MINUTES

MONTANA SENATE
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By Senator Tom Hager, on March 15, 1989, at 1:00 p.m., Room 410, State Capitol

ROLL CALL

Members Present: Senators Tom Hager, Chairman; Tom Rasmussen, Vice Chairman; J. D. Lynch, Matt Himsl, Bill Norman, Bob Pipinich, Harry H. McLane

Members Excused: None

Members Absent: None

Staff Present: Tom Gomez, Legislative Council
Dorothy Quinn, Committee Secretary

Announcements/Discussion: None

HEARING ON HOUSE BILL 389

Presentation and Opening Statement by Sponsor: Bud Campbell, Representative of House District #48, advised that HB 389 is an attempt to slightly revise Montana's nursing laws concerning Licensed Practical Nurses to accomplish several objectives. It would remove an unfair and meaningless phrase from state law which phrase says an LPN can only perform nursing procedures leading to a predictable outcome. This bill would allow well trained and experienced LPNs to use their training and experience to help alleviate the nursing shortage in Montana.

List of Testifying Proponents and What Group they Represent:

Ken Dunham, Montana Licensed Practical Nurse Assoc.
Patricia Dotter, R.N., Helena Vocational Technical Center
Carolyn Squires, L.P.N.
Jim Ahrens, President, Montana Hospital Association

List of Testifying Opponents and What Group They Represent:

Sharon Dieziger, R.N., Montana Nurses' Association
Jeannine Peretti, Montana Organization of Nurse Execu-

tives, St. Patrick Hospital, Missoula
Linda Winchell, St. Patrick Hospital, Missoula
Barbara Booher, read testimony of Laura Lenau, R.N. Director of Nursing Program, Miles City Community College
Shirley Thennis, R.N., read testimony for Gretchen Fitzgerald, R.N., Vice President for Nursing at Montana Deaconess Medical Center, Great Falls
Jeanne Bennetts presented testimony for Maura Fields, R.N., Whitefish
Sharon Dieziger presented testimony for Elaine Watkins, Deaconess Medical Center, Billings

Testimony:

Ken Dunham, Lobbyist for the Montana LPN Association, stated that HB 389 is a critical bill for more than 3,000 LPNs in Montana, many of whom are being held back in their nursing practice unfairly. He read and presented his written testimony to the committee (Exhibit #1).

Patricia Dotter, R.N., stated she is a Practical Nurse instructor at the Helena Vocational Technical Center since 1979. She read and submitted her written testimony to the committee (Exhibit #2).

Carolyn Squires, House Representative, stated she is appearing as a Licensed Practical Nurse. She gave a brief history of the Nurse Practice Act, stating that a task force was established before the actual reformation on the Act. There was one representative of the LPN Association on that task force. They tried prior to that time to have the phrase relating to predictable outcome deleted but were unsuccessful on a vote. She stated she would like to see that phrase deleted because she would like to practice within her scope.

Jim Ahrens, President of the Montana Hospital Association, stated he understands Montana is one of two states that uses this type of language in its legislation. His Association supports HB 389, and he urged a favorable recommendation.

Sharon Dieziger, Montana Nurses' Association, stated she wished to speak against HB 389. She presented her written testimony which she read to the committee (Exhibit #3). She also submitted a copy of Model Nurse Administrative Rules, which she referred to in her testimony (Exhibit #3a).

Jeannine Peretti, R.N., stated her position at St. Patrick Hospital, Missoula, involves management and supervision

of employees, enforcing standards of care and dealing with quality assurance. She read a letter from Diane Field, President of the Montana Organization of Nurse Executives which stated that group is in opposition to HB 389. They are concerned that the educational preparation meet the defined scope of practice, according to her letter. Ms. Field further stated their opposition to HB 389 lies with the lack of clear direction signifying quality care and standards of practice for the LPN. Ms. Peretti stated she is personally opposed to the bill. She drew a parallel between dental hygienists vs. dentists; paralegals vs. lawyers, stating that some of the basic judgments will be the same, but more complicated judgments must be made by the more highly trained person. She stated the level of care expected in a hospital today is highly knowledgeable advanced technology and requires the background of a registered nurse to correlate these things to provide the best quality of care to patients. She does not feel the best interests of those concerned would be served by passage of this bill.

Linda Winchell, R.N., Head Nurse, Pediatric Department, St. Patrick Hospital, Missoula, stated the opinion she wished to express is gained by her experience as a graduate of a LPN program and also a Registered Nurse Program in the state of Montana. She has also worked in both roles; has supervised both roles, and currently works with students in both roles. The training she received as a LPN prepared her well for the basic skills; however, when she chose to go back to school to train for an RN, it was evident to her that she was being prepared in depth to care for patients who did not have a predictable outcome. According to Ms. Winchell, it is to the RNs that the LPNs come when they need validation of the care of the patient. She believes the complexity of care required by today's patients has increased, and the LPNs want to increase their responsibility, but they also want to retain the responsibility of the RN to oversee their work and not assume the accountability or liability in the care of the patient.

Barbara Booher, Executive Director of the Montana Nurses' Association, stated she had been asked to deliver testimony from Laura Lenau, R.N., Director of the Nursing Program at Miles City Community College. She stated she wished to point out that the educational preparation for LPNs in the State of Montana is a four quarter technical program. Comparatively, the Associate Degree Prepared Registered Nurse program consists of seven quarters. Ms. Booher presented written testimony from Ms. Lenau which she submitted to the committee (Exhibit #4).

Shirley Thennis, R.N., stated she is presenting written testimony for Gretchen Fitzgerald, a Registered Nurse with over 17 years of nursing management experience in an acute care facility in Montana. She submitted copies of the testimony for the committee to study (Exhibit #5). Both Ms. Thennis and Ms. Fitzgerald urged that the committee vote "no" on HB 389.

Jeanne Bennetts, Montana Nurses' Association, stated she wished to speak in opposition on behalf of Maura Fields who is a Registered Nurse practicing in Montana for ten years. Ms. Fields is currently serving as President-Elect for the Montana Organization of Nurse Executives and is presently employed at North Valley Hospital in Whitefish as the Director of Professional Services. Because her position entails supervisory responsibilities for acute care nursing, Ms. Fields has taken a keen interest in HB 389. Her written testimony was submitted to the committee (Exhibit #6).

Sharon Dieziger, Montana Nurses' Association, stated she was presenting written testimony for Elaine Watkins, Vice President for Patient Services at Deaconess Medical Center of Billings. Copies of the testimony were provided to the committee members (Exhibit #7).

Questions From Committee Members: Senator Lynch asked what do the LPNs wish to do that they are not now doing. In response, Ken Dunham stated that their role will not be significantly expanded; they will just will be able to do legally many of the things they are now doing.

Senator Lynch stated that was not what he was hearing from the opponents. Carolyn Squires, LPN, stated that in her own situation she has been removed from working in certain areas of the hospitals, but when a shortage occurs she can go in and function in those areas. She believes the criteria of "predictable outcome" has been used to hold LPNs back in some of the areas in which they are trained. She stated she does not wish to expand her role.

Senator Pipinich asked if there is a pay difference between the RNs and LPNs. Ms. Squires stated there is a difference, but it depends upon individual hospitals. However, she stated the issue is not wages.

Senator McLane asked if whether or not this bill passed would LPNs still work under the supervision of a physician and registered nurse. Ms. Squires answered affirmatively. He also asked how close a relationship is there between

LPN and the supervising Nurse. Ms. Squires stated in her facility she would go through the nurse in order to contact the physician.

Senator Himsl asked what is the working relationship with the Physician Assistants. Ms. Squires stated her limited experience with PAs has been good. She was unsure how the new law relating to PAs would affect the LPNs.

Senator Hager asked if the Montana Nursing Association is made up of RNs and LPNs. Sharon Dieziger stated the MNA is made up of Registered Nurses only.

Closing by Sponsor: Representative Campbell stated he believed they had a good hearing, and added that one of the key things to remember was that LPNs are under supervision. He believes this bill would help relieve the nursing shortage, and urged the committee to concur.

DISPOSITION OF HOUSE BILL 389

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 378

Presentation and Opening Statement by Sponsor: Carolyn Squires, Representative of House District #58, stated that HB 378 is an act requiring the Board of Nursing to establish a program to assist licensed nurses who are found to be physically or mentally impaired by habitual intemperance or excessive use of narcotic drugs and alcohol. The intent is to take care of their people whom they find to be impaired by allowing the State Board of Nursing to assess a fee through the rule-making process through a licensure fee. A fiscal note indicates a $5.00 fee, which is an estimated fee. The money would go to the State Board of Nursing to fund the hiring of a person to coordinate the program.

List of Testifying Proponents and What Group they Represent:

Carol R. Sem, R.N., Program for Recovering Nurses
Marge Vanderhodf, PRN, Montana Nurses' Association
Janice Anderson, Montana State Board of Nursing
Sharon Dieziger, Montana Nurses' Association
Ken Dunham, Montana LPN Association
Barbara Booher, Montana Nurses' Association

List of Testifying Opponents and What Group They Represent:

None

Testimony:

Carol Sem, stated she is a Registered Nurse in private practice as a counselor and consultant, specializing in addictions in nursing. She stated she is here as a representative of the Program for Recovering Nurses. The definition of an impaired nurse is one whose job performance is adversely affected by use or abuse of drugs and/or alcohol. The program would create a new arm of the Board of Nursing, and there would be no cost to the general public. The nurse hired by the Board would (1) identify and investigate a potential impaired nurse; (2) intervene and refer for treatment; (3) monitor treatment; (4) educate health care workers and provide prevention education on addiction. Currently in Montana there are an estimated 750 to 2500 nurses who could become or are addicted to chemicals. She presented a fact sheet for the committee's attention (Exhibit #8). The Program for Recovering Nurses is a voluntary program which provides numerous services which Ms. Sem described. They currently do not have early identification or intervention, and do not have money or personnel available for education. She stated that recent figures indicate the number one cause of death for nurses is suicide. Nurses currently in the program have generally welcomed monitoring to protect themselves from false claims of use and to provide documented proof of their recovery. She urged the support of HB 378.

Marge Vanderhodf stated she is a recovered nurse. She read a letter from a nurse in recovery who is also a member of the Program for Recovering Nurses. The letter told the history and outcome of that particular case, which resulted in the nurse losing her license.

Janice Anderson stated she is a public member on the State Board of Nursing and wished to testify in support of HB 378. She advised that the Board of Nursing has adopted a position statement on chemical dependency and the licensed nurse. She read and furnished copies of the statement to the committee (Exhibit #9).

Sharon Dieziger, Montana Nurses' Association, stated that she is Director of the Critical Care Unit of the Montana Deaconess Medical Center in Great Falls. HB 378 is a vital bill from an employer's standpoint. She urged support of HB 378.

Ken Dunham, Montana LPN Association, handed out his statement regarding their position and furnished copies to the committee members (Exhibit #10). He stated the LPN Association supports this measure.

Barbara Booher, Executive Director of the Montana Nurses' Association, advised that MNA does agree with this particular piece of legislation, and urged approval.

Questions From Committee Members: Senator Lynch asked if the nurses are now prohibited by law from establishing a program. Representative Squires stated that there is a PRN established, but they need financial assistance in order to continue.

Senator Himsl asked how serious the problem is. Rep. Squires advised that between 5% to 20% of nurses have a problem with alcohol or drugs. She said the nursing profession recognizes the problem and they want to take care of their own, therefore they are willing to pay the additional expense through their license fees.

Closing by Sponsor: Representative Squires stated that RNs and LPNs agree on many things, and HB 378 is one of those.

DISPOSITION OF HOUSE BILL 378

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 395

Presentation and Opening Statement by Sponsor: Dorothy Cody, Representative of House District #20, stated that HB 395 would grant Nurse Specialists prescriptive authority and would require the Board of Nursing and the Board of Medical Examiners to establish rules relating to that authority. She stated that the rising cost of health care in our nation is an issue especially to a rural state such as Montana. This bill helps to address part of that issue. The Nurse Specialists work under the direct supervision of a doctor and are now writing prescriptions or are calling them into the pharmacist using the doctor's name. This is with consultation of the doctors but there has been a question of who is responsible and accountable for that practice. According

to Rep. Cody, the Nurse Specialists are well trained and qualified to have this authority on their own, and even with that authority they would still be under the supervision of a doctor. She urged HB 395 be given favorable consideration.

List of Testifying Proponents and What Group they Represent:

Cathy Caniparoli, Nurse Practitioner
Donna Schramm, R.N. President, Montana Board of Nursing
Sharon Dieziger, Montana Nurses' Association
Jerome Loendorf, Montana Medical Association
Chad Stoianoff, Montana Association of Counties

List of Testifying Opponents and What Group They Represent:

The following persons did not testify but submitted written testimony in opposition to HB 395:

Paul Wheeler, FNP-C, Deer Lodge (Exhibit #15)
Jim Reid, Montana Academy of Physician Assistants (Exhibit #15a)

Testimony:

Cathy Caniparoli stated she is representing the Montana Nurse Practitioner State Interest Group, and is speaking in favor of HB 395. She read and presented her written testimony to the committee (Exhibit #11). She also submitted fact sheets for the committee's reference (Exhibit #11a).

Donna Schramm, R.N., President of the Board of Nursing, stated she is appearing on behalf of the Board and added that the Board supports HB 395. She read and submitted her written testimony to the committee (Exhibit #12).

Sharon Dieziger, Montana Nurses' Association, stated she speaks in support of HB 395. She commended the work of the Nurse Practitioner groups for their work in preparing this piece of legislation. She read and presented her written testimony to the committee (Exhibit #13).

Jerry Loendorf stated he represents the Montana Medical Association and that group strongly supports HB 395. He stated the key thing is that it contains adequate protection for the consuming public which is the purpose of this type of legislation, and it provides the oversight by a state agency, ie the Board of Medical Examiners and the Board of Nursing working jointly to develop rules to ensure that the care of the people in the state is adequately protected.

Chad Stoianoff, stated he rises in support of this bill on behalf of the Montana Association of Counties. He distributed copies of a resolution drawn up at the MAC convention in June which basicly states that all counties are in support of HB 395 (Exhibit #14). He recommended favorable consideration by the committee.

Questions From Committee Members: Senator Himsl asked for an explanation of the relationship between the authority of this specially trained nurse and the Physician Assistant. Representative Cody stated she is unfamiliar with the PA bill. She stated this legislation only addresses the Nurse Practitioner, who have had a great deal of education beyond their R.N. degree.

Senator Himsl stated that he understands the Nurse Specialist will be originating the prescription. Rep. Cody stated the Nurse Specialist would write the prescription but there will be rules implemented by both the Board of Medical Examiners and Board of Nursing and they will set the criteria under which the prescriptions can be written.

Senator Rasmussen asked if a Nurse Specialist can diagnose a a problem and write a prescription. Rep. Cody stated that is being done in doctors' offices currently; however, if the Nurse Specialist calls the prescription in, it is done under the doctor's signature. Under this legislation, the Nurse Specialist would sign the prescription herself.

Senator Rasmussen asked what are the educational requirements for a Nurse Specialist. Rep. Cody stated that the Nurse Specialist with whom she is acquainted is a Registered Nurse and has an additional three years of training.

Cathy Caniparoli stated that the requirement by law in Montana for a Nurse Specialist is that they must be a Registered Nurse, then they must have either a Master's Degree or one year further education. In addition, they must have taken a National Certification Examination and make application to the Board of Nursing which can then grant them authority to practice as a Nurse Specialist.

Closing by Sponsor: Representative Cody stated that she was convinced this was a good bill based on her association and personal knowledge of the services provided by a Nurse Specialist.

DISPOSITION OF HOUSE BILL 395

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

HEARING ON HOUSE BILL 688

Presentation and Opening Statement by Sponsor: Bruce Simon, Representative from House District #91, stated that he hopes the committee will keep in mind who they are here to serve - the people of the State of Montana - as they listen to the testimony. The bill proposes to allow a nurse working in a family planning center under contract with the Department of Health to dispense pre-packaged oral contraceptives under a prescription from the doctor under strict protocol. He described a scenario of how the procedure of dispensing currently operates and the drawbacks of such a system.

List of Testifying Proponents and What Group they Represent:

Suzanne Nybo, Department of Health and Environmental Sciences, Program Manger of State Family Planning
Don Espelin, M.D., Department of Health
Diane Manning, Director of Family Planning, Butte
Cathy Vickers, R.N., Family Planning, Helena
Molly McDaniel, Public Health Nurse, Kalispell
Karen Moterniwitz, Family Planning Clinic, Bozeman
Barbara Booher, Montana Nurses' Association

The following persons did not testify but submitted written testimony in support of HB 688:
Nancy Lien Griffin, Montana Women's Lobby (Exhibit #22)
Joan McCracken, Executive Director, InterMountain Planned Parenthood
Karen Landers, M.D., Helena

List of Testifying Opponents and What Group They Represent:

Robert Likewise, RPH, Montana Pharmaceutical Assoc.
Lori Morin, Professor, School of Pharmacy, University of Montana, Missoula
Dennis Yost, RPH, St. Peter's Hospital Pharmacy, Helena

Testimony:

Suzanne Nybo stated she is Program Manager for the State Family Planning Program. She distributed copies of her testimony as well as copies of a facts sheet. She read

her testimony to the committee and asked support for HB 688. (Exhibits #16 and #16a). She also furnished copies of a letter from NAACOG, an organization for Obstetric, Gynecologic, and Neonatal Nurses, which sets forth their support of HB 688 (Exhibit #17).

Dr. Don Espelin, a pediatrician, stated he is Medical Director of the Perinatal Program of the Department of Health which deals with the outcome of high risk pregnancies. He read and submitted his written testimony to the committee, and urged support of HB 688 (Exhibit #18).

Diane Manning stated she has been the Director of Family Planning in Butte for three years. Prior to that she was a counselor at the clinic for 12 years. She described the procedure used by that clinic for several years. The workload has continued to increase and they found it difficult to find a pharmacist interested in continuing to serve the clinic. The current procedure is to first educate the patient, counsel her, and after an examination by either a nurse practitioner or doctor in the clinic, the prescription is written in the patient's chart and is then reviewed by the physician and approved. The patient leaves the clinic and is advised to return to pick up her prescription after the pharmacist dispelled it. This creates a burden for the patient to make an additional trip. The pharmacist only sees the patient's chart containing the prescription. He does not see the patient. She feels that barriers to service should be eliminated by allowing trained RNs to dispense pre-packaged oral contraceptives. She presented her written testimony to the committee (Exhibit #19).

Cathy Vickers, R.N., and Women's Health Care Nurse Practitioner for the Helena Family Planning Clinic, stated she urges the passage of HB 688. She believes the bill is desperately needed to improve access to safe and reliable contraceptive care. She urged consideration of three things (1) what is it that the present pharmacy law contributes to the quality of patient care in the clinics; (2) is it safe for Registered Nurses to dispense pills; (3) is this necessary. She wished to stress the fact that pharmacists are a very vital part of the health care profession. However, it must be acknowledged that a system doesn't always work and the person who pays the price for the system's failure is the patient. The penalty is a substantially increased risk of an unplanned pregnancy. She stated the argument of the pharmacist providing checks and balances might apply in a hospital where thousands of drugs might be included, but in a family planning clinic the drugs are extremely limited. She concluded by stating that change must occur, and

health care providers should cooperate to meet community needs for safe, confident and accessible reproductive health care.

Molly McDaniel, Public Health Nurse, Kalispell, stated that the Public Health Community in Kalispell supports HB 688.

