between a standardized procedure that has a predictable outcome versus a standardized procedure that has an unpredictable outcome and Mr. Dunham used the theory of administration of an enema. Rep. Strizich then asked Ms. Caniporali stated that when one was looking at a procedure comes when one looks at the client who is having the procedure done. Some clients can be predicted, i.e. no other existing predicting condition that would generate a predictable outcome.

Rep. Good asked Ms. Caniporali if an LPN could take a blood pressure and Ms. Caniporali and she answered yes. Can an LPN give medication and Ms. Caliporali stated that an LPN could give some medications but it depended on the administration procedure. Can an LPN start an I.V. and Ms. Caniporali said she could. Can an LPN suctioning and clean tubes and the answer was yes. Can an LPN draw blood and Ms. Caniporali stated that she could. Rep. Good asked Ms. Small specifically what procedures do you not want LPN's to do and Ms. Small stated that any procedure that is done in a trauma situation has an unpredictable outcome.

Rep. Whalen then asked Ms. Booher if the new statute would apply only to a hospital situation and she stated that it would be universal. Rep. Whalen asked Ms. Small if the instructions were given by a doctor or do the R.N.'s have the authority to initiate actions on their own and Ms. Small said that LPN's are found across the health care situations, they work in doctors offices, hospitals, nursing homes and there is an inclination at times to put them into situations where they are functioning beyond what was intended by their basic license.

Rep. Gould asked Ms. Cronquist if she wanted the committee to hold off their decision until the Board met again and also of the make-up of the Board. Ms. Cronquist said that the Board had four R.N.'s, 3 LPN's, and two public members.

Rep. Simon asked Ms. Small if there were any states that Montana does not recognize with our reciprocal agreements and Ms. Small said this would only happen if the requirements were less than our state. There are no states whose requirements are less than Montana. Who decides whether or not these procedures are to be performed and Ms. Small stated that the doctor did initiate the order but the nursing staff that carries out the order or the nursing structure that dictates who actually carries out the procedure.

Rep. Strizich asked Ms. Small if there were any liability cases in Montana regarding predictable outcome and said that she was not aware of any and they are not the knowledge of the board.

Closing by Sponsor: Rep. Campbell closed on the bill.

HEARING ON HB 328

Presentation and Opening Statement by Sponsor: Rep. Hanson stated that this bill was an act to establish faculty qualifications for nursing schools.

List of Testifying Proponents and What Group They Represent:

James Ahrens, Montana Hospital Association
Rep. Jessica Stickney
Patricia Dotter, Helena Vocational Technical Center
Larry Akey, Montana Health Network

List of Testifying Opponents and What Group They Represent:

Barb Booher, Montana Nurses Association

Donna Schramm, Montana Nurses Association
Donna Small, Montana Nurses Association

Testimony:

James Ahrens supports this bill and states that his organization has contacted some of the colleges and currently they are using as instructors, persons who have bachelors degrees in nursing. The Board of Nursing has acted and they have a regulation now which went into effect December 12th that instructors must have either a masters degree in nursing, a masters degree in public health or Ph.D, in order to be an instructor in a school of nursing. There are now teaching who cannot even meet the current rule. If there are people being turned away because there is not sufficient faculty, due to these requirements, and salary requirements, why would the state want to increase the requirements?

Rep. Jessica Stickney stated that awareness of the problem and supports this bill. There isn't anyone who would downgrade the standards of health care. Somehow the professional standards pale when we are dealing with the extreme shortage of medical care in the more rural areas and especially in the areas of eastern Montana.

Patricia Dotter supports this bill and states that as a practical nursing instructor this bill concerns her because it does not specify "professional" or "practical" schools of nursing. The instructors of practical nursing are not required to hold a master's degree to teach in the practical nursing program. I believe if this bill was passed as is, the practical nursing instructors would be required to have a masters degree. Exhibit 4.

Larry Akey supports this bill and states that there is a problem in obtaining nurses in the smaller hospitals in eastern Montana. Of the ten small hospitals and the Montana Health Network there is about a 9% vacancy in the nursing lines. Mr. Akey supplied amendments to the committee for consideration. Exhibit 5.

Barb Booher opposes this bill and states that there are three reasons for her objections. First, the national accreditation standards, second, 1986 legislative audit recommendations and the third is the authority of the board of nursing.

Donna Schramm opposes this bill because setting standards for faculty qualifications is within the jurisdiction

of the board as a statutory directive and is within the expertise of the board; the board believes the proposed legislation is insufficient to fulfill the obligation to safeguard life and health; in this fast changing, technologically advance era of health care, no less of a standard should be acceptable for professional nursing than what is required by other disciplines - masters preparation in the area being taught. Exhibit 6.

Donna Small opposes this bill and states there are two reasons for her objection. The rules have always addressed the educational requirements before and if the change happens now, the opposite could occur. In section 37-8-301 is a section which addresses nursing education programs. Exhibit 7.

Questions from the Committee: Rep. Good asked Ms. Cronquist for a sheet for the requirements.

Rep. Simon asked Ms. Schramm if the national accreditation standards require a master level training to maintain accreditation of schools of nursing and Ms. Schramm stated that they did. Rep. Simon then asked if there were a national accreditation of the various schools or is it state accreditation using national standards and Ms. Schramm and she said that some of the schools used either. Rep. Simon then asked that if a school fell below accreditation standards, will their students be allowed to take the R.N. test and Ms. Schramm said that they would not.

Rep. Stickney asked Ms. Schramm if the nursing school at Montana State University was fully staffed with masters prepared instructors and Ms. Schramm said that they were.

Rep. Simon asked Rep. Hanson if the intention of the bill were to require the LPN programs in Montana to meet these requirements and Rep. Hanson stated that it did not. Rep. Simon then asked Mr. Ahern what a masters degree in a related field or what kind of a masters degree would a person have that would include advanced nursing courses or graduate level education courses and not be a graduate with a masters degree in nursing - what other masters degree would this be? Mr. Ahern said that a degree in public health, management, education or some type of business degree with the addition of some advanced nursing courses.

Closing by Sponsor: Rep. Hanson closes on the bill.

HEARING ON HB 395

Presentation and Opening Statement By Sponsor: Rep. Cody stated that this bill was an act granting prescriptive authority to nurse specialists; requiring the Board of Nursing to establish rules regulating prescription of drugs by nurse specialists. An amendment was also proposed by Rep. Cody and is supplied as Exhibit 8.

List of Proponents and What Group They Represent:

Barb Booher, Montana Nurses Association
Cathy Caniporali, Montana Board of Nursing
Brenda Nordlund, Montana Women's Lobbying
Chad Stoianoff, Montana Association of Counties
Jan Cronquest, Montana Board of Nursing
Jerry Loendorf, Montana Hospital Association

List of Opponents and What Group They Represent:

None

Testimony:

Barb Booher supports this bill and states that the safety of the health care consumer would best be protected by granting the Board of Nursing the power to regulate the prescriptive authority of nurse specialists. The standards of safety and professional conduct would be ensured by regulation of this aspect of nursing practice. Exhibit 9.

Cathy Caniporali supports this bill and states that this legislation would allow the Board of Nursing to define any exemptions of medications which clearly exceed the scope of nurse specialist practice, define continuing education requirements and further regulate the prescribing practices of nurse specialists. Exhibit 10.

Brenda Nordlund supports this bill.

Chad Stoenoff supports this bill and states that the Health Care Services Resolution 87-7. Exhibit 11.

Jan Cronquist stated her support and said that in writing the rules, the Board would consider the appropriations of the authority to prescribe specific drugs based on the nurse's area of specialty and education. Exhibit 12.

Jerry Loendorf supports this bill and states that this bill,

like many areas makes a broad grant of authority to a specialized group, there is a broad grant of authority and that is to grant prescriptive authority to nurse specialists. There is two good reasons for enacting legislation in this fashion rather than using the narrow grant of authority.

James Aherns supports this with the amendment the Montana Hospital Association would support the bill.

Questions From the Committee: Rep. Stickney asked Rep. Cody what makes this bill and the request of the nurses to be allowed to prescribe any different from the physicians assistant request and Rep. Cody said that she did not know.

Closing By Sponsor: Rep. Cody closed on the bill.

HEARING ON HB 402

Presentation and Opening Statement By Sponsor: Rep. Jan Brown stated that this bill was an act to continue funding for the statewide genetics program; to increase the fee on health insurers; to appropriate money for the program; and providing an effective date and a termination date. Rep. Brown also supplied written testimony from Alicia Pichette of the Early Intervention Advisory Council of Montana. Exhibit 13.

List of Proponents and What Group They Represent:

Chad Smith, Shodair Hospital
John M. Opitz, M.D., Montana Department of Medical Genetics
Joan Fitzgerald, Shodair Hospital
Denise Gleason
Jerry Loendorf, Montana Medical Association
Barbara Booher, Montana Nurses Association
James Ahern, Montana Hospital Association
Jim Borchardt, Montana Insurance Department
Chuck Butler, Blue Cross and Blue Shield
Brenda Nordlund, Montana Women's Lobby
Chris Volinkady, Developmentally Disabled

List of Opponents and What Group They Represent:

Peter Pauly, Health Insurance Association of America.
Larry Akey, Association of Life Underwriters of Montana

Testimony:

Chad Smith supports this legislation and introduced the

proponents to this bill.

John M. Opitz, M.D. supports this bill and states that the Montana Medical Genetics Program is a service not a research program. Exhibit 14.

Joan Fitzgerald supports this bill and states that the genetic program is able to provide exemplary genetic services for the people of Montana because the services are available and accessible to all of the Montana population. The program provides information not available through the local physician community, and, because of our residence within the state, we can routinely provide the quality follow-up required. The service prevents unnecessary travel for services, long delays in obtaining results, wasted time and finances on unproven treatments, and allows money spent for genetic health care to remain in Montana. Exhibit 15.

Denise Gleason supports this bill and supplied information on the birth of her anencephalic child. Exhibit 16.

Jerry Loendorf supports this bill and speaks of all of the good things that have been done for prospective parents.

Barb Booher supports this bill and states that Shodair program and Dr. Opitz provide state-wide service and the registered nurses of Montana applaud their efforts.

James Ahern supports this bill.

James W. Borchardt and stated that the Montana Insurance Department did not take a particular stand on this bill but do feel that the amendment which he supplied should be strongly considered and passed by committee. Exhibit 17.

Chuck Butler supports this bill has the greatest effect in terms of the number of people that are covered.

Brenda Nordlund supports this bill.

Chris Volinkady supports this bill and states that for the past 6 years, and has worked with some families that have used the services provided by Shodair.

Peter Pauly opposes this bill and states that he wishes the committee to listen to the proponents when they so strenuously argue this program is beneficial to the entire state. That being the case, the general fund should pay for this program. It is grossly unfair for

a particular group (the health insurance industry) to subsidize this program which does not benefit it. Exhibit 18.

Larry Akey opposes this bill and states his question on the funding mechanism without belaboring the point. His suggestion to strike subsection 1 and 2.

Questions From The Committee: Rep. Simon asked Mr. Borchardt about the 90% residents of Montana covered by health insurance. Mr. Borchardt stated that the committee would take into consideration that in many cases you have insurance coverage by insurers where both the husband and wife are covered in policies where they work. Rep. Simon stated that it was not residents but FTE's that were covered, this is not really a resident which is covered by more than one policy and you, Mr. Borchardt are calling this two residents and it is really one. Mr. Simon then stated to Mr. Smith that in the last session, that if two years extension was given, a request for more funding would not be requested. Mr. Smith stated that he did not recall that there was ever any assurance given as to how this would be handled in the future. The proponents did explain that the genetics program would be included in the budget but because of the budget crunch has made it virtually impossible to get in what they consider a new program into the budget.

Closing By Sponsor: Rep. Brown closes on the bill.

DISPOSITION OF HB 402

Motion: Rep. Brown made a Motion DO PASS. A Motion was also made by Rep. Brown to Move the Amendments.

Discussion: Mary McCue stated that the section in the bill that is changing the termination date from 1989 to 1991, or, the original act and whatever was in it, is not going to terminate until 1993. The exemption statute that is presently in the law, which was a part of the original act, is not going to terminate.

Motion: Rep. Brown made a Motion to withdraw her amendment.

Discussion: Rep. Good asked if the Montana Association of Life Underwriters or the National Institute of Health Insurance was included or was Blue Cross and Blue Shield only included. Rep. Brown stated that the question should be asked of the proponents from Shodair and Rep. Simon objected. Rep. Nelson stated that Blue Cross and Blue Shield are not insurance and they are

not contributing several millions of in premium taxes. Rep. Simon questioned the termination of the act in two places in the bill, to eliminate one of the references to the termination. Rep. Simon stated that this was a valuable program and that it had a good cost benefit and that he was voting no as a protest to the fact that the bill belonged in the general fund.

Motion: Rep. Whalen made a Motion to have the researcher take care of the technical data on the bill.

Amendments, Discussion, and Votes: A vote was taken to DO PASS AS AMENDED and all voted in favor with the exception of Reps. Simon, Lee, Gould, Boharski, Nelson. Rep. Knapp indicated that he wanted to abstain his voting.

DISPOSITION OF HB 304

Hearing on HB 304 was February 1, 1989.

Motion: Rep. Simon made a Motion to DO PASS; Rep. Brown made a Motion to move the amendments.

Discussion: Rep. Good stated that she objected to the amendment. Rep. Russell asked Rep. Brown about the addition of Shodair Hospital in the amendment. Rep. Brown stated yes and stated the amendment was on page 9, line 4, delete "of not less than 30 beds", page 9, line 7, delete "between 5 and", substitute "under."

Amendments, Discussion, and Votes: A vote was taken on the amendment, all voted in favor with the exception of Reps. Good, Nelson, Squires, Simon.

Motion: Rep. Brown then made a Motion to DO PASS AS AMENDED. Rep. Lee made a Motion to offer the amendment to strike "non profit."

Discussion: Rep. Lee stated that the amendment would open up to consideration by any otherwise qualified provider. Rep. Squires asked if any facility in the state that would have open beds and would meet the criteria of the bill. Rep. Lee suggested Glacier View as an instance. Rep. Squires stated that if the program is expanded, we are going to lose it. Rep. Simon stated that the amendment should be killed.

Amendments, Discussion, and Votes: A vote was taken on Rep. Lee's amendment. A vote was taken and all voted in favor with the exception of Rep. Lee.

Recommendation and Vote: A vote was taken to DO PASS AS AMENDED. All voted in favor except Reps. Squires, Nelson, Good, Simon, Knapp.

DISPOSITION OF HB 308

Hearing on HB 395 was February 3, 1989.

Motion: Rep. Squires made a Motion to DO PASS.

