

## MINUTES

### MONTANA SENATE 52nd LEGISLATURE - REGULAR SESSION

#### COMMITTEE ON PUBLIC HEALTH, WELFARE & SAFETY

Call to Order: By Chairman Dorothy Eck, on March 18, 1991, at  
3:35 p.m.

#### ROLL CALL

**Members Present:**

Dorothy Eck, Chairman (D)  
Eve Franklin, Vice Chairman (D)  
James Burnett (R)  
Thomas Hager (R)  
Judy Jacobson (D)  
Bob Pipinich (D)  
David Rye (R)  
Thomas Towe (D)

**Members Excused:** None.

**Staff Present:** Tom Gomez (Legislative Council)  
Christine Mangiantini (Committee Secretary)

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

#### HEARING ON HOUSE BILL 620

#### Presentation and Opening Statement by Sponsor:

Representative Carolyn Squires opened by saying HB 620 is the licensing request for the respiratory therapists. It will require licensing and regulating by the State of Montana. The purpose is to protect the public from respiratory care practitioners that are not qualified to provide competent care as well as ensure a minimal level of training for this allied health care profession. There are more than 300 respiratory care practitioners practicing in Montana. They are allowed to administer medication and perform basic medical procedures which require an increasing level of skill and training. Currently, there is no standard in place that ensures competency and continuing education. There is no requirement that respiratory care be practiced under qualified medical direction. The Hospital Association may tell the committee that licensing respiratory care practitioners will increase hospital costs. Research does not indicate this to be the case.

Representative Squires continued by saying the bill establishes the Board of Respiratory Care and requires all practitioners to be licensed and to satisfy continuing education requirements. Licensing will not result in a shortage of practitioners. Respiratory therapists went through the Sunrise process and the State Auditor recommended licensure. She urged the committee to do pass recommendation. She passed the committee copies of Exhibit #5.

#### Proponents' Testimony:

The first witness was Michael Biggins, representing the Montana Society for Respiratory Care and director of Respiratory Services at Missoula Community Hospital. See Exhibit #1 for a copy of his testimony and hand-outs.

The second witness was Dr. Nicholes Wolter, representing himself and the Montana Society of Respiratory Care. He said he supported the bill for a number of reasons but especially because of its impact on the quality of care. It is estimated that one-third of all patients admitted to hospitals will receive some type of respiratory care therapy. This profession involves a great deal of judgement in assessing the patient's condition. Those practicing in critical care medicine depend on respiratory care therapists. The therapy is becoming extremely sophisticated. The proper managing of the equipment can make a difference in the patient's survival.

The third witness was Rich Loney, a respiratory care therapist working in Billings and one of the principal authors of the bill. He urged passage.

The fourth witness was Mary McCue, representing the Montana Society for Respiratory Care. She said there is one minor amendment that was overlooked in the House of Representatives. There is language in the statute that deals with the creation of a quasi-judicial board. One member of that board shall be an attorney unless licensure language speaks otherwise. On page 6 of the bill it does not include language about including an attorney. She passed out Exhibit #2, a copy of the proposed amendment and copies of letters.

Mr. Earl Thomas, executive director of the American Lung Association submitted written testimony to the committee. See Exhibit #3.

#### Opponents' Testimony:

The first witness was Mr. Jim Aherns, president of the Montana Hospital Association. He said they have opposed three licensure bills this session. They met with the respiratory therapists but have a long-standing position about licensure of health care professionals. He said they were opposed to the legislation.

Questions From Committee Members:

Senator Towe asked about the Sunrise process.

Mr. Loney said there were no comments. They worked with the Department of Commerce to set the fees. The vote was 7-1, Representative Simon was opposed.

Senator Towe asked about the number of respiratory therapists practicing in Montana.

Mr. Loney said well over 300. The most recent survey was about 370.

Senator Towe asked about their educational requirements.

Mr. Loney said the National Board of Respiratory Care certification level will be the minimum entry level for the state. Thirty-one other states have implemented licensure and they are all using the same credentials. Three respiratory therapists in Montana have been identified as having on the job training but not formal education. Great Falls offers one and two year programs.

Senator Burnett asked if physicians perform respiratory care services.

Mr. Loney said physicians do perform these services. A variety of physicians perform some of the specialized procedures. He said everything a respiratory care therapist performs is under medical direction.

Senator Hager said he had received good respiratory care during a hospital stay. He asked why the bill was necessary.

Mr. Loney said there is the potential for problems.

Chairman Eck asked if a grandfather clause was included, she continued by saying they did not grandfather any of the licensure bills.

Mr. Loney said once the bill goes into effect all respiratory care therapists are required to complete continuing education. The minimum requirements for licensure are certification by the national board, the minimum education requirement. The dozen people who will get grandfathered in with no formal training. The only requirement is one year documented respiratory care experience at the time the bill is enacted. In Glendive, their program includes a nurses aide and an LPN that are working as respiratory care therapists and are in a formal training program.

Senator Hager asked about the continuing education requirements.

Mr. Loney said there are no requirements. Most hospitals offer programs. The national organization offers correspondence courses.

Closing by Sponsor:

Representative Squire closed by saying it is important to understand a grandfather clause. At the time she started her training as an LPN there was no particular education requirement. When the profession was upgraded we required a GED or high school education. To protect the LPNs that were already practicing we grandfathered them in. Respiratory care will be one of the prime allied health fields. We will probably need more of these types of services. We do not want people using the sophisticated treatments that are not qualified. She urged passage of the bill.

HEARING ON HOUSE BILL 713

Presentation and Opening Statement by Sponsor:

Representative Dick Knox opened by saying this bill will impact slightly the admissions policy and bring the law into conformity. The Montana Center for the Aged serves persons over the age of 55 who have a mental illness and need nursing care but who are not in need of active treatment for their mental illness. A survey of patients in 1990 showed a full range of psychiatric diagnoses among the residents, including mood disorders, personality and organic disorders. Many are not associated with the aging process. This bill clarifies that the patients that are appropriately served are elderly but their mental illnesses are not necessarily related to the aging process.

Proponents' Testimony:

The first witness was Dan Anderson, administrator of the Mental Health division, Department of Institutions. See Exhibit #9 for a copy of his testimony.

The second witness was Kelly Moore, director of the Board of Visitors. See Exhibit #4 for a copy of her testimony.

The third witness was Hank Hudson, director of the Governor's Office on Aging. The Advisory Council on Aging supports this bill. He said they look forward to letting Montanans know about this bill. He said it is an important way to educate the public about the valuable resource we have in our senior citizens.

Opponents' Testimony:

None.

Questions From Committee Members:

Senator Towe asked Dan Anderson about the definition of mental disorder.

Mr. Anderson said people who are seriously mentally ill and qualify for admission to the state hospital need active psychiatric treatment. They need to be in a facility that has on-staff professional care. Those admitted to the Center for the Aged have a mental illness or symptoms of mental illness that need more support than a typical nursing home but do not need the intensive monitoring.

Senator Towe asked if they have the ability to protect their life or health.

Mr. Anderson said some probably do not. Some might meet the definition of seriously mentally ill but the admission to the Center is voluntary.

Senator Rye asked if Alzheimer's disease qualified as a mental disorder.

Mr. Anderson said it does. There is a greater probability that an older person will acquire Alzheimer's disease earlier than a younger person. The difference in the development of this disease is not necessarily a result of growing older.

Senator Towe asked about the number of patients in the Center and wanted to know about the population trend.

Mr. Anderson said the current population is approximately 150 patients. Generally, there has been a reduction over the last ten years.

Chairman Eck asked if there would be a possibility of Warm Springs patients being transferred to Lewistown.

Mr. Anderson said when the Center for the Aging was started it was described as an annex of the State Hospital. Over the years that has become less frequent. Last year the overwhelming number of admissions to the Center did not come through the State Hospital but from the communities. The decision is based upon the needs of the patient.

Senator Towe asked about the transfer from Warm Springs.

Mr. Anderson said a transfer would not be a matter of age. However, a patient at the Center has to be at least 55 years old. It is a matter of condition. It is a voluntary admission process. A person cannot be transferred to Lewistown that does not want to be a patient in that facility. A person may reach a point where they have received all the benefits available from Warm Springs and discharge may be recommended.

Senator Pipinich asked about the 150 patient population. He asked if there was a proposal to increase this bed count to 180.

Mr. Anderson said that was the proposal to close Galen and transfer patients. This bill has nothing to do with Galen. It puts into the statute the current admission criteria. We are only eliminating the phrase, "associated with the aging process".

Senator Pipinich wanted to know why the bill was necessary.

Mr. Anderson said it was necessary to remove inappropriate language from the statute.

**Closing by Sponsor:**

Representative Knox closed by thanking the committee for a good hearing. He said they had much support in the House and came out of committee by unanimous vote. He said there is too much being read into the change of language. He said his district surrounds Lewistown and he has observed patients for many years at the facility. He asked for concurrence.

**HEARING ON HOUSE BILL 831**

**Presentation and Opening Statement by Sponsor:**

Representative Jan Brown opened by saying this bill was requested by the Department of Institutions. This measure would allow the department to adopt standards for the approval of chemical dependency treatment programs. It also allows the department to adopt rules regarding the use of county treatment plans in determining the counties needs for chemical dependency, prevention and treatment programs. Current law allows counties to set up plans for treatment of chemical dependency. The plans are submitted to the Department of Institutions but does they are not allowed to use these plans in determining county needs. The department has been challenged on using the plans to ascertain the needs of the counties.

**Proponents' Testimony:**

The first witness was Darryl L. Bruno, administrator of the Alcohol and Drug Abuse division of the Department of Institutions. See Exhibit #6 for a copy of his testimony.

The second witness was Mike Rupert, president of Chemical Dependency Programs of Montana and executive director of the Boyd Andrew Chemical Dependency Care Center in Helena. He said they are in support of this bill. It tightens up the state approved programs.

Opponents' Testimony:

None.

Questions From Committee Members:

Chairman Eck asked Darryl Bruno about the language on page 2, line 10, and about evaluation program techniques.

Mr. Bruno said they evaluate programs, require reports, review their goals and objectives on a quarterly basis. They are also reviewed during the annual on-site evaluations.

Closing by Sponsor:

Representative Brown closed by saying this measure passed the House of Representatives with only two descending votes. She thanked the committee for a good hearing.

EXECUTIVE ACTION ON HOUSE BILL 831

Motion:

Senator Towe moved concurrence.

Discussion:

None.

Recommendation and Vote:

There being 1 nay by Senator Burnett and 7 ayes the motion carried.