Karen Moterniwitz, R.N., Director, Family Planning Clinic, Bozeman, stated that in the attempt to eliminate the many barriers the present health care system poses to the poverty woman, Title 10 was enacted to provide family planning services at low cast. This bill attempts to eliminate another barrier and that is accessibility to the oral contraceptive for the poverty woman. Since the registered nurses and nurse practitioners do the examinations, counseling and education that has been described, it makes sense that they should follow through with the dispensing of the oral contraceptives. She believes contraception is a far from perfect answer for preventing unintended pregnancies. Their present dispensing system only aggravates this problem. Their intent is to work with all care providers, including pharmacists, to achieve a common goal of safe, quality, affordable and available contraception.

Barbara Booher, Montana Nurses' Association, advised that her group supports this legislation. She pointed out that the registered nurses of Montana are conservative in their practice and they take very seriously their role of prime advocate. They have a regulatory board that monitors and licenses the practice of nursing in the state, and the Montana Nurses' Association feels nurses are competent to perform this very limited pharmacy function. She urged support of HB 688.

Robert H. Likewise, a registered pharmacist and Executive Director of the Montana State Pharmaceutical Association, stated that his group does not oppose the intent but only the wording of HB 688. He advised they wished to propose an amendment which would allow the RN to dispense a one-month supply of an oral contraceptive to cover the problem of unscheduled visits and at the same time provide pharmacy input. He read and submitted his written testimony to the committee (Exhibit #20), and also furnished copies of the proposed amendment (Exhibit #21). He urged the committee to recommend the amendment.

Lori Morin, Professor at the School of Pharmacy, University of Montana, stated she is also a practicing pharmacist who provides pharmacy services to a family planning clinic. She further stated that she does not oppose the intent of this legislation but rather the method that it

implements. She wished to add her support to the amendment which echoes a pilot project going on about nine months in the clinic with which she is connected. She stated that the argument that pharmacy service delays access to care is not valid. She described in detail the procedure used in her particular clinic. She believes there is a better alternative than that which is being proposed in HB 688.

Dennis Yost, Director of Pharmacy at St. Peter's Hospital, Helena, stated he is representing Montana Society of Hospital Pharmacists, a group of over 200 hospital pharmacists in Montana. He stated that they agree with the intent of the bill which is to improve the delivery of health care services. They are in support of the proposed amendment. He stated that if the proposed procedure occurred in a hospital's outpatient department, it would never be accredited. He believes the bill develops two tracks of health care (1) one for those who can pay, and (2) one for those who are poor, in which the checks and balances are eliminated because it is a cheaper way to go. He believes those checks and balances are important, and they are provided by the pharmacist. He was disturbed by the testimony that a secretary at a family planning clinic would actually be the one to dispense. He added that the current law simply needs a modification.

Questions From Committee Members: Senator Lynch asked Diane Manning of the Butte Family Planning Clinic if the costs would be prohibitive to incorporate a program as described by Lori Morin. Ms. Manning stated that one cycle would work for the first time, but down the road they do not have the facility or the financial support to have the pharmacist fill packages of pills which must be stored. She stated storage is a definite problem.

Senator Rasmussen asked if a Nurse Specialist would be able to write a prescription for oral contraceptives. Cathy Caniparoli advised that currently Nurse Specialists work in a significant number of family planning clinics, and they work under protocol to define what contraceptives they can prescribe.

Senator McLane asked if under the proposed amendments would the patient have to come back every month. Bob Likewise responded by stating that they would not have to come back at the end of the first month since their pills could be mailed to them if they so desired.

Closing by Sponsor: Representative Simon stated that he does not support the amendment proposed by the pharmacists.

He also stated that storage is a problem in Title 10 family planning clinics. He reiterated that the people who should be served are the patients, not the pharmacists. He stated that low income people are being considered here and their safety is assured. He urged the committee to make a do pass recommendation.

DISPOSITION OF HOUSE BILL 688

Discussion: None

Amendments and Votes: None

Recommendation and Vote: None

ADJOURNMENT

Adjournment At: 3:00 p.m.

SENATOR TOM HAGER, Chairman

TH/dq

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ROLL CALL

PUBLIC HEALTH COMMITTEE

51st LEGISLATIVE SESSION -- 1989 Date 3/15/89

NAME	PRESENT	ABSENT	EXCUSED
Sen. Tom Hager	X		
Sen. Tom Rasmussen	X		
Sen. Lynch	X		
Sen. Himsl	X		
Sen. Norman	X		
Sen. McLane	X		
Sen. Pipinich	X		

Each day attach to minutes.

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

Ken Dunham, Management Consultant
406/443-0640

SENATE HEALTH & WELFARE
EXHIBIT NO. #1
DATE 3/15/89
BILL NO. HB 389

#1

3/15/89

TESTIMONY OF KEN DUNHAM
Lobbyist/Montana LPN Association

House Bill 389

House Bill 389 is a critical bill for more than 3,000 Licensed Practical Nurses in Montana, many of whom are being held back in their nursing practice unfairly because the present definition of an LPN says an LPN can only perform nursing procedures that are "leading to predictable outcomes."

The words "leading to predictable outcomes" has been used over the years by nursing supervisors, administrators and the Montana Board of Nursing in their rulings to unfairly restrict LPN's from performing nursing tasks they are well trained to do. Some of the examples provided me by LPN's across the state include an inability to work in some intensive care units, in emergency rooms, in nursury units, in performing intravenous procedures, and administering various types of medications.

It should be noted that by law any LPN performs any of his or her tasks under the supervision of a physician or registered nurse. This is the present state law and the change we are asking for in House Bill 389 would not change any of this.

LPN's in Montana, as well as those in other states, work in a variety of nursing positions in hospitals, clinics, and other nursing situations.They are trained, through education in the classroom, in clinical training, and often additional training after obtaining a job.

The major problem with having this phrase in the law is that it is largely meaningless. Virtually every medical or nursing procedure has an outcome that is predictable or expected, but that outcome many not always happen the way the book says it will.

The LPN is trained to respond to anything unusual just the way a registered nurse is, of reporting it to the supervising physician or other person in charge, and taking the appropriate action as directed by that supervisor.

In the past few weeks, since this bill was prepared, we have researched all 50 states on their definitions of an LPN. 47 other states do not have it in their definition, only Montana, Wyoming and Rhode Island have it.(I might add that we missed the wording in the Rhode Island definition and had previously said that only Montana and Wyoming have the phrase.) Additionally,the National Council of State Boards of Nursing, in their 1988 proposed Model Nursing Practice Act does not include the phrase, either.

We are aware of the objections to the bill from those registered nurses in Montana who are represented here by the Montana Nurses Association. Those objections seem to center on the argument that this should have gone to the Board of Nursing for some approval first, and a second argument that this will somehow increase the scope of practice of an LPN.

The Montana Board of Nursing has debated this issue, I am told, at various times over the years when considering nursing rulings. With the makeup of the board having R.N.'s outnumbering LPN's by a 4-3 margin, I'm not surprised that the issue was never resolved there. The Board did vote, however, on February 28 of this year to take a neutral position on this bill.

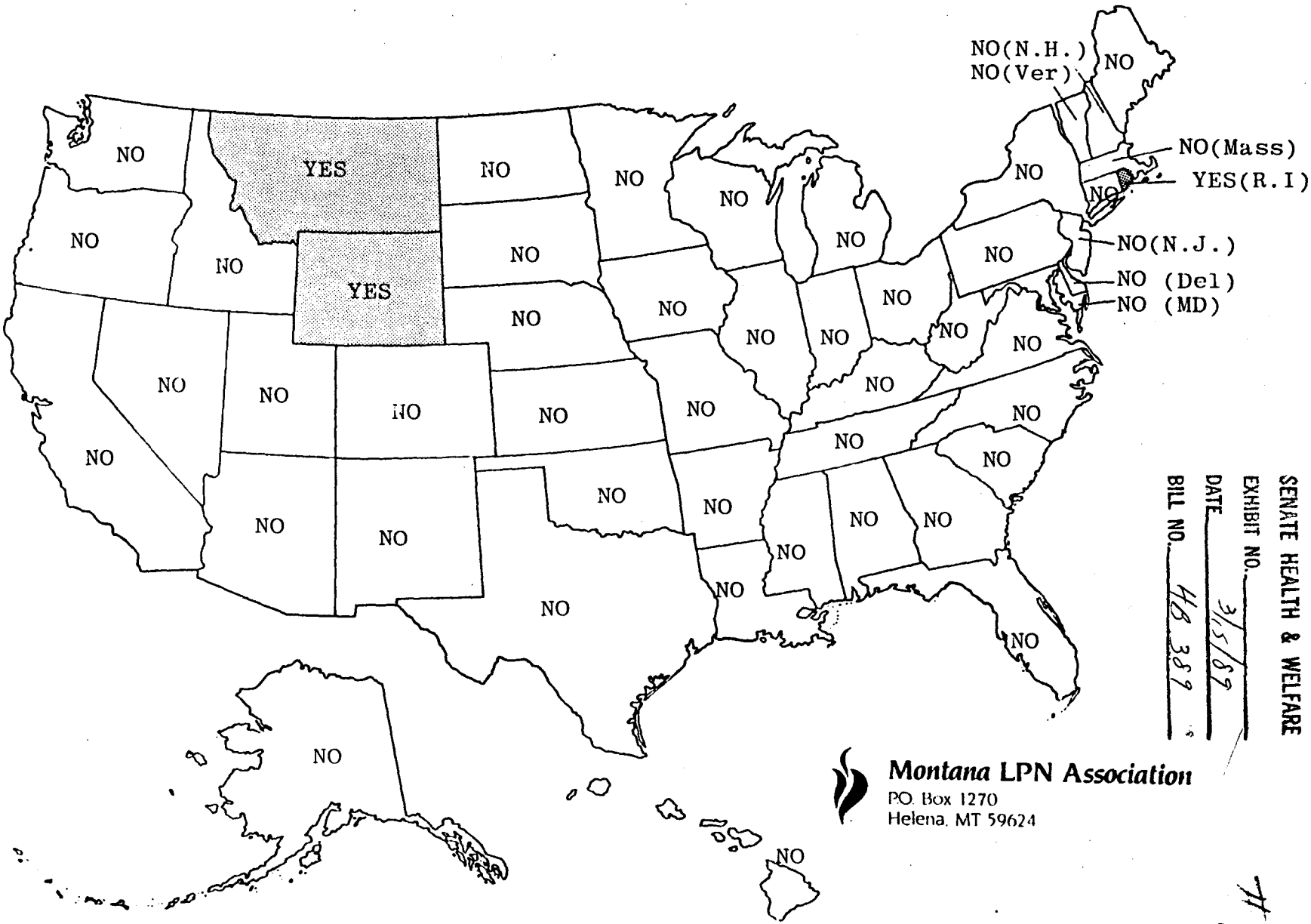
The claim that this will somehow increase the scope of practice of an LPN can be answered by pointing out that nothing else in the nursing laws of Montana is being changed.

LPN's continue to be supervised by RN's and physicians and their "scope of practice" is clearly defined in that they would perform standardized procedures after education and training in practical nursing.

Montana's LPN's are educated in virtually the same manner as are LPN's all across the country. Before being licensed as an LPN, a standardized test under the supervision of the Board of Nursing must be taken and passed. None of this changes in any manner.

This bill simply allows LPN's to do what they are trained and qualified to do in nursing care.

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



SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 3/15/89
BILL NO. HB 389

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

DEFINITIONS OF LICENSED PRACTICAL NURSES VARIOUS STATE LAWS

ALABAMA

b. PRACTICE OF PRACTICAL NURSING. The performance, for compensation, of acts designed to promote and maintain health, prevent illness and injury and provide care utilizing standardized procedures and the nursing process, including administering medications and treatments, under the direction of a licensed professional nurse or a licensed or otherwise legally authorized physician or dentist. Such practice requires basic knowledge of the biological, physical and behavioral sciences and of nursing skills but does not require the substantial specialized skill, independent judgment and knowledge required in the practice of professional nursing. Additional acts requiring appropriate education and training may be performed under emergency or other conditions which are recognized by the nursing and medical professions as proper to be performed by a licensed practical nurse.

ALASKA

(7) "practice of practical nursing" means the performance for compensation or personal profit of nursing functions that do not require the substantial specialized skill, judgment, and knowledge of a registered nurse;

ARIZONA

6. "Practical nursing" means the performance for compensation or profit of services requiring technical skills acquired by means of a course in an approved school of practical nursing and continuing education courses offered by an approved school of practical nursing. The practice of practical nursing consists of participating with registered nurses in the assessment, planning, implementation and evaluation of nursing care by:

(a) Providing for the emotional and physical comfort of patients.

(b) Observing, recording and reporting the condition of patients.

(c) Performing nursing procedures recognized by the board.

(d) Assisting with the rehabilitation of patients according to the patient's care plan.

(e) Assisting with maintenance of health.

ARKANSAS

(3) "Practice of practical nursing" means the performance for compensation of acts involving the care of the ill, injured, or infirm under the direction of a registered professional nurse or a licensed physician or a licensed dentist, which acts do not require the substantial specialized skill, judgment, and knowledge required in professional nursing;

CALIFORNIA

The practice of vocational nursing within the meaning of this chapter is the performance of services requiring those technical, manual skills acquired by means of a course in an accredited school of vocational nursing, or its equivalent, practiced under the direction of a licensed physician, or registered professional nurse, as defined in Section 2725 of the Business and Professions Code.

A vocational nurse, within the meaning of this chapter, is a person who has met all the legal requirements for a license as a vocational nurse in this State and who for compensation or personal profit engages in vocational nursing as the same is hereinabove defined.

COLORADO

(9) "Practice of practical nursing" means the performance, under the supervision of a dentist, physician, or professional nurse authorized to practice in this state, of those services requiring the education, training, and experience, as evidenced by knowledge, abilities, and skills required in this article for licensing as a practical nurse pursuant to section 12-38-112, in caring for the ill, injured, or infirm, in teaching and promoting preventive health measures, in acting to safeguard life and health, or in administering treatments and medications prescribed by a legally authorized dentist or physician. Nothing in this article shall limit or deny a practical nurse from supervising other practical nurses or other health care personnel.

CONNECTICUT

(b) The practice of nursing by a licensed practical nurse is defined as the performing of selected tasks and sharing of responsibility under the direction of a registered nurse and within the framework of supportive and restorative care, health counseling and teaching, case finding and referral, collaborating in the implementation of the total health care regimen and executing the medical regimen under the direction of a licensed physician or dentist.

DELAWARE

(c) "The practice of practical nursing" as a licensed practical nurse means the performance for compensation of nursing services by a person who holds a valid license pursuant to the terms of this chapter and who bears accountability for nursing practices which require basic knowledge of physical, social and nursing sciences. These services, at the direction of a registered nurse or a person licensed to practice medicine, surgery or dentistry, include:

(1) Observation;
(2) Assessment;
(3) Planning and giving of nursing care to the ill, injured and infirm;
(4) The maintenance of health and well being;
(5) The administration of medications and treatments prescribed by a licensed physician, dentist or podiatrist; and
(6) Additional nursing services and supervision commensurate with the licensed practical nurse's continuing education and demonstrated competencies.

FLORIDA

(b) "Practice of practical nursing" means the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the maintenance of health and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatrist, or a licensed dentist.

The professional nurse and the practical nurse shall be responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

GEORGIA

(4) "Practice of nursing by a licensed undergraduate nurse" means the performance for compensation of selected acts in the care of the ill, injured, or infirm under the direction of a licensed registered professional nurse or a physician practicing medicine in accordance with Article 2 of Chapter 34 of this title [Chapter 84-9], *or a dentist practicing dentistry in accordance with Chapter 11 of this title* [Chapter 84-7], *or a podiatrist practicing podiatry in accordance with Chapter 35 of this title* [Chapter 84-6].

HAWAII

"The practice of nursing as a licensed practical nurse" means the performance of those acts commensurate with the required educational preparation and demonstrated competency of the individual, whereby the individual shall be accountable and responsible to the consumer for the quality of nursing care rendered. The foregoing may include, but not be limited to, implementation of basic nursing procedures in the plan of care; or observing and caring for individuals at all levels of the health spectrum, giving counsel and acting to safeguard life and health and functioning as a part of the health care team, under the direction of a dentist, medical doctor, registered nurse, osteopath, or podiatrist licensed in accordance with chapter 448, 453, 457, 460, or 463E; or administration of treatment and medication as prescribed; or promotion of health maintenance of individuals, families, or groups; or teaching and supervision of auxiliary personnel.

IDAHO

(2) "Licensed practical nurse" means a person who practices nursing by:
a. Functioning at the direction of a licensed professional nurse, licensed physician, or licensed dentist;
b. Contributing to the assessment of the health status of individuals and groups of individuals;
c. Participating in the development and modification of the strategy of care;
d. Implementing the appropriate aspects of the strategy of care as defined by the board, including administering medications and treatments as prescribed by nurse practitioners, licensed physicians, and licensed dentists;
e. Maintaining safe and effective nursing care rendered directly or indirectly;
f. Participating in the evaluation of responses to interventions; and
g. Delegating nursing interventions that may be performed by others and that do not conflict with this act.

ILLINOIS

3. "Practical nursing" means the performance for compensation of services in the care of the ill, injured, or infirm, selected by and performed under the direction of a registered professional nurse or a licensed physician or a licensed dentist, not requiring the substantial skill, judgment and knowledge required in professional nursing.

4. "Practical nurse" and "licensed practical nurse" mean a person who practices practical nursing as defined in paragraph 3 of this Section. Only a practical nurse licensed under this Act is entitled to use the title "licensed practical nurse" and the abbreviation "L.P.N.".

INDIANA

(d) The term "the practice of practical nursing" means the performance for compensation of any of those services in observing and caring for the ill, injured or infirm, in applying counsel and procedures to safeguard life and health in administering treatment and medication prescribed by a licensed physician or dentist which are commonly performed by licensed practical nurses and which require specialized knowledge and skill such as are taught or acquired;

IOWA

For the purpose of this title the practice of nursing as a licensed practical nurse shall mean the performance of such duties as are required in the physical care of a convalescent, a chronically ill or an aged or infirm patient, and in carrying out such medical orders as are prescribed by a licensed physician or nursing services under the supervision of a registered nurse, requiring the knowledge of simple nursing procedures but not requiring the professional knowledge and skills of a registered nurse.

KANSAS

(2) The practice of nursing as a licensed practical nurse means the performance for compensation or gratuitously, except as permitted by K.S.A. 65-1124 and any amendments thereto, of tasks and responsibilities defined in part (1) of this subsection (d) which tasks and responsibilities are based on acceptable educational preparation within the framework of supportive and restorative care under the direction of a registered professional nurse, a person licensed to practice medicine and surgery or a person licensed to practice dentistry.

KENTUCKY

(9) "Licensed practical nursing practice" shall mean the performance of s requiring knowledge and skill such as are taught or acquired in proved schools for practical nursing in:

(a) The observing and caring for the ill, injured or infirm under the direction of a registered nurse, a licensed physician or dentist.

(b) The giving of counsel and applying procedures to safeguard life and alth, as defined and authorized by the board.

(c) The administration of medication or treatment as authorized by a ysician or dentist licensed in this state and as further authorized or limited by the board which is consistent with the National Federation of censed Practical Nurses or with standards of practice established by tionally accepted organizations of licensed practical nurses.

(d) Teaching or supervising except as limited by the board.

(e) The performance of other nursing acts which are authorized or limited y the board and which are consistent with the National Federation of actical Nurses' Standards of Practice or with standards of practice established by nationally accepted organizations of licensed practical nurses.