Discussion: Mary McCue stated that the codification instruction is in error. Codification on page 32, line 6-9, delete section 16 in its entirety.

Amendments, Discussion, and Votes: Rep. Gould made a Motion to Move the Amendment. A vote was taken and all voted in favor.

Recommendation and Vote: Rep. Gould made a Motion to DO PASS AS AMENDED. A vote was taken and all voted in favor.

DISPOSITION OF HB 395

Hearing on HB 395 was February 3, 1989.

Motion: Rep. Whalen made a Motion to DO PASS. Rep. Gould made a Motion to Move the Amendments.

Discussion: Mary McCue questioned page 6, subsection B, that this language is going to replace both of the sentences. The change in the reference to the Board acting jointly and title adjustment.

Amendments, Discussion, and Votes: A vote was taken on the amendments and all voted in favor.

Motion: Rep. Gould then made a Motion to DO PASS AS AMENDED.

Discussion: Rep. Lee questioned the amendment on page 6, line 19, does this indicate that if a nurse specialist applied for prescriptive authority, the Board cannot turn her down? Should not the Board have the authority over the program. Rep. Whalen stated that the intent of the legislation is not to give any discretion to the Board, if a person is licensed as a nurse specialist, they shall have the authority to do this. The language is appropriate. Rep. Simon stated his agreement, the language to grant that nurse specialists the authority within the area that they are the specialist and not appropriate that they be granted authority in a

specialty that they are not qualified.

Recommendation and Vote: A vote was taken, all voted in favor of the bill as DO PASS AS AMENDED.

DISPOSITION OF HB 389

Hearing on HB 389 was February 3, 1989.

Motion: A motion was made by Rep. Stickney to DO PASS.

Discussion: None.

Recommendation and Vote: A vote was taken and all voted in favor.

ADJOURNMENT

Adjournment At: 7:30 p.m.

REP. STELLA JEAN HANSEN, Chairman

SJH/ajs

F0307.min

DAILY ROLL CALL

HUMAN SERVICES AND AGING COMMITTEE

51st LEGISLATIVE SESSION -- 1989

Date 2-3-89

NAME	PRESENT	ABSENT	EXCUSED
Stella Jean Hansen	✓		
Bill Strizich	✓		
Robert Blotkamp	✓		
Jan Brown	✓		
Lloyd McCormick	✓		
Angela Russell	✓		
Carolyn Squires	✓		
Jessica Stickney	✓		
Timothy Whalen	✓		
William Boharski	✓		
Susan Good	✓		
Budd Gould	✓		
Roger Knapp	✓		
Thomas Lee	✓		
Thomas Nelson	✓		
Bruce Simon	✓		

STANDING COMMITTEE REPORT

February 4, 1989

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 304 (first reading copy -- white) do pass as amended .

Signed: _____
Stella Jean Hansen, Chairman

And, that such amendments read:

1. Page 9, line 4.
Strike: "of not less than 30 beds that is"

2. Page 9, line 7.
Strike: "between 5 and"
Insert: "under"

STANDING COMMITTEE REPORT

February 4, 1989

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 308 (first reading copy -- white), with statement of intent attached, do pass as amended .

Signed: _____
Stella Jean Hansen, Chairman

And, that such amendments read:

1. Page 32, lines 6 through 9.
Strike: section 16 in its entirety
Renumber: subsequent sections

STANDING COMMITTEE REPORT

February 4, 1989

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 395 (first reading copy -- white) do pass as amended .

Signed: _____
Stella Jean Hansen, Chairman

And, that such amendments read:

1. Title, line 6.
Following: "NURSING"
Insert: "AND BOARD OF MEDICAL EXAMINERS, ACTING JOINTLY,"

2. Page 6, line 15.
Following: "board"
Insert: "of nursing and the board of medical examiners, acting jointly,"

3. Page 6, line 18.
Strike: "board"
Insert: "boards"

STANDING COMMITTEE REPORT

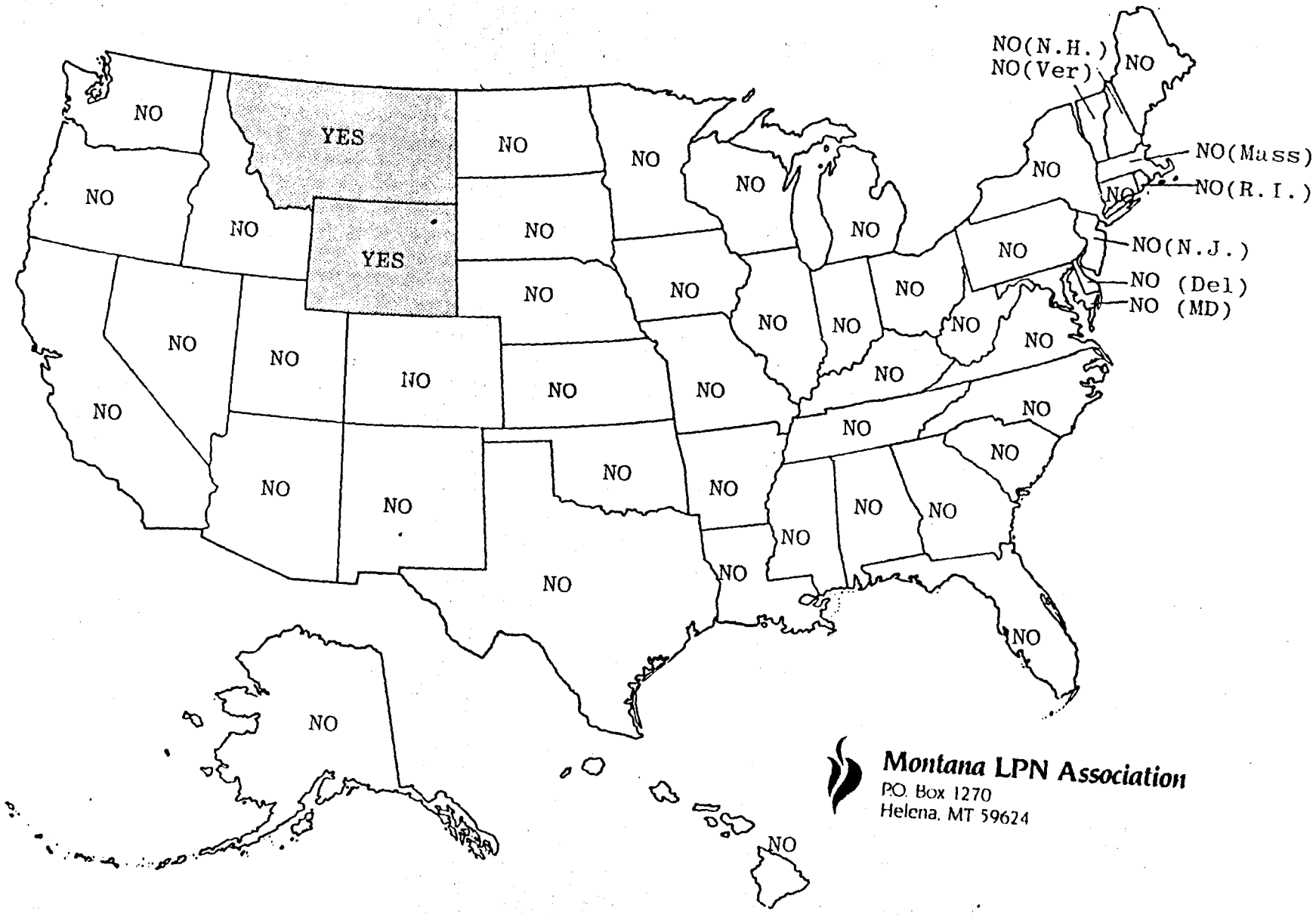
February 4, 1989
Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 389 (first reading copy -- white) do pass .

Signed: _____
Stella Jean Hansen, Chairman

300901SC.HRT

STATES IN WHICH "PREDICTABLE OUTCOME"
IS A PART OF THE DEFINITION OF AN LPN



Montana LPN Association
P.O. Box 1270
Helena, MT 59624

EXHIBIT 1
DATE 2-23-89
HB 389

HAVRE CLINIC
20 W. 13th ST. • P.O. BOX 7348 • HAVRE, MT 59501 • PH. 406-265-783

January 31, 198

House Human Services & Aging Committee
State Capitol
Helena, MT 59620

Dear Sir or Madam:

I am writing to you in reference to House Bill 389. This is legislation which concerns modification of the definition of Licensed Practical Nursing. I am in favor of this modification. The modification would simply drop the words "leading to predictable outcomes" from the definition of Licensed Practical Nurse.

It is difficult for me to see why this wording was chosen, and it is difficult to see what this actually means in nursing practice. My concern is that such wording could lead to restrictions on the utilization of LPN's in the hospital and clinic settings.

The LPN's with whom I work are highly trained, very skilled nurses. There is really no difference in the tasks performed by or the capabilities of RN's and LPN's.

Given Montana's severe nursing shortage, I think it makes sense to eliminate any possible legal impediments to the full utilization of our Licensed Practical Nurses.

I hope you will support House Bill 389, and I hope you will do everything in your power to secure its passage.

Sincerely,

James S. Rogers, M.D.

JSR/kg

Chairman Stella Jean Hansen,

I am writing to you to urge your support of House Bill 389, which would change the definition of a Licensed Practical Nurse in the state law.

As vice president of the Montana Licensed Practical Nurses Association and a practicing L.P.N. for 12½ years, I am convinced that HB 389 would be a plus for many of us. By eliminating the words "leading to predictable outcomes" from the definition of an L.P.N., Montana L.P.N.s would be allowed to be better utilized in their places of work, thus benefiting not only the L.P.N.s, but their employers also. The L.P.N.s in the state of Montana receive adequate training in their schooling, as well as continued training on the job. By allowing L.P.N.s to perform to their fullest capabilities, the consumer is also benefited, since L.P.N.s are able to meet many of the consumers needs in a health care setting, in a more cost effective manner, in comparison to Registered Nurses.

It is interesting to note that only two states, Montana and Wyoming, have the phrase "leading to predictable outcomes" in their definition of an L.P.N. This is certainly a vague term, and I believe that it is used against L.P.N.s in Montana.

Thank you for your time and for any support that you might show towards L.P.N.s.

Sincerely,

Cindy D. Marshall
Box 104
Kremlin, Montana 59532

Montana LPN Association
P.O. Box 1270
Helena, MT 59624

Ken Dunham, Management Consultant 406/443-0640

TESTIMONY OF 2/3/89
KEN DUNHAM
Lobbyist for Montana LPN Association

House Bill 389

This issue of changing Montana's nursing laws to remove four words from the definition of a Licensed Practical Nurse may not seem to some to be a major issue, but to the more than 3,200 LPN's licensed in Montana, it is a critical concern for their best utilization in nursing situations.

The words "leading to predictable outcomes" has been used by supervisors, directors of nursing, and the Montana Board of Nursing over the years to restrict LPN's from performing nursing tasks they have been trained to perform. Some of the examples provided me from LPN's across Montana include prevention from working in intensive care units, in emergency rooms, in nursery units in hospitals, intervenous procedures, and administering various types of medication - even though all LPN's work under the supervision of a registered nurse, physician, dentist, osteopath or podiatrist.

LPN's in Montana, and other states, work in a variety of nursing positions in hpspitals, clinics and other nursing situations, and with this change in Montana law our LPN's will be allowed to do what they are trained to do more effectively, and continue to be a part of that nursing care process.

The major problem with a definition of an Licensed Practical Nurse containing such wording is that it is a meaningless phrase. Perhaps no medical or nursing procedure has a "predictable outcome". Each procedure has an outcome that should be achieved by what is done, but that outcome may not always happen.

In the past few weeks we have researched the nursing laws of the other 49 states concerning the definition of an LPN. 48 other states do not have this working in their state law; only Wyoming and Montana have it.

Additionally, the National Council of State Boards of Nursing, in their 1988 proposed Model Nursing Practice Act does not include this wording either.

The role of a Licensed Practical Nurse is carefully defined in Montana law, with the exception of this one phrase, stating that LPN's utilize standardized procedures requiring basic knowledge in a variety of nursing procedures. And as I mentioned before, LPN's would continue to function under the direction of an RN or physician.

In many nursing situations, physicians and others make virtually no distinction between the treatment and nursing duties assigned LPN's and RN's. The major difference is in the type of nursing education in a formal setting, in the record keeping process associated with nursing care, and in the supervision of nursing care.

LPN's are an important part of the nursing profession and this change in the definition will allow LPN's to do more of what they have been trained to do, to allow RN's and physicians to make better use of LPN's, and help alleviate some of the nursing shortage we hear so much about. Montana's LPN's would hope that this small change would be made in nursing law to help that all happen.

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Testimony - House Bill #389

Montana State Legislature
Human Services and Aging Committee

February 3, 1989

By: Gretchen Fitzgerald, RN

Good afternoon Madame Chairman, Members of the Committee, Ladies and Gentlemen. I speak as an opponent of House Bill #389. My name is Gretchen Fitzgerald, I am a Registered Nurse with over 17 years of nursing management experience in an acute care facility in Montana. Currently I am Vice President for Nursing at the Montana Deaconess Medical Center in Great Falls —— a position, I have held for the past 7 years. In this position, I am ultimately responsible for the patient care delivery system and all aspects of professional and practical nursing practice in a 288 bed hospital.

Approximately 15 - 18% of the staff employed within the Division of Nursing are Licensed Practical Nurses. Areas of employment for these LPN's range from Medical - Surgical units to the Operating Room. Our LPN's are contributing, caring members of our nursing team who compliment the overall performance of delivering safe, effective patient care.

You are aware of the changing climate in our health care delivery system; aware of the increased acuity of patients admitted to hospitals; aware of the "sicker and quicker" theory in acute care settings; i.e., sicker patients are admitted and dismissal occurs more quickly; you are aware of sophisticated diagnostic and therapeutic techniques, and the rapid escalation of high technology utilized in health care across our nation.

EXHIBIT 2
DATE 2-3-89
HB 389

Given all these dynamic changes, I feel it is prudent, practical and perceptive to retain the present language of the Statutes and Rules Relating to Nursing which identifies "predictable outcomes" in defining the practice of practical nursing. Given the scope of education, training, and purpose of the LPN practice , that language protects the practitioner as well as the patient.

Although one might argue that "predicted outcomes" cannot be assured, they can be anticipated. Assignments given, scope of practice and competency levels should all take into account the educational preparation and content of curriculum when defining the role of the licensed practical nurse or any health discipline. To remove language from the current Nurse Practice Act could result in an expansion of the LPN scope of practice without first addressing the basic preparation, skills expectation, and general intent of the role of practical nursing.