HEARING ON HOUSE BILL 862

Presentation and Opening Statement by Sponsor:

Senator Keating opened for Representative Dorothy Bradley because she was unable to leave the House of Representatives Appropriations Committee hearing.

Senator Keating said this bill pertains to voluntary admittance to the State Hospital. In the past, anyone could present themselves at Warm Springs for admittance. This bill attempts to establish a case management system. If a resident would like to enter the State Hospital there will be admission procedures for in-patient treatment. The professional counselor in the community and the hospital will coordinate whether it is appropriate to enter the hospital. It changes the admission procedures to allow recourse for inappropriate admissions to the State Hospital.

Proponents' Testimony:

The first witness was Dan Anderson, administrator of the mental health division of the Department of Institutions. See Exhibit #8 for a copy of his testimony.

The second witness was Kelly Moorse, director of the Board of Visitors. See Exhibit #7 for a copy of her testimony.

The third witness was Jane Edwards, superintendent of the Montana State Hospital. She said they were in support of the bill. It is hopeful that passage of this bill will begin to streamline the process of admissions to the Montana State Hospital and will help ensure that mentally ill persons receive treatment in the least restrictive environment. In addition, it is hoped that this bill will begin to assist other persons inappropriately admitted to the hospital in finding alternative care and treatment. The intent of the bill is to facilitate an ongoing communication between the community professional and the professional on the hospital staff in the effort of seeking a joint decision on admission to the hospital.

The fourth witness was Kathy McCowan, representing the Montana Council of Mental Health Centers. This past year this subject has been discussed at the quarterly meetings. It is a concern and does need to be addressed.

Opponents' Testimony:

None.

Questions From Committee Members:

Senator Burnett asked about the current requirements.

Mr. Anderson said the current screening process allows professional persons to originate the process by helping the patient fill out the form and referring them to a community mental health center. He said the State Hospital is not involved in this process. There are many people who should be involved in this process. There needs to be feedback.

Senator Franklin asked Ms. Edwards for an example of an inappropriate admission.

Ms. Edwards said recently a patient was admitted voluntarily that was developmentally disabled. The reason for the admission was to assist the patient in integrating into a residential setting. Montana State Hospital does not treat persons primarily diagnosed as developmentally disabled. Many times persons suffering from alcoholism are admitted to the Warm Springs campus instead of the Galen campus.



Senator Franklin asked where the admission originated of the developmentally disabled patient.

Ms. Edwards said the referral was from a physician in a community.

Senator Franklin asked if they had any process to intervene.

Ms. Edwards said from the time of discharge we attempt to make referrals out. It is difficult in many cases to intervene in getting a patient discharged once they are admitted. It is time consuming. They attempt to seek those services in the community that are available for developmentally disabled clients, for example.

Senator Towe asked Dan Anderson about the bill not specifically directing the Department of Institutions to define an admitting person. It allows them to adopt rules to implement the subsection. But asked if he was concerned about the vague language.

Mr. Anderson said page 2, lines 3 through 5 speak to rules addressing the qualifications of admitting professionals. He said he thought that was enough authority to set qualifications.

Senator Towe suggested that on page 3, line 24 at the end of the sentence, add language that would define what is met by an admitting professional and to implement this subsection.

Chairman Eck said that was already in the bill.

Senator Hager asked about the effective date.

Mr. Anderson said he did not know why the effective date was July 1 instead of October 1.

Senator Keating said he suspected it had to do with the fiscal year. If this bill was implemented as soon as possible it would allow the department to also work with the federal regulations.

Senator Hager asked about the rulemaking process.

Senator Keating said it would take time. But the sooner the effective date the sooner the rulemaking process could be commenced.

Senator Franklin asked Dan Anderson about the language on page 3, line 14. She asked if that precluded private referrals.

Mr. Anderson said if a person were seeing a private practitioner and they thought the person should be admitted to the State Hospital the private practitioner could notify the admitting professional from the community.

Senator Franklin said the worst case scenario would be that an individual would need in-patient mental health treatment but not be connected to the community based mental health system.

Mr. Anderson said their are funds devoted to that process.

Senator Franklin said her concern was that it was not explicit in the bill and that community based systems will not have adequate funds.

Mr. Anderson said they will pay for the screening process and has been paid for in previous years. It has not been well coordinated.

Closing by Sponsor:

Senator Keating closed by thanking the committee for a good hearing.

HEARING ON HOUSE BILL 635

Presentation and Opening Statement by Sponsor:

Representative Bruce Measure opened by saying HB 635 pertains to living wills. Montana has one of the more progressive Living Will Acts in the nation. This bill revises the Act to conform with the Uniform Rights of the Terminally Ill Act, which is a national regulation. This will allow someone to draft a living will. If someone were to get into a position where they were in a vegetative state the health care professionals could be notified of the living will and make the medical decisions based upon the desires expressed in the living will. It allows both the physician and the families to conference on addressing the decisions that the patient made but did not reduce to writing. He read from the bill. He said the definition of 'a relatively short time,' lead to confusion. He referred to page 2, line 17 (7). He said a person had to be in the process of dying. He asked the chairman to recognize the witnesses.

Proponents' Testimony:

The first witness was John Ortwein, representing the Montana Catholic Conference. See Exhibit #10 for a copy of his testimony.

The second witness was Steve Browning, representing the Montana Hospital Association. He said everyone in the room has probably thought about this issue. As a lawyer he has spent hundreds of hours working on these issues. The latest incident was the United States Supreme Court decision of Cruzan versus Missouri. This bill came at a timely moment.

Mr. Browning continued by saying the National Conference on the Commission of Uniform State Laws was meeting and developed their new set of recommendations. See Exhibit #11 for a copy of his hand-out. The principal change in this bill from Montana's existing law on living wills, is that it begins to deal with the subject of decisionmaking. If you recall the case of Nancy Cruzan, her parents were trying to make the decision for her because she had not left a living will. Although she had expressed to other people her views about what she would like to have happen to her if she found herself in a comatose situation that was irreversible. Two recommended changes were made. Section 3, page 4, 'Declaration relating to the use of Life Sustaining Treatment'. This allows a designee to make decisions for the patient. This language begins on line 12 through line 15. Page 6, line 6, deals with the composition of the designation. The second change is related to this. It is a new section, page 16, line 2. He read this section of the bill. The bill establishes a list of priorities, starting with the spouse of the individual, an adult child, parents and others. On page 17, the decision to grant or withhold consent must be made in good faith. The consent is not valid if it conflicts with the expressed intention of the individual. Page 13, lines 20 through 24, this chapter does not require a physician or other health care provider to take action contrary to reasonable medical standards. Is it reasonable for a physician to allow the withholding of insulin from a diabetic. Page 13, line 23 (7), this chapter does not condone, authorize or approve mercy killing or euthanasia. That is clarifying existing law. He explained Exhibit #11 to the committee.

The third witness was Hank Hudson, director of the Governor's Office on Aging. He said they support the bill. The good part in this bill is the provision of appointing another person to make the decisions, it eliminates having to hire an attorney. All of the provisions are agreeable to the Governors Council on Aging.

#### Opponents' Testimony:

None.

#### Questions From Committee Members:

Senator Towe asked Representative Measure about several areas of concern. First, the position of Mr. Ortwein. Is their a problem regarding abuse because of the problem with the definition of terminal illness.

Representative Measure said the definitions presently in the law do not change under this Act. The expansion of the Act and its relationship with the definitions should not pose a problem. Physicians have a code of ethics of which they will be working from. It is a difficult situation for any family to be placed in.

Representative Measure continued by saying it would provide the ability for an individual who did know the intentions of the patient to communicate them to the physician.

Senator Towe said it has to be the conclusion of the physician that it is an irreversible situation. It cannot apply to a condition that limits quality of life.

Representative Measure said that is not a legal implication of the bill but is what the medical community would decide. He read from page 13 of the bill. He said his conclusion was probably correct.

Senator Towe asked about the Emergency Medical Services allowing an individual to refuse medical treatment.

Representative Measure said Representative Brooke has introduced a bill that pertains to this area. A person can wear a designation regarding resuscitation.

Senator Hager asked Representative Measure about Mr. Ortwein's suggested language.

Representative Measure said he would resist that amendment because of the last line pertaining to life support equipment. Some people are opposed to artificial preservation of life.

Senator Hager said he had a problem with the phrase, 'death within a relatively short period of time'.

Representative Measure said they were unable to agree upon any better language. Within the confines of this Act and within the medical professions code of ethics, it is cross-referenced in several areas. A finding may have to be made by the medical community that the person is dying.

Senator Hager said he had problems with the bill.

Senator Towe asked Mr. Browning to comment.

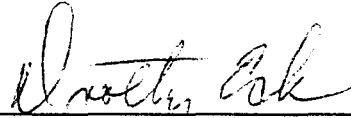
Mr. Browning said this issue was dealt with at great length by the Uniform Code of Commissioners. He said his hand-out has extensive descriptions of these areas. Individuals have the right to indicate their positions.

Closing by Sponsor:

Representative Measure closed by thanking the committee for a good hearing and said the bill was well presented.

ADJOURNMENT

Adjournment At: 5:35 p.m.



\_\_\_\_\_  
SENATOR DOROTHY ECK, Chairman



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CHRISTINE MANGIANTINI, Secretary

DE/cm

ROLL CALL

PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

Date 03/18/91

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NAME	PRESENT	ABSENT	EXCUSED
SENATOR BURNETT	X		
SENATOR FRANKLIN	X		
SENATOR HAGER	X		
SENATOR JACOBSON	X		
SENATOR PIPINICH	X		
SENATOR RYE	X		
SENATOR TOWE	X		
SENATOR ECK	X		

Each day attach to minutes.


SENATE STANDING COMMITTEE REPORT

Page 1 of 1  
March 19, 1991

MR. PRESIDENT:

We, your committee on Public Health, Welfare, and Safety having had under consideration House Bill No. 831 (third reading copy -- blue), respectfully report that House Bill No. 831 be concurred in.

Signed: \_\_\_\_\_



Dorothy Eck, Chairman

LB 3/19/91  
Amd. Coord.

SB 3-19-91 9:20  
Sec. of Senate

The unregulated practice of Respiratory Care in Montana can be hazardous to public health, safety, and welfare.

EXHIBIT NO. immediate Ex 1DATE 3/18/91HEALTH AND SAFETY# BILL NO. 620

The constant progressive march of technology in the field of respiratory care and medicine in general, demands highly skilled practitioners. No longer can on-the-job trainees with no formal education be allowed to practice unsupervised. But worse yet, no longer can the practitioner who once long ago passed a national exam and has since not picked up a journal, gone to a class, or kept up in the field in any way.