LOUISIANA

(2) The "practice of practical nursing" means the performance for compensation of any acts, not requiring the education, training and preparation required in professional nursing, in the care, treatment or observation of the ill, injured or infirm and for the maintenance of the health of others and the promotion of health care, including the administration of medications and treatments or in on job training or supervising licensed practical nurses, subordinate personnel or instructing patients consistent with the licensed practical nurse's education and preparation, under the direction of a licensed physician or dentist acting individually or in his capacity as a member of the medical staff, or registered nurse. The licensed practical nurse may perform any of the foregoing duties, and with appropriate training may perform additional specified acts which are authorized by the Board of Practical Nurse Examiners when directed to do so by the licensed physician or dentist acting individually or in his capacity as a member of the medical staff, or registered nurse.

MAINE

"3. **Practical nursing.** The practice of 'practical nursing' is defined as the performance of tasks and responsibilities for compensation, under the direction of a licensed or registered professional nurse, physician or dentist, including at least:

"A. Observing and caring for the ill, injured or infirm;

"B. Performing selected aspects of designated nursing services, requiring specialized knowledge, skill and judgment, but not requiring the qualifications essential for the practice of professional nursing;

"C. Counseling and health teaching of persons who are experiencing normal developmental changes, or who require assistance in the maintenance of health, the management of health or the management of illness, injury or infirmity; and

"D. Administering medications and treatment as prescribed by a legally authorized person.";

MARYLAND

(e) *Practice licensed practical nursing.* — "Practice licensed practical nursing" means to perform in a team relationship an act that requires specialized knowledge, judgment, and skill based on principles of biological, physiological, behavioral, or sociological science to:

(1) Administer treatment or medication to an individual;

(2) Aid in the rehabilitation of an individual;

(3) Promote preventive measures in community health;

(4) Give counsel to an individual;

(5) Safeguard life and health;

(6) Teach or supervise; or

(7) Perform any additional acts authorized by the Board under § 7-205 of this title.

MASSACHUSETTS

"Practical nursing" shall mean the performance for compensation of any of those services in observing and caring for the ill, injured or infirm, in applying counsel and procedures to safeguard life and health, in administering treatment or medication prescribed by a physician or dentist, or in teaching or supervising others, which are commonly performed by licensed practical nurses and which require specialized knowledge and skill such as are taught and acquired under the established curriculum in a school for practical nurses duly approved in accordance with this chapter.

MICHIGAN

(b) "Practice of nursing as a licensed practical nurse" or "l.p.n." means the practice of nursing based on less comprehensive knowledge and skill than that required of a registered professional nurse and performed under the supervision of a registered professional nurse, physician, or dentist.

MINNESOTA

Subd. 4. "The practice of nursing by a Licensed Practical Nurse" means the performing for compensation or personal profit services required in the nursing care of the sick not involving the specialized education, knowledge, and skill required in professional nursing.

MISSISSIPPI

(c) The practice of nursing as a licensed practical nurse means the performance for compensation of selected acts in the care of the ill, injured or infirm under the direction of a registered nurse or a licensed physician or a licensed dentist which does not require the substantial specialized skill, judgment and knowledge required of a registered nurse.

MISSOURI

(7) "Practical nursing" is the performance for compensation of selected acts for the promotion of health and in the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment and knowledge. All such nursing care shall be performed under the direction of a person licensed in this state to prescribe medications and treatments or under the direction of a registered professional nurse;

MONTANA

(b) "Practice of Practical Nursing" means the performance for compensation of services requiring basic knowledge of the biological, physical, behavioral, psychological, and sociological sciences and of nursing procedures. Practical nursing practice utilizes standardized procedures leading to predictable outcomes in the observation and care of the ill, injured, and infirm; in the maintenance of health; in action to safeguard life and health; and in the administration of medications and treatments prescribed by a physician, dentist, osteopath, or podiatrist authorized by state law to prescribe medications and treatments. These services are performed under the supervision of a registered nurse or a physician, dentist, osteopath, or podiatrist authorized by state law to prescribe medications and treatments.

NEBRASKA

(5) The practice of nursing by a licensed practical nurse shall mean the assumption of responsibilities and the performing of acts, within the educational background of the practical nurse, under the direction of a licensed physician, dentist, osteopath, podiatrist, or registered nurse. These acts include:

(a) Application of nursing techniques and procedures in the observation, teaching, and caring for the ill, injured, and infirm; and

(b) Promoting community health;

NEVADA

6. "Practice of practical nursing" means the performance for compensation of selected acts in the care of the ill, injured or infirm under the direction of a registered professional nurse, a licensed physician, a licensed dentist or a licensed podiatrist, not requiring the substantial specialized skill, judgment and knowledge required in professional nursing.

NEW HAMPSHIRE

IV. "Practical nursing" means the performance for compensation of selected services in the observation and care of the ill, injured or infirm, and in carrying out activities and procedures to safeguard life and health which are prescribed by and performed under the direction of a physician, dentist, or registered professional nurse licensed in New Hampshire. This practice requires basic knowledge and skill acquired in an accredited school or program of practical nursing but does not require the specialized, comprehensive knowledge, professional judgment and skill necessary for the practice of professional nursing as a registered professional nurse.

NEW JERSEY

The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.

NEW MEXICO

B. "practical nursing" means nursing under the direction of a physician, dentist or registered nurse which involves the performance of those services required in observing and caring for the ill, injured or infirm; promoting preventive measures in community health; giving counsel and acting to safeguard life and health; and administering treatment and medication, prescribed by a person authorized in this state to prescribe such medications and treatments, that requires the skill, judgment and knowledge of a licensed practical nurse.

The foregoing definition shall not prevent the advanced practice of a licensed practical nurse who has satisfactorily completed a recognized program of study or its equivalent as determined by the board;

NEW YORK

2. The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding, health teaching, health counseling, and provision of supportive and restorative care under the direction of a registered professional nurse or licensed or otherwise legally authorized physician or dentist.

NORTH CAROLINA

(8) The "practice of nursing by a licensed practical nurse" consists of the following five components:

a. Participating in assessing the patient's physical and mental health including the patient's reaction to illnesses and treatment regimens;

b. Recording and reporting the results of the nursing assessment;

c. Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide such supervision;

d. Reinforcing the teaching and counseling of a registered nurse, physician licensed to practice medicine in North Carolina, or dentist; and

e. Reporting and recording the nursing care rendered and the patient's response to that care. (1981, c. 360, s. 1.)

NORTH DAKOTA

3. The "practice of nursing as a licensed practical nurse" is defined as the performance of those services, requiring the basic knowledge of biological science and technical skills, commonly performed by a licensed practical nurse under the direction of a registered nurse, licensed physician, or dentist for the purpose of:
   a. The maintenance of health and prevention of illness.
   b. The observation and nursing care of persons experiencing changes in their health processes.
   c. Administering prescribed medications and treatments.
   d. Teaching and evaluating health practices of patients.
   e. Providing specialized nursing care when such service is authorized by the board through its rules and regulations and delegated by a registered nurse, physician, or dentist, to a licensed practical nurse who has had additional preparation or experience.

OHIO

"Practical nursing" means the performance for compensation of nursing services requiring the employment of technical skills, a basic knowledge of biological and behavioral sciences and of nursing procedures acquired through a course in an approved school of practical nursing and performed at the direction of a licensed physician, licensed dentist, or other person legally authorized to prescribe medical or dental treatment or at the direction of a registered nurse, provided, however, the practice of practical nursing shall not be construed to include services rendered by technicians and medical assistants under the direction or control of a licensed physician or dentist.

Acts of medical diagnosis or prescription of medical therapeutic, or corrective medical measures by a nurse are prohibited.

This section does not apply to persons employed as nursing aides, attendants, orderlies, or other auxiliary workers in patient homes, nurseries, nursing homes, hospitals, or other similar institutions.

A licensed practical nurse is a person who has complied with sections 4723.01 to 4723.38, inclusive, of the Revised Code, and has been granted a license to engage in practical nursing by the board of nursing education and nurse registration.

OKLAHOMA

(c) The practice of practical nursing means the performance for compensation of nursing services (a) in the care of those not acutely ill, such as the convalescent, aged or infirm, (b) in other care, such as in the case of those more acutely ill under the supervision and/or direction of a registered professional nurse, or a licensed physician or dentist, which includes the administration of medications and treatments prescribed by a licensed physician or dentist, and (c) the teaching of nurse aides.

OREGON

(7) "Practice of practical nursing" means the application of knowledge drawn from basic education in the social and physical sciences in planning and giving nursing care and in assisting persons toward achieving of health and well-being.

PENNSYLVANIA

(1) The "practice of practical nursing" means the performance of selected nursing acts in the care of the ill, injured or infirm under the direction of a licensed professional nurse, a licensed physician or a licensed dentist which do not require the specialized skill, judgment and knowledge required in professional nursing.

RHODE ISLAND

(g) Practical nursing: Is practiced by licensed practical nurses (L.P.N.'s). It is an integral part of nursing based on a knowledge and skill level commensurate with education. It includes promotion, maintenance, and restoration of health and utilizes standardized procedures leading to predictable outcomes which are in accord with the professional nurse regimen under the direction of a professional nurse. In situations where professional nurses are not employed, the licensed practical nurse functions under the direction of a duly licensed physician, dentist, or podiatrist. Each L.P.N. is responsible for the nursing care rendered.

SOUTH CAROLINA

(g) The term "practice of practical nursing" means the performance for compensation, under the direction of a registered nurse, licensed physician or licensed dentist, of acts in health care maintenance, care of the ill, injured and infirm, and in administering treatments and medications as authorized and prescribed by a licensed physician or licensed dentist, which acts require knowledge, judgment and skill as prerequisites to licensure under this chapter, and which shall not include acts of diagnosis or prescription of therapeutic or corrective measures.

A licensed practical nurse may perform additional acts requiring special education and training, approved by the State Board of Nursing, which are recognized jointly by the medical and nursing professions as proper for the licensee to perform and which are recognized by the State Board of Nursing through its rules and regulations.

SOUTH DAKOTA

36-9-4. Scope of licensed practical nursing practice. As used in this chapter, the practice of licensed practical nursing means:

(1) The performance of any acts in the care, treatment, or observation of the ill, injured or infirm;

(2) Maintenance of health of others and promotion of health care;

(3) Assisting with health counseling and teaching; and

(4) Applying procedures to safeguard life and health, including the administration of medications and treatments consistent with the practical nurse's education and preparation under the direction of a physician licensed or exempt from licensing pursuant to chapter 36-4, dentist or registered nurse.

TENNESSEE

63-7-108. "Practical nursing" defined. — The practice of practical nursing means the performance for compensation of selected acts required in the nursing care of the ill, injured or infirm and/or carrying out medical orders prescribed by a licensed physician or dentist under the direction of a licensed physician, dentist, or professional registered nurse. The licensed practical nurse shall have preparation in and understanding of nursing, but shall not be required to have the same degree of education and preparation as required of a registered nurse. [Acts 1967, ch. 78, § 17; T.C.A., § 63-745.]

TEXAS

Section 1. (a) The term "Licensed Vocational Nurse" as used in this Act, shall mean any person who directly attends or cares for the sick for compensation or hire, and whose personal qualifications, preliminary education or nursing education in biological, physical and social sciences will not qualify that person to become certified as a professional registered nurse, as defined and regulated under the laws of this State, and who uses the designation Licensed Vocational Nurse, or the abbreviation L. V. N.

UTAH

(7) "Practice of practical nursing" means the performance for compensation of acts in the care of the ill, injured, or infirm under the direction of a registered nurse, a licensed physician, or other specific licensed health care professional as defined in the rules, by one having the substantial specialized skill, judgment, and knowledge required in practical nursing.

VERMONT

(3) "The practice of practical nursing" means the performance of services requiring the specialized knowledge, skill and judgment necessary for carrying out selected aspects of the designated nursing regimen at the direction of a registered professional nurse or licensed physician or licensed dentist in:

(A) Health teaching and health counseling;

(B) Provision of care which is supportive or restorative to life and well-being directly to the patient or through supervision of assistants; or

(C) Execution of a medical regimen at the direction of a licensed physician or licensed dentist, who need not be physi-

VIRGINIA

"Practical nursing" or *"licensed practical nursing"* means the performance for compensation of selected nursing acts in the care of individuals or groups who are ill, injured, or experiencing changes in normal health processes; in the maintenance of health; or in the prevention of illness or disease. Practical nursing or licensed practical nursing requires knowledge, judgment and skill in nursing procedures gained through prescribed education. Practical nursing or licensed practical nursing is performed under the direction or supervision of a licensed medical practitioner, a professional nurse, registered nurse or registered professional nurse or other licensed health professional authorized by regulations of the Board.

WASHINGTON

(4) "Licensed practical nurse practice" shall mean "the performing for compensation, services required in the nursing care of the ill, injured or infirm, under the direction of a licensed physician and surgeon, osteopathic physician and surgeon, dentist, chiropodist, or under the direction and supervision of a licensed registered professional nurse and not involving the specialized education, knowledge, skill and exercise of independent judgment required in professional nursing."

WEST VIRGINIA

(a) The term "practical nursing" means the performance for compensation of selected nursing acts in the care of the ill, injured or infirm under the direction of a registered professional nurse or a licensed physician or a licensed dentist, and not requiring the substantial specialized skill, judgment and knowledge required in professional nursing.

WISCONSIN

(3) Practice of practical nursing. The practice of practical nursing under this chapter means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse, physician, podiatrist or dentist. A simple act is one which does not require any substantial nursing skill, knowledge or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts and is one which is of a nature of those approved by the board for the curriculum of schools for licensed practical nurses.

WYOMING

(a) "Practice of practical nursing" means the performance of technical services requiring basic knowledge of the biological, physical, [illegible]ral, psychological and sociological sciences and of nursing procedures. These services are performed under the direction of a licensed [illegible]n or dentist, or registered professional nurse, and utilize standard procedures leading to predictable outcomes in the observation [illegible]e of the ill, injured and infirm in the maintenance of health, in [illegible]o safeguard life and health and in the administration of [illegible]ions and treatments prescribed by any person authorized by state [illegible]e prescribe;

#2

SENATE HEALTH & WELFARE
EXHIBIT NO. #2
DATE 3/15/89
BILL NO. HB 389

March 13, 1989

TO: Senate Committee on Public Health, Welfare and Safety

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

RE: H.B. 389 - "An act clarifying the definition of the practice of practical nursing"

As a practical nursing instructor I have had to try to explain what a "predictable outcome" is to my students since 1981. I have never seen a formal definition of the term but knew it had been written by a task force appointed in 1980 to change the definition of practical nursing.

When this bill was introduced by Representative Campbell, it made me stop and think - Is this a meaningful or meaningless phrase in the Nurse Practice Act? I have always questioned in my own mind what it meant and what it allowed or didn't allow the L.P.N. to do.

After H.B. 389 was introduced, I have been doing a lot of brainstorming, questioning and researching this issue. I use a textbook by Kozier and Erb called Techniques in Clinical Nursing to teach routine nursing procedures in a class called Nursing Fundamentals. This book is organized and written in a form called the nursing process. At the end of each technique, you will note in the handout, there are expected outcomes and unexpected outcomes. In the preface at the beginning of the book, the authors explain that there are, and I quote, "examples of expected and unexpected outcomes, recognizing that in practice these outcomes are specific for each patient". I do believe that this means due to the variables of each patient and their diagnosis that outcomes cannot be predicted.

If a nurse, either R.N. or L.P.N., obtains an unexpected outcome, he or she must be able to recognize this and reevaluate the findings and procede accordingly. This is just good nursing care.

In my opinion, as an instructor in a practical nursing program, this change will not increase the role or scope of practical nursing, but make the definition more realistic. Please support H.B. 389. If you have any questions please call me at 442-0060(work) or 449-7332(home).

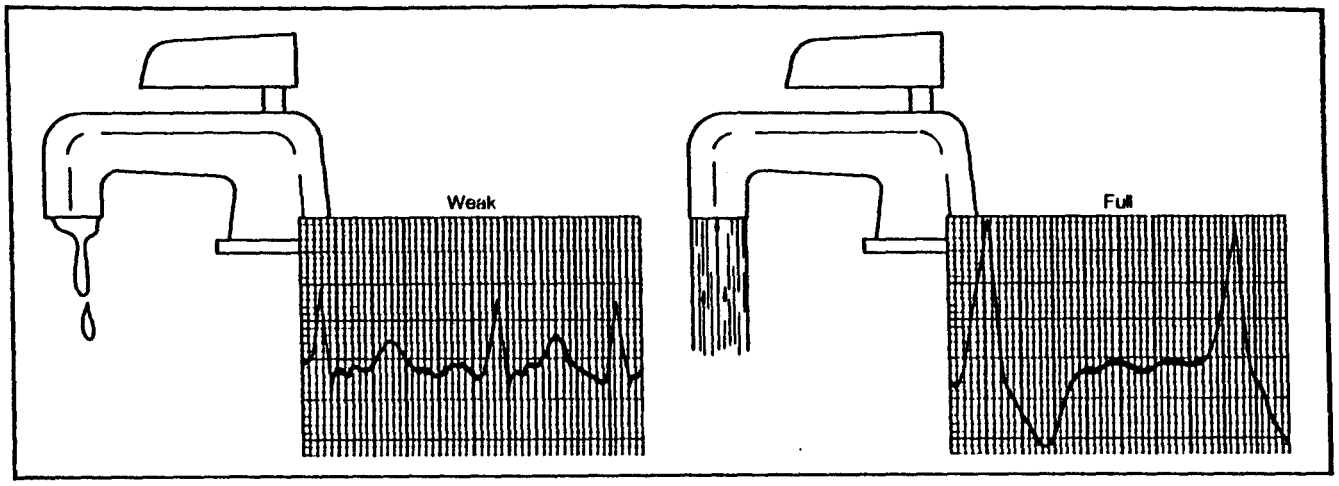


FIGURE 8-11 ■ Two comparative electrocardiographs, one illustrating a weak pulse volume and one a full pulse volume.

arrhythmia. In terms of volume, a pulse that is weak and easily obliterated is described as *weak, feeble,* or *thready;* an abnormally strong pulse is referred to as *full* or *bounding.* Abnormalities of pulse tension are an arterial wall that feels *rough* or *beady* (uneven) and an artery that lacks elasticity and feels *hard* or *gritty* to the touch.

TECHNIQUE 8-4 ■ Assessing a Peripheral Pulse

A pulse is commonly measured by palpation (feeling) or auscultation (hearing). The middle three fingertips are used for palpating all pulse sites except the apex of the heart. A stethoscope is used for assessing apical pulses and fetal heart tones. Increasingly ultrasound (Doppler) equipment is being used to assess pulses that are difficult to assess. See Intervention, step 3b.

Occasionally a radial pulse and an apical pulse are taken simultaneously by two persons (see Technique 8-6). This is called an apical-radial pulse. Differences between the two rates can indicate cardiovascular disorders.

The cardiac monitoring machine is another device for assessing the pulse rate. It indicates the rate on a screen or readout graph. However, this method is beyond the scope of this chapter.

A peripheral pulse, usually the radial pulse, is assessed for all individuals *except:*

1. Newborns and children up to 2 or 3 years. Apical pulses are assessed in these patients.
2. Very obese or elderly patients, whose radial pulse may be difficult to palpate. Doppler equipment may be used for these patients or the apical pulse is assessed.
3. Individuals with a heart disease, who require apical pulse assessment.
4. Individuals in whom the circulation to a specific body part must be assessed, eg, following leg surgery the pedal (dorsalis pedis) pulse is assessed.