LPN's with whom I have visited, recognize that 12 months of didactic and clinical preparation prepare them for supervised, structured and predictable settings in our complex health care system. If this bill is passed, healthcare institutions could unfairly expect expansion of the role of the LPN which exceeds their intended scope of practice.

I urge you to vote "no" on this bill.

Thank you.

February 2, 1989

To the members of the House Human Service and Aging Committee:

My name is Maura Fields. I am writing in opposition to H.B. 389. I have practiced as a registered nurse in the State of Montana for ten years. I am serving as President-Elect for the Montana Organization of Nurse Executives and am presently employed at North Valley Hospital in Whitefish as the Director of Professional Services. Because my position entails the supervisory responsibilities for acute care nursing, I have taken a keen interest in H.B. 389.

I am opposed to the passage of this bill for the following reasons:

1. LPN practice, according to the Montana Nurse Practice Act, is founded on the "basic knowledge of the biological, physical, behavioral, psychological and sociological sciences and of nursing procedures." Their current training reflects this purpose. Because this knowledge and training is not as broad based and comprehensive as that of the professional registered nurse, LPN practice lends itself—to procedures with predictable outcomes. Expanded knowledge base is essential for developing skill and judgement required in procedures with unpredictable outcomes. The result of H.B. 389 would expand the scope of LPN practice without expanding education and training. The existing system of nursing education allows for expanded practiced based on expanded education. This option is available to LPNs in both A.D.N and B.S.N. programs. If scope of nursing practice is expanded without corresponding preparation, the net result will be a lower standard of nursing care to the consumer. There is not one health care profession that has suggested expanding scopes of practice without expanding training and educational preparation.

2. It has been argued by some that expanding LPN roles will alleviate the nursing shortage. Again, expanding practice roles of LPNs is a standard of care issue. By not having a corresponding educational component to expanded practice is to suggest that lowering standards of nursing care is a sensible solution to the nursing shortage. As a nursing administrator I find this unacceptable as it proposes a safety issue for patients under their care and a professional concern for all professionals who supervise them.

3. A final concern centers around a directive given to those of us in organized nursing in the state during the 1987 legislature. During the debate on, "Entry into Practice" the legislature directed nurses to reach agreement on changes in state law relative to practice. The fact that the LPN association has not done so goes contrary to that request. It amounts to a unilateral move without input and dialogue from Montana Organization of Nurse Executive, Montana Nurses' Association and other nursing organizations in the state. At minimal, this professional courtesy is warranted.

In summary, I urge you to vote NO to H.B. 389. Thankyou!

Sincerely,

Maura Fields RN

Maura Fields, RN
Director of Professional Services
NORTH VALLEY HOSPITAL

TESTIMONY: HOUSE BILL 389

My name is Elaine Watkins. I am Vice President for Patient Services at Deaconess Medical Center of Billings, Incorporated. I am responsible for the delivery of nursing care services at Deaconess. We utilize primarily Registered Nurses and Licensed Practical Nurses in our delivery model. Both disciplines equally contribute to our ability to provide a quality care product.

I am gravely concerned with the proposal of House Bill 389 to eliminate predictable outcomes from the definition of the practice of practical nursing.

Over the past five to seven years, major changes have occurred in our health care delivery system. We have watched the acuity of our patients rise as advances in medical knowledge, treatments, modalities, technological advances, and even more acutely reimbursement pressures have driven these changes.

Now our industry is concerned over the predicted shortage in healthcare providers - specifically nurses.

The development of the role of the Practical Nurse and its definition as established in the Nurse Practice Act was established as a safeguard to public welfare and protection taking into consideration the educational preparation of the practical nurse. From todays practice settings, we have already raised the question of the need for increasing the educational time of the practical nurse to meet the changes in the health care environment. The answer to a nursing shortage is not to expand the scope of practice of a particular discipline without taking into consideration the additional education necessary to provide safe, quality patient care.

Todays practical nursing education only allows a basic knowledge of nursing procedures, and therefore the scope of practice must remain in an arena of standardized procedures with predictable outcomes.

Thank you for your consideration of this issue that is so important in the safe practice of nursing care delivery.

Elaine J. Watkins

Elaine J. Watkins
Vice President for Patient Services
Deaconess Medical Center

EXHIBIT 3
DATE 2-3-89
HB 389

February 3, 1989

TO: Human Services and Aging Committee

FROM: Patricia Dotter, Coordinator/Instructor
Practical Nursing Program
Helena Vocational Technical Center

RE: House Bill No. 328 "An Act to Establish Faculty Qualifications for Nursing Schools; and Amending Section 37-8-301, MCA."

As a practical nursing instructor this bill concerns me because it does not specify "professional" or "practical" schools of nursing. The instructors of practical nursing are not required to hold a master's degree to teach in the practical nursing programs. I beleive if this bill was passed as is, the practical nursing instructors would be required to have a masters degree. If you note in the Administrative Rules on page 32 of the "Statutes and Rules Related to Nursing" (attatched), the requirements for practical nursing faculty differ from the rules for professional nursing faculty as listed on page 29.

If this bill was amended to read "professional schools of nursing", I would support this bill. The ADN programs are having a difficult time recruiting faculty with just a master"s degree in nursing. I understand Miles Community College was unable to fill all their nursing classes because of the lack of faculty members. With the shortage of RNs, perhaps this need could be met by allowing these schools to hire nurses who are well qualified to teach nursing, but just do not have the correct letters behind their names. This, in no way, will lower the standards for our schools because different types of education can add new dimensions to nursing education.

Thank you, If you have any questions please call or write to me.

Patricia Dotter RN,BSN
Practical Nursing Program
Helena Vocational Technical Center
1115 North Roberts
Helena, MT 59601
442-0060(work)
449-7332(home)

EXHIBIT 4
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policies must provide the student right of appeal. These policies should be written and available to the students. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72; AMD, Eff. 5/6/76; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81; AMD 1982 MAR p. 286-287, Eff. 2/12/82.)

8.32.914 REPORTS (1) Annual reports shall be submitted to the board of nursing in the designated form.

(2) Quarterly reports shall be submitted to the board on the designated form at the designated time. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; NEW 1982 MAR p. 286-287, Eff. 2/12/82.)

Sub-Chapter 10

Standards for Montana Schools of Practical Nursing

8.32.1001 INTRODUCTION (1) These standards are the result of years of study and cooperative planning between the Montana state board of nursing and faculty of Montana schools of practical nursing. The statements are viewed as serving several purposes:

(a) as an informative criteria they may provide a basis for interpretation of nursing eduation to school of nursing faculty and other groups interested in nursing education;

(b) they may be used as a guide in the self-evaluation of school programs by the faculty; and

(c) they will be used by the board of nursing as an evaluation tool in the approval of Montana schools of practical nursing.

(2) The standards are to be used in appraising the quality and specific nature of nursing eduation programs. They have been largely formulated by the joint efforts of faculty members in schools of practical nursing in Montana. Therefore, the statements represent acceptable goals at a minimum level of desirability. They are not intended to be ideals or maximum goals. The board has attempted to state the criteria in general terms so that schools may set forth several approaches in meeting them. The board expects to interpret these standards in terms which will insure the minimum requirements set forth but which will leave faculty in each school free to determine the scope, limits and direction of the program offered to its students. Since the practice of practical nursing is an intergral part of the chaning social scene, these standards will also change to meet the demands for programs which prepare practitioners of practical nursing competent to serve the practical nursing needs of society. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-301, 302, MCA; Eff. 12/31/72; AMD, Eff. 5/6/76; TRANS, from Dept. of Prof. & Occup. Lic. C. 274, L. 1981, Eff. 7/1/81.)

8.32.1002 DEFINITIONS (1) Board: The Montana state board of nursing.

(2) The practice of practical nursing: is the performance for compensation in the care of the ill, injured or infirm, of acts selected by and performed under the direction of a registered nurse, or a person licensed in this state to prescribe such medications and treatments, and not requiring the substantial specialized skill, judgement and knowledge required in professional nursing. (Section 37-8-102(3)(b), MCA)

(3) School (program): An educational unit responsible for preparing persons for practice as practical nurses qualified to write the state licensing examination.

(4) Approved school (program): A school which has met the requirements of the law and the minimum standards approved and specified by the Montana state board of nursing as outlined in these rules.

(5) Conditionally approved school (program): A school which fails to meet requirements of the law and of the board and has been given a definite time in which to meet the requirements.

(6) Initially approved school (program): A school which has met the requirements of the law and the board, but which has not been in operation long enough to qualify for full approval.

(7) Governing body (controlling body): The institution responsible for the operation of the school.

(8) Faculty: Body of persons to whom are entrusted the administration and instructions of the school.

(9) Curriculum: The total learning experience organized in a systematic manner.

(10) Requirements: The minimum standards which schools must meet in order to be approved. The words shall or will designate the statements of requirements. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72, AMD, Eff. 5/6/76; AMD 1980 MAR p. 2970, Eff. 11/29/80; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81; AMD 1982 MAR p. 1603-1605, Eff. 8/27/82.)

8.32.1003 PHILOSOPHY AND OBJECTIVES (1) The school shall have a clearly defined statement of philosophy and objectives that is consistent with the philosophy of the governing body.

(2) The objectives shall be consistent with the philosophy and shall describe the competencies of the graduate of the program.

(3) The philosophy and objectives formulated and adopted by the practical nursing faculty shall be used in developing, implementing and evaluating the total program. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72, AMD, Eff. 5/6/76; AMD 1980 MAR p. 2970, Eff. 11/29/80; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81.)

8.32.1004 ADMINISTRATION AND ORGANIZATION (1) Educational institutions conducting programs shall be approved by the appropriate state, regional or national accrediting agencies.

(2) All facilities conducting or cooperating to provide clinical experiences shall be approved by the appropriate state agency.

(3) The organization and administration of the nursing program shall be consistent with those of other programs in the institutions.

(4) There shall be written organizational plans which clearly define relationships of the nursing program to the governing body, to other departments in the institution and to other institutions and agencies used by the nursing program.

(5) The administration of the governing body shall appoint one nursing instructor as coordinator or director. The coordinator/director will have sufficient time provided for carrying out administrative responsibilities. Instructional assignments of the coordinator/director will be consistent with the span or degree of administrative responsibility.

(6) The governing body shall establish formal relationships with agencies used for clinical learning experiences. Such agreements shall be in writing, shall clearly define the respective responsibilities and shall provide for periodic review and renewal.

(7) There shall be adequate financial resources for effective operations of the program.

(a) A seperate annual budget for the nursing program shall be provided.

(b) The nurse faculty member responsible for the coordination/direction of the program shall actively participate in the preparation and control of the annual budget. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72/ AMD, Eff. 5/6/76; AMD 1980 MAR p. 2979, Eff. 11/29/80; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81.)

8.32.1005 FACULTY (1) There shall be an adequate well qualified faculty to meet the educational needs of the program.

(2) Nursing faculty members shall be graduates of approved schools of professional nursing and shall be currently licensed to practice nursing in Montana. Each faculty member shall have academic preparation and experience as follows:

(a) The coordinator/director of the program shall have a minimum of a baccalaureate degree in nursing supplemented by courses in curriculum development; principles and methods of teaching and measurement; and evaluation. The coordinator/director shall have had at least two years experience in registered nursing practice within the last five years and at least two years teaching experience in nursing education.

(b) The nurse faculty members shall have a minimum of a baccalaureate degree in nursing supplemented by courses in principles and methods of teaching and measurement and evaluation. Faculty members shall have had at least two years experience in registered nursing practice within the last five years.

(3) All non-nurse faculty shall have academic and professional education and experiences in the field of their specialization.

(4) Faculty work loads are equitable and shall allow time for classes and and lab preparation, teaching, program revision, improvements of teaching methods, guidance of students, participation in faculty organization and committees, attendance at professional meetings and participation in continuing education activities.

(5) There shall be a ratio of no more than 10 students for each faculty person in the clinical area at any given time.

(6) Written job specifications including responsibilities and qualifications shall be available for each position.

(7) Personnel policies shall be in writing and shall include selection, appointment, and promotion, salary increements, teaching load, faculty development and welfare.

(8) Regularly scheduled meetings shall be held by the nursing faculty and minutes shall be on file.

(9) At the time of employment, each faculty member shall file a faculty qualification record on the required form with the board. Any changes in faculty qualifications shall be included with the school's annual report. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72, AMD, Eff. 5/6/76; AMD 1980 MAR p. 2970, Eff. 11/29/80; TRANS, from Dept. of Prof. & Occup.Lic., C. 274, L. 1981, Eff. 7/1/81.)

provide for understanding and application of public health, mental health and rehabilitation concepts should include the giving of safe nursing care to patients of all age groups with a variety of health problems.

(i) nursing and current trends in health and disease, principles of leadership and citizenship, legal aspects of nursing, team concepts and contributions to allied disciplines, current nursing problems, historical development as it shows the origin of our present professional problems.

(ii) practice in assuming professional responsibilities may be achieved through participation in student organization and by working with allied discipline.

(iii) development of the team concept broadens understanding of the nurse's place and responsibility as a citizen, practitioner, and member of the profession of nursing.

(iv) laboratory shall provide at least 2 hours of clinical experience for each theory hour.

(v) The research process and it's contribution to nursing practice shall be an integral part of the curriculum. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72; AMD, Eff. 5/6/76; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81; AMD 1982 MAR p. 286-287, Eff . 2/12/82.)

8.32.906 EVALUATION (1) Provisions shall be made for periodic evaluation of curriculum and student progress. Adequacy of performance should be evaluated. Provisions should be made for student participation in evaluation and for student-instructor conference.

(2) There should be provision for continous or periodic review, evaluation, and planning in relation to:

(a) the philosophy, objectives and curriculum of the school;

(b) policies governing recruitment, admission, promotion, graduation, and other matters effecting education, health and welfare of the students;

(c) adequate and sufficient clinical facilities available for student practice in the cooperating agencies; and

(d) factors contributing to faculty growth, welfare and effectiveness.

(3) Instruction. The school shall be expected to show that it utilizes a variety of instructional procedures which contribute to the effectiveness of the preparation of the student. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72; AMD, Eff. 5/6/76; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81; AMD 1982 MAR p. 286-287, Eff. 2/12/82.)

8.32.907 ORGANIZATION AND ADMINISTRATION OF THE SCHOOLS OF NURSING (1) A clearly defined statement of the philosophy and objectives of the school shall be included in the school's catalogue. This statement identifies the beliefs which the faculty accepts about nursing and education. The philosophy shall be in agreement with that of the controlling institution and recognizes that the primary purpose of the school is the development of the student as a nurse, a person, and a citizen.