To prove my point I'll discuss three procedures currently done by respiratory care practitioners in Montana: Arterial Blood Gas Puncture, Intubation of the Trachea, and Aerosol Therapy.

Arterial Blood Gas Puncture

This is a blood sample usually drawn from an artery in the wrist, elbow area, or groin. The gases in this sample which are measured by a gas analyzer are oxygen and carbon dioxide. Other measurements and calculations are also made from this sample.

The difficulty with this maneuver unlike in drawing venous blood is one cannot routinely see the vessel. The artery is palpated as one does to take their pulse. Then a very sharp needle is inserted at the spot where the strongest pulseatile sensations is felt.

The problems in drawing arterial blood include, some people don't sit still, some people's arteries roll under the skin, veins and nerves run parrallel and nearby arteries.

The first two problems can be dealt with. The latter can cause problems to the health and safety of Montanans. If the sample comes from a vein instead of an artery, erroneous values are reported and if not caught in time, medical intervention which may be hazardous to a patient can be initiated. If a nerve is nicked the pain feels similar to the feeling one gets when bumping their funny bone. Further damage to the nerve and surrounding blood vessels can result when the patient moves while a needle is still in their arm or leg.

Intubation of the Trachea

Placing an artificial airway in a person's trachea for a non-surgical procedure is an event done in an emergency situation. If not done correctly and the error goes unrecognized, a Montanan will die within a few minutes. Even if the error is recognized, the time it takes to remove the airway from the esophagus and again try to intubate the trachea; the person's lungs are not being ventilated with life-sustaining oxygen. Also because the esophagus was intubated instead of the trachea, the stomach had air pumped into it. When the airway is removed the person usually vomits resulting in aspiration of this material into the lung. The tissues of the lung do not function well with the acid of the stomach contents in them.

The question I pose to the people of Montana: Would they want themselves or someone in their family, after being involved in a serious traffic accident near a small town in Montana, be intubated by an unlicensed practitioner who may not have a lot of skill?



## Aerosol Therapy

Respiratory care providers aerosolize many therapeutic liquids to be inhaled by patients. Currently one of the most commonly used liquid for asthma is a medication called Albuteral. The dosage for this medication is in tenths of milliliters, e.g., .2ml with .5ml being the recommended maximum dosage. For your information I've provided a copy of the listed side effects of this medication.

Doctors write the order for Albuteral to be given. But suppose, for the sake of discussion, I present a scenario where an error is made in the order:

An 8 year old girl comes to an emergency room of a Montana hospital in the early hours of the morning with a severe asthma attack. The ER physician, nearing the end of a very busy 24-hour shift, sees the little girl. After evaluating the situation, the physician writes the order for an aerosol treatment with 3ml of Albuteral. At this point it's up to the respiratory care practitioner to recognize a decimal point is missing from the order and to contact the physician for a correct dosage order.

Currently with the unregulated practice of respiratory care in Montana. Someone with little or no formal training may be responsible for making decisions concerning medication errors.

The above is not a far fetched scenario. Medication errors happen in Montana hospitals. Hopefully someone well trained points them all out before a Montanan needlessly suffers from incompetence.

## WELFARE

The attached report is from a study by the Respiratory Care Department of Missoula's Community Medical Center. It details the number of inappropriate aerosol treatment orders and the cost associated with providing those treatments.

### North Dakota Blue Cross Study

In 1985 Marlene Moderow, R.N., a medical review field auditor for Blue Cross of North Dakota looked at the cost per day for respiratory services delivered by the educated and the uneducated provider. She found at two facilities the cost to be \$7.04 per day for educated providers and \$22.76 per day for uneducated providers, at the other hospital costs were \$12.50 per day for educated and \$20.87 for uneducated.

Ms. Moderow writes, "It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when services are delivered by the uneducated individual. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient."

Inappropriate therapy goes on in all the hospitals of Montana. The point being made here is that when competent respiratory care practitioners, who keep current on the appropriate criteria for various therapies, and work to inform their local physicians about these issues, help reduce the cost of health care to all Montanans, by not paying for needless therapies. The cost of needless therapies are reflected in every insurance premium the people of Montana pay. Simply put, the most money spent down the drain the more we pay.

How will Licensing protect the public beyond means presently available?

Attached is the standard from the Joint Committee on Accreditation of Hospitals manual for Respiratory Care Services. The standards RP.1.6.1, and RP.1.7 are what protect the public from incompetent respiratory care practitioners.

These standards leave open the possibility for facilities in Montana to hire people with little or no experience to be respiratory care practitioners.

Standard RP.1.6.1 states a Technical Director should be registered or certified by the NBRT or have the documented equivalent education, training, and/or experience. The question arises: If someone has the equivalent education, training, and experience then why can't they pass the NBRT exam? Also who is to determine what is equivalent education, training and experience?

The same can be said for standard RP.1.7. Also the standards do not deal with continuing education requirements. Currently there are none.

Licensing respiratory care practitioners will provide specific requirements and continuing education standards that must be met by respiratory care practitioners in Montana leaving nothing for others to interpretate.

## Schering—Con

Store between 15° and 30°C (59° and 86°F). Shake well before using.

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Revised 2/86

Shown in Product Identification Section, page 429

**PROVENTIL®**

brand of albuterol sulfate

Solution for Inhalation 0.5%\*

Solution for Inhalation 0.083%\*

(\*Potency expressed as albuterol)

**DESCRIPTION**

PROVENTIL, brand of albuterol sulfate. Solution for Inhalation, is a relatively selective beta<sub>2</sub>-adrenergic bronchodilator (see **CLINICAL PHARMACOLOGY** section below). Albuterol sulfate has the chemical name  $\alpha$ -[1-(*tert*-Butylamino)methyl]-4-hydroxy-*m*-xylene- $\alpha$ , $\alpha$ '-diol sulfate (2:1) (salt).

Albuterol sulfate has a molecular weight of 576.7 and the empirical formula (C<sub>13</sub>H<sub>21</sub>NO<sub>3</sub>)<sub>2</sub>·H<sub>2</sub>SO<sub>4</sub>. Albuterol sulfate is a white crystalline powder, soluble in water and slightly soluble in ethanol.

The international generic name for albuterol base is salbutamol.

PROVENTIL Solution for Inhalation is available in two concentrations. The 0.5% solution is in concentrated form. Dilute 0.5 ml of the solution to 3 ml with normal saline solution prior to administration. The 0.083% solution requires no dilution prior to administration.

Each ml of PROVENTIL Solution for Inhalation (0.5%) contains 5 mg of albuterol (as 6.0 mg of albuterol sulfate) in an aqueous solution containing benzalkonium chloride; sulfuric acid is used to adjust the pH between 3 and 5. PROVENTIL Solution for Inhalation (0.5%) contains no sulfiting agents. It is supplied in 20 ml bottles.

Each ml of PROVENTIL Solution for Inhalation (0.083%) contains 0.83 mg of albuterol (as 1.0 mg of albuterol sulfate) in an isotonic aqueous solution containing sodium chloride and benzalkonium chloride; sulfuric acid is used to adjust the pH between 3 and 5. PROVENTIL Solution for Inhalation (0.083%) contains no sulfiting agents. It is supplied in 3 ml bottles for unit-dose dispensing.

PROVENTIL Solution for Inhalation is a clear, colorless to light yellow solution.

**CLINICAL PHARMACOLOGY**

The prime action of beta-adrenergic drugs is to stimulate adenylyl cyclase, the enzyme which catalyzes the formation of cyclic 3', 5'-adenosine monophosphate (cyclic AMP) from adenosine triphosphate (ATP). The cyclic AMP thus formed mediates the cellular responses. *In vitro* studies and *in vivo* pharmacologic studies have demonstrated that albuterol has a preferential effect on beta<sub>2</sub>-adrenergic receptors compared with isoproterenol. While it is recognized that beta<sub>2</sub>-adrenergic receptors are the predominant receptors in bronchial smooth muscle, recent data indicate that 10 to 50% of the beta receptors in the human heart may be beta<sub>2</sub> receptors. The precise function of these receptors, however, is not yet established. Albuterol has been shown in most controlled clinical trials to have more effect on the respiratory tract, in the form of bronchial smooth muscle relaxation, than isoproterenol at comparable doses while producing fewer cardiovascular effects. Controlled clinical studies and other clinical experience have shown that inhaled albuterol, like other beta-adrenergic agonist drugs, can produce a significant cardiovascular effect in some patients, as measured by pulse rate, blood pressure, symptoms, and/or ECG changes. Albuterol is longer acting than isoproterenol in most patients by any route of administration because it is not a substrate for the cellular uptake processes for catecholamines nor for catechol-O-methyl transferase.

Studies in asthmatic patients have shown that less than 20% of a single albuterol dose was absorbed following either IPPB or nebulizer administration; the remaining amount was recovered from the nebulizer and apparatus and expired air. Most of the absorbed dose was recovered in the urine 24 hours after drug administration. Following a 3.0 mg dose of nebulized albuterol, the maximum albuterol plasma level at 0.5 hours was 2.1 ng/ml (range 1.4 to 3.2 ng/ml). There was a significant dose-related response in FEV<sub>1</sub> and peak flow rate (PFR). It has been demonstrated that following oral administration of 4 mg albuterol, the elimination half-life was five to six hours.

Animal studies show that albuterol does not pass the blood-brain barrier. Recent studies in laboratory animals (minipigs, rodents, and dogs) recorded the occurrence of cardiac arrhythmias and sudden death (with histologic evidence of myocardial necrosis) when beta-agonists and methylxanthines were administered concurrently. The significance of these findings when applied to humans is currently unknown.

In controlled clinical trials, most patients exhibited an onset of improvement in pulmonary function within 5 minutes as determined by FEV<sub>1</sub>. FEV<sub>1</sub> measurements also showed that the maximum average improvement in pulmonary function usually occurred at approximately 1 hour following inhalation of 2.5 mg of albuterol by compressor-nebulizer, and remained close to peak for 2 hours. Clinically significant improvement in pulmonary function (defined as maintenance of a 15% or more increase in FEV<sub>1</sub> over baseline values) continued for 3 to 4 hours in most patients and in some patients continued up to 6 hours.

In repetitive dose studies, continued effectiveness was demonstrated throughout the three-month period of treatment in some patients.

**INDICATIONS AND USAGE**

PROVENTIL Solution for Inhalation is indicated for the relief of bronchospasm in patients with reversible obstructive airway disease and acute attacks of bronchospasm.