■ Assessment

Assess the patient for:

1. Skin color and warmth, eg, assess the color and warmth of the foot when taking a pedal pulse
2. Facial pallor and cyanosis of the lips and nail beds

Additional data include:

1. Baseline data about the peripheral pulse rate, volume, and rhythm and the arterial wall
2. Most recent pulse assessments
3. Nursing or medical orders to be implemented as a result of the assessment

■ Nursing Diagnosis

Nursing diagnoses that may indicate the need to assess a patient's peripheral pulse include:

1. Potential or actual activity intolerance related to:
   a. Alterations in the oxygen transport system (cardiac, respiratory, or circulatory)

b. Chronic disease
c. Malnourishment
d. Prolonged bed rest
e. Sedentary life-style

2. Alterations in cardiac output (decreased) related to:
   a. Cardiac factors
   b. Pulmonary disorders
   c. Endocrine disorders
   d. Hematologic disorders
   e. Fluid and electrolyte imbalances
   f. Stress
   g. Surgery
   h. Medications (diuretics, antihypertensives, vasoconstrictors, vasodilators)
   i. Allergic response
   j. Sepsis
3. Alterations in respiratory function related to:
   a. Excessive or thick secretions
   b. Infection
   c. Neuromuscular impairment
   d. Loss of lung elasticity
   e. Anesthesia
   f. Smoking
   g. Suppressed cough reflex
   h. Immobility
4. Actual or potential fluid volume deficit related to:
   a. Decreased fluid intake
   b. Abnormal fluid loss

■ Planning

Nursing goals

1. To acquire baseline data against which future assessments can be compared
2. To evaluate a patient's pulse following special therapy, such as digitalis medication
3. To assess an abnormal pulse

Equipment

1. A watch with a second hand or indicator to count the pulse rate
2. A pencil or pen to record pulse data
3. A book, record, or worksheet on which to record pulse data
4. If a Doppler ultrasound stethoscope (DUS) will be used, the transducer in the DUS probe (a device resembling a small transistor radio), a stethoscope headset, and transmission gel. See Figure 8-12. Do not use K-Y jelly, which contains probe-damaging salts. The DUS headset has earpieces similar to standard stethoscope earpieces but it has a long cord attached to a volume-controlled audio unit and an ultrasound transducer. The DUS detects *movement* of red blood cells through a blood vessel. In contrast, the conventional stethoscope amplifies only *sound*, not movement. The DUS can detect blood flow if the blood cells are moving faster than 6 cm per second and at a depth of about 5 cm (Hudson, 1983, p 55). It cannot detect blood flow in deep vessels or in those underlying bone, such as the vessels in the abdomen, thorax, or skull. The DUS is battery operated, and batteries need replacement about every 6 months. Many agencies write the date of battery installation on a small adhesive label and attach it to the case as a reminder to replace the battery.

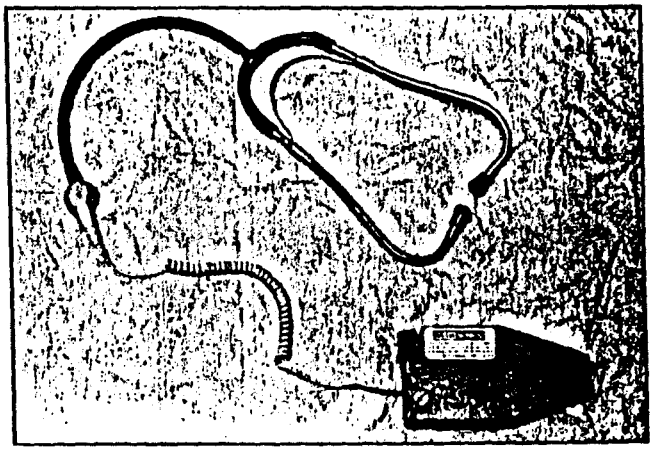
■ Intervention

1. Select the pulse point. Normally, the radial pulse is taken, unless it cannot be exposed or circulation to another body area is to be assessed.
2. Assist the patient to a comfortable resting position. When the radial pulse is assessed the arm can rest alongside the patient with the palm facing downward or the forearm can rest at a 90° angle across the chest with the palm downward. For the patient who can sit, the forearm can rest across the thigh with the palm of the hand facing downward or inward.
3. a. When palpating the pulse, place three middle fingertips lightly and squarely over the pulse point. See Figure 8-13.

   Rationale Using the thumb is contraindicated because the thumb has a pulse that the nurse could mistake for the patient's pulse.

   b. For using a Doppler ultrasound device, Hudson (1983, p 56) outlines the following steps:

FIGURE 8-12 ■ An ultrasound (Doppler) stethoscope.



- Plug the stethoscope headset into one of the two output jacks located next to the volume control. DUS units have jacks for two headpieces and accessory loudspeakers so that another person can listen to the signals.
- Apply transmission gel either to the probe, at the narrowed end of the plastic case housing the transducer, or to the patient's skin.

  Rationale Ultrasound beams do not travel well through air. The gel makes an airtight seal, which promotes optimal ultrasound wave transmission.
- Press the "on" button.
- Hold the probe at a 45° angle against the skin over the pulse site. Use a light pressure, and keep the probe in contact with the skin.

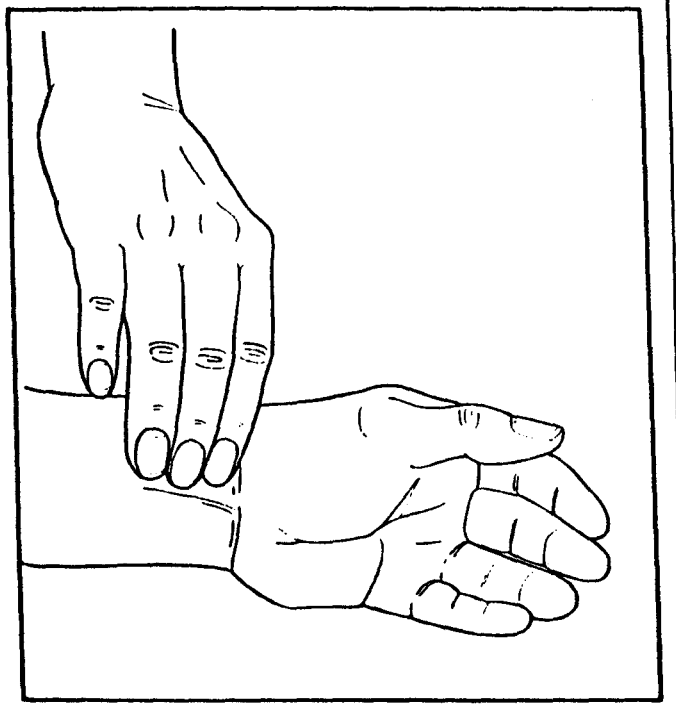
  Rationale Too much pressure can stop the blood flow and obliterate the signal.
- Distinguish between artery and vein sounds. The artery sound (signal) is distinctively pulsating and has a pumping quality. The venous sound is like the wind, is intermittent, and varies with respirations.

  Rationale Both artery and vein sounds are heard simultaneously through the DUS, since major arteries and veins are situated close together throughout the body.
- If you have difficulty hearing arterial sounds, reposition the probe.

4. Count the pulse for 30 seconds and multiply by 2 if the pulse is regular. If it is irregular, count for one full minute.

   Rationale An irregular pulse requires a full minute's count for a correct assessment.
5. Assess the pulse rhythm by noting the pattern of intervals between the beats. A normal pulse has equal time periods between beats. If this is an initial assessment, assess for one full minute.
6. Assess the pulse volume. A normal pulse can be felt with moderate pressure, and the pressure is equal with each beat. A forceful pulse volume is full; an easily obliterated pulse is weak.
7. To assess the arterial wall, compress the artery firmly and run a finger distal to the heart along the artery. See Figure 8-14. A normal arterial wall is smooth and straight.
8. Record the pulse rate, rhythm, and volume, and the condition of the arterial wall.

FIGURE 8-13



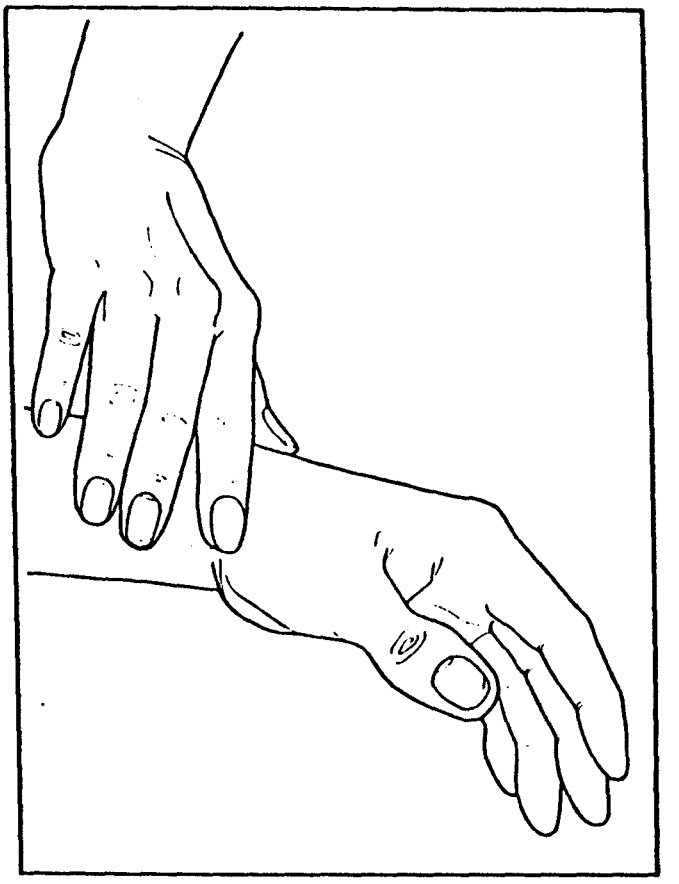


FIGURE 8-14

Sample Recording

Date	Time	Notes
5/8/86	0900	Pale and listless. Pulse 116, weak and thready. Reported above to Ms. N. McNamara. ———— Sally M. Sahara, NS

9. After using the DUS, remove all the gel from the probe to prevent damage to its surface. Clean the transducer with aqueous solutions.

   Rationale Alcohol or other disinfectants may damage the face of the transducer.

■ Evaluation

Expected outcomes

1. A pulse rate within the normal range for the patient
2. A normal pulse volume for the patient
3. A regular pulse rhythm
4. An arterial wall that is smooth and straight

Unexpected outcomes

1. A pulse rate faster or slower than normal for the patient
2. A full, bounding or weak pulse volume
3. An irregular pulse rhythm
4. A tortuous arterial wall

Upon obtaining an unexpected outcome:

1. Reassess the patient's pulse immediately.
2. Assess the patient's respirations and blood pressure.
3. Report your findings to the responsible nurse and/or physician.

TECHNIQUE 8–5 ■ Assessing an Apical Pulse

An apical pulse, at the apex of the heart, is commonly assessed for newborns, infants, and children up to 2 or 3 years. It may also be indicated for patients with cardiac arrhythmias and those receiving medications to improve heart action.

■ Assessment

Assess the patient for:

1. Skin pallor and/or cyanosis of the lips or nail beds
2. Shortness of breath or restlessness
3. The emotional state, since emotions can increase the pulse rate

Other data include:

1. Baseline data about the apical pulse and recent previous assessments
2. The frequency and times at which the apical pulse has been assessed
3. Nursing and/or medical orders to be implemented as a result of the assessment

■ Nursing Diagnosis See Technique 8–4 on page 115.

■ Planning

Nursing goals

1. To establish a baseline in the initial assessment of the patient
2. To determine a change from prior measurements
3. To determine the rate, rhythm, and volume of the apical pulse

Equipment

1. A watch with a second hand to time the rate of the apical pulse.
2. A stethoscope with a bell-shaped or a flat-disc diaphragm to listen to the heartbeats. See Figure 8–15.
3. Antiseptic wipes to clean the earpieces and diaphragm of the stethoscope if their cleanliness is in doubt. Only the diaphragm needs to be cleaned if the nurse's own stethoscope is used.
4. If using ultrasound, a Doppler ultrasound stethoscope, probe (transducer), and transmission gel.
5. A pencil or pen to record pulse data.
6. A book, record, or worksheet on which to record pulse data.
7. A pacifier if necessary to quiet a newborn or infant.

■ Intervention

1. Assist an adult or young child to a comfortable supine position with the head of the bed elevated or to a sitting position on a chair, the edge of the bed, or the examination table. Place a baby on his or her back, and offer a pacifier if the baby is crying or restless.

   Rationale Crying and physical activity increase the pulse rate. For this reason, the nurse also takes the

PROCEDURES THE PRACTICAL NURSING STUDENT CAN DO

Admitting, transferring, and discharging patient

Applications of heat and cold

Assisting with physical examination

Bedmaking - open, closed, and occupied

Binders and bandages

Blood sugar monitoring*

C/A

Catheterization

Charting

Collection of specimens: urine, stool, and sputum

Colostomy care*

Cultures - wound and throat

Discontinue IV's and dressing change*

Enemas and rectal tubes

Insertion of naso-gastric tube*

Intake and output

Irrigations - vaginal, wound, eye, ear, and bladder*

Isolation*

Oxygen therapy

Personal care and hygiene

Pharyngeal suctioning*

Pre and post operative care*

Range of motion

Removal of staples and sutures

Restraints

Serving trays and feeding patients

Sterile technique - dressings

TPR and B/P, Apical pulse, *breath sounds, and *bowel sounds

*Will be taught during Winter Quarter

#3

Montana Nurses' Association

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

SENATE HEALTH & WELFARE
EXHIBIT NO. #3
DATE 3/15/89
BILL NO. HB389

Senator Hager, Members of the Committee

My name is Sharon Dieziger and I represent the Montana Nurses' Association. I'm here to speak **against HB 389.**

I am pleased to be back before a committee that understands the importance of scope of practice and the responsibility that licensing boards have to be as specific as possible in defining scope of practice.

HB 389 attempts to remove the words "predictable outcome" from the Licensed Practical Nurse Scope of Practice. Predictable outcomes vs unpredictable outcomes are key to the practice of Licensed Practical Nurses, Student Nurses and Registered Nurses. It is primary for the LPN's protection also, and should provide guidance and protection to practice within the legal boundaries of their educational preparation. It also tells the employer and the consumer that there are boundaries of practice based on educational preparation.

All patients potentially fall into categories that go from predictable to unpredictable outcomes. Predictable: Some patient problems are well defined, clearly discernible, and therefore have predictable outcomes. In these situations, nurses tend to implement well established, frequently utilized nursing interventions. Unpredictable: These outcomes are related to problems that are complex, confounded and/or infrequently encountered. The solution to these idiosyncratic problems requires insight, in-depth analysis of multiple factors, and the implementation of creative nursing interventions. Colleges of Nursing utilize these definitions to move students from relatively structured to unstructured learning situations, from dependence to independence, throughout a four-year educational process. Institution managers plan patient care and make assignments for patient care based on the complexity of patient illness and preparedness of staff by the license they carry.

Institutions that hire Licensed Practical Nurses and Registered Nurses, and have students in their facilities, must have definitive definitions in order to assign personnel appropriately and safely to patient care. Again, that comes from a job description based on their licensed scope of practice or from their level of education as students.

It is certainly not appropriate to bring this complex issue to the Legislature without ever approaching your own licensing board, who is responsible for your definition of practice. The Board of Nursing was not approached on this issue prior to the legislative session. This is where it needs to begin.

In this session alone, you know that PAs went to their Board of Medical Examiners for endorsement of legislation, Nurse Practitioners and nurses sponsoring legislation for chemical dependency both met with their Board of Nursing prior to coming to the Legislature. Why would the LPNs choose to just come directly to the Legislature and bypass their own licensing board?

If this bill passes, the onus would be on the vo-tech educational programs to prepare Licensed Practical Nurses to provide care to patients with unpredictable outcomes. These programs are less than 12 months in length. Associate Degree programs for Registered Nurses which are two years in length do not even attempt this.

The National League for Nursing states that part of the practice of graduates of two-year Associate Degree programs consists of nursing interventions selected from established nursing protocols where probable outcomes are predictable. This potential expansion in the LPN Scope of Practice is so out of sync with national standards and the national licensure exam that there would be no way to test LPNs on their proficiency to provide such care safely.

Model definitions have become fairly broad, but Administrative Rules define the standards very specifically. In May of 1988, the National Council of State Boards of Nursing published Model Nurse Administrative Rules. On pages 10 and 11, the standards are clearly defined.

Purpose of Standards:
To establish minimal acceptable levels of safe practice for the Licensed Practical Nurse.

Standard 3 states:
Participate in the assisting, delegating and giving of direct care by:

a. Providing care for clients whose conditions are stabliized or predictable.
b. Assisting with the provision of care for clients whose conditions are critical and/or unpredictable under the direct supervision by a Registered Nurse.

The Licensed Practical Nurse is an integral and important care giver in today's health care setting. We value them as colleagues; however we must ask this committee to not support expansion of the Licensed Practical Nurse role without accompanying expansion of education preparation and licensing examination standards. HB 389 is not a credible answer to the nursing shortage, the liability of institutions nor to patients who should assume that a license to practice assures a scope of practice based on education and preparation.

If the Licensed Practical Nurses desire to remove the terminology of predictable outcomes from their definition of practice, then they must define what is their scope of practice, based on their educational preparation and exactly what it is they are prepared to do and what are the limitations. A licensee cannot just choose to remove key language in the scope of practice and retain accountability to the public.

Vote NO on HB 389 and demand that practitioners follow appropriate channels and utilize their own licensing boards before coming to the Legislature and utilizing your valuable time for an issue that should be first addressed at the licensing board level.

Thank you for your thoughtful consideration.

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

HB 389 DEFINITION OF PRACTICAL NURSING

1. Definition describes the responsibilities and scope of practice for which the LPN will be held accountable.

2. Clearly distinguishes LPN responsibilities and practice from that of RN.

3. Standardized Procedure - Board has determined this to mean "rountinely executed nursing actions for which there is an established level of knowledge and skill."

4. Predictable Outcome - means an expected response to a standardized procedure.

5. Both the RN and LPN are required to have the same basic concepts of nursing care including the necessary manual skills for basic procedures but the understanding, knowledge and skill necessary for complex nursing problems is not included in the basic practical nursing education program.

6. The LPN is authorized to perform selected nursing acts in accordance with the nature and amount of knowledge and skill required for the act.

7. As the law is written - it differentiates between the types of practice. It recognizes the difference in the educational preparation of the practical and professional practitioners of nursing.

8. The current definition of practical nursing recognizes the singular element that distinguishes the LPN from the RN, ie; the breadth and depth of educational preparation of the practitioner. Standardized procedures with predictable outcomes clearly delineates this.

9. Practical nursing programs prepare persons to give nursing care under the supervision of a registered nurse or a physician, to patients in simple nursing situations. In more complex situations, the LPN functions as an assistant to the registered nurse.

10. LPN's perform therapeutic nursing techniques, incorporating basic biological and phychological principles in giving care. This type of expected performance does not go beyond the standardized procedure described as a routinely executed nursing action.

11. Removal of the phrase "predictable outcome" would remove all barriers to the LPN performing activities relative to the complex nursing problems for which they do not have the necessary knowledge base or skill.

#3

SENATE HEALTH & WELFARE
EXHIBIT NO. #3a
DATE 3/15/89
BILL NO. HB 389

SENATE HEALTH & WELFARE
EXHIBIT NO.
DATE
BILL NO.

Model Nurse

Administrative Rules

NATIONAL COUNCIL

Chapter	Comment

12. Conduct practice without discrimination on the basis of age, race, religion, sex, sexual preference, national origin, handicap or disease.
13. Respect the dignity and rights of clients regardless of social or economic status, personal attributes or nature of health problems.
14. Respect the client's right to privacy by protecting confidential information unless obligated by law to disclose the information.
15. Respect the property of clients, family, significant others and the employer.

Regulation II - Standards of Nursing Practice for the Licensed Practical Nurse. MNPA, Article III, Section 2(c)(ii).