(2) The curriculum of the school will be a reflection on the philosophy and objectives and provide for the accomplishment of the stated objectives. The philosophy and objectives shall be accepted by the governing board, the officers, faculty, and students.

(3) The school of nursing or the institution of which it is a part shall be incorporated.

(4) Educational institutions conducting a nursing program shall be accredited by the appropriate state, regional or national accrediting agencies. Hospitals and other agencies with which the school maintains cooperative agreements shall have approval or accreditation appropriate to the hospital and to those agencies.

(5) Any type of cooperative relationship between the school and another education, health or welfare institution or agency shall be stated in writing and signed by the responsible officers of each. The agreement may provide for instruction, practice, supervision, or other student experience.

(6) Instruction, practice, and/or other opportunities for learning which are provided by participating agencies shall meet the stated purposes of the educational program and the standards required by the board.

(7) When the school is in a college or university, the organizational pattern of the school shall be comparable to other like units in the college or university.

(a) Such department or school shall be administered by a nurse director with appropriate rank, position rank, and authority.

(b) Charts showing the structure of the school, its relationship to administration and other units, shall be developed.

(c) The budget of the school shall be a part of the budget of the college or university. The nurse director shall be responsible for the preparation, presentation, and administration of the budget for the school of nursing.

(d) Policies governing schools of nursing shall be the same as policies governing other educational departments of the controlling institution, including the establishment of committees to carry out tasks of administration and shall be constructed along the same lines as those of the controlling institution. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72; AMD, Eff. 5/6/76; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81; AMD 1982 MAR p. 286-287, Eff. 2/12/82.)

8.32.908 THE INDEPENDENT SCHOOL is hereby repealed. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-301, 302, MCA, Eff. 12/31/72; AMD, Eff. 5/6/76; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81; REP, 1982 MAR p. 286-287, Eff. 2/12/82.)

8.32.909 FACULTY (1) The best single index of ability to prepare adequate practitioners of professional nursing is the competency of the faculty in providing a program of recognized quality. Each faculty member shall devote full time to instructional responsibilities and be qualified by academic preparation and experience in the teaching area to which assigned. Teachers of nursing practice shall be responsible for all instruction in the area assigned including laboratory practice in the clinical field.

(2) The director of the school shall have a minimum of a masters degree in nursing and at leaast 2 years experience teaching in a nursing education program.

(3) Nursing faculty members shall be graduates of approved schools of professional nursing, shall hold a master's degree, have advanced preparation for teaching and shall be licensed as registered nurses in Montana. Personal, academic and professional qualifications shall be appropriate to the area of assignment.

(4) The titles of faculty members shall be consistent with their functions.

(5) There shall be secretarial and clerical staff sufficient to meet routine requirements for administration of the school and assistance to the instructional staff.

8.32.1006 STUDENTS (1) Requirements for admission shall be consistent with the policies of the governing body and shall include a high school diploma or its equivalent.

(2) Classes shall be admitted only at regular intervals and each class should consist of not less than 10 students.

(3) Policies consistent with those of the governing body shall be in writing regarding re-admission of students and admission by transfer.

(4) Student progress shall be reviewed periodically to substantiate retention in the nursing program.

(5) Policies providing for student welfare as related to counseling and guidance, health and financial aid shall be available.

(6) Requirements for graduation shall be in writing. Upon successful completion of the program, the student shall receive a certificate or diploma from the governing body. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72; AMD, Eff. 5/6/76; AMD 1980 MAR p. 2970, Eff. 11/29/80, TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81.)

8.32.1007 CURRICULUM (1) Program length shall be based upon completion of the approved curriculum within the structure and the framework of the governing body and be consistent with the philosophy and objectives of the program.

(2) The study, development, implementation and evaluation of the nursing curriculum shall be the responsibility of the practical nursing faculty.

(3) The philosophy and objectives of the nursing program shall serve as the basis for development, implementation and evaluation of the curriculum.

(4) The curriculum shall be divided into identifiable areas of content which provide a progressive development of knowledge, skills and attitudes.

(5) The choice and placement of courses, selection of learning activities and the organization of these shall provide continuity, sequence and integration in the total curriculum.

(6) Learning experiences shall reflect written behavioral objectives.

(7) The program shall include practical nursing theory and guided clinical practice based on the broad areas of the nursing model and essential to current practice in practical nursing. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72, AMD, Eff. 5/6/76; AMD 1980 MAR p. 2970, Eff. 11/29/80; TRANS, from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81.)

8.32.1008 RESOURCES AND FACILITIES (1) Classrooms, laboratories, conference rooms and instructional offices shall be adequate in size, number and type and shall provide an environment conducive to learning.

(2) Library resources and instructional resources shall be adequate and appropriate to meet the needs of students and faculty.

(3) Clinical facilities shall be selected to provide learning experiences sufficient to achieve the objectives of the program. Consideration shall be given to the philosophy and objectives of care in the facility, environment conducive to learning, learning experience available and quality and quantity of the professional and supportive staff.

(4) Secretarial and other supporting services will be sufficient to the needs of the program. (History: Sec. 37-8-202, MCA; IMP, Sec. 37-8-202, 301, 302, MCA; Eff. 12/31/72, AMD, Eff. 5/6/76; AMD 1980 MAR p. 2970, Eff. 11/29/80; TRANS from Dept. of Prof. & Occup. Lic., C. 274, L. 1981, Eff. 7/1/81.)

Amendment to HB328, Introduced Copy
Proposed by Montana Health Network

1. Page 1, line 20.
   Following: " or "
   Insert: " a bachelor's degree in nursing and "

2. Page 2, line 21 and 22.
   Following: " field "
   Strike: " which includes advanced nursing or graduate level nursing education courses "

EXHIBIT 5
DATE 2.3.89
HB 328

BOARD OF NURSING
DEPARTMENT OF COMMERCE

1424 9TH AVENUE

STATE OF MONTANA

(406) 444-4279

HELENA, MONTANA 59620-0407

To: Representative Stella Jean Hansen, Chairman and Members of the Human Services and Aging Committee

Date: February 3, 1989

Subject: Testimony on House Bill 328

I am Donna Schramm, president of the Montana State Board of Nursing and speaking for the Board in opposition to HB328.

(1) The State Board of Nursing has had a rule with the intent to require a Masters in Nursing as a faculty requirement for Professional Schools of Nursing since 1974. Over the years the Board has communicated with the various Schools of Nursing as they have worked towards compliance.

MCA 37-8-301 directs the Board to adopt rules for Nursing education programs to ensure their graduates will meet the qualifications necessary to practice as a professional nurse. We feel the present rules fulfill that statutory directive.

We oppose the legislation because:

1) Setting standards for faculty qualifications is within the jurisdiction of the Board as a statutory directive and is within the expertise of the Board.
2) We believe the proposed legislation is insufficient to fullfill the obligation to safeguard life and health as in

EXHIBIT 6
DATE 2-3-89
HB 328

MCA 37-8-101(1).

3) In this fast changing, technologically advanced era of health care, no less of a standard should be acceptable for professional nursing than what is required by other disciplines - masters preparation in the area being taught.

(2) The Board believes to safeguard public life and health in this rapidly changing and increasingly complex health care system, faculty of professional nursing programs should have preparation at the master in nursing level in order to adequately prepare qualified practitioners of nursing for today and the future.

(3) Among the characteristics of graduate education, the master program in nursing prepares the individual to gain advanced theoretical knowledge and to develop the ability to translate that knowledge to students in the didactic and clinical practice settings. Pertinent also to the functional role of teaching, the master program in nursing provides preparation in a specialty area of nursing appropriate to the area of instruction and responsibility and promotes the development of research and leadership skills. In comparison, graduates of the baccalaureate program in nursing are prepared as 'generalists' to give high quality nursing care to patients and their families in a variety of settings and to direct the nursing care given by other nursing team members working with them under their supervision.

Based on these characteristics of masters in nursing preparation, the Board takes the position the existing faculty standards must be maintained to insure quality care is provided

in the complex, rapidly changing health care environment. The quality of a nursing education program is dependent on the quality of its faculty

Thank you for the opportunity to present these comments on behalf of the Board of Nursing.

Madam Chairman - Members of the Committee

My name is Donna Small, R.N., a member of the Montana Nurses' Association and former member and president of the Board of Nursing.

I speak in **opposition** to **HB 328** for two reasons:

1. Educational qualification has previously been addressed in rules. To now address this in statute means that if change is needed, it can only be made by returning to the legislature in a future session.
2. Section 37-8-301 is a section which addresses Nursing Education Programs. It is a general statement which addresses both LPN and RN programs. This bill raises the qualifications for LPN schools and lowers the qualifications for RN schools. If this is not what was intended, it gives you a good example of what can happen when a law is changed for a specific purpose without regard to its effect on the rest of the content.

Health Care is changing everyday. We are experiencing a nursing shortage today. To feel this shortage can be addressed by lowering the standards for nursing faculty oversimplifies the problem.

Shortage of clinical settings, low salaries, higher wages in formerly non-female occupations, are all recognized as being responsible for the shortage in rural as well as urban areas.

Madam Chairman, Members of the Committee: I believe this is a flawed bill.

I ask you to vote **No** on **HB 328.**

Thank you.

EXHIBIT 7
DATE 2-3-89
HB 328

Amendment to H.B. 395

The authority granted by this act to nurse specialists to prescribe and dispense drugs may be defined and limited by the Board of Nursing and the Board of Medical Examiners by joint rule.

EXHIBIT 8
DATE 2-3-89
HB 395

PRESCRIPTIVE AUTHORITY FOR NURSE SPECIALISTS

(Nurse Practitioners, Nurse Midwives, Nurse Anesthetists)

NURSE SPECIALISTS-

There are approximately 140 nurse specialists practicing in Montana (55 nurse anesthetists, 9 nurse midwives, and 76 nurse practitioners.) All of these nurses have completed their registered nurse education (most with either a diploma[3 years] or a bachelor's degree), completed either 1 year or a Master's degree in addition to their registered nurse education and successfully completed a national certification examination. There are mandatory continuing education requirements for recertification for all 3 types of nurse specialist. All nurse practitioners who were certified by the American Nurses Association after 1985 must have a bachelor's degree in nursing and in 1992, a Master's degree will be required. Nurse specialists are located in 30 communities across Montana.

PRESCRIPTIVE AUTHORITY-

Nurse specialists are prescribing medications in all 50 states. The preactice is regulated by the Board of Nursing in 28 states with 4 states seeking prescriptive authority in 1989. In Montana, the legislative changes would allow the Board of Nursing to develop rules and regulations for this aspect of nurse specialist practice, just as they do now for other aspects of nurse specialist practice. These rules and regulations would define the scope of medications which would be prescribed by nurse specialists, define continuing education requirements, develop a process for notifying the Board of Pharmacy and clarify the accountability of the nurse specialist for his/her practice. Prescriptive authority would be optional and would be in addition to current recognition requirements. Agencies who utilize the services of a nurse specialist could set additional requirements or limit the use of prescriptive authority just as they currently do.

QUALIFICATIONS OF NURSE SPECIALISTS TO PRESCRIBE-

1. Organic and inorganic chemistry, anatomy and physiology, pharmacology courses in R.N. education which are further developed in nurse specialist education.
2. Extensive education in the theraputic action, risks, side effects, administration and evaluation of medication effectiveness in both R.N. and nurse specialist education programs.
3. Supervised experience in nurse specialist education programs by both physicians and nurse specialists in the theraputic use of medications.
4. Extensive experience in the administration and client education of the use of medications through R.N. and nurse specialist education and clinical experience.
5. Complaints of R.N. substance abuse/misuse can be investigated by the Board of Nursing.

DISADVANTAGES OF CURRENT SYSTEM-

1. Prescriptions are written, for clients seen by nurse specialists, under a physician's name. In most instances, the physician never sees the client.
2. It is unclear to the pharmacist, who dispenses the medication, who actually wrote the prescription and who is responsible.
3. The client chooses to utilize the services of the nurse specialist and is often confused when the prescription is written under a physician's name. The client may also find it inconvenient to have the prescription filled if the nurse specialist must call it in to a pharmacy and that pharmacy is closed or busy.
4. If other health care staff (e.g. office nurses) are involved in calling in the prescription to the pharmacy, the risk of medication errors increases.
5. The responsibility and accountability for the prescription is unclear. Is the physician responsible because his/her name appears on the prescription, even when they don't see the client? Is the nurse specialist responsible because he/she saw the client and prescribed the medication?
6. There is no clear authority to protect client safety with the current system.

ADVANTAGES OF GRANTING PRESCRIPTIVE AUTHORITY-

1. Clearly defined lines of authority and accountability
2. Pharmacists know who is prescribing and who is responsible
3. Reduced client confusion and inconvenience
4. Fewer risks of medication errors
5. Bring prescriptive practices by nurse specialists under supervision of the Board of Nursing to ensure client safety.
6. The Board of Nursing can investigate complaints about nurse specialist prescribing practices.