**CONTRAINDICATIONS**

PROVENTIL Solution for Inhalation is contraindicated in patients with a history of hypersensitivity to any of its components.

**WARNINGS**

As with other inhaled beta-adrenergic agonists, PROVENTIL Solution for Inhalation can produce paradoxical bronchospasm, which can be life threatening. If it occurs, the preparation should be discontinued immediately and alternative therapy instituted.

Fatalities have been reported in association with excessive use of inhaled sympathomimetic drugs and with the home use of sympathomimetic nebulizers. It is, therefore, essential that the physician instruct the patient in the need for further evaluation if his/her asthma becomes worse. In individual patients, any beta<sub>2</sub>-adrenergic agonist, including albuterol solution for inhalation, may have a clinically significant cardiac effect.

Immediate hypersensitivity reactions may occur after administration of albuterol as demonstrated by rare cases of urticaria, angioedema, rash, bronchospasm, and oropharyngeal edema.

**PRECAUTIONS**

**General:** Albuterol, as with all sympathomimetic amines, should be used with caution in patients with cardiovascular disorders, especially coronary insufficiency, cardiac arrhythmias and hypertension; in patients with convulsive disorders, hyperthyroidism or diabetes mellitus, and in patients who are unusually responsive to sympathomimetic amines.

Large doses of intravenous albuterol have been reported to aggravate preexisting diabetes mellitus and ketoacidosis. Additionally, beta-agonists, including albuterol, when given intravenously may cause a decrease in serum potassium, possibly through intracellular shunting. The decrease is usually transient, not requiring supplementation. The relevance of these observations to the use of PROVENTIL Solution for Inhalation is unknown.

**Information for Patients:** The action of PROVENTIL Solution for Inhalation may last up to six hours and therefore it should not be used more frequently than recommended. Do not increase the dose or frequency of medication without medical consultation. If symptoms get worse, medical consultation should be sought promptly. While taking PROVENTIL Solution for Inhalation, other anti-asthma medicines should not be used unless prescribed.

See illustrated "Patient's Instructions for Use."

**Drug Interactions:** Other sympathomimetic aerosol bronchodilators or epinephrine should not be used concomitantly with albuterol.

Albuterol should be administered with extreme caution to patients being treated with monoamine oxidase inhibitors or tricyclic antidepressants, since the action of albuterol on the vascular system may be potentiated.

Beta-receptor blocking agents and albuterol inhibit the effect of each other.

**Carcinogenesis, Mutagenesis, and Impairment of Fertility:** Albuterol sulfate, like other agents in its class, caused a significant dose-related increase in the incidence of benign leiomyomas of the mesovarium in a 2-year study in the rat, at oral doses corresponding to 10, 50 and 250 times the maximum human nebulizer dose. In another study, this effect was blocked by the coadministration of propranolol. The relevance of these findings to humans is not known. An 18-month study in mice and a lifetime study in hamsters revealed no evidence of tumorigenicity. Studies with albuterol revealed no evidence of mutagenesis. Reproduction studies in rats revealed no evidence of impaired fertility.

**Teratogenic Effects—Pregnancy Category C:** Albuterol has been shown to be teratogenic in mice when given subcutaneously in doses corresponding to the human nebulization dose. There are no adequate and well-controlled studies in pregnant women. Albuterol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. A reproduction study in CD-1 mice with albuterol (0.025, 0.25 and 2.5 mg/kg subcutaneously, corresponding to 0.1, 1, and 12.5 times the maximum human nebulization dose, respectively) showed cleft palate formation in 5 of 111 (4.5%) of fetuses at 0.25 mg/kg and in 10 of 108 (9.3%) of fetuses at 2.5 mg/kg. Noose were observed at 0.025 mg/kg. Cleft palate also occurred in 22 of 73 (30.5%) of fetuses treated with 2.5 mg/kg isoproterenol (positive control). A reproduction study in Stride Dutch rabbits revealed craniochisis in 7 of 19 (37%) of fetuses at 50 mg/kg, corresponding to 250 times the maximum human nebulization dose.

**Labor and Delivery:** Oral albuterol has been shown to delay preterm labor in some reports. There are presently no well controlled studies which demonstrate that it will stop preterm labor or prevent labor at term. Therefore, cautious use of PROVENTIL Solution for Inhalation is required in pregnant patients when given for relief of bronchospasm so as to avoid interference with uterine contractility.

**Nursing Mothers:** It is not known whether this drug is excreted in human milk. Because of the potential for tumorigenicity shown for albuterol in some animal studies, a decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

**Pediatric Use:** Safety and effectiveness of albuterol solution for inhalation in children below the age of 12 years have not been established.

**ADVERSE REACTIONS**

The results of clinical trials with PROVENTIL Solution for Inhalation in 135 patients showed the following side effects which were considered probably or possibly drug related: **Central Nervous System:** tremors (20%), dizziness (7%), nervousness (4%), headache (3%), insomnia (1%). **Gastrointestinal:** nausea (4%), dyspepsia (1%). **Ear, Nose and Throat:** pharyngitis (<1%), nasal congestion (1%).

**Cardiovascular:** tachycardia (1%), hypertension (1%). **Respiratory:** bronchospasm (8%), cough (4%), bronchitis (4%), wheezing (1%).

No clinically relevant laboratory abnormalities related to PROVENTIL Solution for Inhalation administration were determined in these studies.

In comparing the adverse reactions reported for patients treated with PROVENTIL Solution for Inhalation with those of patients treated with isoproterenol during clinical trials of three months, the following moderate to severe reactions, as judged by the investigators, were reported. This table does not include mild reactions.

Percent Incidence of Moderate To Severe Reactions

Reaction	Albuterol N=65	Isoproterenol N=65
<b>Central Nervous System</b>		
Tremors	10.7%	13.8%
Headache	3.1%	1.5%
Insomnia	3.1%	1.5%
<b>Cardiovascular</b>		
Hypertension	3.1%	3.1%
Arrhythmias	0%	3.0%
**Palpitation	0%	22.0%
<b>Respiratory</b>		
*Bronchospasm	15.4%	18%
Cough	3.1%	5%
Bronchitis	1.5%	5%
Wheeze	1.5%	1.5%
Sputum Increase	1.5%	1.5%
Dyspnea	1.5%	1.5%
<b>Gastrointestinal</b>		
Nausea	3.1%	0
Dyspepsia	1.5%	0
<b>Systemic</b>		
Malaise	1.5%	0

\* In most cases of bronchospasm, this item was generally used to describe exacerbations in the underlying pulmonary disease.

\*\* The finding of no arrhythmias and no palpitations after albuterol administration in this clinical study should not be interpreted as indicating that these adverse effects can not occur after the administration of inhaled albuterol.

Rare cases of urticaria, angioedema, rash, bronchospasm and oropharyngeal edema have been reported after the use of inhaled albuterol.

**OVERDOSAGE**

Manifestations of overdose may include anginal pain, hypertension, hypokalemia, and exaggeration of the pharmacological effects listed in **ADVERSE REACTIONS**.

The oral LD<sub>50</sub> in rats and mice was greater than 2,000 mg/kg. The inhalational LD<sub>50</sub> could not be determined. There is insufficient evidence to determine if dialysis is beneficial for overdose of PROVENTIL Solution for Inhalation.

**DOSAGE AND ADMINISTRATION**

The usual dosage for adults and children 12 years and older is 2.5 mg of albuterol administered 3 to 4 times daily by nebulization. More frequent administration or higher doses is not recommended. To administer 2.5 mg of albuterol, either dilute 0.5 ml of the 0.5% solution for inhalation to a total vol-

January 30, 1985

Mr. Gary Brown  
Respiratory Therapy  
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#### RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were \$7.04 per day for educated providers and \$22.76 for the uneducated provider. Another bed-sized hospital statistic was \$12.50 for the educated provider while \$20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

*Marlene Moderow R.N.*

MARLENE MODEROW, R.N.  
Medical Review Field Auditor

Circle One

RP.1.6.1 When the scope of services warrants it, respiratory care services are supervised by a technical director who is registered or certified by the National Board for Respiratory Therapy, Inc, or who has the documented equivalent education, training, and/or experience.

1 2 3 4 5 NA

RP.1.6.1.1 The technical director's duties include responsibility for assuring

RP.1.6.1.1.1 the supervision of respiratory personnel in the performance of respiratory therapy and any designated related laboratory procedures;

1 2 3 4 5 NA

RP.1.6.1.1.2 the care, maintenance, and disinfection or sterilization of all ventilatory equipment, accessories, and, as required, supplies; and

1 2 3 4 5 NA

RP.1.6.1.1.3 the maintenance of appropriate records and reports.

1 2 3 4 5 NA

RP.1.6.1.2 Additional responsibilities may be designated to the technical director by the physician providing medical direction for the respiratory care services.

1 2 3 4 5 NA

RP.1.7 Other qualified respiratory care personnel provide respiratory care services commensurate with their documented training, experience, and competence.\*

1 2 3 4 5 NA

RP.1.7.1 Such personnel may include

RP.1.7.1.1 registered respiratory therapists or certified respiratory therapy technicians, or individuals with the documented equivalent in education, training, and/or experience;

1 2 3 4 5 NA

RP.1.7.1.2 qualified cardiopulmonary technologists; and

1 2 3 4 5 NA

RP.1.7.1.3 appropriately trained licensed nurses.

1 2 3 4 5 NA

RP.1.8 Personnel who provide respiratory care services comply with all applicable law and regulation.\*

1 2 3 4 5 NA

RP.1.9 The training of respiratory therapy students is carried out only in programs accredited by the appropriate professional educational organization.

1 2 3 4 5 NA

RP.1.9.1 Students are directly supervised by a qualified respiratory therapist or technician, particularly when engaged in patient care activities.

1 2 3 4 5 NA

RP.1.9.2 When the hospital provides clinical facilities for the education and training provided by an outside program, the respective roles and responsibilities of the respiratory care department/service and the outside educational program are defined.

1 2 3 4 5 NA

\*The established items are key factors in the accreditation decision process. For an explanation of the use of the key factors, see "Using the Manual," page xi.