A. Purpose of Standards

1. To establish minimal acceptable levels of safe practice for the Licensed Practical Nurse.
2. To serve as a guide for the Board to evaluate nursing care to determine if it is safe and effective

B. Standards related to the licensed practical nurse's contribution to and responsibility for the nursing process.

The licensed practical nurse under the direction or supervision of a registered nurse, licensed physician or dentist shall:

1. Contribute to the nursing assessment by:
    a. Collecting, reporting and recording objective and subjective data in an accurate and timely manner. Data collection includes:
        i. Observation about the condition or change in condition of the client.
        ii. Signs and symptoms of deviation from normal health status.
2. Participate in the development of the strategy of care in consultation with other nursing personnel by:
    a. Providing data.
    b. Contributing to the identification of priorities.
    c. Contributing to setting realistic and measurable goals.

Chapter

Comment

d. Assisting in identification of measures to maintain comfort, support human functions and responses, maintain an environment conducive to well-being, and provide health teaching and counseling.

3. Participate in the assisting, delegating and giving of direct care by:

✓a. Providing care for clients whose conditions are stabilized or predictable.

✓b. Assisting with the provision of care for clients whose conditions are critical and/or unpredictable under the direct supervision by a registered nurse.

c. Implement nursing care according to the priority of needs and established practice.

d. Providing an environment conducive to safety and health.

e. Documenting nursing interventions and responses to care.

f. Communicating nursing interventions and responses to care to appropriate members of the health team.

4. Contribute to the evaluation of the responses of individuals or groups to nursing interventions.

a. Evaluation data shall be documented and communicated to appropriate members of the health care team.

b. The Licensed Practical Nurse shall contribute to the modification of the strategy of care on the basis of the evaluation.

c. Evaluate the responses of individuals to nursing interventions.

C. Standards Relating to the Licensed practical Nurse's Responsibilities as a Member of the Health Team.

The Licensed Practical Nurse shall:

1. Have knowledge of the statutes and regulations governing nursing and function within the legal boundaries of practical nursing practice.

2. Accept responsibility for individual nursing actions and competence.

4

SENATE HEALTH & WELFARE
EXHIBIT NO. # 4
DATE 3/15/89
BILL NO. HB 389

March 11, 1989

To: Senate Public Health, Welfare and Safety Committee

Re: Testimony offered in opposition to HB 389, An Act Clarifying the Definition of the Practice of Practical Nursing.

By: Laura Lenau, R.N., M.S., Director, Nursing Program, Miles Community College. Program Director, 6 years; AD/RN Nursing Instructor, 4 years.

The Licensed Practical Nurse (LPN), by definition of scope of practice and by educational preparation, focuses practice on the performance of skills, techniques, and procedures which have predictable outcomes that are performed for patients with common healthcare needs, in a supervised setting. The educational preparation for LPNs in the State of Montana is a four quarter technical program. Comparatively, the Associate Degree Prepared Registered Nurse (AD/RN) is prepared to practice in supervised settings caring for patients with common healthcare needs. The AD/RN educational preparation consists of seven quarters.

In order to protect patient safety if the LPN role is expanded to include skills, techniques, and procedures that do not have predictable outcomes, there should be a requirement for curricular change to reflect the theoretical foundation required for the application of the Nursing Process. Differentiated practice requires differentiated educational preparation.

Analysis and synthesis of patient information is necessary to the safe practice of nursing in situations that are unpredictable. Such analysis and synthesis are only possible with in depth theoretical scientific knowledge. LPN curriculum is not designed to provide such a basis for decision-making.

In the interest of patient safety I urge you to vote in opposition to HB 389.

Laura Lenau, R.N., M.S.
Director, Nursing Program

S. [illegible] #5

Montana
Deaconess
Medical Center
1101 Twenty Sixth Street South
Great Falls, Montana 59405-5193
406 761-1200

SENATE HEALTH & WELFARE
EXHIBIT NO. #5
DATE 3/15/89
BILL NO. HB 389

Chairman Hager - Members of the Committee

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 thes LPNs range from medical-surgical units to the operating room. Our LPNs 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 hsopitals; 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.

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.

LPNs with whom I have visited, recognize that 12 months of didactic and clinical preparation prepares 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.

NORTH VALLEY HOSPITAL AND EXTENDED CARE CENTER
6575 HIGHWAY 93
WHITEFISH, MONTANA 59937

#6

SENATE HEALTH & WELFARE
EXHIBIT NO. #6
DATE 3/15/89
BILL NO. HB 389

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

#7

SENATE HEALTH & WELFARE
EXHIBIT NO. #7
DATE 3/15/89
BILL NO. HB 389

Deaconess Medical Center

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

PROGRAM FOR RECOVERING NURSES
127 N. Higgins
Missoula, Montana 59802
(406) 721-4618

Exhibit #8
SENATE HEALTH & WELFARE
EXHIBIT NO. #8
DATE 3/15/89
BILL NO.

Carol R. Sem RN, BSN
Program Director

Carol Judge RN, MSN, CCDC
Chairperson, Legislative Task Force

FACT SHEET
DIVERSION PROGRAM FOR CHEMICALLY DEPENDENT NURSES

Nurses who practice under the influence of drugs and/or alcohol unintentionally jeopardize the lives of their patients. The exact number of nurses who are chemically dependent is unknown but it is estimated that 6-20% of nurses become addicted. In Montana with 12,500 licensed nurses, 750-2500 nurses are/may become dependent on alcohol and/or drugs.

The diversion program will provide the Board of Nursing with an alternative to their traditional disciplinary action which is probation, suspension, or revocation of a license. The program would assist with the identification of nurses who are chemically dependent and would direct the nurse into treatment so that he/she may remain in or return to the practice of nursing in a manner which will not endanger the public health and safety.

THE DIVERSION PROGRAM WILL:

- **increase the identification and treatment of licensed nurses who are chemically dependent.**
- **increase the protection to the public as a result of increased detection and early identification of chemically dependent nurses.**
- **decrease the incidence of suicide among nurses awaiting disciplinary action by the regulatory agency.**
- **provide an economic savings to the State of Montana and Montana employers by:**
  - **keeping nurses employed and not underemployed**
  - **decreased nurse turnover in employing agencies and the need to hire and orient new nurse employees**
  - **direct nurses into treatment earlier thus reducing the cost of prolonged treatment, unemployment or underemployment of nurses, and family problems**
- **provide the nursing profession with increased knowledge of chemical dependency among nurses.**
- **facilitate the recovery of nurses through an extensive monitoring program.**
- **funded thru an adjustment of the license fee commensurate with the cost of the program. Cost to the public=0.**

From 1986-1988 (calendar years) the Montana State Board of Nursing has received 13 complaints involving drug related issues and 12 cases involving licensees who have had a nursing license encumbered in another state for drug related grounds. This is a total of 25 cases/complaints.

Currently the Program for Recovering Nurses is monitoring the recovery of 10 nurses who have asked to be monitored. The nurses who monitor recovering nurses in the PRN program are volunteers who donate the time and money required for monitoring. The PRN program has been in existence for 2 years.

A Legislative Task Force was developed to study and plan a legislative approach to dealing with this tragic problem. The Task Force is comprised of representatives of the PRN, Montana Nurses Association, Montana Licensed Practical Nursing Association, and the Montana State Board of Nursing.

MAXIMUM

HB 378
#8

Proposed Budget for Montana State Board of Nursing Diversion Program

Cost: Nursing license surcharge $5.00

Budget: 12,500 licensed nurses @ $5.00= $62,500

1. SALARY-full time		
(Contracted Director) $26,000/year+ (20% benefits)	$5,200=	$31,200
Total		$31,200
2. TRAVEL		
Mileage $.22/mi@ 20,000 miles (base in Helena)	=	4,400
Meals $20/day @ 5 days/month	=	1,200
Lodging $35/day @ 5 days/month	=	2,100
Plane fare (winter travel) $350/trip @ 5 trips	=	1,750
Advisory Board Expenses (3 members/4 annual meetings)		
Travel 400mi @ .22/mile/member/meeting	=	1,056
Food $20/day (2 days)	=	480
Lodging $35/day (2 days)	=	840
Miscellaneous Expenses (emergency lodging etc)	=	664
Total		$12,490
3. OPERATING COSTS		
Paper/files/stationary/envelopes/pens/business cards/announcements/posters	=	$1,150
Copying	=	420
Postage/Stamps	=	300
Telephone Service ($200/month)	=	2,400
Rent (Office)	=	2,400
Rent (Computer/printer/typewriter) ($50/month)	=	600
Telephone/Answering machine	=	200
Quarterly meeting expenses (refreshments)	=	120
Professional Journal Subscriptions 8 @ $30/yr	=	240
Professional Membership NNSA	=	50
Continuing Education : National Conference	=	825
Regional Conference	=	725
Total		$9,430
4. CONSULTANT FEE'S		
Attorney fee $125/hr @ 4hrs/month	=	$6,000
Bookkeeping $15.00 @ 4 hrs/month	=	720
Start-Up Impaired Nurse Consultant Program Development (Nancy Miller-Cross)	=	2,000
Total		$8,720

5. CAPITAL OUTLAY

Office Furniture	=	$520
Equipment Repair	=	140
	Total	$660

SUMMARY OF OVERALL COSTS

Salary	**$31,200**
Travel	**12,490**
Operating Costs	**9,430**
Consultant Fee's	**8,720**
Capital Outlay	**660**
TOTAL	**$62,500**

HB378
#8

To: House Human Services Committee

From: Carol Judge, R.N., M.N.

Chairman, Montana Legislative Task Force on the Impaired Nurse

Regarding: HB 378

Date: February 1, 1989

The Program for Recovering Nurses is vitally interested in all aspects of the Impaired Nurse problem: from education to interventions with nurses, assisting with treatment referrals and offering support and monitoring after treatment. Last spring the Program for Recovering Nurses saw the need for a committee to study and write legislation to assist nurses impaired by their use of alcohol and/or drugs. This task force came into existance during the summer of 1988 and is comprised of representatives from PRN, the Montana Nurses' Association, the Montana Licensed Practical Nursing Association, and the Montana State Board of Nursing.

Throughout the fall, the Legislative Task Force on the Impaired Nurse carefully studied legislation from the American Nurses' Association, the National Nurses' Society on Addictions and legislation introduced by the Montana M.D.s and passed by the 1987 Legislature. Furthermore, the Task Force reviewed legislation from other state nurses' associations. This information was available as a result of a survey I conducted in 1988 of all of the state nurses' associations (49) to ascertain how many of them had established a program for impiared nurses. Twenty four of the nurses' associations responded, a 49% return. Two thirds reported either currently having a Diversion Program through their Board of Nursing or actively working toward such legislation.

After a good deal of deliberation the Task Force chose to pattern the nurses' legislation after the M.D.s legislation. In 1987, this was HB 555. The Board of Nursing has been informed of the intent of this task force and

HB 378
#8

members of the task force have presented information to the Board and have addressed their questions and concerns.

Realizing that chemical dependency is a preventable and treatable disease and with a serious committment to protecting the public as well as assisting nurses in need of help, we urge your support of HB 378.

Thank you for your kind consideration.

HB 378
#8

TO: MONTANA STATE LEGISLATORS

RE: HB378

FROM: M L PROTHEROE,BSN,RN

In the past four years is has been my unhappy task to take administrative action against more than one Registered Nurse in this state who was actively Chemically Dependent and under my employ in a hospital. As a result of current law and Board of Nursing Regulations it was not possible for me to ensure the following;

1. Force the employee to obtain adequate treatment,
2. Ensure that she/he could not continue to use the Montana State license to obtain work elsewhere
3. Provide for her/his safe return to the workplace so as not to forfeit the skills we need so much.

HB378 provides the remedy for these problems and will make the level of care provided to the citizens of this state that much safer and more humane. It will provide us with a way to regain those professional skills stolen by this wide-spread disease process of Chemical Dependency. Surely if its important enough to ensure that the members of the legal profession have this type of protection and enforced control until they are able to handle their professional role then its doubly important we ensure that the nurses who provide bedside care and administer medications do so drug-free. Currently, we are "throwing out the baby with the bathwater" and that should no longer be acceptable nor possible.

HB 378
#8

THOMAS H. SCHIMKE, M.D., J.D.

MISSOULA MEDICAL PLAZA
900 N. ORANGE, SUITE 101
MISSOULA, MONTANA 59802
(406) 728-1970

UNIVERSITY OF PENNSYLVANIA
MEDICAL SCHOOL

UNIVERSITY OF MONTANA
SCHOOL OF LAW

BOARD CERTIFIED - INTERNAL MEDICINE
BOARD CERTIFIED - PULMONARY DISEASE
BOARD CERTIFIED - ADDICTIONOLOGY

February 2nd, 1989

The House Health & Human Services Committee
% Carol Sem
127 N. Higgins
Missoula, MT. 59802

RE: House Bill #378

Dear Committee Members:

I am writing to support House Bill #378 requiring the Montana State Board of Nursing to establish a drug rehabilitation program for impaired nurses.

As the chairman of an impaired physician committee in Missoula, I am aware of the benefits which physicians have derived from a similar program of the Montana State Board of Medical Examiners. By granting the power to the State Board of Nursing to develop and operate a drug program for nurses, the State of Montana will gain by rehabilitating and retaining a very valuable and scarce source of health care providers. The nurses should be afforded no less than physicians in overcoming this very common and devastating problem within the professions.

Voluntary programs are effective but have their limits. Statutory power for the nursing board will greatly enhance their effectiveness in this area.

Passage of this bill will cost the State of Montana nothing. Passage of this bill will ensure healthy nurses and improved quality of health care for the citizens of Montana.

Sincerely,

Thomas H Schimke

Thomas H. Schimke, M.D., J.D.

THS/rs

#6378
#8

Toole County Hospital
and Nursing Home
640 Park Drive
P.O. Box P
Shelby, Montana 59474
Phone: 434-5536

Montana House Committee:
Health and Human Services
Helena, Montana

February 3, 1989

Dear Sirs:

This is a letter of support for House Bill 378 to develop a diversion program for chemically impaired nurses.

I am the Director of Nurses at Toole County Hospital and Nursing Home in Shelby, Montana. We have spent the last two months trying to find a solution for the continued employment of a nurse who has completed a chemically dependent treatment program.

The Program for Recovering Nurses directed by Carol Sem, R.N. of Missoula is the best solution for all concerned parties. It must be mandatory to maintain supervision of the employee. This would also alleviate many problems experienced by the hospitals with the nursing shortage.

I will be available for questions or to supply information of our involvement with the program.

Sincerely,

Edith J. Clark RN.

Edith J. Clark R.N. DON

EJC/sj

HB 378
#8

Montana Nurses' Association

2001 ELEVENTH AVENUE (406) 442-6710

P.O. BOX 5718 • HELENA, MONTANA 59604

September 29, 1988

Board of Nursing
Phyllis McDonald, Exec. Sec.

Dear Phyllis,

On behalf of the Montana Nurses' Association Board of Directors, I would like you to share with your Board of Nursing a concern of ours. We would like you to consider the plight of the recovering nurses as they battle their way back from addictions and alcohol abuse.

The numbers of registered nurses recovering from drugs and/or alcohol is growing. We would like to assist these nurses in any way we can. As you know, their total recovery time may extend to weeks, months, and possibly even years.

We would like you to consider legislation or rule changes to allow them to be employed on a limited basis during their recovery period. With the nursing shortage, it is unfortunate that we lose these nurses for possibly long periods of time. Their recovery period is also a long, expensive burden for them to bear with no employment.

Thank you for your consideration in this matter.

Sincerely,

Peggy Mussehl

Peggy Mussehl, President
Montana Nurses' Association

copy: MNA Board Of Directors

HB 378
#8

FRANCES MAHON DEACONESS HOSPITAL
CHEMICAL
DEPENDENCY CENTER

621 3rd St. South
Glasgow, MT 59230
1-800-422-LOVE

February 3, 1988

Department of
House, Health and Human Services

Re: Legislative Bill @ Nurses: HB #378

To Whom it May Concern:

We are writing to lend our support and encourage the passage of House Bill #378 to help chemically dependent nurses. We feel it is vitally important that chemically dependent nurses receive treatment, and that they have every right to have this illness arrested - just as we would treat the cancer or diabetic person.

We are in favor of the chemically dependent nurses not losing their jobs or licenses as this is seen as a punishment rather than a way to deal with someone who has a disease. We also feel the loss of nurses' income would be a burden to his/her already devastating problem of chemical dependency.

In our experience with post-treatment, nurses returning to work under structured supervision have a higher percentage of success, and employers report better performance. Monitoring the nurse during follow up treatment is effective and can promote public safety.

Since Montana now has a support program for recovering nurses and an extended follow up care for these individuals, we feel it would be deterimental for them to lose their vocations.

If we can be of any further help in this endeavor, please feel free to contact us at 1-800-422-LOVE, and ask for any of us any time.

Cordially yours,

Kyle Hopstad, Hospital Administrator

Ivan Kuderling, Executive Director

Kit Voakes, Clinical Director

Pat Nessland, Director of Nurses

/wc

HB 378
#9

LEONARD W. JOHNSON, M.D., P.C.
CARDIOLOGY
601 West Spruce
Missoula, Montana 59802
(406) 721-1617

February 3, 1989

House, Health & Human Services Committee
Helena, MT 59601

RE: House Bill 378

I want to state that I unequivocally support the diversion program proposed by this bill. I feel that nurses as well as physicians can frequently, in fact, usually be rehabilitated and clearly deserve the chance to stay in their profession in much the same way that clinically dependent physicians are handled in Montana.

If you have any questions regarding the above, please feel free to call me.

Very sincerely,

L. W. Johnson, M. D.

LWJ:cl

HB 378
#8

Counseling and Consulting Services
Kay Flinn, CDC
555 Fuller, Suite 2
P.O. Box 552
Helena, MT 59624

Telephone: 449-7401

2/1/89

Health and Human Services Committee

re HB 378

I have worked in direct service as well as administration in the chemical dependency field for fifteen years.

I am in total support of a program to assist the chemically dependent persons in this state.

Respectfully,
Kay Flinn, BA, CDC

HB 378
#8

845 1/2 Edith
Missoula, Montana 59802
February 7, 1989

To: House Health and Human Services Committee
Re: HB 378

My story is one of sadness, silence, isolation, shame, joy and victory.
6 1/2 years ago, I went to treatment for drug and alcohol addiction. I was luckily referred by a friend of mine. After treatment my license was revoked and faced bankruptcy. I was overqualified/underqualified for other jobs and knew nothing but nursing from age 15 to 26. 1 1/2 years of poverty and inability to pay my bills was to be my future with a 4 year bachelors degree to my name which was useless.

When the hospital confronted me with my diverting drugs from the hospital, I was severely addicted to toxic doses of intravenous narcotics.
I was told to resign or I would be fired. There was no mention of treatment or hospitalization. It was like I was an unwanted wart that was to be immediately excised. Where would I go? I remember an overwhelming fear come over me. I was suicidal after all I just knew then the world was better off without me. I felt so shameful, and humilated. I honestly did not know why I took the drugs and noone explained the disease to me. Instead I went home, drank rum to block out the intense pain and suicidal thinking, and proceeded to passed out. When I woke I was experiencing the worst nightmare of my life...withdrawl. If you haven't been through it it is difficult to explain the physical nausea, profuse sweating, skin crawling, hallucinations, and the extreme emotional torment. I experienced this alone, I did not know then that people die in withdrawl. I was alone, noone to reach out to.

6 1/2 years later I have never forgotten those 3 days of hell. The joy and victory for me now is that I am alive thanks to a very dear friend who helped me identify my problem as the hospital couldn't. That seems odd doesn't it. With my experience I have now a deep passion for reaching out to other nurses with these problems and break the secrecy and isolation our own profession can create. Thank God this is changing. The pain and guilt is enough pain to deal with. Professional shame is optional.