STATES WHICH HAVE PRESCRIPTIVE AUTHORITY FOR NURSE SPECIALISTS

28 states grant this authority

State	Year granted	Form for Prescriptive Authority
Alaska	1979	N. P.'s have independent prescriptive authority including controlled drugs Schedule II-V)
Arizona	1982	N.P.'s have full prescriptive & dispensing authority upon application & fulfillment of criteria established by the Board of Nursing. The enabling statute is in the pharmacy statute with rules & regs. in the Nurse Practice Act. N.P.'s have D.E.A. #'s for Controlled Substances but there are time restrictions on the legnth of time on the prescription.
California		N.P.'s who have completed at least 6 month of M.D. supervised experience in furnishing drugs/devices & who have completed a course in pharmacology & who have a Board of Nursing furnishing # may furnish certain drugs used in Family Planning
Connecticut		Will be introduced in 1989 Legislature
Delaware		All R.N.'s can apply(with their delegating physician) to a joint-practice committee of the Board of Nursing & Board of Medicine to have their protocols(including a list of prescriptive drugs to be prescribed by the R.N.) approved. Accepted protocols must be re-evaluated yearly.
District of Columbia		The D.C. statute provides for prescriptive authority for N.P.'s. Rules & regs. are pending.
Florida	1988	Prescriptive privileges were obtained for N.P.'s as a result of a decision by the Board of Nursing/Board of Medicine joint committee; controlled substances are excluded.
Georgia		Will be introduced in 1989 Legislative session
Idaho	1977	Prescribing is allowable for certified N.P.'s with written practice protocols; N.P.'s may not prescribe Controlled Substances.

tate	Year granted	Form for Prescriptive Authority
ansas		N.P.'s may prescribe under jointly adopted protocols between the N.P. & the M.D. The Board of Nursing will adopt rules & regs. for permanent regulations allowing N.P.'s to prescribe following jointly agreed upon protocols with the "responsible physician", excluding controlled substances.
entucky		Will be introduced in 1989 Legislature
Maine	1977	Prescriptive authority is approved by Board of Medicine (N.P.'s have their own D.E.A. #'s). Limits in prescribing formulary by exclusion (i.e. narcotics)
aryland	1981	N.P.'s prescribe medications as agreed upon in writing with M.D.'s. The N.P. uses his/her own signature on the prescriptive pad; a list of N.P.'s "certified to practice" is sent to pharmacists.
ssachusetts		N.P.'s, after registering with the Department of Health, may prescribe for patients in long-term care facilities as well as for chronic-disease patients in their homes, if this would avoid their being institutionalized.
chigan	1980	A January, 1980 attorney general decision interpreted the statutes to allow M.D.'s to delegate the prescribing of drugs to R.N.'s.
Minnesota	1988	C.N.M.'s just received authority to prescribe. N.P.'s hope to try in the next few years for their own prescriptive authority.
ssissippi	1980	N.P.'s have statutory prescriptive authority granted by the Board of Nursing; the prescriptive authority is based on accepted "protocol" which lists the treatments & medications the N.P. expects to prescribe in his/her practice. No controlled substances.
ntana		Will be introduced in 1989 Legislatur
raska		N.P.'s may prescribe as specified on the "practice agreement" form. Drugs

ate	Year granted	Form for Prescriptive Authority
		prescribed must be listed on N.P.'s protocols & may not be Schedule II drug The N.P. must use an R_x pad containing the M.D.'s name preprinted at the to the signature contains N.P. name/M.D name.
Nevada	1983	N.P.'s may prescribe if they submit the Board of Nursing documentation of 1,000 hours as a N.P. under a supervisir M.D. & a signed statement from the M. The N.P. can then prescribe any meds (excluding controlled substances) listed in his/her protocols(developed by th supervising M.D. at the site & update yearly.)
New Hampshire	1983	N.P.'s who function in connection wit protocols established jointly with a collaborative physician, may prescribe medications from the official formula agreed upon by the Board of Nursing & Board of Medicine. N.P.'s are assigned D.E.A. #'s.
w Jersey		Legislation was pending in 10/88.
New Mexico	1978	N.P.'s have prescriptive privileges w h their own signature in accordance to written protocols with M.D. supervision. N.P.'s are listed at the Board of Nurs ng Board of Pharmacy & Board of Medicine.
New York	1988	N.P.'s have prescriptive authority in a collaborative relationship with a M. with written practice agreement and protocols. No restrictions on type of drugs except protocols
North Carolina	1975	N.P.'s may write prescriptions with limited refills from an approved list of drugs. Authority to presribe is gi n at the time of approval to practice as N.P.
Oregon	1979	N.P.'s have prescribing authority which is regulated by Board of Nursing. A council consisting of N.P.'s, M.D.'s & pharmacists determines the formulary from which N.P.'s can prescribe. N.P.'s must have a postgraduate pharmacology course to be certified to prescribe.

State	Year granted	Form for prescriptive authority
Pennsylvania	1977	N.P.'s have petitioned the Board of Nursing to set up rules and regs. with the Board of Medicine.
Rhode Island	1988	No rules and regulations as yet.
South Dakota	1979	N.P.'s may prescribe because prescribi is considered a delegated function. N.P.'s must submit their "practice agreement" (including the list of medications the N.P. will prescribe, & the N.P.'s scope of practice) to the joint board; the agreement is on file with the Board of Nursing.
Tennessee	1980	Master's prepared N.P.'s who are nationally certified & who have specified pharmacology courses may apply to Board of Nursing for a "certificate of fitness" to write & si prescriptions &/or issue non-controlle legend drugs.
Utah	1983	N.P.'s in practice with an M.D. can ap for prescribing privileges. The M.D. only need be in contact by phone. Protocols are developed by the M.D. & I & are submitted for approval to the prescriptive board consisting of 3 NP's 3 M.D.'s & a pharmacist..
Washington	1980	Legislation for prescriptive authority is authorized under the Board of Nursi & entails additional certification bey the N.P.

States experiences with prescriptive authority

Strengths:
1. Increased access to health care for the consumer(high quality, cost e
2. No increase in safety problems with N.P. prescriptions
3. Clearly defined accountability and responsibility.

Weaknesses:
1. Regulatory boards with multi-disipline representation have problems with funding, meeting times, "turf" issues and travel distances.
2. "Laundry" list of drugs which can be prescribed are difficult to keep current as drugs are changing all the time.
3. Protocols which define interventions may increase the liability because clients don't always fit the standard. Protocols defined by M.D. only may not reflect current standards of nursing practice

Sources: The Nurse Practitioner, January, 1989 pp-27-34

LaBar, Clare. Prescribing Privileges for Nurses: A Review of Current Law. American Nurses Association, February, 1984.

MONTANA COMMUNITIES SEEKING PHYSICIANS--Those listed with the Montana Area Health Education Center

Some of these communities could utilize the services of a nurse specialist to provide health care, if nurse specialists are granted prescriptive authority.

Anaconda	Chester	Hardin
Baker	Columbia Falls	Harlowton
Belgrade	Columbus	Havre
Big Sandy	Crow Agency	Helena
Billings	Cut Bank	Malta
Boulder	Ennis	National Health Service Corps Regional Office
Box Elder	Forsyth	Plentywood
Bozeman	Glascow	Poplar
Browning	Glendive	Red Lodge
Butte	Great Falls	Scobey
Shelby	Three Forks	White Sulpher Springs
Whitefish	Wolf Point	

COMMUNITIES CURRENTLY UTILIZING THE SERVICES OF A NURSE SPECIALIST

Billings	Bozeman	Butte
Chinook	Deer Lodge	East Glacier Park
Fort Harrison	Glascow	Great Falls
Hamilton	Helena	Hot Springs
Kalispell	Libby	Livingston
Miles City	Missoula	Polson
Poplar	Shelby	Scobey
Wolf Point	Dillon	Lewistown
Anaconda	Big Timber	Superior
Big Arm	Sidney	Ronan

Thus, I need to stress that the Montana Medical Genetics Program is a service, not a research program. We are serious about the teaching provisions of the law so long as they don't interfere with our service obligations.

In 1987, the 50th legislature re-appropriated funds for the program under HB 716 with the same premium-tax funding mechanism by a 3:1 vote. We are most grateful to Blue Cross/Blue Shield for its support of HB-402 on the basis of the need for and the merit of the Program.

Genetic Services have been provided in Montana since Dr. Pallister established a Genetics unit at Boulder in 1961 under the Department of Institutions; when Dr. Pallister retired from Boulder in 1976 the unit closed and the Board of Trustees of Shodair Children's Hospital asked him to establish a Genetics and Birth Defects unit at Shodair. This is the only Medical Genetics unit in Montana.

Need for the Program: Genetic services to ranchers through agricultural extension services of our land-grant college and genetic research in crops and livestock have received extensive legislative funding in Montana for several decades before it was realized that the people of Montana also have needs for genetic services.

In Montana, no less than in the rest of the nation,

° Some 15-20% of the people are in need of a genetic service, whether that is diagnosis, counseling, prenatal diagnosis, chromosome studies or fetal pathology; this means 120,000 to 160,000 persons in Montana, including 40,000 alone who are carriers of cystic fibrosis.

HB 402: AN ACT TO CONTINUE FUNDING FOR THE STATEWIDE GENETICS PROGRAM

Testimony by Dr. John M. Opitz, M.D., M.D.(hc), D. Sci.(hc)
Chairman, Department of Medical Genetics
Clinical Professor of Pediatrics and Medicine
(Medical Genetics), University of Washington;
Adjunct Professor of Medical Genetics and
Pediatrics, University of Wisconsin-Madison; and
Adjunct Professor of Biology (Genetics), History,
Medicine (WAMI) and Veterinary Science, MSU.

Date: 3 February, 1989, House Committee on Human Services and Aging.

History: In 1985 the 49th legislature passed HB430 which established and funded 50-19-211 MCA - the voluntary genetics program (Montana Medical Genetics Program). This "program includes, but is not limited to, the following services:

1.) Follow-up programs for newborn testing, with emphasis on the counseling and education of women at risk for maternal phenylketonuria;

2.) comprehensive genetic services to all areas of the state and all segments of the population;

3.) development of counseling and testing programs for the diagnosis and management of genetic conditions and metabolic disorders; and

4.) development and expansion of educational programs for physicians, allied health professionals, and the public with respect to:

   a.) the nature of genetic processes;

   b.) the inheritance patterns of genetic conditions; and

   c.) the means, methods, and facilities available to diagnose, counsel, and treat genetic conditions and metabolic disorders."

EXHIBIT 14
DATE 2-3-89
HB 430

ALICIA PICHETTE
CHAIRPERSON
EARLY INTERVENTION ADVISORY COUNCIL
(406) 442-8309
STATE OF MONTANA
714 6th AVENUE
HELENA, MONTANA 59601

Alicia Pichette

Feb 2,

Chairman Hansen & members of the committee;

For the record, my name is Alicia Pichette. I speak today as a proponent of HB 402 As the parent of a disabled child, I applaud your past support for the Montana Genetics Program at Shodair Hospital in Helena.

Under the guidelines of P.L. 99-457 Section 672, Montana will be required to provide "diagnostic and evaluation services" for handicapped infants and toddlers.

Montana is fortunate to have an excellent genetics program, nationally respected and providing services to this region of the west.

It is very important to preserve this high quality, Montana-based genetics research and counseling service for families of disabled children.

I urge your continued support for the Montana Genetics Program.

Thank you.

EXHIBIT 13
DATE 2-3-89
HB 402

BOARD OF NURSING
DEPARTMENT OF COMMERCE

1424 9TH AVENUE

STATE OF MONTANA

(406) 444-4279

HELENA, MONTANA 59620-0407

To: Representative Stella Jean Hansen, Chairman, and Members of the Human Services and Aging Committee

Date: February 3, 1989

Subject: Testimony on HB395

Madam Chairman, Committee Members:

I am Jan Cronquist, a public member of the Board of Nursing, speaking on behalf of the Board of Nursing.

The Board of Nursing supports HB395 under which the Board would adopt rules regarding authorization for prescriptive authority of nurse specialists.

In writing the rules, the Board would consider the appropriateness of the authority to prescribe specific drugs based on the nurse's area of specialty and education.

EXHIBIT 12
DATE 2-3-89
HB 295

RESOLUTION 87- 7

HEALTH CARE SERVICES

WHEREAS, there is a critical need to maintain basic health care services in sparsely populated areas of the state of Montana; and

WHEREAS, many of these sparsely populated areas are unable to recruit a licensed physician to provide local emergency care and medical services, due to financial, social and other consideration.

NOW THEREFORE BE IT RESOLVED that the Montana Association of Counties urges the Legislature and the State Licensing Department to develop laws and regulations to allow physician assistants and nurse practitioners to provide basic medical services to sparsely populated areas similar to other states such as South Dakota, Washington and Alaska.

SPONSORED BY: DISTRICTS 1-2-3

APPROVED: ANNUAL CONVENTION

DATE: JUNE 9, 1987

REAFFIRMED: ANNUAL CONVENTION

DATE: JUNE 15, 1988

EXHIBIT 11
DATE 2-3-89
HB 395

The second limitation on the type of medications which a nurse specialist would prescribe is also contained in the rules which define the scope of practice for the nurse specialist. Nurse practitioners can only practice as nurse practitioners in primary health care settings. A primary health care setting is a clinic, physician's office, senior citizen's center, health department, or outpatient department where people begin contact with the health care system. The primary health care setting focuses on the identification of health care problems, prevention, health maintainance, health education, treatment of uncomplicated problems, collaboration with other health care providers and referral to the most appropriate health care provider. The role of the nurse specialist in these settings is on prevention and health maintainance. Acutely ill people are always referred to physicians for evaluation and proper treatment.

Nurse midwives provide prenatal care, labor and delivery and postpartum care to women with essentially normal pregnancies. The nurse midwives are a part of the primary health care system where consultation, collaboration and referral are available.

Nurse Anesthetists work very closely with surgeons and anesthesiologists in the administration of anesthesia. Generally, the surgeon is the supervising physician if an anesthesiologist is not directly available.

Under this legislation, these processes would remain esentially the same. This legislation would allow the board of nursing to define any exemptions of medications which clearly exceed the scope of nurse specialist practice, define continuing education requirements and further regulate the prescribing practices of nurse specialists. The Board could also handle complaints about nurse specialist prescribing practices. This legislation would make the nurse specialist clearly accountable for this aspect of their practice as they are for other aspects of their practice. The physician would remain accountable for practice guideline review, collaboration and for the care they give upon referral.

I am Cathy Caniparoli and I am representing the Montana Nurse Practitioner State Interest Group. We are here to speak in favor of H.B. 395.

One of the most commonly asked questions about this legislation is what type of medications would nurse specialists be prescribing and what limitations are there on these medications. Currently, in Montana, nurse specialists are required to use protocols to prescribe. Protocols are practice guidelines which describe assessment factors, diagnostic tests which would confirm the diagnosis, other diagnosis which might give similar symptoms and the treatment needed. Because these practice guidelines must reflect both nursing practice and some aspects of what has come to be seen as medical practice, they are developed jointly by physicians and nurse specialists. The practice guidelines are the agency limits on the nurse specialist's practice. They describe the type of practice which the nurse specialist functions in, for example guidelines for treatment of ear infections in a pediatric setting. The guidelines define what medications can be used by the nurse specialist. Any other medications which might be needed must be gotten either through referral to a physician or by collaboration with a physician. The physician then issues a prescription. The only changes which would occur because of this legislation is that the nurse specialist would actually sign the prescription and the Board of Nursing could design methods of regulating this practice. I have included 2 examples of protocols in your packet--one which includes medications which are used to treat the problem and one where the nurse specialist provides care and the medication, if needed, would come from referral or collaboration with a physician.

EXHIBIT 10
DATE 2-3-89
HB 395

high quality, safe, cost effective health care for many of the common reasons that people seek health care.

In the interest of consumer safety and the promotion of access to health care services, the Montana Nurses Association urges a "do pass" recomendation on H.B. 395.

serious inconvenience to the patient. In these times of increased demand for accountability, the need for clear lines of responsibility and the use of safe practices becomes increasingly critical.

The safety of the health care consumer would best be protected by granting the Board of Nursing the power to regulate the prescriptive authority of nurse specialists. The standards of safety and professional conduct would be ensured by regulation of this aspect of nursing practice.