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Endotracheal Intubation	Emergency or elective placement of endotracheal tube into the trachea or respiratory tract in order to provide an airway and/or ventilate a patient, includes infants, children, adults.	Cardiac or respiratory arrest. Any other event whereby patients can no longer breathe on their own or require possible assisted ventilation. Routinely done for long operative procedures.	<ol style="list-style-type: none"> <li>1. Improper placement of tube resulting in asphyxiation, hypoxia (lack of oxygen to brain and other vital organs), carbon dioxide narcosis.</li> <li>2. Damage and/or paralysis of vocal cords.</li> <li>3. Rupture and hemorrhage to esophagus and/or trachea.</li> <li>4. Atelectasis--collapsed lung.</li> <li>5. Pneumothorax (lung collapse)</li> <li>6. Dental fractures.</li> <li>7. Aspiration of blood, stomach contents.</li> <li>8. Infection.</li> </ol>
Suctioning	A procedure necessary for removal of secretions from endotracheal, tracheostomy tubes or the respiratory tract directly to maintain a patent, functioning airway.	Patients that have endotracheal /tracheostomy tubes in place. Patients unable to cough to remove secretions. Newborns or infants with pulmonary distress.	<ol style="list-style-type: none"> <li>1. Sudden death syndrome second vagal stimulation.</li> <li>2. Cardiac arrest or standstill</li> <li>3. Cardiac arrhythmias.</li> <li>4. Hypoxia--oxygen lack to brain vital organs.</li> <li>5. Bleeding/hemorrhage, damage trachea.</li> <li>6. Infection.</li> </ol>



PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Arterial Blood Gas Sampling	A procedure whereby a therapist inserts a needle into an artery (radial, brachial or femoral) to obtain arterial blood for analysis. Determines the need for oxygen therapy and amounts of oxygen and carbon dioxide in blood. Determines metabolic status (A/B).	To determine cardio-respiratory status of patients: Including patients with--- Shortness of breath Mechanically ventilated patients Kidney failure Trauma victims Diabetic crisis Cardiac/respiratory arrest--pre-arrest state Drug overdose Post-operative patients	<ol style="list-style-type: none"> <li>1. Damage or destruction of artery resulting ultimately in amputation of affected limb</li> <li>2. Hematoma/hemorrhage.</li> <li>3. Damage/paralysis of nerve adjacent to sampling site.</li> <li>4. Infection.</li> <li>5. Intense pain due to poor technique.</li> <li>6. Air embolus.</li> </ol>
C.P.R. - Cardio-Pulmonary Resuscitation	A life saving procedure requiring immediate and appropriate assessment and response to a patient with cardiac or respiratory arrest. Includes providing airway and artificial ventilation along with external cardiac compressions.	Cardiac or respiratory arrest. Newborn-premature infants requiring resuscitation measures at birth. Airway obstruction-chooking victims.	<ol style="list-style-type: none"> <li>1. Improper technique can result in death.</li> <li>2. Fractured ribs, sternum</li> <li>3. Liver lacerations.</li> <li>4. Gastric distention (air in stomach) with resultant aspiration/pneumonitis.</li> <li>5. Fractured necks in infants/children.</li> <li>6. Pneumothorax--burst/collapsed lung in infants/children.</li> </ol>

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
<p>Oxygen Therapy</p>	<p>Oxygen is a drug administered by a mask, nasal cannula, tent (infants/children) or positive-pressure demand valves.</p>	<p>Hypoxemia -- low oxygen content in the blood. Examples of patients requiring oxygen are:            Chronic lung patients            Emphysema            Pneumonia            Asthma            Bronchitis            Cystic Fibrosis            Cardiac patients            *There are approximately 8,000 patients in New Jersey <u>AT HOME</u> on oxygen.</p>	<ol style="list-style-type: none"> <li>1. Oxygen toxicity--results in damage to lung tissue.</li> <li>2. Blindness in infants.</li> <li>3. Can eliminate the drive to breathe in some patients (COPI)</li> <li>4. Infection.</li> </ol>
<p>Postural Drainage            Chest Percussion</p>	<p>A mode of therapy requiring proper positioning of patient for safe/effective drainage of lung segments.</p>	<p>Any disease state requiring removal of mucous secretions from lungs.            Cystic Fibrosis            Pneumonia            Bronchitis            Asthma            Emphysema</p>	<ol style="list-style-type: none"> <li>1. Can increase intracranial pressure--patient must be properly monitored--especially infants--may cause intracranial bleeding.</li> <li>2. Spread of infection to another lung segment.</li> <li>3. Aspiration.</li> <li>4. Pneumothorax.</li> </ol>



PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
<p>Aerosol Therapy</p>	<p>A mode of therapy to dispense medication directly to respiratory tract. Given by mask or hand-held device. Can be given with compressed air or oxygen to infants, children, adults. Drugs used include: Sympathomimetic agents (bronchodilators) Antibiotics Antifungal agents Mucolytics</p>	<p>Patients with shortness of breath (SOB) due to: Asthma Emphysema Chronic Lung Disease Cystic Fibrosis Tuberculosis Pneumonia Bronchitis Retained Secretions (mucous) Inhalation burns (heat, smoke) Chemical inhalation</p>	<ol style="list-style-type: none"> <li>1. Irregular heart rates/rhythms. Tachycardias/arrhythmias leading to cardiac arrest.</li> <li>2. Effects blood pressure.</li> <li>3. Can effect central nervous system causing tremors, agitation, insomnia.</li> <li>4. Nausea.</li> <li>5. Overhydration--fluid overload with resultant heart failure from excessive use of ultrasonic therapy.</li> <li>6. Allergic reactions to medications.</li> <li>7. Infection from improperly dispersed medication.</li> <li>8. Inherent problems from overuse of oxygen (see Oxygen Therapy).</li> <li>9. Can aggravate asthmatic attack if improperly administered.</li> </ol>
<p>IPPB Therapy</p>	<p>A mode of therapy to disperse medication directly to respiratory tract. Similar to aerosol therapy, but IPPB (Intermittent Positive Pressure Breathing) is administered under pressure to the lungs. Can be used with compressed air or oxygen to children, adults. Drugs include: Sympathomimetic agents Antibiotics</p>	<p>Patients with S.O.B. See Aerosol Therapy (above)</p>	<p>Same hazards as aerosol therapy and</p> <ol style="list-style-type: none"> <li>1. Pneumothorax-- air which does not belong in chest cavity requiring emergency insertion of chest tube to prevent cardio-respiratory arrest.</li> <li>2. Decreases cardiac output. Can result in arrest.</li> <li>3. Oxygen complications.</li> </ol>

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
<p>Mechanical Ventilation Respirators</p>	<p>A life support device-machine to which the patient is directly attached via endotracheal/tracheostomy tube for the purpose of providing ventilation (breathing) for the patient.</p>	<p>Any condition affecting the ability of the person to breathe thereby maintaining proper oxygen, carbon dioxide levels, adequate metabolic status to maintain life. Respiratory/Cardiac Failure Trauma/Shock Post Operative complications Anesthetic Overdose Drug Overdose Ethanol poisoning (alcohol overdose) Foreign Body Obstruction Premature Infants</p>	<p>Due to the fact that once a patient is placed on a life support system/ventilator, the ultimate hazard secondary to mechanical failure, poor monitoring of patient is, <u>death</u>, permanent brain or vital organ destruction. Some of the major medical emergencies that arise are:</p> <ul style="list-style-type: none"> <li>Decreased cardiac output</li> <li>Decreased blood pressure</li> <li>Decreased urinary output</li> <li>Barotrauma-pneumothorax</li> <li>Collapsed lung</li> <li>Oxygen toxicity</li> <li>Severe metabolic imbalances</li> <li>Severe electrolyte imbalances</li> <li>Infection</li> <li>Tracheal hemorrhage</li> </ul>

SUPPORTING LITERATURE

AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Statement advocating respiratory therapy licensure.

HOSPITAL & HEALTH SERVICES ADMINISTRATION

Spring 1990

Study demonstrating that rural hospitals with allied health services that include qualified respiratory care services are less likely to risk closure.

AMERICAN ENTERPRISE FOR PUBLIC POLICY RESEARCH

Study of occupational licensure and regulation demonstrating that licensure has no significant effect on earnings and that licensed occupations demonstrate a higher retention rate than those without licensure.

BLUE CROSS OF NORTH DAKOTA

Letter from Blue Cross of North Dakota demonstrating increased patient care costs when respiratory care is provided by uneducated providers.

# Statement Regarding Respiratory Therapy Licensure

## STATEMENT REGARDING RESPIRATORY THERAPY LICENSURE

(Approved by House of Delegates on October 16, 1985)

Anesthesiology is the practice of medicine which, in addition to the personal performance or medical direction of anesthesia care, includes clinical management of problems in Respiratory Care. The provision of Respiratory Care involves the participation of non-physicians, typically Respiratory Therapists, working under the medical direction of an Anesthesiologist or other qualified physicians. The American Society of Anesthesiologists, believing that all personnel involved in providing direct patient care must possess appropriate qualifications and competence to perform the aspects of the patient's care in which they are involved, has enthusiastically supported the efforts of the Joint Review Committee for Respiratory Therapy Education and the National Board for Respiratory Care to provide accredited educational programs and national credentials for Respiratory Therapists.

Increasingly, state legislatures are considering legal credentialing for qualified non-physician Respiratory Care Practitioners (Respiratory Therapists). Given the adequacy of non-governmental credentialing mechanisms, the Society does not support Respiratory Care licensure bills which would define the scope of practice of Respiratory Therapists and establish the qualifications of persons entitled to participate in Respiratory Care, unless no other method of credentialing appears viable and unless the bill contains adequate provisions for medical direction and educational requirements.

Any legislation relating to the credentialing of Respiratory Therapists, whether or not providing for formal licensure, should in any event be consistent with the following principles: 1) The practice of Respiratory Care by non-physicians should be permitted only under the medical direction of an Anesthesiologist or other qualified physician and 2) Minimum standards of education, training and competency should be consistent and compatible with existing national standards of non-governmental credentialing in Respiratory Care.

When called upon to deal with proposed legislation involving the credentialing of Respiratory Therapists, Component Societies of this Society are urged to assure through appropriate testimony and legislative advocacy that any proposed credentialing statute, even involving licensure, is in accordance with the principles stated above.