I did get my RN license reinstated and am proud to say I have been working sucessfully as a nurse for the last 5 years. The Program for Recovering Nurses has been the greatest treatment for my shame and has continued to fuel my passionate drive to continue to make the world a kinder place to be for nurses with addiction.

I ask of you distinguished members of the committee, help us to break into the isolated, painful world of nurses with drug/alcohol addictions by passing HB 378. Silence, isolation can kill. By requiring the Montana State Board of Nursing to develop this program, nurses don't have to die because they are so ashamed they can't ask for help...they can live and heal themselves as I have done.

Sincerely,

Carol

Carol R. Sem RN, BSN

HB 378
#8

Mary Jean Marron
910 Kensington
Missoula, MT

January 25, 198

MT. Legislative Session
Human Services Committee
Helena, MT

Dear Hearings Committee,

As a member of the Program for Recovering Nurses from its incession two years ago. I wish to ask for your support in this legislation of HB 378.

I am a recovering chemically dependent R.N. who did not have the benefit of a program like this. Had the education, awarenesses, and diversion program been available four years ago I feel I could have been in treatment earlier, my professional performance would have been much improved and my patients would have had much safer care.

I have seen this program help many nurses treat their addiction, the ensuring medical competence.

Please support us in our efforts.

Sincerely,

#9

BOARD OF NURSING
DEPARTMENT OF COMMERCE

SENATE HEALTH & WELFARE
EXHIBIT NO. #9
DATE 3/15/89
BILL NO. HB378

1424 9TH AVENUE
STATE OF MONTANA
(406) 444-4279
HELENA, MONTANA 59620-0407

To: Senator Tom Hager, Chairman
and Members of the Public Health, Welfare and Safety Committee

Date: March 15, 1989

Subject: Testimony on HB378

My name is Janice Anderson. I am a public member of the Montana State Board of Nursing and am here to testify on behalf of that body in support of HB378.

The Board of Nursing has adopted the following position statement on chemical dependency and the licensed nurse. (Attached statement read aloud.)

The Board believes that the proposed program can increase public protection by 1) drawing impaired nurses into treatment under Board control sooner 2) providing a more reliable means of monitoring the impaired nurse and 3) insuring that a greater number of those nurses are rehabilitated.

BOARD OF NURSING
DEPARTMENT OF COMMERCE

1424 9TH AVENUE

STATE OF MONTANA

(406) 444-4279

HELENA, MONTANA 59620-0407

POSITION STATEMENT

CHEMICAL DEPENDENCY AND THE LICENSED NURSE

The Montana State Board of Nursing recognizes an increasing awareness of the needs of licensed nurses whose functioning is impaired by chemical dependency. Insofar as:

- Alcoholism and drug addiction are primary illnesses and should be treated as such;
- Problems resulting from these illnesses can include personal, legal and health problems that may impair the nurse's personal health and ability to practice safely;
- Nurses who develop these illnesses can be helped to recover with appropriate treatment;
- Programs that include treatment and monitoring, as an alternative to a disciplinary process, have been helpful in rehabilitating the licensed nurse and in protecting the public;
- Nurses who are willing to cooperate with a program of assistance for them and accept treatment for these illnesses should be allowed to avoid disciplinary action provided they cooperate fully with recommended treatment and comply with the requirements for monitoring of their continued recovery after formal treatment is completed.

Therefore, the Montana State Board of Nursing supports the enactment of language to the statutes regarding Nursing Practice in Montana, calling for a diversion program for nurses who have been, or are likely to be, charged with a violation of the Nurse Practice Act but who are willing to stipulate to certain facts and enter into a diversion program approved by the Board.

To enable the implementation of a diversion program, the Board supports the increase of license renewal fees to cover all associated costs.

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

Ken Dunham, Management Consultant

406/443-0640

SENATE HEALTH & WELFARE EXHIBIT NO. #10
DATE 3/15/89
BILL NO. HB 378

STATEMENT OF
KEN DUNHAM
Lobbyist for Montana LPN Association

HB 378 March 15, 1989

The issue of nurses abusing alcohol and drugs is a problem that should be of concern in Montana. In conversations with LPN's in recent weeks, a number of them indicated they were aware of other nurses - both RN's and LPN's - who were alcohol and drug abusers.

Long hours, the pressures of nursing, and the life and death aspects of nursing all add to the chances that a nurse will succumb to alcohol or drugs to escape.

This bill will help some, in providing some official and established program to deal with and monitor the problem.

It will also be an additional protection to the public by being able to identify and help those nurses who, under drugs or alcohol, could be a threat to patients as well as themselves.

The Montana LPN Association supports this measure.

-0-

SENATE HEALTH & WELFARE
EXHIBIT NO. #11
DATE 3/15/89
BILL NO. HB-395

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, other diagnosis which might give similar symptoms and the treatment needed. The practice guidelines are the agency limitations on the nurse specialist practice. The guidelines define what medications can be used by the nurse specialist. Any other medications must be gotten either through referral or collaboration with a physician. The only change, which would occur because of this legislation, is that the nurse specialist would actually sign the prescription and the Board of Nursing and the Board of Medical Examiners could design methods of regulating this practice.

The second limitation on the type of medications which a nurse specialist could prescribe is contained in the rules which currently define the scope of practice for the nurse specialist. Nurse practitioners practice as nurse practitioners in primary health care settings. A primary health care setting is a clinic, physician's office, senior citizen's center, school, health department, outpatient department or medical assistance facility where people begin their contact with the health care system. The role of the nurse specialist in these settings is on prevention and health maintainace. Acutely ill people are referred to physicians for evaluation and 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 available.

This legislation would allow the Board of Nursing and the Board of Medical Examiners to define continuing education requirements and regulate the prescribing practices of nurse specialists. The Board of Nursing could also handle complaints about nurse specialist prescribing practices. This legislation would make sure the public could be protected from unsafe practice.

For these reasons, we urge you to give this legislation a "do pass" recommendation.

#11

SENATE HEALTH & WELFARE
EXHIBIT NO. 4 11a
DATE 3/15/89
BILL NO. HB 321

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 practice 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.

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

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 & dispensi 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 mor of M.D. supervised experience in furnisl drugs/devices & who have completed a course in pharmacology & who have a Boai 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 delegat 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 prescript 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.

State	Year granted	Form for Prescriptive Authority
Kansas		N.P.'s may prescribe under jointly adopted protocols between the N.P. & M.D. The Board of Nursing will adop rules & regs. for permanent regulatio allowing N.P.'s to prescribe followi jointly agreed upon protocols with t "responsible physician", excluding controlled substances.
Kentucky		Will be introduced in 1989 Legislatu
Maine	1977	Prescriptive authority is approved b Board of Medicine (N.P.'s have their D.E.A. #'s). Limits in prescribing formulary by exclusion (i.e. narcotic
Maryland	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.
Massachusetts		N.P.'s, after registering with the Department of Health, may prescribe fo patients in long-term care facilities as well as for chronic-disease patient in their homes, if this would avoid the being institutionalized.
Michigan	1980	A January, 1980 attorney general decisi interpreted the statutes to allow M.D. to delegate the prescribing of drugs t 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 prescripti authority.
Mississippi	1980	N.P.'s have statutory prescriptive authority granted by the Board of Nursi the prescriptive authority is based on accepted "protocol" which lists the treatments & medications the N.P. expect to prescribe in his/her practice. No controlled substances.
Montana		Will be introduced in 1989 Legislature
Nebraska		N.P.'s may prescribe as specified on the "practice agreement" form. Drugs

State	Year granted	Form for Prescriptive Authority
		prescribed must be listed on N.P.'s protocols & may not be Schedule II drugs The N.P. must use an R_x pad containing the M.D.'s name preprinted at the top; the signature contains N.P. name/M.D. name.
evada	1983	N.P.'s may prescribe if they submit to the Board of Nursing documentation of 1,000 hours as a N.P. under a supervisir M.D. & a signed statement from the M.D. The N.P. can then prescribe any meds (excluding controlled substances) listec in his/her protocols(developed by the supervising M.D. at the site & updated yearly.)
ew Hampshire	1983	N.P.'s who function in connection with protocols established jointly with a collaborative physician, may prescribe medications from the official formulary agreed upon by the Board of Nursing & Board of Medicine. N.P.'s are assigned D.E.A. #'s.
New Jersey		Legislation was pending in 10/88.
New Mexico	1978	N.P.'s have prescriptive privileges witl their own signature in accordance to written protocols with M.D. supervision. N.P.'s are listed at the Board of Nursin Board of Pharmacy & Board of Medicine.
New York	1988	N.P.'s have prescriptive authority in a collaborative relationship with a M.D. 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 give 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. w[illegible] the Board of Medicine.
Rhode Island	1988	No rules and regulations as yet.
South Dakota	1979	N.P.'s may prescribe because prescrib[illegible] is considered a delegated function. N.P.'s must submit their "practice agreement" (including the list of medications the N.P. will prescribe, [illegible] the N.P.'s scope of practice) to th[illegible] joint board; the agreement is on fi[illegible] 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 & [illegible] prescriptions &/or issue non-controlle[illegible] legend drugs.
Utah	1983	N.P.'s in practice with an M.D. can ap[illegible] for prescribing privileges. The M.D. only need be in contact by phone. Protocols are developed by the M.D. & [illegible] & are submitted for approval to the prescriptive board consisting of 3 N[illegible]s 3 M.D.'s & a pharmacist..
Washington	1980	Legislation for prescriptive authori[illegible] is authorized under the Board of Nurs[illegible]n & entails additional certification beyo[illegible] the N.P.

States experiences with prescriptive authority

Strengths:
1. Increased access to health care for the consumer(high quality, cost e[illegible]
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.

#12

SENATE HEALTH & WELFARE
EXHIBIT NO. #12
DATE 3/17/89
BILL NO. HB 395

BOARD OF NURSING
DEPARTMENT OF COMMERCE

STATE OF MONTANA

(406) 444-4279

1424 9TH AVENUE
HELENA, MONTANA 59620-0407

To: Senator Tom Hager, Chairman
and Members of the Public Health, Welfare And Safety Committee

Date: March 15, 1989

Subject: Testimony on HB395

I am Donna Schramm, RN, President of the Montana Board of Nursing and I am here on behalf of the Board.

The Board of Nursing supports HB395 under which the Board, acting jointly with the Board of Medical Examiners, would establish rules regarding authorization for prescriptive authority of nurse specialists.

HB395 would more clearly define lines of authority and accountability in the management of patient care by the nurse specialists. There is no clear authority to protect patient safety with the current system of the nurse specialist making decisions about patient drug use within established protocols.

The requirement for nurse specialists to prescribe only through a physician makes it very difficult to provide services to rural and isolated communities in Montana. Allowing nurse specialists to prescribe can aid in finding solutions for rural Montana health care.

In collaborating with the Board of Medical Examiners in establishing rules, the Board would consider the appropriateness of the nurse specialist's authority to prescribe specific drugs based on the nurse's area of specialty and education. HB395 would be implemented in accordance with what constitutes safe practice and protection of the public health and welfare.

Montana Nurses' Association

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

SENATE HEALTH & HUMAN SERVICES
EXHIBIT NO. 4
DATE 3/15/93
BILL NO. HB 395

11 / 9

Senator [redacted]ive Hager and Members of the Committee

My name is Sharon Dieziger and I represent the Montana Nurses' Association.

We speak in **support** of **HB 395.**

We commend the work of the Nurse Practitioner group for the months of work in preparing for this piece of legislation. They sought concensus within their own group, and worked with the Montana Nurses' Association, the Board of Nursing and the Montana Medical Association to develop acceptable language.

As you know, we worked with this committee to make the Physician's Assistant Bill acceptable. Physician's Assistants and Nurse Practitioners are named in the Medical Facilities Act legislation that was passed last session. **HB 395** compliments the efforts of that legislation.

SENATE HEALTH & WELFARE
EXHIBIT NO. #14
DATE 3/15/89
BILL NO. HB 395

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, JUNE 9, 1987

Paul Wheeler FNP-C
808 Milwaukee
Deer Lodge, MT 59722
406-846-2861

March, 1989
Senate Public Health Committee
Opponent to HB395

Mr. Chairman and members of the committee,

I am Paul Wheeler. As a nurse specialist licensed in the state of Montana, I am speaking in opposition to HB395 which grants prescribing privileges to nurse specialists. I am not opposed to the concept of nurse specialist prescribing, only to the bill in its present form.

Specifically, I am concerned that there is no provision in this bill for physician supervision. It is my personal and professional opinion that any non-physician medical care provider who assumes some of the functions and responsibilities of a physician, and particularly the function of prescribing medications, should be allowed to do so only under the supervision and review of a physician. Nothing in this bill places such a requirement on nurse specialists.

I encourage this committee to amend HB395 to statutorily require physician supervision of nurse specialist prescribing. Only if that is done, will this bill represent a very positive step toward expanding the delivery of health care services by mid-level providers, and at the same time protect the health care consumer from potential harm incurred by unsupervised non-physician prescribers. In the interest of all Montana health care consumers, please amend HB395

to require physician supervision and then give it a do pass.

Thank you.

MAPA

Montana Academy of Physician Assistants
P.O. Box 307, Deer Lodge, MT 59722

A Constituent Chapter of the American Academy of Physician Assistants

March, 1989

SENATE HEALTH & WELFARE
EXHIBIT NO. #15a
DATE 3/15/89
BILL NO. HB395

Senate Public Health Committee
Opponent to HB395

Chairman Hager and members of the committee,

I am Jim Reid, and I am speaking on behalf of the Montana Academy of Physician Assistants in qualified opposition to HB395. MAPA has actively supported the concept of mid-level provider prescribing. We have always done so however with two basic concepts in mind. First, that prescribing authority should be regulated by the board of medical examiners, which this bill provides for, as amended in the House. Second, that mid-level provider prescribing should be supervised by a physician. Nothing in this bill requires that nurse specialists be supervised by a physician or submit to any physician review of their prescribing practices. I hope that the rationale for requiring physician supervision is obvious to you.

Having reviewed the statutes and rules pertaining to nurse specialist practice, we are unable to find any current language requiring physician supervision of nurse specialists. When nurse specialists function within the scope of nursing, such supervision is of course, not necessary. But, when nurse specialists take on the responsibility of prescribing medications, a function generally reserved for physicians, we feel it absolutely necessary that physician supervision be statutorily required. Why this was not included in the original bill, we do not know? We hope however that this committee will not recommend passage of a bill that

grants very general prescribing authority to non-physicians.

It is worth pointing out that the current language of HB395 is very broad and applies absolutely no limitations on the prescribing authority of nurse specialists. Specifically, nothing in this bill prohibits nurse specialists from prescribing schedule II narcotics for indefinite periods. Nothing in this bill requires nurse specialists to register with the federal drug enforcement administration. The committee may wish to consider why nurse specialists are seeking such broad and unlimited prescribing authority.

MAPA would like to offer you an amendment for your consideration. This amendment addresses the physician supervision issue by incorporating into Section 3, paragraph 5(b), the requirement that nurse specialist prescribing be supervised by a licensed physician and that the joint boards adopt rules to implement this requirement.

Please do not allow this bill to pass without statutorily requiring physician supervision of these non-physician providers. If HB395 is amended to require physician supervision, the interests and well-being of Montana's health care consumers will have been protected. Only then can MAPA support HB395.

Thank You.

House Bill No. 395
Proposed Amendment

Drafted by Montana Academy of Physician Assistants
Submitted to Senate Public Health Committee

Page: 6

Line: 19

Following: "specialists."

Insert: "Nurse specialist prescribing must be supervised by a licensed physician and the rules adopted will provide for such supervision."

TESTIMONY
IN SUPPORT OF HOUSE BILL 688
SENATE PUBLIC HEALTH, WELFARE AND SAFETY
DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
MARCH 15, 1989

1. Delivery of Family Planning Services (Title X)

The Department of Health and Environmental Sciences (DHES) is the recipient of federal Title X family planning funds from the Department of Health and Human Services (DHHS). DHES, through a statewide network of local health departments and other public and private non-profit clinics, has provided family planning services since 1972. Services were provided by 15 local programs to over 24,000 women in Montana in SFY 1988. This lengthy experience with the Title X program affords DHES an important perspective concerning the reproductive health needs of poor women, the availability of services to meet their needs, and the responsibility to ensure access to equitable low cost, quality health care.

2. DHHS Audit Recommendations

A federal audit team from the DHHS recommended that DHES serve as a catalyst to secure a legal basis for Title X clinics in Montana to dispense pre-packaged contraceptives.

3. Problem Statement

Title X clinics in Montana hold a Class IV facility pharmacy license (attached). Under this license, any legend (prescription) drugs dispensed must be packaged, labeled and otherwise prepared by a registered pharmacist. This standard prohibits factory prepackaged prescriptive oral contraceptives which are medically prescribed by a licensed physician, from being dispensed by anyone other than the pharmacist. Approximately 17,500 women use oral contraceptives. They are at high risk for unplanned pregnancy, and are placed at greater risk because of this restriction.

If a pharmacist is not on site during all client hours, clients have to return to a clinic at a later date to begin oral contraceptives, which are available at much lower or no cost through Title X programs to low-income women.

Women from all 56 counties in the state receive services at Title X clinics. In rural areas especially, clients may have difficulty getting to a family planning clinic. Once the client is at the clinic, she expects to obtain contraception or receive a continuation of her prescriptive method. However, the client must wait to have a prescription filled, often having to return a week later. This presents a barrier to services for low income clients who may come in from as far as 70-90 miles for subsidized services. Clinically, a woman could start oral contraceptives the day of service,. but under existing pharmacy standards, may have to wait until the following week to get her prescription. This may be too late for her to begin oral contraceptives. In the meantime, she is instructed to use a non-prescription method until the prescription is filled.

The primary purpose of Title X is the provision of services and information to lower the incidence of unintended pregnancy, to improve maternal health and to reduce abortion.

The existing pharmacy standard creates a barrier to services and defeats the purpose of family planning clinics: accessible, cost-effective quality care for people needing services.

4. Dispensing practices in other western states

Nine western states have recognized and addressed the problem of providing prepackaged oral contraceptives within their existing pharmacy law. The following states have allowed nurses to dispense prepackaged prescription oral contraceptives in Title X family planning clinics with varying guidelines: Arizona, California, Colorado, Idaho, New Mexico, Texas, Nevada, Wyoming and North Dakota.

5. The Pharmacy Bill

The pharmacy bill will allow Registered Nurses (RN) employed by Title X family planning clinics to dispense prepackaged prescription oral contraceptives.

6. Standardized Dispensing Protocol and Pharmacy Requirements Under the Bill

A physician's written protocol for the dispensing of prepackaged prescriptive oral contraceptives by an RN will be developed specifying the circumstances under which dispensing is appropriate. Drug labeling, storage and recordkeeping will be followed in accordance with board of pharmacy's requirements.

SUMMARY

The following problems have been identified by both DHHS and DHES regarding the dispensing of prepackaged prescription oral contraceptives under the existing pharmacy license that adversely affect the delivery of Title X family planning services:

1) Limited client access to prepackaged prescription oral contraceptives.

2) Increased likelihood of unintended pregnancy, abortions, and maternal health problems to women who choose prepackaged prescriptive oral contraceptives as the method of choice.

3) With decreasing funds and an increasing patient load, it becomes cost prohibitive to hire pharmacists to be available to cover all client service hours to package, label, and dispense factory prepackaged prescriptive oral contraceptives, and comply with current pharmacy standards.

SN/vg-104e

#16

October, 1988

SENATE HEALTH & WELFARE
EXHIBIT NO. #16a
DATE 3/15/88
NO. HB 688

MONTANA STATEWIDE FAMILY PLANNING PROJECT

In Montana, 24,711 clients were served by programs in SFY 1988. This is a 524% increase in caseload since the program's statewide inception in 1972.