The second issue which is important here is access to health care services especially in rural areas of Montana. Montana is experiencing a crisis in health care. As of January, 1989, there were 34 Montana communities listed with the Montana Area Health Education Center, who were looking for a physician. Many of these communities could utilize the services of a nurse specialist, who had prescriptive authority. There would still be a physician who would work with the nurse specialist and be available for referral and consultation. Some physicians are understandably hesitent to utilize a nurse specialist when the issue of accountabilit for prescription writing is unclear. Some pharmacists are hesitent to fill nurse specialists prescriptions because they know that the physician did not see the patient but the physician's name is on the prescription. Montana, Wyoming, Colorado and North Dakota are the only western states who do not grant some form of prescriptive authority to nurse specialists. Since recruitment to Montana generally comes from other Western states, it is difficult to recruit nurse specialists to move to a state where prescriptive authority is more restrictive. Utilizing a nurse specialist in many rural communities would give the community

Montana Nurse Association Testimony--H.B. 395

My name is Barbara Fisher and I am representing the Montana Nurses Association. We are here to speak in support of H.B. 395 authorizing the Board of Nursing to grant prescriptive authority to nurse specialists.

Granting prescriptive authority to nurse specialists would help address some very important issues for nursing and health care in Montana. Currently, nurse specialists are writing prescription in all 50 states. The practice of prescribing, as a component of nursing practice, is regulated in 28 states, with 4 more states, including Montana, approaching their Legislatures in 1989. You have in your packet of materials, a list of these states, how they manage prescriptive authority and a summary of the advantages and disadvantages of the various ways of managing prescriptive authority.

Currently, nurse specialists are licensed as registered nurses and recognized as nurse practitioners. Their practice is defined by the definition of professional nursing and is further defined in the rules 8.32.301, 8.32. 302, and 8.32.303. Nurse specialists are writing prescriptions under protocols which define what medications and in what circumstances these medications can be prescribed. In all instances, in Montana, a physician is available for consultation and referral as needed. The methods used to write prescriptions do not clearly define accountability, may lead to medication errors and may cause

EXHIBIT 9
DATE 2-3-89
HB 395

2. For reinfection cystitis in women without risk factors: same as for first episode of cystitis. Important to distinguish reinfection from relapse. Reinfection occurs within weeks to months of preceding cystitis, and is often caused by a new organism. Relapse is a recurrence of symptoms and infection after finishing a medical course, and is caused by the same organism as the original infection
3. For relapse cystitis in women: refer to physician
4. For patients with risk factors (past history of pyelonephritis, known urinary tract abnormality, use of catheter, diabetes): refer to physician
5. For males: Trimethoprim and sulfamethoxazole (Bactrim DS®) BID x 14 days: will also treat prostatitis

B. For pregnant women
   1. The causative pathogen in pregnant women is usually E. coli. Do culture before treatment; sensitivity only if no improvement on medication
      a. First choice: Ampicillin 250 I QID x 10 days
      b. Second choice: Nitrofurentoin (Macrodantin®) or other sulfa drug (do not use sulfa in third trimester)
      c. Do not use Septra® or Bactrim®

C. Pain relief: Phenazopyridine Hydrochloride (Pyridium®) 100 TID x 24°

D. General measures
   1. Advise voiding before and after sex
   2. Advise adequate lubrication for sex
   3. Teaching re: hygiene, contamination
   4. Treat as above (B.) if bacteria present; consider treatment with Pyridium® only if client symptomatic in absence of pathogenic organism

VIII. Complications

Pyelonephritis

IX. Consultation/Referral

A. Physician consult on all high-risk patients including
   1. Those who have had previous episodes of pyelonephritis

   2. Those with known urinary tract abnormality
   3. Those with underlying disease such as diabetes
   4. Those who are pregnant women
   5. Chronic catheter users: quadriplegics, paraplegics

B. Physician consult on
   1. All patients with relapsed infections
   2. All women who are still symptomatic after 3 days of treatment
   3. All women who have more than 3 episodes of cystitis in a year

C. Indications for urologic work-up needed for referral
   1. First episode in a male
   2. Any episode of pyelonephritis
   3. Relapsing infection with same organism
   4. History of renal calculi
   5. Multiple recurrent infections in women

X. Follow-up

Follow-up screen/culture 1 week after completion of medication course (sooner if patient is symptomatic) to check for presence of the causative agent

For bibliography on cystitis, see page 293.

C. External examination for lesions, infection, atrophy, anomaly
   1. Urethra
   2. Clitoris
   3. Labia
   4. Perineum
D. Vaginal examination (speculum)
   1. Walls
   2. Discharge
   3. Lesions
   4. Cervix
   5. Atrophy scar from hysterectomy
E. Bimanual examination
   1. Adnexa
      a. Tenderness
      b. Masses
      c. Enlarged tubes or ovaries, if present
   2. Uterus
      a. Size
      b. Mobility
      c. Tenderness
      d. Masses

V. Laboratory Examination

A. Appropriate cultures, smears if suspicion of infection
B. Papanicolaou smear if none done in past year

VI. Differential Diagnosis

A. Carcinoma of genital tract
B. Pregnancy

VII. Treatment

A. Medication: Referral for severe menopausal symptoms, strong family history of osteoporosis, evaluation for postmenopausal estrogen replacement therapy
B. General measures
   1. Teaching about normal menopausal symptoms, changes with aging, need for more time for arousal, use of supplemental lubrication (saliva, water-soluble jelly, safflower oil, coconut oil, baby oil, cocoa butter), changes in sexual response that accompany removal of the uterus if surgical menopause has occurred
   2. Teaching about self-care: diet, exercise, prevention of osteoporosis; breast self-examination, need for Papanicolaou smear and pelvic examination yearly; contraception until one full year without menses; signs and symptoms of problems: postmenopausal bleeding; prevention of vaginal infections

VIII. Complications/Risks

A. Pregnancy
B. Carcinoma of reproductive tract
C. Breast cancer (risk is higher after menopausal years)
D. Incapacitating menopausal symptoms: hot flashes that disrupt normal life
E. Osteoporosis

IX. Consultation/Referral

A. To physician for complications listed above
B. Medical consultation for
   1. Medication
   2. Possible pathology
C. Sex therapist for prolonged or severe disruption in sexual relationship
D. Counseling: stresses of the middle years

X. Follow-up

A. Annual examination, Papanicolaou smear, pelvic examination
B. As needed for continuation or exacerbation of problems or concerns

For bibliography on peri- and postmenopausal care, see page 291.

C. Other predisposing factors
   1. Size of inoculum
   2. Virulence of organism
   3. Incomplete or infrequent bladder emptying
   4. Urinary tract abnormalities: obstruction, calculi, congenital defects, prostatic hypertrophy
   5. Use of catheters
   6. Newly sexually active (honeymoon cystitis)

III. History

A. What the client presents with
   1. Dysuria
   2. Frequency, urgency
   3. Suprapubic pain
   4. No systemic symptoms except occasionally a low grade fever, < 101
   5. Gross hematuria

B. Additional information to obtain
   1. Any previous cystitis or pyelonephritis: when, how treated, response to treatment
   2. Previous urologic work-up
   3. Any vaginal discharge
   4. Any chronic condition, diabetes, paraplegia, quadriplegia; cerebral palsy, meningomyelocele, spina bifida
   5. Duration of symptoms
   6. Possible pregnancy with high-risk complications or use of contraindicated drugs
   7. Sexual activity

IV. Physical Examination

A. Vital signs: temperature
B. Abdomen: any tenderness
C. Back: any costovertebral angle tenderness
D. Pelvic examination essential to rule out pelvic inflammatory disease, vaginitis, or sexually transmitted disease
E. Prostate examination and work-up to rule out prostatitis

V. Laboratory Examination

A. U/A: clean catch midstream urine; pyuria => 5 WBC/hpf
B. Culture alone is sufficient on first time ever with cystitis with no risk factor; all others should have culture and sensitivities
   1. Culture and sensitivities typically > 100,000 organisms felt to be diagnostic
   2. If between 10,000 and 100,000, probably significant if clinical symptoms support diagnosis
C. Note: Urine may be stored at room temperature for 1 hour or refrigerated up to 72 hours

VI. Differential Diagnosis

A. Upper tract disease: pyelonephritis
B. Urethritis due to
   1. Chlamydia
   2. Bacteria from urethral manipulation causing irritation; thought to be early cystitis
C. Vaginitis
D. Pelvic inflammatory disease
E. Sexually transmitted disease
F. Prostatitis
G. No recognized pathology, "honeymoon cystitis"
H. Pregnancy

VII. Treatment

A. Antibiotics
   1. For first episode of cystitis in women without risk factors: institute treatment with any of the following, provided the woman is not allergic to the drug
      a. Nitrofurantoin (Macrodantin®) 50 mg QID x 7 days and depending on repeat culture results, possibly 25 mg QID x 7 more days
      b. Trimethoprim and sulfamethoxazole (Septra®) 1 BID x 10 days
      c. Amoxicillin 500 mg TID x 10 days
      d. Sulfisoxazole (Gantrisin®) 8 stat, 1 QID x 10 days

Peri- and Postmenopausal Care

I. Definition

The menopause is the landmark event of the climacteric, the 10-to-15-year period, beginning at about age 40, when women's bodies are changing, winding down, and preparing for cessation of menses. A woman cannot say that she has gone through menopause until at least one full year has passed without any menstrual period. The postmenopausal time begins when menopause is complete and menses no longer occur. For women today, the postmenopausal years may comprise as much as 3/8 of their lives or more, the mean age for menopause being 50.

II. Etiology

A. The gradual diminution of estrogens, resulting in cessation of ovulation and thus of menstruation
B. Surgical removal of the uterus which results in an abrupt end to menstruation, and/or surgical removal of the ovaries which results in surgical menopause, an abrupt end to ovulation and menstruation

III. History

A. What the client presents with
   1. Changes in character of the menstrual cycle
      a. Menstrual periods that are more frequent, less frequent, of longer duration or shorter duration
      b. Scanty flow
      c. Flooding at onset of flow
      d. Gradual or abrupt cessation of menses for one or more months
      e. Irregular periods over a period of time or abrupt cessation of menstruation

   2. Other changes
      a. Hot flashes, hot flushes
      b. Vaginal dryness, atrophy of vaginal tissues
   3. Changes related to aging but not due to menopause
      a. Dry skin and hair; skeletal pain or stiffness
      b. Graying of hair
      c. Loss of skin elasticity
      d. Alterations in sleep patterns
      e. Developmental occurrences of aging: empty nest, caring for aging parents, changing roles, retirement
      f. Alterations in sexual response: longer time needed for arousal, lessened vaginal lubrication
   4. Recent history of gynecologic surgery: hysterectomy, oophorectomy, salpingectomy

B. Additional information to be obtained
   1. Menstrual history, past year
   2. Contraceptive use to present
   3. Obstetrical history: pregnancies, abortions, stillbirths
   4. Gynecologic history: surgery, endometriosis, infertility, anomalies, last Papanicolaou smear, any breast problems, sexually transmitted disease, infections
   5. Sexual history: dysfunction, unresponsiveness, recent changes
   6. Life event changes: resumption of career, retirement, caring for older family members, children in or out of home, divorce, separation, marriage, new sexual relationship
   7. Life-style: exercise, diet, smoking, recreation, stressors

IV. Physical Examination

A. Vital signs
   1. Blood pressure
   2. Pulse

B. General health examination
   1. Head
   2. Neck
   3. Heart
   4. Lungs
   5. Abdomen
   6. Extremities; joints, spine

° Genetically-caused or -predisposed conditions are responsible for over 50% of all deaths;

° In 1985 the total Montana health care bill was 1.4 billion dollars. Very conservatively estimated, some 54% of that bill, or $756 million in Montana, is spent on genetically-caused or -predisposed disorders. This amounts to $945 - 1,000/person/year. Compared to that, 45 cents per health-insured person is a trivial sum.

Cost of the Program: No clinical genetics program anywhere pays for itself through fees and third party payments. That is because clinical genetics is an extremely labor-intensive activity with heavy emphasis on library and information services which generate virtually no income, and the need to see many patients and families unable to pay a part or any portion of their bill. We receive no support from the universities with whom we are affiliated, and no federal funds have been available to Montana directly since the early 1980's.

Progress Report: Since the formal inauguration of the Montana Medical Genetics Program on 7/1/85 we have:

° Seen 1161 patients at Shodair and on field clinics in Missoula, Kalispell, Great Falls, Billings, Sidney and Miles City. This number does not include hundreds of phone and mail consultations provided during that time;

° Performed 366 fetal genetic pathology studies;

° Performed (since 7/1/87) 3215 maternal serum alphafetoprotein determinations;

- completed cytogenetic tests on 2290 specimens including blood lymphocytes, fibroblasts, amniocytes, bone marrows, etc;
- filled almost 14,000 library requests including computer searches, answers to questions, copies of articles, use of library site and materials, instructions in library resources, and interlibrary loans. About half of the requests were made by Shodair staff.

During this time we have received almost $200,000 worth of free consultative services from the University of Wisconsin in fetal pathology, and are able to draw on a national and international network of hundreds of consultants who give free service and information on difficult diagnostic and management problems.

Also during that time, Shodair, in collaboration with Dr. Bill Peters of Bozeman, pioneered a chorionic villus sampling program as a most attractive and equally safe alternative to mid-trimester amniocentesis.

As the appended map shows, this is not just a Helena program, but truly a state-wide program with services provided in every county of Montana.

Alliances: Out of our work has come a very strong alliance between the program and the health care providers in Montana, and state, county, municipal, university and numerous voluntary agencies to provide the best possible medical genetic care program for the people of Montana in order to prevent and to alleviate the pain and suffering associated with birth defects and genetic disorders of humans.

Program Support: The Montana Medical Genetics Program has or is anticipating support of:

- The Department of Health and Environmental Sciences;
- The Montana Chapters of:
  - The American College of Obstetrics and Gynecology;
  - The American Academy of Pediatrics;
  - The American Hospital Association;
  - The American Public Health Association;
  - The American Nurses Association.
- The Montana Perinatal Association
- Child and Family Services of Montana
- The March of Dimes - Birth Defects Foundation
- The Montana Center for Handicapped Children
- The Developmental Disabilities Council of Montana
- The Montana Children's Alliance
- The Maternal-Child Health Council
- The Montana Medical Association

and many other organizations and individuals who are writing and appearing in support of this legislation and Program.