**ASA** AMERICAN SOCIETY  
OF ANESTHESIOLOGISTS

The American Society of Anesthesiologists

515 Busse Highway / Park Ridge, IL 60068 / (312) 825-5586

January 30, 1985

Mr. Gary Brown  
Respiratory Therapy  
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### RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

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Actual statistics for a past year for a particular bed-sized hospital were \$7.04 per day for educated providers and \$22.76 for the uneducated provider. Another bed-sized hospital statistic was \$12.50 for the educated provider while \$20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

*Marlene Moderow, R.N.*

MARLENE MODEROW, R.N.  
Medical Review Field Auditor

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# Rural Hospital Survival: An Analysis of Facilities and Services Correlated with Risk of Closure

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*Ross M. Mullner is Associate Professor in Health Resources Management, School of Public Health, University of Illinois, Chicago. Robert J. Rydman is Associate Director for Research and Development, and David G. Whiteis is Research Associate, Center for Health Services Research, School of Public Health, University of Illinois, Chicago.*

## Summary

To test whether the facilities and services offered by rural hospitals can put them at risk of closure or protect against it, this study compares U.S. rural community hospitals that closed during the period 1980–1987, with a matched set of hospitals that remained open. Utilizing epidemiologic matched case-control methods and controlling for type of ownership, we found that (1) physical therapy, respiratory therapy, intensive care unit, computed tomography scanner, hospital auxiliary, and diagnostic radioisotope were negatively correlated with closure (i.e., had a protective effect); (2) the facilities and services correlated with risk of closure differed significantly between the pre-PPS (1980–1983) and post-PPS (1984–1987) periods; and (3) the presence of a skilled nursing or other long-term care unit was a significant risk factor during the period 1984–1987. Implications of these findings for hospital survival strategies and rural health care delivery under PPS are discussed.

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*Address correspondence and requests for reprints to Ross M. Mullner, Ph.D., 10301 S. Kostner, Oak Lawn, IL 60453.*

# Has Occupational Licensing Reduced Geographical Mobility and Raised Earnings?

D. Peter Pashigian

In principle, there are several ways to determine the effects of occupational licensing on earnings and mobility. It is as difficult as possible to compare licensed with unlicensed states (since licensed occupations tend to be licensed in all or most states), but one can compare states that apply stringent standards in licensing an occupation with states that enforce less stringent standards. This popular method of measuring the effects of licensing has distinct limitations when state differences in licensing stringency are difficult to measure. An alternative approach would be to compare an occupation before and after the advent of licensing. Unfortunately, many occupations were licensed before the second decade of the twentieth century, and the dearth of information often precludes a before-and-after study.<sup>1</sup> Given these obstacles, one is forced to consider a third alternative. Licensed occupations may be compared with unlicensed occupations to determine how earnings and mobility are affected by occupational licensing. Within this approach also suffers from several drawbacks (one of which is the comparability of occupations). It does have the merit of comparing extremes: licensing and no licensing, rather than some licensing versus more licensing. The objective of this kind of study would be to determine if a "representative" licensed occupation differs in important ways from a "representative" unlicensed occupation.

This is the approach adopted here. One hundred and fifty-seven occupations, some licensed and many unlicensed, are analyzed to determine if members of licensed occupations (1) are less likely to move across state boundaries, (2) are less likely to move from one market to another within the state, (3) are less likely to change occupations, and (4) report higher earnings.

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Note: The author acknowledges the helpful comments by the discussants at the conference, Stuart Dorsey and Janice Meekins, and by participants in the 1990 Workshop and the Workshop in Applications of Economics at the University of Chicago.  
<sup>1</sup> Thomas O. Moore, "The Purpose of Licensing," *Journal of Law and Economics* (April 1961), pp. 93-117.

From: Kollerberg, S.

Occupational Licensing

Regulation - 1 Washington, DC

American Enterprise Institute  
for Public Policy Research, 1980

FROM:

ROTTENBERG, S.

OCCUPATIONAL LICENSURE AND

REGULATION

AMERICAN ENTERPRISE INSTITUTE

FOR PUBLIC POLICY RESEARCH

WASHINGTON DC.

Exhibit 1A  
3/18/91  
HB 620

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 18 day of March, 1991.

Name: Nicholas WOLFE M.D.

Address: 2921 W Macdonell Dr  
Billings MT 59102

Telephone Number: 406 652 6594

Representing whom?  
SELF + mt Soc Resp Care

Appearing on which proposal?  
Bill 620 Licensing Resp Care Practitioners

Do you: Support?  Amend?  Oppose?

Comments:  
Licensing important to ensure  
quality of care delivered to  
hospitalized patients



SENATE HEALTH & WELFARE

EXHIBIT NO. 2

DATE 3/18

HBILL NO. 620.

Amendment to HB 620

Prepared by Mary McCue for Montana Society of Respiratory Care

1. Page 6, line 6.

Following: "board"

Insert: ", except that one member of the board need not be an attorney licensed to practice law in this state"

# THE RESPIRATORY CENTER



RONALD E. BURNAM, M.D., F.C.C.P.  
FREDERICK W. KAHN, M.D., F.C.C.P.  
THOMAS P. THIGPEN, M.D., F.C.C.P.

February 8, 1991

Montana State Legislature  
State Capitol  
Helena, MT 59624

To Whom It May Concern:

I am writing you in regards to the proposed respiratory care legislature act that is before the current session of the legislature.

I am a practicing physician in Billings and a respiratory specialist. I would like to go on record as being a firm supporter of this type of legislative act.

Respiratory care has expanded rapidly over the past several years with very sophisticated modalities now available both as inpatient and outpatient possibilities. Because of the sophistication of these services that need to be provided I think that it is adamant that there be some mechanism to oversee the training and supervision of the individuals who provide these various services. It seems to me that the way that this bill is proposed it is obvious that a great deal of thought has been put into this and that the public can be assured that people who are providing services are in fact qualified.

Once again, I think this is a good thing to have and I would very much encourage your support.

Sincerely,

Thomas P. Thigpen, M.D.

TPT/bjs

# GREAT FALLS CLINIC

1400 TWENTY-NINTH STREET SOUTH  
P.O. BOX 5012  
GREAT FALLS, MONTANA 59403-5012  
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February 19, 1991

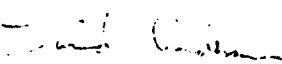
To whom it may concern:

This letter is concerning the respiratory therapy licensure bill. I very strongly favor this bill since it would standardize respiratory therapy in the state of Montana. Since Montana has two schools of respiratory therapy, namely in Great Falls and Missoula, almost every hospital in this state now has access to properly trained people in respiratory therapy, that is either certified respiratory therapy technicians or registered respiratory therapists. Therefore there should be no hardship caused by a requirement that only qualified people give respiratory therapy in hospitals in Montana.

I have been medical director of the respiratory care service at Montana Deaconess Medical Center for about 13 years and am well aware of the quality of service rendered by people properly trained in respiratory therapy compared to people who receive on-the-job training. When I took over as medical director of the respiratory care service at Deaconess, most of the people giving respiratory therapy treatments received on-the-job training. As a consequence I saw many mistakes made and also very little in the way of patient education being performed. Once the policy changed to where Montana Deaconess hired only certified or registry-eligible people or encouraged people who had received on-the-job training to get their certification or registry, there was a significant improvement in the quality of care. Licensure of respiratory therapists would also allow respiratory therapists to render services on an out-patient basis to government-financed medical care programs such as Medicaid, welfare, etc. This would significantly improve the quality of care that these people receive and I suspect in many cases would initiate respiratory care treatment early enough such that later hospital admissions for an untreated respiratory problem would not be necessary.

For these reasons, therefore, I strongly endorse a bill that would ally licensure of respiratory therapy practitioners in the state of Montana.

Best wishes,

  
David E. Anderson, M. D.

DEA/mns

INTERNAL MEDICINE  
S.P. AKRE, M.D.  
Rheumatology  
F.J. ALLAIRE, M.D.  
DE. ANDERSON, M.D.  
R.D. BLEVINS, M.D.  
Pulmonary Disease  
G.A. BUFFINGTON, M.D.  
Nephrology  
S.J. EFFERTZ, M.D.  
Rheumatology  
J.D. EIDSON, M.D.  
K.A. GUTER, M.D.  
Oncology  
PA. KREZOWSKI, M.D.  
Endocrinology  
T.J. LENZ, M.D.  
BL. MAYNARD, M.D.  
WN. MILLER, M.D.  
Gastroenterology  
TW. ROSENBAUM, M.D.  
Nephrology  
G.D. SPENCER, M.D.  
Gastroenterology  
J.D. WATSON, M.D.  
Cardiology

OBSTETRICS AND GYNECOLOGY  
CJ. BELL, DO.  
PL. BURLEIGH, M.D.  
F.J. HANDWERK, M.D.  
R.J. McCLURE, M.D.  
G.K. PHILLIPS, M.D.  
S.M. WARD, R.N., C.  
Certified Nurse Practitioner

NEURO-SCIENCES  
DE. ENGSTROM, M.D.  
Psychiatry  
WH. LABUNETZ, M.D.  
Neurology-EEG  
E.E. SHUBAT, Ph.D.  
Psychology  
T.J. KRAJACICH, Ph.D.  
Psychology

OPHTHALMOLOGY  
A.A. JORDAN, JR., M.D.

ORTHOPAEDIC SURGERY  
PA. SUAREZ, M.D.

PEDIATRICS  
J.M. EICHNER, M.D.  
NC. GERRITY, M.D.  
J.R. HALSETH, M.D.  
J.P. HINZ, M.D.  
CC. MATELICH, M.D.  
N.J. MAYNARD, M.D.  
J.G. ROSENFELD, M.D.  
D.P. RUGGERIE, DO.  
Pediatric Cardiology

SURGERY  
WP. HORST, M.D.  
Urology  
R.E. LAURITZEN, M.D.  
General and Vascular  
J.E. MUNGAS, M.D.  
Vascular and General  
M.B. ORCUTT, M.D.  
General and Vascular  
J.A. SCHVANEVELDT, M.D.  
Ear, Nose & Throat  
L.M. TAYLOR, M.D.  
General and Thoracic  
WC. VASHAW, M.D.  
General and Vascular

FAMILY PRACTICE CENTER  
J.A. ROSS, M.D.  
JW SPEER, M.D.  
TC. WEILL, M.D.  
1220 Central Avenue  
771-0090

IMMEDIATE CARE CENTER  
DR. ENGBRECHT, M.D.  
TJ. SWEENEY, M.D.  
1220 Central Avenue  
771-0000

ADMINISTRATION  
WD TAYLOR  
M.D. MISSIMER  
JC. KIRINA



# AMERICAN LUNG ASSOCIATION OF MONTANA

Christmas Seal Bldg. — 825 Helena Ave.  
Helena, MT 59601 — Ph. 442-6556

EARL W. THOMAS  
EXECUTIVE DIRECTOR

SENATE HEALTH & WELFARE

EXHIBIT NO. 3

DATE 3/18

# BILL NO. 620

TO: PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE  
CHAIR: Dorothy Eck

ROOM: 410 Monday, March 18, 1991

FROM: EARL THOMAS, EXECUTIVE DIRECTOR

SUBJECT: HB620 - SPONSOR CAROLYN SQUIRES  
"LICENSURE FOR RESPIRATORY CARE. ESTABLISHING A RESPIRATORY  
CARE BOARD:

THE AMERICAN LUNG ASSOCIATION OF MONTANA SUPPORTS HB 620  
BECAUSE WE BELIEVE IT WILL PROTECT THE PUBLIC FROM UNQUALIFIED  
RESPIRATORY CARE.