Each program functions under the medical supervision of a licensed physician.

Family Planning meets the needs of those who otherwise cannot afford services and could eventually become dependent on government agencies.

-- The cost to the government for a mother on welfare and an unplanned child averages $3,432 per year plus food stamps and Medicaid.

-- The average cost per family planning medical encounter is $24.

-- The short-term benefits (savings) to federal, state, and local governments are estimated to be $2 for each dollar invested in family planning.

-- The long-term benefits are estimated to be $26 for each dollar invested.

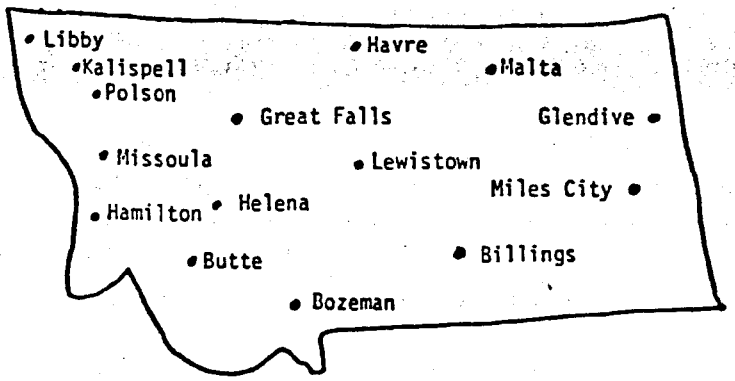
Family Planning is a preventive health effort with potential to reduce significantly certain social, psychological and medical problems of women and children. It is characterized by two important aspects:

-- Improvement of the health of women and children.

-- The acceptance of family planning services must always be the voluntary decision of the individual.

The goal of Montana family planning services is to maintain or improve the reproductive health of Montana people in their reproductive years.

In Montana there are presently 15 family planning clinics. Currently the funding is provided by: Federal Title X, Preventive Health (PH) Block Grant, and Maternal and Child Health (MCH) Block Grant funds through the Health Services and Medical Facilities Division of the Montana State Department of Health and Environmental Sciences; third party reimbursement; local funds; and direct fees paid by the clients based on their ability to pay. In addition, some counties have elected to utilize MCH Block Grant funds for Family Planning. Total funds expended in SFY 1988 were $2,078,784.



The preventive health based programs provide:

- counseling in all aspects of family life
- educational services
- physical examinations
- cervical cancer screening
- self-breast exams
- blood tests for anemia, rubella & syphilis
- immunization for rubella
- blood pressure recordings
- urinalysis for sugar and protein
- inter-agency referral for other problems
- dispensation of contraceptives
- screening and treatment for gonorrhea
- pregnancy tests

Family planning services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women, and children, particularly through the detection and prevention of cancer and venereal disease with women.

- Prevent birth defects and mental retardation. Mental retardation tends to be associated with prematurity and low birth weight. The Comptroller General's report to Congress on Mental Retardation, 1977, identified the family planning program as an existing program with the ability to make a significant contribution towards reducing the incidence of mental retardation.

- Reduce the incidence of abortion by preventing unplanned pregnancies.

- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects.

- Decrease maternal and infant mortality and morbidity.

- Assist couples who want to have children but cannot.

- Prevent unplanned pregnancies (particularly in child abuse and poverty situations).

- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.

- Assist couples in having the number of children they desire so that every child is intended and loved.

The Need:

- There are an estimated 44,047 women-in-need of subsidized family planning services in Montana.

- About 46% of these women (20,071) are being served by the 15 programs. Roughly estimated, an additional 9,317 women-in-need (or 21%) are being provided family planning services by physicians.

- This leaves some 14,659 Montana women needing family planning services who are not receiving them. They are at risk for unplanned children.

Accomplishments:

-- 81% of the 24,711 clients served in SFY 1988 lived in families with incomes at or below 150% of the poverty level.

-- Medical and/or education services were provided by programs to women in all 56 counties in SFY 1988.

In SFY 1988 the 15 programs detected and referred for treatment:

-- 892 positive pap smears for cervical cancer
-- 397 cases of anemia
-- 483 abnormal urine chemistry results
-- 53 cases of gonorrhea
-- 7,386 cases of vaginal infections/STD's
-- 1,006 cases of chlamydia
-- 1,146 cases of breast diseases or other physical findings (heart, thyroid, etc.)
-- 557 cases of high blood pressure

MONTANA STATEWIDE FAMILY PLANNING PROJECT

SFY 1988 FUNDS EXPENDED: $2,078,784

Family Planning Programs	SFY 1988 Patient Load
Cascade	2,305
Custer	650
Dawson	665
Fergus	460
Flathead	1,220
Gallatin	3,446
Hill	712
Lake	288
Lewis & Clark	1,913
Lincoln	890
Missoula	2,976
Phillips	170
Ravalli	217
Silver Bow	1,479
Yellowstone	7,320
Total	24,711

County (All 56 Counties Served)	SFY 1988 Patient Load
Beaverhead	205
Big Horn	67
Blaine	87
Broadwater	24
Carbon	169
Carter	14
Cascade	2,226
Chouteau	36
Custer	550
Daniels	6
Dawson	408
Deer Lodge	78
Fallon	39
Fergus	410
Flathead	1,214
Gallatin	3,109
Garfield	25

Glacier	11
Golden Valley	17
Granite	37
Hill	607
Jefferson	74
Judith Basin	31
Lake	318
Lewis and Clark	1,828
Liberty	15
Lincoln	889
Madison	31
McCone	18
Meagher	14
Mineral	36
Missoula	2,720
Musselshell	65
Park	78
Petroleum	18
Phillips	182
Pondera	8
Powder River	41
Powell	39
Prairie	14
Ravalli	305
Richland	226
Roosevelt	26
Rosebud	83
Sanders	33
Sheridan	4
Silver Bow	1,348
Stillwater	92
Sweetgrass	19
Teton	26
Toole	9
Treasure	8
Valley	14
Wheatland	51
Wibaux	20
Yellowstone	6,180
Out-of-state	396
Unknown	113
TOTAL	24,711

FAMILY PLANNING PROGRAM

UNPLANNED PREGNANCIES PREVENTED

In 1987 the 15 family planning programs in Montana prevented an estimated 7,532 unplanned pregnancies. These pregnancies would have resulted in 5,182 births, 970 abortions, and 1,380 miscarriages. This would have included approximately 155 cases of congenital abnormalities, 155 cases of hypoxic brain damage, 26 cases of chromosomal abnormalities and 347 high-risk premature deliveries.

PROGRAM	Prenancies Prevented	Births Prevented	Abortions Prevented	Miscarriages Prevented
Billings	2,142	1,474	276	392
Bozeman	1,149	791	148	210
Butte	419	288	54	77
Glendive	208	143	27	38
Great Falls	721	496	93	132
Hamilton	72	50	9	13
Havre	250	172	32	46
Helena	577	397	74	106
Kalispell	323	222	42	59
Lewistown	125	86	16	23
Libby	304	209	39	56
Malta	53	36	7	10
Miles City	199	137	26	36
Missoula	910	626	117	167
Polson	80	55	10	15
STATEWIDE	7,532	5,182	970	1,380

SOURCE: Trussell Method Effectiveness Estimates, "Cost Versus Effectiveness of Different Birth Control Methods", T. James Trussell

Montana Family Planning Facts

Figure 1

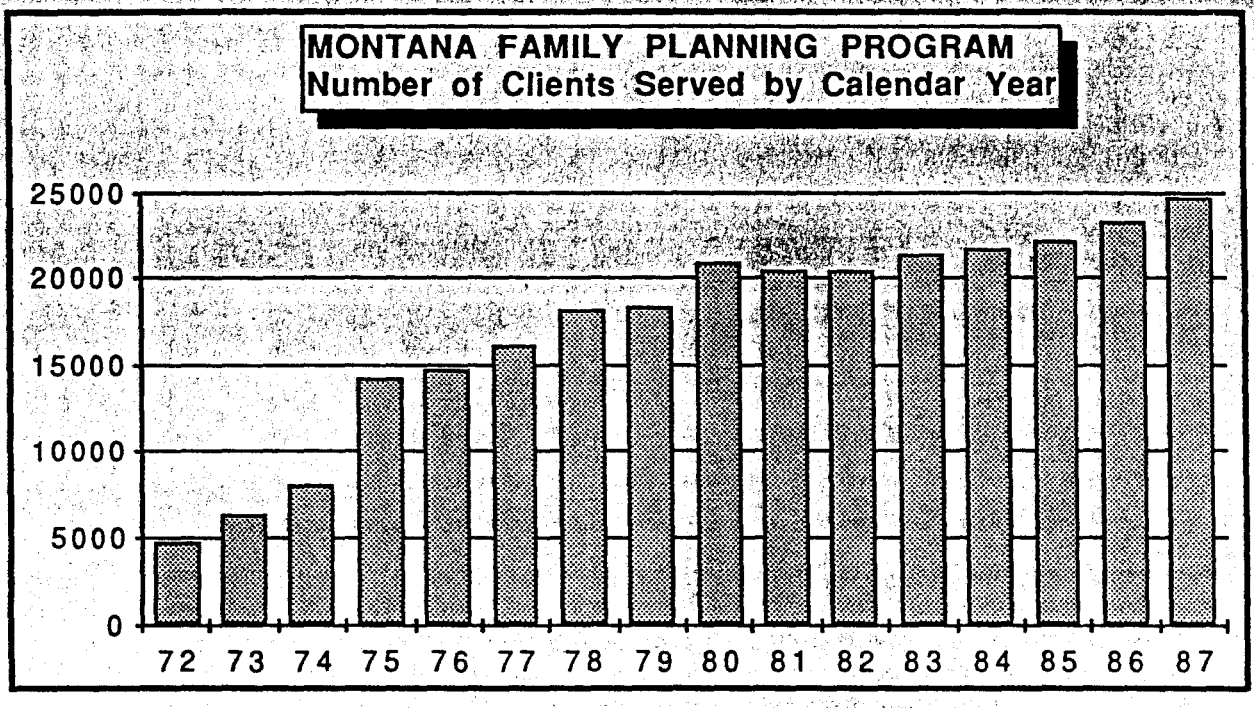


Figure 2

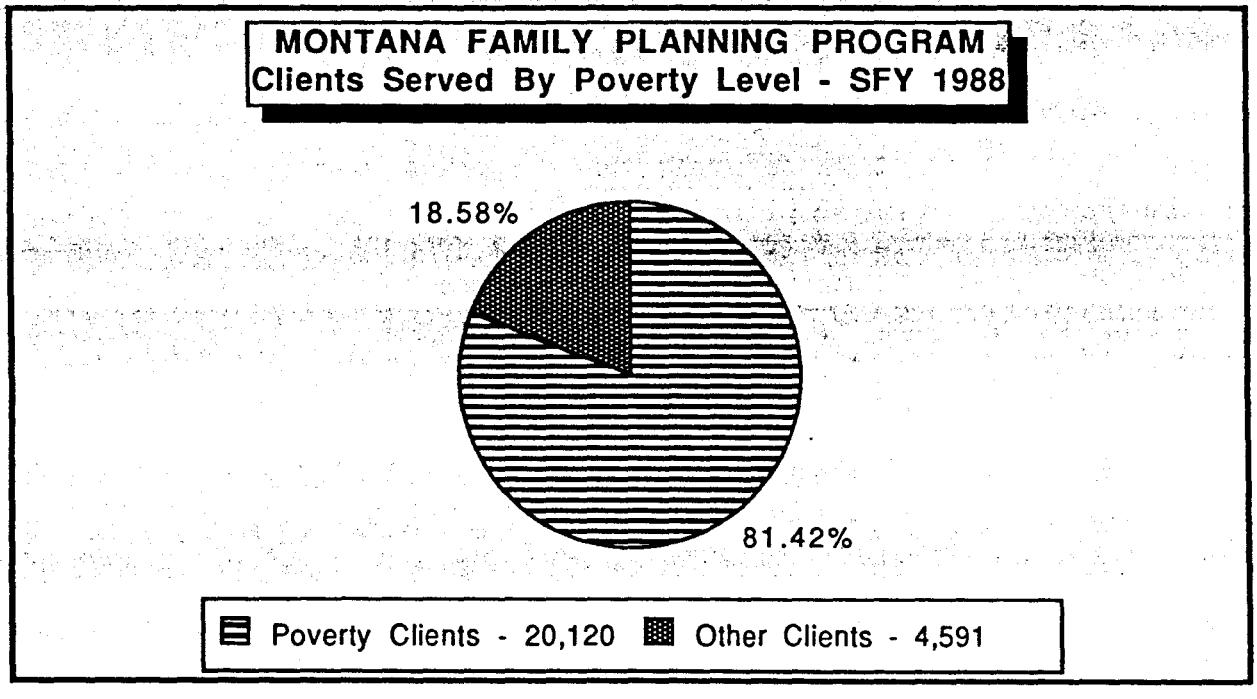


Figure 3

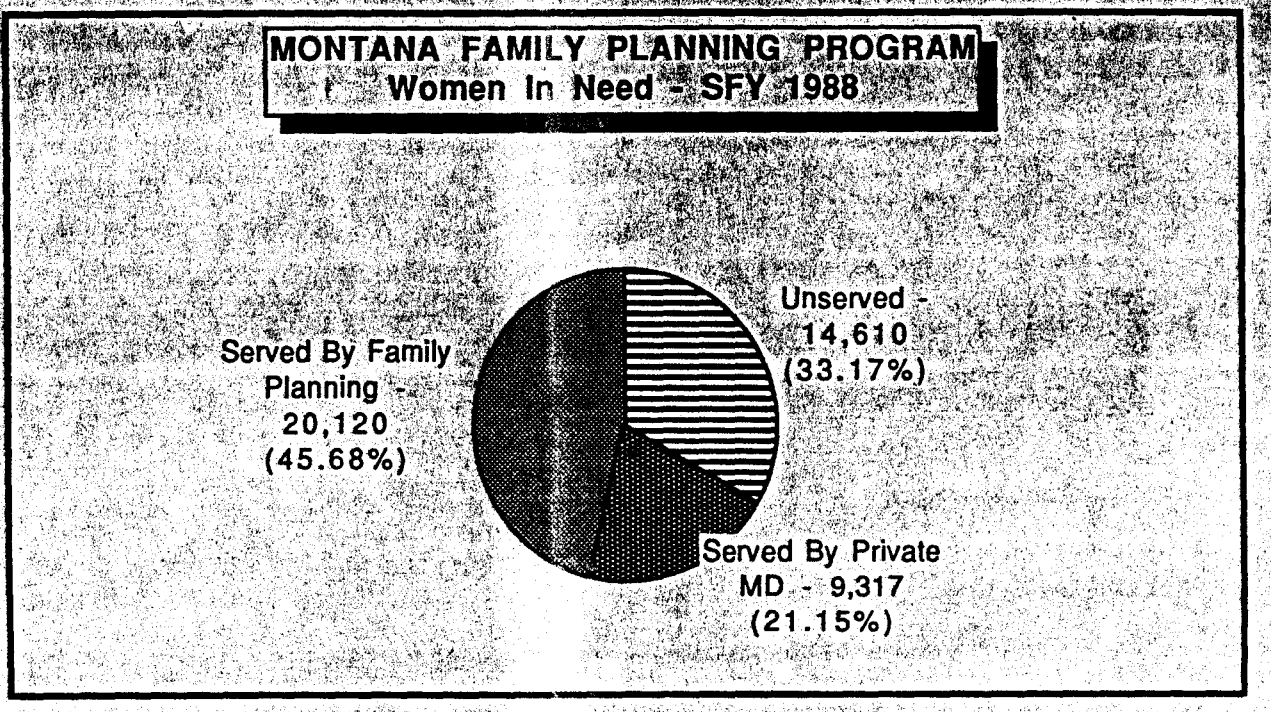
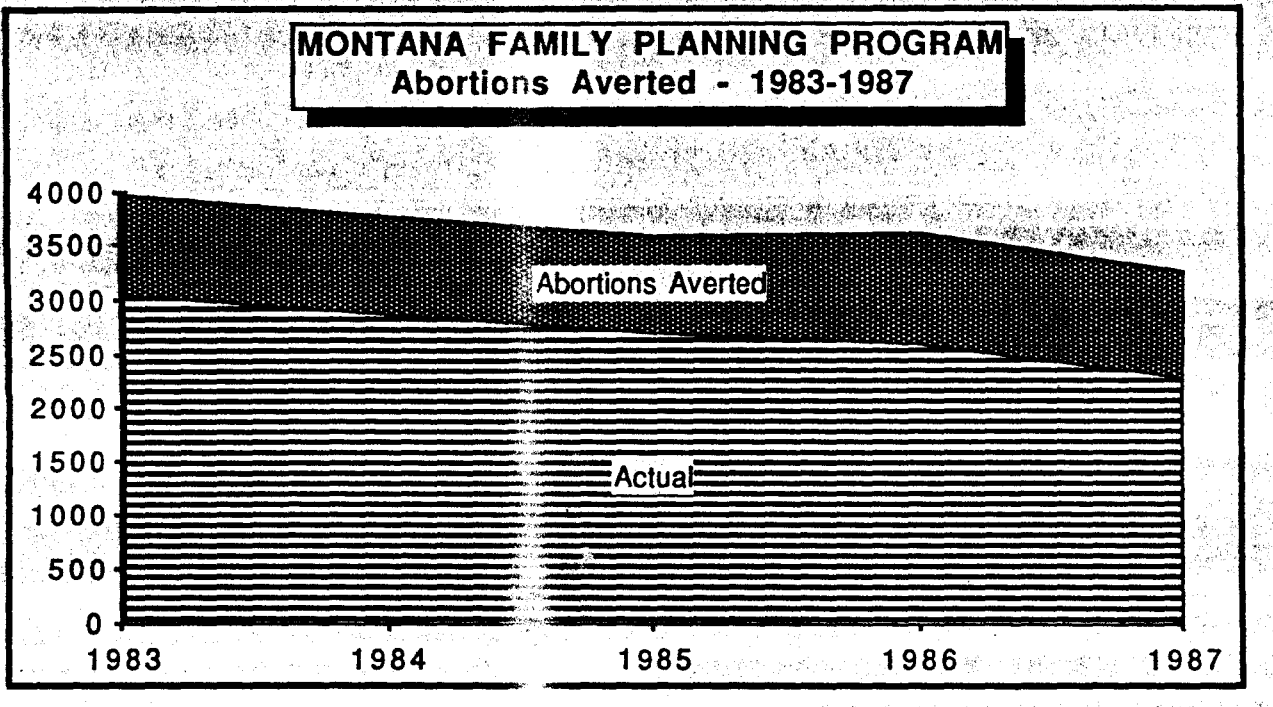


Figure 4



FEB

#17 SENATE HEALTH & WELFARE
EXHIBIT NO. #17
DATE 3/15/89
BILL NO. # HB686

naacog
The Organization for Obstetric, Gynecologic, & Neonatal Nurses

Feburary 5,1989

Suzanne Nybo
Program Manager
Family Planning
State of Montana
Department of Health and Environmental Sciences
Helena, Montana 59601

Dear Suzanne,

Mt. Section NAACOG offers support for the Pharmacy Legislation proposed by the State Family Planning Project regarding the providing of prescriptions for contraception.

NAACOG members are Obstetrical, Gynecological, and Neonatal Nurses concerned about the welfare of women of all ages—Teens, Child Bearing, and the Maturing Woman. Access to contraception at the time of a health care visit improves compliance and results in a positive outcome. Montana has an ever increasing unplanned and often unwanted pregnancy rate, especially among the teen population. There are many women unable to obtain care or afford care without the Family Planning Project. Montana NAACOG members work with these women, and are very aware of their needs.