Cost-Benefit Considerations: No price can be set on a human life. Our strong preference is to think of the benefits bestowed by the Program on Montana in terms of the conceptions, pregnancies and births of normal individuals that we have encouraged over the years through our activities. Nevertheless, benefit-to-cost ratio studies of genetic services have been

published, and show that clinical genetics is by far the most cost-effective form of preventive medicine. Some published ratios are: PKU detection and management 9:1; prenatal diagnosis in a muscular dystrophy prevention program 14:1 to 21:1; amniocentesis for women over 35 years 4.3:1. A prenatal diagnosis and counseling program concerning 8 potentially affected men (Fig.2) with mental retardation residing each for 20 years at Boulder was calculated at 333:1 (i.e., $10,080,000 "benefit" versus $30,233 cost-for-services).

These are abstract considerations. However, more concretely I should like to tell you about a 17-year-old boy from Kalispell with Wilson disease who was referred to us recently for genetic counseling. Wilson disease is a recessive disorder which is lethal without treatment. The boy was being treated with penicillamine pending a liver transplant at the Mayo Clinic. Before our evaluation his brother and 2 sisters had been considered normal. Indeed, his 21-year-old brother and 13-year-old sister had been evaluated clinically and by a lab test, and on the basis of the results their parents were told that these sibs were unaffected. After our evaluation it was found that the lab test was inadequate to rule out the diagnosis and we recommended additional tests which showed that both are affected with Wilson disease. Even though clinically asymptomatic, both are now being treated with penicillamine which may prevent deterioration and need for a liver transplant and will allow them to live a normal and productive life.

Quality Assurance: A critical peer-review of the Montana Medical Genetics Program was done shortly before Christmas, 1988, by Prof. John C. Carey of

the Division of Genetics, Department of Pediatrics, University of Utah, Salt Lake City. This was a highly favorable review.

Pro-Life Assurance: Genetic services encourage conception and birth of normal individuals and, in 96% of the time, reassure pregnant women after amniocentesis that they are carrying a normal child, avoiding termination if genetic services had not been available.

Finally, I must stress that this is primarily the Montana, not the Shodair Medical Genetics Program, since the grant to provide services is awarded competitively after submission of a grant application.

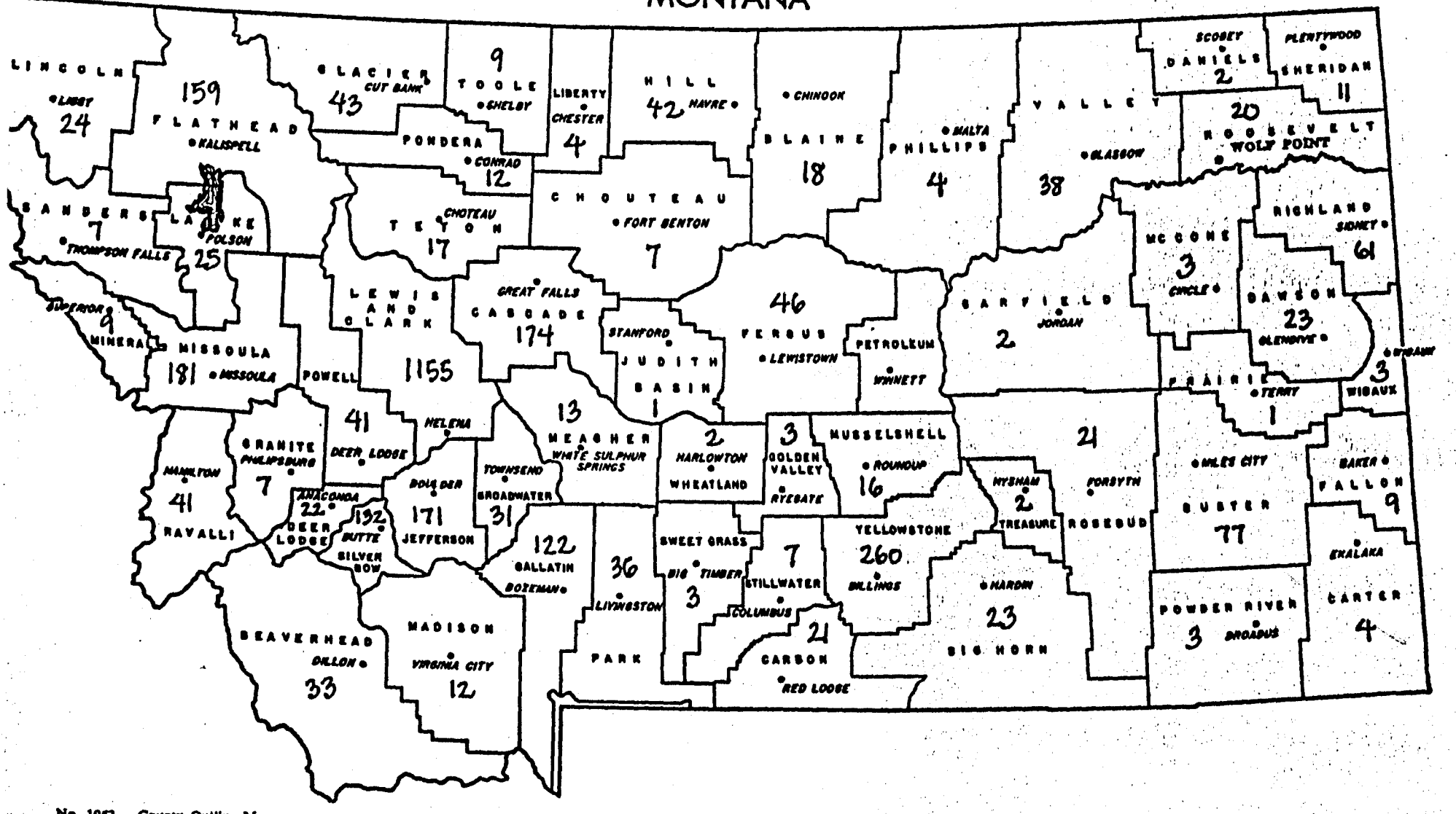
We should like to request your favorable consideration of HB 402.

Respectfully submitted,

John M. Opitz, M.D.

Director, Montana Medical Genetics Program

MONTANA



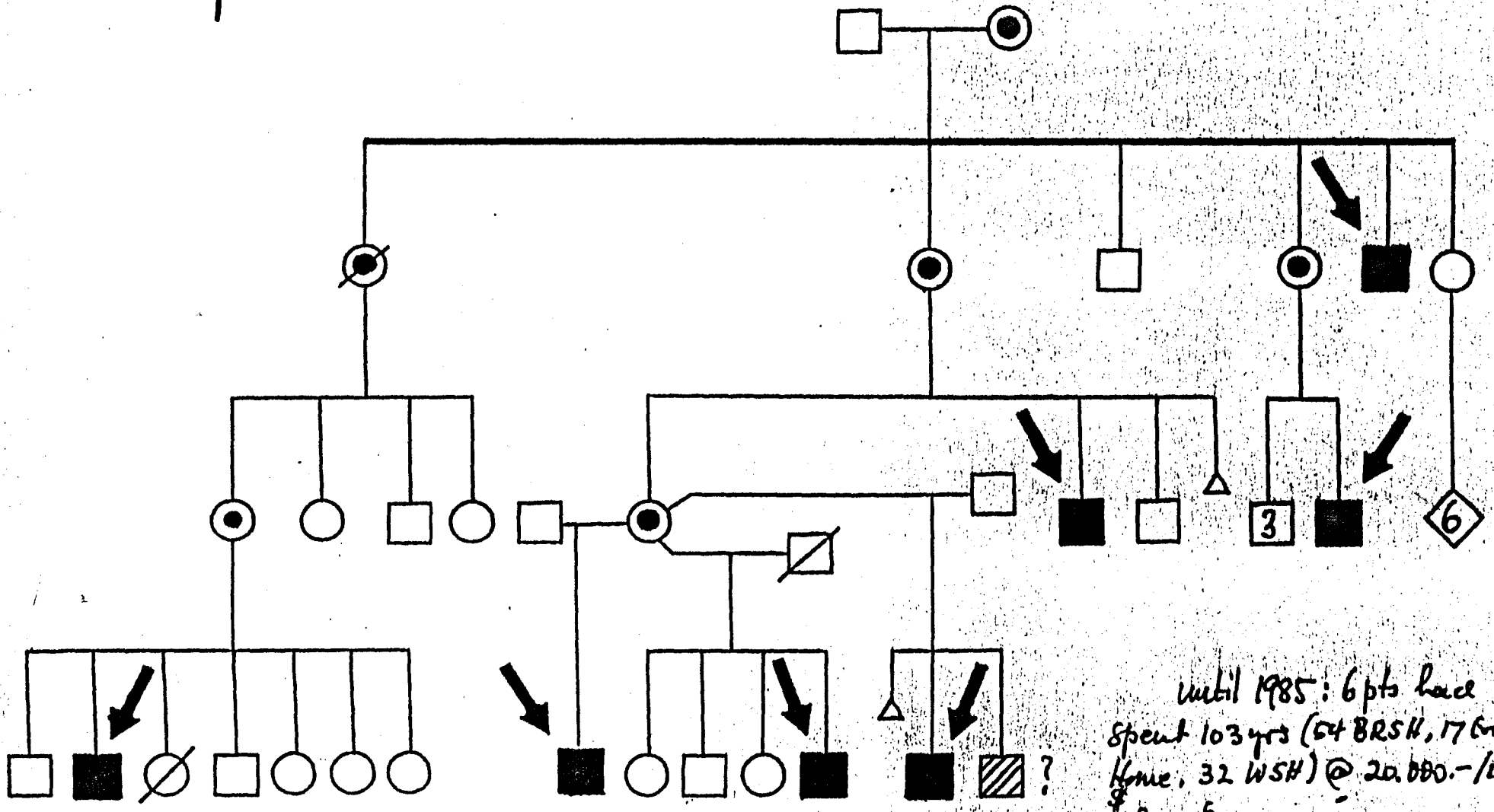
No. 1052 — County Outline Map

STATE PUBLISHING COMPANY
Helena

XLMR Family at BRS&H (fra(X)-)

Fig. 2

7 Propositi



until 1985: 6 pts have spent 103 yrs (64 BRSH, 17 Comp Home, 32 WSH) @ 20,000.-/pt = 2×10^6

HB 909 Response.

December 1, 1988

Optiz honored for genetic work

Dr. John M. Opitz, chairman of the Department of Medical Genetics at Shodair Hospital, was recently selected to receive the "Pool of Bethesda Award" presented by Bethesda Lutheran Home of Watertown, Wisconsin.

Opitz

Opitz received the award in recognition of his worldwide contributions of service and leadership in the field of mental retardation and medical genetics.

The award was established in 1979 on the 75th anniversary of Bethesda Lutheran Home and honors persons who have made outstanding contributions in the field of mental retardation. Bethesda serves 650 retarded children and adults and provides Christian care and training to help each resident move forward to a less restrictive setting.

TESTIMONY

My name is Joan FitzGerald. I am the genetic counselor and clinical coordinator for the Shodair Department of Medical Genetics. I would like to address the specifics of our genetics services to, hopefully, demonstrate 1.) the need in the state filled by our presence, 2.) the impact of the service on the financial, temporal and psychologic cost of genetic conditions and, 3.) the value of a local, by that I mean, available in the state, genetics service.

There is no question that easy access to a genetics service is foremost in reducing cost. For individuals needing a genetic service, travel out of state to large universities involves enormous expense in actual travel costs like gasoline, airline tickets, motel room, etc, as well as requiring work absences, arrangements for daycare for other family members, and other loss of valuable time. Many individuals needing services will not travel great distances because of financial considerations and will not, therefore, receive the genetic information they need. Also, a number of families we serve depend on public assistance and will ask for State travel money to finance their trips out of state for required medical genetic care. Traditionally, cases seen in a large university setting are subjected to many "routine" tests and see numerous doctors due to the teaching requirement of university-based programs. Many families will not seek services from these large institutions because of this "guinea pig" reputation. We currently hold 27 clinics per year in 6 locations around the state: Missoula, Kalispell, Great Falls, Billings, Miles City and Sidney. The map shows the geographic distribution of

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clients we have seen for an initial visit. Each blue pin represents 10 new cases and each red - 1 initial contact. This does not account for additional family members seen, or follow-up visits. The geographic distribution for our clinic sites and Helena's centralized location allows driving access from anywhere in the state. We have seen families, your voting constituents, from every county represented on this committee within the last 12 months.

If access and availability are considered, the fetal pathology service would not exist if genetic services were moved out of the state. This would mean that in 1988 numbers, 86 families would suffer the tragic loss of a desired child with no one available to answer their questions of "why". These same 86 families in addition to the other 300 currently served per year would be forced to seek answers from experts outside of the state who are already struggling from overburdened caseloads.

We are continuing to offer screening in early pregnancy to rule out a common birth defect, namely spina bifida and anencephaly. The condition results in multiple handicaps and an average of 10-12 surgeries by the age of 6 years. Through a blood test, affected fetuses can be identified so that delivery in a center capable of immediate neurosurgery can be arranged, thus, helping to minimize the subsequent physical handicaps aggravated by traditional delivery. Since the last legislative session, 3,215 pregnancies have been screened and current volume dictates an anticipated 2,000 in 1989. These specimens come from all areas of the state with follow-up provided by myself.

FOLLOW-UP

The availability of follow-up is vital for effective genetic services. If Montana families did not have this service available in the state, they would receive diagnosis, counseling, etc, in another state and would then be lost to follow-up. After an initial evaluation, many families have additional questions and concerns and contact us routinely for more information. Because of our permanent residence in the state, we can offer ongoing support for families in crisis after the death of a child, provide follow-up for critically ill newborns transported out of state and subsequently returned to their local community, provide consultation and counseling in cases of prenatal diagnosis where an abnormality is identified, continue to reassure expectant parents of the normality of their babies, and facilitate adjustment and acceptance of a genetic condition in an individual or family. We have extensive written information for lay and professional people and can involve our clients with local and national support and information organizations. Much genetic information is not heard by individuals in crisis, and follow-up is vital to their understanding. Additionally, other family members, unaware of their risk, must be contacted and counseled. We also continue to follow undiagnosed cases as knowledge is gained in the field and to learn more about the effects of a particular condition.

In summary, we are able to provide exemplary genetic services for the people of Montana because the services are available and accessible to all of the Montana population, our program provides information not available through the local physician community, and, because of our residence within

the state, we can routinely provide the quality follow-up required. The service prevents unnecessary travel for services, long delays in obtaining results, wasted time and finances on unproven treatments, and allows money spent for genetic health care to remain in Montana. I am hopeful the benefits of this program for the people of Montana will convince you to retain the established genetic services in this state.

Respectfully submitted,

Joan Fitzgerald

Joan M. Fitzgerald, M.S.

Genetic Counselor

Staff

John M. Opitz, M.D., D.Sci.h.c., M.D.h.c., F.A.A.P.
Chairman, Department of Medical Genetics
Diplomate–American Board of Medical Genetics and American Board of Pediatrics

James F. Reynolds, M.D., F.A.A.P.
Director, Medical Division
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Fellow of the Royal College of Physicians of Canada (Pediatrics)

Joan FitzGerald, M.S.
Genetic Counseling Associate
Clinical Services Program Manager
Diplomate–American Board of Medical Genetics

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AFP Technologist

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Acting Director, Cytogenetics and Molecular Cell Biology

Linda Ekblom, B.A., C.L.Sp.(CG)
Cytogenetics Technologist

Sandra Phillips, B.S., C.L.Sp.(CG)
Cytogenetics Technologist

Suzy Holt, M.A.
Director, Genetic Information and Library Services

Barbara Ridgway, M.L.S.
Assistant Librarian

Claire Hull, B.A.
Library Technical Assistant

Shodair Hospital

Post Office Box 5539
840 Helena Avenue
Helena, Montana 59604
Telephone 406/444-7500

THE DEPARTMENT OF MEDICAL GENETICS

Shodair Hospital

HELENA, MONTANA

MONTANA MEDICAL GENETICS PROGRAM

The Problem:

-20% of Montanans (160,000) are affected by or are at risk of transmitting a genetic condition.

-Inherited conditions are responsible for over 50% of all human suffering and death in industrialized countries.

-Inherited malformations are the second leading cause of infant deaths. After immaturity, they are the commonest cause of death in infants.

-HB 430 (1985) and HB 716 (1987) provided funding for the Montana Medical Genetics Program (MMGP) through the assessment of a small fee on health insurance policies. Continuation of funding depends on similar legislation for the next biennium.

-The program has not been included in the DHES budget and will close if the current legislative appropriation is eliminated.

The Toll:

-In 1983, an estimated 180 billion dollars were spent nationwide on the care of individuals with inherited diseases. Currently it costs $62,000 per year to maintain one resident at the Montana Developmental Center in Boulder.

The Solution:

-The Montana Medical Genetics Program at Shodair Children's Hospital has been providing service to every county in Montana for over 12 years. It provides clinical, laboratory, counseling and educational services to address the morbidity and mortality associated with serious birth defects and genetic handicapping conditions. The MMGP does not counsel for or perform abortions and is a strong pro-life program.

-In the future, the Montana Medical Genetics Program may also provide the state with forensic DNA services needed for paternity, rape, and criminal identification.

-Montana Medical Genetics Program funding should be continued by increasing the fee on health insurance policies to 45¢.

The Cost:

-$688,300/biennium from health insurance fees.

Cost Savings:

-Current and future cost vs benefit analyses demonstrate a tax savings of at least $4.00 for every dollar invested in genetic services. This ratio is increased further by the birth of many normal persons to families counselled by the MMGP.

Denise Gleason
2/3/89 Pro HB 402

Our tragic story began durning my third pregnancy when an ultrasound showed the baby I carried was anencephalic, a condition where the brain and skull are not completely formed. I carried him six more weeks knowing that when his body left mine he would die.

Durning that time Joan Fitzgerald helped us understand anencecpaly; that our baby was not "headless" as a physician had told us; and she shared pictures with us. That helped us plan our birth experience so as to fully participate in our son's brief life. Nine hours after Daniel's birth he died in my arms... Spending that time with him was so important to our grief process. If we had not met Joan and seen those pictures I'm not sure if we'd have had the courage to even look at our Son. We might have left Daniel alone to die and carried that guilt always.

I'm glad Shodair is in Helena as I called the Genetic Department frequently with questions before and after delivery. They had so much more knowledge of anencephaly then my physician. They also made calls to search out the possibility of live organ donation.

Joan came to the hospital after I delivered. I needed someone who could say, "Yes, he looks like others I've seen". She helped us look beyond Daniel's defect and cherish his other features.

Dr. Opitz picked up Daniel's body right after his death as we donated his pancreas for research. This needed to be done rather quickly so it was important that Shodair was close.

The support we recieved from them continued as we entered our next pregnancy and faced the odds of reoccurence. My physician requested Joan's guidance in selection of pre-natal tests. Termination of my pregnancy was not an acceptable choice for us so we wanted to be prepared to cope with a possible defect or be reassured if none were present. We were then blessed with a healthy son!!

Shodair Genetics has really pulled us through. I would encouraged this committee to vote in favor of House Bill 402.

Thank you!!

Denise Gleason

EXHIBIT 16
DATE 2-3-89
HB 402

James W. Borchardt
Chief Examiner, Montana Insurance Department
State Auditor's Office
444-2997

AMENDMENT TO HOUSE BILL 402

1. Title, line 7.
Strike: "SECTION"
Insert: "SECTIONS"
Following: "33-2-712"
Insert: "AND 33-2-713"

2. Page 1.
Following: line 24
Insert: "Section 2. Section 33-2-713, MCA, is amended to read:

33-2-713. *(Temporary)* **Group disability policy exemption.** The fee required in 33-2-712 does not apply to blanket group disability insurance as defined in Title 33, chapter 22, part 6, where the total premium charged per person is less than $10 a year. For these policies, the fee is to be assessed on the basis of the number of blanket group policyholders in Montana. ~~*(Terminates June 30, 1989 — sec. 7, Ch. 654, L. 1987.)*~~

Renumber: subsequent sections

INS 529

EXHIBIT 17
DATE 2-3-89
HB 402

HOUSE BILL 402

FUNDING FOR GENETICS RESEARCH
HOUSE HUMAN SERVICES COMMITTEE

3:00 p.m. February 3, 1989

Madam Chairperson
~~Mr. Chairman~~, Members of the Committee,

My name is Peter Pauly. My partner, Tom Hopgood, and I represent the Health Insurance Association of America.

You have heard a lot this afternoon about what the genetics research program is. The Association expresses no opinion about whether the program is worthwhile. Our only concern is with its funding.

If this program is so great and if it benefits all the people of this state, as its sponsors say it does, then this body can accept what its sponsors say -- our point is that it should be funded out of the general fund and not supported by the health insurance industry which gets no benefit from it.

The history of this funding source should be examined by this committee. In 1985, an appropriation for this program was sought from the general fund, but, it was 1985, and there was a budget crunch and there was no room in the general fund for it. So, the program was funded by imposing a tax on health insurance companies. They were required to pay ~~45¢~~ 35¢ for every person in Montana with a health insurance policy. The money was earmarked for the genetics research program.

The funding mechanism was sold to the legislature, to Blue Cross and Blue Shield and to the commercial insurance companies on the basis it would sunset after two years. We were told this

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HB 402

source would terminate on June 30, 1987 and we wouldn't have to worry about it any more. We were told the genetics research people would find a new funding source.

Then came 1987. There was still a budget crunch and still no room in the general fund for the genetics research program. This head tax was continued another two years upon the express representation that the genetics research people would find a new funding source and that hopefully the head tax would disappear in 1989.

Well, it is now 1989, and there is still a budget crunch and there is still no room in the general fund for the genetics research project. And here we are again.

This bill continues to fund the program from the same source -- a head tax on insureds paid by the insurance companies.

Notwithstanding the repeated representations that this source of funding for the program was to be a temporary one, my client feels it is unfair to once again have the burden of this program laid on its shoulders.

Historically, the health insurance companies have paid approximately $3.6 million per year to Montana by way of the 2 3/4% premium tax. The head tax for the support of the genetics research program adds approximately $235,000 to the amounts the insurance companies already pay to the State of Montana every year.

What I would ask the committee to do is to listen to the proponents when they so strenuously argue this program is beneficial to the entire state. That being the case, the general fund

should pay for this program. It is grossly unfair for a particular group (the health insurance industry) to subsidize this program which does not benefit it.

Peter C. Pauly, Attorney at Law,
Representing the Health Insurance
Association of America

February 3, 1989

Representative Budd Gould
Capitol Station
Helena, Montana

Dear Representative Gould:

Because the weather does not permit me to travel to Helena to present testimony at the hearing regarding House Bills 328 and 389, I am sending my testimony to you as a member of the Human Services and Aging Committee. I hope that my testimony will be considered as you make decisions regarding these two bills. Thank you.

Sincerely,

Rita E. Cheek

Rita Cheek, R.N., M.N.

401 Plymouth
Missoula, Mt.

Bert,
Please add these ~~testor~~ to the record if possible.

TESTIMONY HOUSE BILL 389

I am against H.B. 389 which would remove the phrase "leading to predictable outcomes" from the definition of the practice of practical nursing.

It is necessary to keep this phrase in order to more clearly delineate differences between the practical nurse and the professional nurse. Removal of this phrase without providing further clarification of the differences between the two levels will create additional chaos in the provision of nursing care.

Allowing the Licensed Practical Nurse (L.P.N.) to perform any standardized procedure would jeopardize patient care in acute care settings. I have worked in hospital settings for twenty years. Many procedures are standardized. For example there are standardized procedures for care of the person admitted with a heart attack, care of the person after heart surgery, and for numerous intravenous medications. Professional nurses are responsible for implementing these standard procedures. The outcome is not predictable. Management of the nursing care of these folks requires someone able to deal with unpredictable outcomes.

Basic knowledge of science and nursing procedures is not enough to provide safe nursing care when implementing standardized procedures leading to unpredictable outcomes. L.P.N.s are very skilled, capable people, but they are not prepared to manage the possible consequences of all standardized procedures.

I urge you to maintain the clarification between the professional and the practical nurse. Please vote against H.B. 389. Thank you for your consideration!

TESTIMONY HOUSE BILL 328

I am speaking against House Bill 328 which would establish educational criteria for the faculty of nursing schools.

I do not believe it is appropriate for the legislative body to focus on these details. I believe it is the Board of Nursing's responsibility to make such determinations. The Board is knowledgeable about nursing and has the expertise to give such criteria the necessary consideration it deserves.

Faculty in nursing schools are required to organize a large amount of information. It requires a person who is intimately involved with nursing processes and able to focus specifically on nursing. Faculty should be nurses! Allowing people from "related fields" to teach nursing will not provide the needed expertise regarding nursing care. For example, social work is a related field. It requires a Master's degree. These are highly skilled people but their focus is different than nursing. The social worker can be a valuable source of information for nursing and its students but should not be responsible for identifying nursing content or planning learning activities for nursing students. Social workers are better prepared to do so for students of social work.

In section 37-8-202 (2) of the Montana Code, the Board of Nursing is authorized to prescribe standards for nursing schools. One of those standards is faculty qualifications. We have a Board of Nursing with the skill and experience to make decisions regarding standards in nursing schools. We need to utilize that Board for maximum efficiency and for the best possible decisions regarding legal requirements for nursing in Montana.

Stand behind the Board of Nursing in Montana. Please vote against H.B. 328. Thank you.

State of Montana

DEVELOPMENTAL DISABILITIES PLANNING AND ADVISORY COUNCIL
25 South Ewing - Room 506, Helena, MT 59620 (406) 449-8325

BEFORE THE COMMITTEE ON HUMAN SERVICES AND AGING
Representative Stella Jean Hansen, Chairman, Presiding
February 3, 1989

The Montana State Developmental Disabilities Planning and Advisory Council (DDPAC) was formed in 1971 and is authorized by both federal and state law to provide a forum for consumers and professionals to assist in reducing the effects of developmental disabilities and to share in the effort of bringing about the social, personal, physical, and economic habilitation or rehabilitation of persons with developmental disabilities. The Council is composed of 22 members and represents eight consumers of service or consumer representatives, four professionals in the fields of law, education, medicine and social work, four legislators and representatives of Montana's five regional councils on developmental disabilities

The Council supports House Bill 402, which would fund the Shodair genetics project for another biennium.

One of the Council's major interests is in the area of prevention of developmental disabilities. The Council recognizes that prevention is one of the most effective approaches to reducing or eliminating the occurrence of developmental disabilities. Through research we can identify the causes of birth defects and through counseling we can help to reduce the frequency. Projects such as Shodair's allow Montanans to receive the counseling and testing services that make prevention of disabilities possible.

Shodair's project is a nationally and internationally recognized leader in the area of medical genetics. The funds spent today by the legislature for this program can result in substantial savings to the state as a result of the information gained concerning the prevention and treatment of developmental disabilities. We urge your support.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 328 DATE 2/3/89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Pat Dotter	Helena	X	
Jan Cronquist	Mols.		X
Barb Ethelw MNA	Helena		X
Donna Small RN	Helena		X
Donna Schramm	Billings		X
Larry Akey - Health Network	Helena	X	
Jim Allen	Helena	X	
Jessica Stiles	Miles City	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 389 DATE 2/3/89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
CATHY CANIPAROLI	GREAT FALLS		X
~~Pat Dotter~~	Helena	X	
Dan Cronquist	Mpls.		X
Donna Small	Mt Nurses Assoc		X
Barb Booher MNA	Helena		X
Donna Schramm	Billings		X
KEN DUNHAM	MT LPN ASSOCIATION	X	
Charlotte Heath	3416 Flod Helena	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 395 DATE 2/3/89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
CATHY CANIPAROLI	GREAT FALLS	X	
Jan Cronquist	Mpls.	X	
Barb Bocher MNA	Helena	X	
Dana Small	Helena	X	
Dana Schramm	Billings	X	
CHAD STOIANOFF (MACo)	Helena	X	
Rep Dorothy A. Cody	Wolf Point HD 20	X	
		owned & support	
Brenda Nordlund	MT Women's Lobby	X	
DAN PEASLEE	HELENA		
Jim Ahrens	HELENA	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

HUMAN SERVICES AND AGING COMMITTEE

BILL NO. HB 402 DATE 2/3/89

SPONSOR

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
CATHY CAMPBELL	GREAT FALLS	X	
John M. Opitz	Helena	X	
Chris Volinkaty	DD Lobbyist	X	
Wm J. Harris	Helena	X	
Joan FitzGerald	Helena	X	
Susan Levin	Helena	X	
Katherine Berry	Helena	X	
Barb Bachew MNA	Helena	X	
George Turman	"	X	
Jack Casey	Helena	X	
Karen Jacobsen MD	Montana Council Maternal + Child Health Helena	X	
Pat Dolter	Helena	X	
[illegible]	Helena	X	
[illegible]	HELENA - HIAA LOBBYIST		X
JAMES W. BIRCHARDT	Montana Dept. of Health		
[illegible]	HELENA	X	
LARRY AKEY - MAHA	HELENA		X
[illegible]	HELENA	X	
[illegible]	HELENA	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

VISITORS' REGISTER

Human Services COMMITTEE

BILL NO. _____ DATE _____

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
JAMES F. REYNOLDS	Helena mt March of Dimes.	X	
Lon T Laendorf	Helena	C	
Brenda Nordlund	MT Women's Lobby	X	

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.