We offer support in your legislative effort, and wish to Congratulate the Montana Family Planning Project for the outstanding wook they have done in providing health care for the women of Montana.

Sincerely,

Patricia Oriet R.N.,C.N.P.
Patricia Oriet R.N.,C.N.P.

Vice Chairman
Sr. Sharon Houle, RN, MSN
128-15th St.
Helena, MT 59601
(406) 442-0366

Chairman
Pat Oriet, RN-CNP
2080 Nelson Road
Bozeman, MT 59715
(406) 587-3073

Secretary/Treasurer
Ruth Tombre, RN, MSN
3307 Poly Drive
Billings, MT 59102
(406) 656-2498

#18

Testimony
In Support of House Bill 688
Senate Public Health, Welfare and Safety
Prepared by: Donald Espelin, M.D.
Department of Health and Environmental Sciences
March 15, 1989

SENATE HEALTH & WELFARE
EXHIBIT NO. #18
DATE 3/15/89
BILL NO. HB 688

As the Chief of the Preventive Health Services Bureau for the Department and as the Medical Director of the Montana Perinatal Program, I am testifying in support of HB 688. I feel Family Planning has been recognized as a valuable public health resource in addressing maternal and child health concerns. The Institute of Medicine in its 1985 report "Preventing Low Birthweight" concluded that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants." In a fundamental sense, healthy pregnancies begin before conception. A 1986 report by the National Academy of Sciences on strategies to alleviate the problems of teen pregnancy and childbearing reached a similar conclusion.

Low birthweight babies are those that weigh less than 5 pounds 8 ounces. In Montana in 1987, 637 babies weighed 5 1/2 pounds or less at birth. Low birthweight babies are at greater risk for handicapping conditions such as cerebral palsy and mental retardation, as well as death. The lower the birthweight, the greater the problem. Low birthweight is related to one-half of the infant deaths in Montana.

The Institute of Medicine report emphasized the importance of pre-pregnancy risk identification, counseling and risk reduction, health education related to pregnancy outcome generally to low birth weight in particular, and full availability of family planning services, especially for low income and adolescents. I feel we must remove all barriers to the delivery of care.

Passage of HB 688 would enhance the ability of family planning programs in our state to serve low income women. HB 688 removes restrictions that are hampering delivery of high quality services. I urge your support of this bill.

SN/war-43xt

#19

The Family Services Center

A Service of the Butte-Silver Bow Health Department
25 WEST FRONT STREET
BUTTE, MONTANA 59701
Phone: 723-6507

Diane Manning
Director

SENATE HEALTH & WELFARE
EXHIBIT NO. #19
DATE 3/15/89
BILL NO. HB 688

- Family Planning
- Well Child
- WIC Program
- Lamaze Prenatal
- Teen Group Counseling
- Blood Pressure Clinic
- Diabetic Screening
- VD Treatment
- Community Education
- Nutritional Counseling
- Pregnancy Testing
- Problem Pregnancy Counseling

I have been the director of the Family Planning Clinic in Butte for 3 years. Prior to my position as director I was the counselor at the clinic for 12 years.

When I took over as director of the clinic we were utilizing a private pharmacy in town to dispense our oral contraceptives. This pharmacy was stocked by our clinic personnel with our supplies and they then would dispense the oral contraceptives to our patients when they would bring with them a signed written prescription to the pharmacy. The prescription would have been given to our patient after being examined at our clinic.

This system worked very well for many years, however, the work load became too large for the Pharmacy and they choose to discontinue this service. No amount of negotiation could convince the pharmacy to continue this service. At this time I contacted every other pharmacy in town and could get no-one who was interested in contracting with us to dispense our contraceptives. The big advantage was that the pharmacy was open 7 days a week until 9 p.m. Mon. thru Fri. so that our patients could pick up their pills at any time.

I then had to look for a pharmacist who was willing to contract with us to come to the clinic to dispense our prescriptions. It was very difficult to find a pharmacist as no-one was interested in working only two hours per week. I do presently have a contract pharmacist but the turn-over rate is high.

Let's look at how the present law affects our clinic procedure now. After a patient has been educated, counseled and examined by a Nurse Practitioner, a prescription is written in her chart. She then leaves the clinic and is advised to return to pick up her prescription after the pharmacist has filled it. Because we cannot afford to hire a pharmacist to work full-time in our clinic, we contract for a pharmacist to visit our clinic two hours each week. The pharmacist usually comes to the clinic on Thursday evening at 7:00 p.m., after the clinic is closed. The pharmacist only sees the patient's chart with the prescription, not the actual patient. Each prescription has a pre-printed computer label that a clerical person prepares with the patients name and places it in the patient's chart before the pharmacist arrives. Each chart also has a prescription sack prepared with the patient's name and date of the pharmacist's dispensing. The pharmacist then places the pre-typed label on the individual cycle of pills and puts the pills into the sack. A staff person refiles all the filled sacks. When the patient is required to make a second visit to the clinic and the pharmacist is long gone, the staff person actually hands the sack to the patient. At no time does the pharmacist have any direct contact with the patient.

Our present system is a definite barrier to quality contraceptive service. We serve women who are residents of Silver Bow County but also see many women who drive long distances to get affordable reproductive health care. Many women from Butte find it very difficult to come back to the clinic after the pharmacist has filled the prescription but we find the second trip prohibitive for the women who needs to make a second (90) ninety mile round trip to pick up her pills. For example we have a client from Deer Lodge, married, mother of 5 children, with a history of high risk pregnancies with a monthly family income of $500.00 She had to go off the pill in the past because she did not have gas money to make the ninety mile trip to get her pills after the pharmacist filled the prescription.

As specialists in Women's Health Care, we could eliminate the barrier to service by allowing trained R.N.'s to dispense these pre-packaged oral contraceptives.

Thank you for your consideration.

Diane Manning
Director

+ Amendment

#20

SENATE HEALTH & WELFARE
EXHIBIT NO. #20
DATE 3/15/89
BILL NO. HB 688

MONTANA STATE PHARMACEUTICAL ASSOCIATION
P. O. Box 4718
Helena, Montana 59604

To: Public Health, Welfare and Aging

From: Robert H. Likewise, Executive Director

Re: HB 688

Date: March 15, 1989

Mr. Chairman, members of the Committee. For the record, I am Robert H. Likewise, a registered pharmacists and Executive Director for the Montana State Pharmaceutical Association.

As a registered pharmacist and spokesman for the Montana State Pharmaceutical Association, I would like to state that the we do not oppose the intent but only the wording of HB 688. We would like to propose an ammendment to this bill in the form of a rewording which would in fact allow the RN to dispense a months supply of an oral contraceptive to cover the problem of unscheduled visits and at the same time provide pharmacy input.

I would like to emphasize that we have a genuine concern that the patient not be without medication. We want them to be able to obtain medication regardless of whether the visit is scheduled or unscheduled.

The pharmacists providing the service feel that they provide more of a service than just putting labels on packages of oral contraceptives and that their input in the health care delivery system is justified.

As I stated before the House Committee I learned that

the University School of Pharmacy and Allied Health Sciences had started collecting data from pharmacists working in family planning facilities across the state early in the summer to evaluate the sites for clerkship assignments for pharmacy students as well as for preparations of an article for publication in a consulting pharmacy journal. I asked if they would share this information with me which they did. The following is a brief summary of the information in the survey. They found that the pharmacists spends on an average of 2 to 3 hours per week performing pharmacy functions. A number of functions were listed, however, a majority of the pharmacists indicated that they spent time labeling oral contraceptives, OTC drugs and other prescriptions for distribution to patients. They also indicated they monitored inventory levels of oral contraceptives and other drugs, they answered drug information questions from the staff, provided inservices to the staff, attend staff meetings and a few indicated they helped counsel patients on OCs and other drugs. Granted not all of these functions are performed by all pharmacists. They also indicated that about half worked from the patient's chart and half worked from prescriptions. Documentation is also done on the chart or the prescription. In working from the chart, some of the pharmacists indicated that they are able to help the family planning staff monitor patient's for their annual exams. The survey also indicated that the pharmacists dispenses an average of 139

prescriptions or 435 cycles per month. I might explain that a cycle equals one month and a prescription is equal to 3 months. This certainly indicates to me that pharmacists are providing a service beyond just labeling oral contraceptives.

The pharmacists providing these services are reimbursed either at an hourly rate or a flat monthly fee. In a couple of cases, the services are provided at no charge. The average reimbursement was determined to be $105.25 per month. When I broke this down I found that the average cost to the facility for the pharmacist's time is 24 cents per cycle or 76 cents per prescription.

The above information would appear to me to justify a pharmacist in these facilities. If the pharmacist is eliminated, we lose secondary checks and balances that are so important in the health care delivery system and have been deemed necessary to a greater extent by hospitals and institutions over the years. Elimination would not be in the best interest of quality and accurate health care delivery.

We therefore urge this Committee to recommend this ammendment in the interest of maintaining the high standard of a health care delivery that Montana now enjoys.

#21

SENATE HEALTH & WELFARE
EXHIBIT NO. #21
DATE 3/15/89
BILL NO. HB 688

Section 1, Page 2

~~(f) the dispensing of factory prepackaged oral contraceptives by a registered nurse employed by a family planning clinic under contract with the department of health and environmental sciences if the dispensing is in accordance with:~~

~~(i) a physician's written protocol specifying the circumstances under which dispensing is appropriate and~~

~~(ii) the drug labeling, storage, and RECORDKEEPING requirements of the board of pharmacy."~~

(f) the dispensing of the first month's cycle or one month emergency cycle in the event of an unscheduled appointment of a factory prepackaged oral contraceptives by a registered nurse employed by a family planning clinic under contract with the department of health and environmental sciences:

(i) if the dispensing is in accordance with a physician's written protocol specifying the circumstances under which dispensing is appropriate; and

(ii) provided a registered pharmacist has prelabeled the factory packaged oral contraceptive for use as an initial or emergency cycle in accordance with Class IV regulations. The registerd nurse will complete the label by adding the patient's name and date of issue.

Section 2, page 3

~~(5) nothing in this chapter prevents a registered nurse employed by a family planning clinic under contract~~

~~with the department of health and environmental sciences from dispensing factory prepackaged oral contraceptives if the dispensing is in accordance with a physician's written protocol specifying the circumstances under which dispensing is appropriate and with the board of pharmacy's requirements for labeling, storage, and RECORDKEEPING of drugs."~~

(5) nothing in this chapter prevents a registered nurse employed by a family planning clinic under contract with the department of health and environmental sciences from dispensing the first month's or emergency cycle of a factory prepackaged oral contraceptive if the dispensing is in accordance with the physician's written protocol specifying the circumstances under which dispensing is appropriate and provided that a registered pharmacist has prelabeled the oral contraceptive in accordance with Class IV statute 8.40.706.

Section 3, page 5

~~(3) If the drug is a factory prepackaged oral contraceptive, it may be dispensed as provided in subsection (1) or by a registered nurse employed by a family planning clinic under contract with the department of health and environmental sciences pursuant to a physician's written protocol specifying the circumstances under which dispensing is appropriate and pursuant to the board of pharmacy's rules concerning labeling, storage, and RECORDKEEPING of drugs.~~

(3) If the drug is the first month's or emergency cycle of a factory prepackaged oral contraceptive, it may be

dispensed as provided in subsection (1) or by a registered nurse employed by a family planning clinic under contract with the department of health and environmental sciences pursuant to a physician's written protocol specifying the circumstances under which dispensing is appropriate and pursuant to the board of pharmacy's rules for Class IV pharmacies (section 8.40.706).

MONTANA WOMEN'S LOBBYIST FUND

P.O. Box 1099 Helena, MT 59624 406/449-7917

3/15/89

SENATE HEALTH & WELFARE
EXHIBIT NO. #22
DATE 3/15/89
BILL NO. HB688

H.B. 688 - Support
Nancy Lien Griffin

Mr. Chairman, Members of the Committee:

H.B. 688 provides authority to R.N.'s to dispense..not prescribe, but dispense...birth control pills. Often clinics which provide this service to their women patients, serve lower income and younger women. It is important to these patients that repeat trips to the clinic are unnecessary. Transportation is a factor--and in the case of many younger patients, delays in dispensing birth control, may mean delays in preventing pregnancy. Pharmicists are not employed full time in these clinics.

If a patient makes an appointment with the doctor on Monday, and he prescribes that the birth control must begin on Wednesday to coincide with the woman's menstrual cycle, but the pharmacist only comes on Thursday, that can mean up to a 28 day delay in birth control. Although the bill allows for emergency dispensing by R.N.'s, there is no functional need for a pharmicist to put the pills in a bag.

I have attached a fact sheet for your information. We urge your support for H.B. 688.

MAR 9 1989

SENATE HEALTH & WELFARE
EXHIBIT NO. #23
DATE 3/15/89
BILL NO. HB 688

Testimony of Joan McCracken
Executive Director of InterMountain Planned Parenthood
on HB 688.
March 15, 1989

I am unable to be at the hearing today but did want to tell you how important it is for those of us in family planning to have you give positive consideration to HB 688, which would allow nurses to dipense prepackaged, prelabeled contraceptives to women who choose to use this method of family planning. As you know, throughout the state, 82% of our patients fall below the poverty guideline. Often these are women who have no other access to health care and depend on our clinics to meet many of their needs. Many have walked or ridden the bus to obtain services. Many live the sort of lives where any barrier can be just one barrier too many. Some are not very sophisteicated and have the most limited knowledge of the health care system. They do not understand why they must return a second and third time to get the birth control method of their choice. Someone must speak out for those women.

I am also asking you to consider this bill from an administrator's viewpoint. In Billings, we have two clinics. In one, we have a full-time pharmacist at great expense just so that women experience no delay in obtaining their family planning method. But we have a large clinic that sees more than a quarter of all the patients seen in the state. In our other clinics, where there is no pharmacist, we have what we call the "baggie" method of dispensing birth control pills. The labels are prepared, and the prepackaged, prelabeled pills are dropped in the "baggie". Since a patient may pick up from one to 12 cycles of pills at a time, we have to put this number of prepackaged, prelabeled pills into each baggie. Not only does this take up a great deal of space (in Great Falls we have one entire room filled with drawers and drawers of baggies) but from an economic viewpoint, this is absurd. We are sitting on thousands of dollars worth of inventory that cannot be turned over because it has already been bagged. For those of you who know accounting lingo, we put into the bag FIFO, or first in first out. But in this case, it is first in, first into the bag. This does not mean that the patients get the most current birth control pills. Some of them will come in on the eleventh month and get pills that have been sitting there for 11 months. This does not make good sense medically or pharmaceutically. Please support HB 688.

Did not testify

SENATE HEALTH & WELFARE
EXHIBIT NO. #24
DATE 3/15/89
BILL NO. HB688

TESTIMONY FOR SENATE PUBLIC HEALTH WELFARE AND SAFETY COMMITTEE

Support HB 688 Dispensing privileges for RNs in Family Planning Clinics

Name: Karen Landers, MD, Pediatrician from Helena

Representing: Montana Council for Maternal and Child Health

The Montana Council for Maternal and Child Health represents hundreds of health care professionals serving Montana's mothers and children, including family physicians, OB/Gyn physicians, pediatricians, school nurses, and OB/Gyn nurses. Recognizing the importance of preventing unintended pregnancy, reducing abortion, and reducing the number of low birthweight infants, both the Council and the Montana Children's Agenda support HB 688, enabling registered nurses in family planning clinics to dispense physician prescribed commercially prepackaged contraceptives.

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

NAME: Linda L. Winchell DATE: 3/15/89

500 West Broadway, Missoula, MT (59801) (WORK)

ADDRESS: 1627 So 4th W. Missoula, MT (Home)

543-7271 EXT 2249 (WORK)

PHONE: 549-1936 (home)

REPRESENTING WHOM? St. Patrick Hospital

APPEARING ON WHICH PROPOSAL: H.B. 289

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

COMMENT: I have graduated from both an LPN & RN Program, worked in both roles, supervised both Roles & work with students in both programs. The LPN has been prepared & trained with basic science skills & nursing procedures. The RN has a much more thorough preparation in assessment, planning, nursing intervention & management of patient care & the evaluation of such intervention & patient response. The RN has a greater understanding of pathophysiology & human response to therapy. LPN's are not prepared to care for patients that do not have predictable outcomes. This is a protection to them as well as the public -- especially in view of the increasing complexity of patients, often the most vulnerable patients in the acute care facility.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

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

NAME: Jeannine H. Peretti DATE: 2/15/89

ADDRESS: St. Patrick Hospital 500 West Broadway Missoula, Mt. 59801

PHONE: 543-7271

REPRESENTING WHOM? M.O.N.E. - St. Patrick Hospital

APPEARING ON WHICH PROPOSAL: House Bill 389

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

COMMENT: Scope of practice of LPN as now defined places constraints based on 1 calendar year Vocational Technical program. These constraints protect the public as well as the LPN. The complexity of todays hospitalized patients requires the depth of knowledge & advanced skills to insure safe quality nursing care. An LPN is not prepared to assume responsibilities outside defined scope of practice, but is a valuable addition in a supportive role under the supervision of an RN.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

DATE 3/15/89

COMMITTEE ON Public Health

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
Lynne Bryant.	N.P.	688	X	
Robert H Likewise	MSPA	688		X
Donna Schramm	MT State Bd of Nurs	395	X	
Jan Anderson	Mt State Bd of Nursing	378	X	
Margie Vanderhoof	PRN	378	X	
	Mont Nurses Assn	389		X
Don Connors	self	688	X	X
Melanie Reynolds	Family Planning	688	X	
Dorothy A. Cody	H.D. 20	395	X	
Cathy Vickers	RN - Family Planning	688	X	
Mollie McCarney	RN	389	X	
Susan Sandwell	Public Health Nurse	688	X	
Denis Gorst	Montana Society of Hospital Pharmacists	688		X
Irene F. Thurston	SPN	378	X	
" " "	"	389	X	
HAD Stoianoff	Mt Assoc. of Counties	395	X	
Jim Reid	MAPA	395		X
Paul Wheeler	Self-	395		X
Lori Lundholm, RN, BSN	P.R.N.	378	X	
" " "	Tri-County Fam Planning	688	X	
Diane Sands	Mt. Women's Lobby	688	X	
Sharon Holmquist	Practical Nursing Instructor	378	X	
Karen Landers MD	Montana Council for Mat. Child Health Montana Children's Alliance	688	X	
Pat Dorter	self - Helena Vo-Tech	389	X	

(Please leave prepared statement with Secretary)

DATE

ON Public Health 3/15/89

VISITORS' REGISTER

	REPRESENTING	BILL #	Check One Support	Oppose
role	Mt. Nurse Practitioners	395	X	
		389		X
		688	X	
		378	X	
watts	Mt. Nurses' Association		395, 688 378	389
Leggis	MT Nurses Assoc	389	395 —	✓
Elizabeth Fitzgerald	Montana Nurses	389		✓
Peretti RN	St. Patrick's Hospital	389		✓
L Winchell Rn	St. Patrick Hosp. #1	389		✓
SEM	Program For Recovering Nurses	378	X	
ine Jaggar	Blue Mt Women's Clinic	378	X	
		395	X	
		688	X	
Brown	Blue Mtn Womens Clinic	395	X	
		688	X	
		378	X	
b Bodner	MT. Nurses Assoc.	378	X	
		688	X	
		395	X	
		389		X
Morin		688		X
ie Hardy	State DHES Family Plan	688	X	
ne Manning	Butte Family Planning	688	X	
anne Nyle	DHES - Family Planning	688		
MINTHAM	MT LPN ASSOC.	378	X	
	" " "	389	X	

* with Secretary)