THE FIELD OF RESPIRATORY CARE IS A VERY DEMANDING ONE. ONE  
ONLY NEED LOOK AT THE COURSE OF STUDY AT EITHER OF MONTANA'S  
TWO RESPIRATORY THERAPY SCHOOLS TO RECOGNIZE WHAT A RIGOROUS  
AND SOPHISTICATED FIELD THIS IS.

RESPIRATORY CARE IS AN EXPANDING FIELD BECAUSE RESPIRATORY  
ILLNESS IS ONE OF THE FASTEST RISING DISEASES IN THE UNITED  
STATES AND MONTANA CONSISTENTLY RANKS IN THE TOP FIVE.

A NATIONAL HEALTH INTERVIEW SURVEY DONE IN 1987 SHOWED THAT  
PERSONS SUFFERING FROM CHRONIC BRONCHITIS, EMPHYSEMA AND ASTHMA  
INCREASED 75.9% FROM 1970 TO 1987. \* THE ATTACHED YELLOW SHEET  
PROVIDES FURTHER SUPPORT ON HOW LUNG DISEASE DEATHS ARE  
INCREASING.

SINCE LUNG ILLNESSES ARE 75 TO 85% PREVENTABLE. WE ARE NOW  
PAYING THE PRICE FOR THE 43% OF THE POPULATION WHO SMOKED IN  
THE 1960'S. WE ARE PROUD TO STATE THAT MONTANA CURRENTLY  
HAS ONE OF THE LOWEST SMOKING RATES IN THE COUNTRY WITH LESS  
THAN 20%. HOWEVER IT WILL BE MANY YEARS BEFORE WE SEE THE  
BENEFITS OF THIS.

RESPIRATORY CARE PRACTITIONERS ARE NOT ONLY IN HOSPITALS AND  
CLINICS BUT ALSO IN THE PATIENTS HOMES PROVIDING CARE AND  
EDUCATION.

PLEASE GIVE HB 620 A DO PASS RECOMMENATION TO INSURE THE  
CONTINUED HIGH QUALITY OF RESPIRATORY CARE

*attachment  
needed*

OFFICE OF THE GOVERNOR  
MENTAL DISABILITIES BOARD OF VISITORS



STAN STEPHENS, GOVERNOR

CAPITOL STATION

STATE OF MONTANA

(406) 444 3955  
OR TOLL FREE 1-(800)-332-2272

HELENA, MONTANA 59620

March 18, 1991

Senator Dorothy Eck  
Senate Public Health  
State Capitol  
Helena, MT 59620

SENATE HEALTH & WELFARE

EXHIBIT NO. 4

DATE 3/18

HB BILL NO. 713

Madame Chair and Members of the Committee:

For the record, my name is Kelly Moore and I serve as the Director of the Board of Visitors. The Board of Visitors reviews patient care and treatment at the Center for the Aged, along with other state-run mental health facilities. The Board of Visitors supports the changes offered in House Bill 713.

The admissions process at the Center for the Aged is covered by rule-making and the admissions screening process. Key to the admission process is a mental disorder, which is defined earlier in the commitment law. The reference to "associated with the aging process" is simply not needed. A diagnosis of a mental illness is not a result of the aging process.

We urge this committee to pass HB 713.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Moore".

Kelly Moore  
Executive Director

SENATE HEALTH & WELFARE

EXHIBIT NO. 5

DATE 3/18

H BILL NO. 620

Some Facts About House Bill 620  
Sponsored by Rep. Carolyn Squires  
Licensure of Respiratory Care Practitioners

--- Will respiratory care practitioners be given an exclusive license to practice respiratory care?

No, this bill allows other health care providers who are allowed under their own scope of practice to perform respiratory care to continue to do so.

--- How many states currently license respiratory care practitioners?

31 states have some form of licensure and regulation.

--- Do present statutes guarantee quality respiratory care? Why is licensure necessary?

Due to the legal liability of personnel departments that prevents them from providing detailed information regarding a job applicant, it is difficult for hospitals and other employers to know if a prospective respiratory care practitioner employee is competent. This allows those few incompetent practitioners to move from job to job without detection. Licensure and regulation provide a means to ensure quality respiratory care. There also presently are no mandatory continuing education requirements to ensure continuing quality respiratory care.

The Joint Commission on the Accreditation of Hospitals (JCAH) requirements that accredit hospitals has not dealt with the problem of incompetent practitioners and does not mandate continuing education.

--- Will licensure raise the cost of employing respiratory care practitioners?

No. Regarding salaries, the market dictates what respiratory care practitioners are paid, not the fact the group licensed. As to insurance reimbursement issues, Medicare, Medicaid, and private insurance policies already provide for reimbursement of respiratory care services, for both inpatient and outpatient services. This bill does not add a new group to the list of health care providers seeking reimbursement for their services.

--- Will the respiratory care practitioners who received their training on the job and who have no formal school training be able to continue working?

Yes. The bill contains a "grandfather" provision that allows respiratory care practitioners who have worked in Montana for 12 months to be licensed without examination and without completing the education requirement. They then will have to satisfy the continuing education requirement the same as other licensees.

--- Will there be a shortage of respiratory care practitioners if practitioners are licensed?

No, there are programs at the Missoula and Great Falls vo-tech centers that graduate between 30-40 respiratory technicians each year.

--- How many respiratory care practitioners are there presently in Montana?

More than 300.

SENATE WELFARE

EXHIBIT NO 6

DATE 3/18

4 BILL NO. 713

DARRYL L. BRUNO, ADMINISTRATOR ALCOHOL AND DRUG ABUSE  
DIVISION  
DEPARTMENT OF INSTUTIONS  
3/18/91

TESTIMONY FOR HB 831

The present statute is limiting as 53-24-208(1) states "The standards may concern only the health standards to be met and standards of treatment to be afforded patients." The Alcohol and Drug Abuse Division proposes the following: The standards shall be adopted by rule and may concern the health standards to be met and standards for the approval of treatment programs for patients.

This allows standards addressing administration\ organizational management, personnel/certification/staff development and client treatment addressing five components. These are necessary to the optimal functioning of a chemical dependency treatment program. Examples include personnel standards which address qualifications and certification of staff and administrative standards encompassing goals and objectives with required effectiveness indicators.

National accreditation organizations providing on site program inspections in hospitals and rehabilitation centers across Montana i.e. the Joint Commission on Accreditation of Hospitals (JCAH) and the Commission on Accreditation of Rehabilitation Facilities (CARF), conduct comprehensive reviews focusing on all areas of operation listed. Our responsibility at the state level is essentially no less than theirs.

Our current standards encompass all these but unfortunately, the Alcohol and Drug Abuse Division has had to utilize legal counsel with every rule revision to obtain rules crucial to effective programming.

Additionally, this bill expands current statute 53-24-211 (4) MCA: which states: The department may adopt rules regarding the submission, submission dates, updates, approval, and disapproval of plans." The following statement will be added " and the use of plans by the department in determining the needs of the county for the treatment, rehabilitation, and prevention of chemical dependency."

Montana law 53-24-204(1)(h) states: "The department shall encourage planning for the greatest utilization of funds by discouraging duplication of services, encouraging efficiency of services through existing programs, and



encouraging rural counties to form multicounty districts or contract with urban programs.

This expansion is necessary as the department has been challenged on its ability to utilize the relevance of the county plan in need determinations and therefore comply with Montana law. This is becoming even more critical as the public funds for community treatment programs are declining coupled with an increase in demand for services. Federal treatment funds have remained the same the past 3 years from the Alcohol, Drug Abuse and Mental health Services (ADMS) Block grant and because of declining sales of liquor beer and wine earmarked tax revenue for treatment has declined. With legislation requiring the repeat DUI offenders to receive treatment welfare clients to receive treatment if needed and a general awareness from all human service agencies of the importance of chemical dependency treatment, the demand for chemical dependency services has increased dramatically.

County plan guidelines issued by the Department require counties to perform the following tasks:

- . Document collaboration with human service agencies, law enforcement, education, prevention organizations, etc.
- . Describe service area and the county's planning process.
- . Needs assessment of the county by providing the following information: population, arrests, hospitalizations, DUI's, minor in possession arrests, admissions to treatment, and an estimation of number in need of treatment.
- . Treatment and rehabilitation services available and what county sees as a need for services. Also identifying their critical populations.
- . Prevention\education and early intervention services available and what needs the county identifies in this area, again identifying critical populations.

Given the comprehensive process, the department wishes to incorporate this information into the need determination procedure.

This bill has no fiscal impact. Realistically, the bill will save the department money. Historically, the department has been required to pay legal fees to establish our rule making authority.

OFFICE OF THE GOVERNOR  
MENTAL DISABILITIES BOARD OF VISITORS



STAN STEPHENS, GOVERNOR

CAPITOL STATION

STATE OF MONTANA

(406) 444-3955  
OR TOLL FREE 1-(800) 332-2272

HELENA, MONTANA 59620

March 18, 1991

Senator Dorothy Eck  
Senate Public Health  
State Capitol  
Helena, MT 59620

SENATE HEALTH & WELFARE

EXHIBIT NO. 7

DATE 3/18

*H* BILL NO. 862

Madame Chair and Members of the Committee:

For the record, my name is Kelly Moorse and I serve as the Director of the Board of Visitors. The MCTA was created in response to the need to establish safeguards and procedures in the area of commitment procedures, treatment standards and rights protection.

Statistics provided by the Intake Unit of MSH indicate last fiscal year that 20% of admissions were inappropriate to the state hospital.

Moreover this number of inappropriate admissions means valuable staff time and treatment is taken away from the most ill patients who are in need of treatment.

House Bill 862 provide a positive means to address the issue of inappropriate admissions.

We urge passage of HB 862.

Sincerely,

A handwritten signature in cursive script that reads "Kelly Moorse".

Kelly Moorse  
Executive Director

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 18 day of March, 1991.

Name: Dan Anderson

Address: 1539 11th Ave

Telephone Number: 444-3969

Representing whom? Dept. Justice

Appearing on which proposal? HB 713, HB 862

Do you: Support?  Amend?  Oppose?

Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
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TESTIMONY ON HB 862  
BY DAN ANDERSON  
SENATE PUBLIC HEALTH, WELFARE AND  
SAFETY COMMITTEE

MARCH 18, 1991

SENATE HEALTH & WELFARE

EXHIBIT NO. 8

DATE 3/18

H BILL NO. 862

MADAM CHAIR, MEMBERS OF THE  
COMMITTEE. MY NAME IS DAN  
ANDERSON. I AM THE  
ADMINISTRATOR OF THE MENTAL  
HEALTH DIVISION OF THE  
DEPARTMENT OF INSTITUTIONS.

THE DEPARTMENT OF INSTITUTIONS  
ESTABLISHED A MENTAL HEALTH  
LAW TASK FORCE IN 1990 TO REVIEW  
MENTAL HEALTH STATUTES AND  
MAKE RECOMMENDATIONS FOR  
CHANGE. THAT TASK FORCE  
CONSISTED OF MENTAL HEALTH  
PROFESSIONALS, ADVOCATES,  
CONSUMERS, PHYSICIANS,

ATTORNEYS AND FAMILY  
MEMBERS OF CONSUMERS. THIS BILL  
WAS DRAFTED BY, AND  
UNANIMOUSLY RECOMMENDED BY THE  
TASK FORCE. IN ADDITION, THE  
MONTANA STATE MENTAL HEALTH  
PLANNING AND ADVISORY COUNCIL  
HAS UNANIMOUSLY ENDORSED HB 862.

THIS LEGISLATION IS PART OF THE  
DEPARTMENT OF INSTITUTIONS'  
EFFORTS TO ESTABLISH A GENUINE  
SYSTEM OF MENTAL HEALTH  
SERVICES IN MONTANA. A GOAL OF  
THAT SYSTEM IS TO ASSESS  
PATIENT NEEDS AT THE LOCAL

LEVEL AND PROVIDE SERVICES THAT ARE APPROPRIATE FOR THAT PATIENT IN THE LEAST RESTRICTIVE ALTERNATIVE WHICH IS POSSIBLE. THE DEPARTMENT BELIEVES THAT ENTRY INTO THE PUBLIC MENTAL HEALTH SYSTEM SHOULD OCCUR AT A LOCAL LEVEL AND A DECISION SHOULD BE MADE THERE WHETHER OR NOT THE PERSON NEEDS THE MORE INTENSIVE SERVICES AVAILABLE AT THE MONTANA STATE HOSPITAL. A PATIENT'S FIRST CONTACT WITH THE PUBLIC MENTAL HEALTH SYSTEM SHOULD NOT BE AT MONTANA STATE HOSPITAL.

THIS LEGISLATION SEEKS TO  
STREAMLINE AND STRENGTHEN THE  
SCREENING PROCESS WHICH IS  
ALREADY IN PLACE FOR VOLUNTARY  
ADMISSIONS TO THE MONTANA  
STATE HOSPITAL. THE DEPARTMENT  
PROPOSES TO SET UP A NETWORK  
OF MENTAL HEALTH PROFESSIONALS  
WHO WILL HAVE THE AUTHORITY TO  
APPROVE ADMISSION TO THE STATE  
HOSPITAL.

MORE IMPORTANTLY, THESE  
PROFESSIONALS WILL HAVE THE  
KNOWLEDGE AND SKILLS NECESSARY  
TO FIND LESS RESTRICTIVE

COMMUNITY BASED SERVICES WHEN  
THOSE SERVICES WOULD BE  
ADEQUATE TO MEET THE PATIENT'S  
NEEDS.

THE PROCESS IS DESIGNED TO BE  
SIMILAR TO THE ADMITTING  
PROCESS OF OTHER HOSPITALS  
WHERE THERE IS A LIMITED NUMBER  
OF PEOPLE WHO HAVE ADMITTING  
PRIVILEGES TO THE HOSPITAL. WE  
BELIEVE THAT BY HAVING A  
LIMITED NUMBER OF PEOPLE WHO  
CAN MAKE REFERRALS TO THE  
STATE HOSPITAL, WE WILL BE ABLE  
TO PROVIDE TRAINING FOR THOSE



INDIVIDUALS AND ASSURE THAT  
THOSE INDIVIDUALS ARE  
PROFESSIONALS WHO ARE SKILLED  
AT ASSESSING PATIENT NEEDS AND  
ALSO SKILLED AT OBTAINING  
WHENEVER POSSIBLE, APPROPRIATE,  
NON-INSTITUTIONAL SERVICES ON  
BEHALF OF THE PATIENT.

AN IMPORTANT FEATURE OF THIS  
LEGISLATION IS THAT MONTANA  
STATE HOSPITAL STAFF WILL HAVE  
A HAND IN MAKING THE DECISION  
REGARDING VOLUNTARY ADMISSIONS.  
THIS PROVIDES FOR A CONTINUAL  
DIALOGUE BETWEEN COMMUNITY-

BASED MENTAL HEALTH  
PROFESSIONALS AND THE STAFF OF  
THE STATE HOSPITAL REGARDING  
THE APPROPRIATENESS OF  
ADMISSIONS.

IT IS IMPORTANT TO EMPHASIZE  
THAT THE GOAL OF HB 862 IS NOT  
A DECREASE IN ADMISSIONS TO  
MONTANA STATE HOSPITAL,  
ALTHOUGH THAT MAY RESULT. THE  
TRUE GOAL IS TO PROVIDE THE  
APPROPRIATE LEVEL OF SERVICES  
TO PEOPLE WITH MENTAL ILLNESS.  
STATE LAW REQUIRES THAT THE  
APPROPRIATE LEVEL OF SERVICE BE

IN THE LEAST RESTRICTIVE SETTING  
POSSIBLE.

THE DEPARTMENT VIEWS THIS  
LEGISLATION NOT AS A CURE-ALL  
FOR ASSURING APPROPRIATE  
ADMISSIONS TO THE STATE  
HOSPITAL, BUT, WE THINK HB 862  
WILL PROVIDE THE FRAMEWORK FOR  
A CONTINUUM OF CARE AND  
TREATMENT WHICH CAN BE MORE  
RESPONSIVE TO PATIENT NEEDS.

I WANT TO EMPHASIZE THAT THIS  
BILL HAS THE WIDE APPROVAL AND  
ENDORSEMENT OF THE MENTAL

HEALTH COMMUNITY IN MONTANA AS  
ONE STEP THAT WE ARE TAKING IN  
ATTEMPTING TO CREATE A GENUINE  
SYSTEM OF PUBLIC MENTAL HEALTH  
SERVICES FOR THE CITIZENS OF  
MONTANA WHO HAVE A MENTAL  
ILLNESS.

THANK YOU.

WITNESS STATEMENT

To be completed by a person testifying or a person who wants their testimony entered into the record.

Dated this 18<sup>TH</sup> day of MARCH, 1991.

Name: JANE EDWARDS

Address: MONTANA STATE HOSPITAL  
WARM SPRINGS, MT.

Telephone Number: 693-7013

Representing whom?

MONTANA STATE HOSPITAL

Appearing on which proposal?

HB 862

Do you: Support? YES Amend?      Oppose?     

Comments:

THIS BILL WOULD ALLOW <sup>JOINT</sup> ~~THE~~ DECISION-MAKING  
AND FACILITATE COMMUNICATION BETWEEN THE  
COMMUNITY PROFESSIONAL AND THE HOSPITAL  
FURTHER, BY HOPEFULLY LIMITING INAPPROPRIATE  
ADMISSIONS, IT WOULD ALLOW HOSPITAL STAFF  
TO CONCENTRATE THEIR TIME <sup>AND EFFORTS</sup> IN EVALUATING AND  
TREATING OF THE SERIOUSLY MENTALLY. FINALLY,  
THIS BILL WOULD HELP ENSURE THAT MENTALLY ILL  
PERSONS WOULD BE TREATED IN THE LEAST  
RESTRICTIVE SETTING.

TESTIMONY ON HB 713

BY: Dan Anderson, Administrator  
of Mental Health Division

TO: Senate Public Health, Welfare  
and Safety Committee

March 18, 1991

SENATE HEALTH & WELFARE

EXHIBIT NO. 9

DATE 3/18

H. BILL NO. 713

The Department is proposing this legislation to clarify the admission criteria for the Montana Center for the Aged.

It is not appropriate to refer to a mental disorder as "associated with the aging process" because it implies that the process of growing old in some way is or causes a mental disorder.

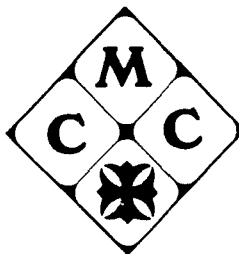
The patients admitted to the Montana Center for the Aged are older people, the minimum age is 55. All of them have a mental disorder which makes placement in a less restrictive community setting impossible.

The mental disorders of Center for the Aged residents span the diagnostic gamut from schizophrenia to organic disorders. In some cases the onset of illness was at a young age and in some cases the onset was later in life.

For none of the patients is the mental disorder attributable to the aging process and therefore, the Department requests that this language be deleted from this statute.

DA/jeb





# Montana Catholic Conference

HB 635  
MARCH 18, 1991

SENATE HEALTH & WELFARE

EXHIBIT NO. 10

DATE 3/18

HB BILL NO. 635

## MADAM CHAIRMAN ECK AND MEMBERS OF THE COMMITTEE

I am John Ortwein, representing the Montana Catholic Conference. I serve as the liaison for the two Roman Catholic Bishops of the State of Montana in matters of public policy.

The National Bishops' Committee on Pro-Life Activities has not endorsed or encouraged the enactment of living will legislation. However, as the number of states that have enacted living will legislation has grown, the Committee has sought to provide guidance by pointing to problems which deserve the special attention of legislators such as yourselves. To this end the Committee has developed two documents entitled: Guidelines for Legislation on Life-Sustaining Treatment (1984) and Statement on the Uniform Rights of the Terminally Ill Act (1986). The latter document is particularly relevant because the Montana Living Will law is based on the Uniform Act. The two guiding principles used by the Committee are: (1) One is obliged to use "ordinary" means of preserving life--that is, means which can effectively preserve life without imposing grave burdens on the patient--and the failure to supply such means is "equivalent to euthanasia"; and (2) Recognition of the patient's right to refuse "extraordinary" means--that is, means which provide no benefit or which involve too grave a burden.

The Montana Catholic Conference has several concerns about HB 635. The first deals with the definition of "terminal condition" on page 3, line 25. This definition is extremely important because it defines the overall scope of the bill. A proxy decisionmaker can demand withholding or withdrawal of virtually any health care that sustains life so long as the patient is in a "terminal condition." A patient is terminal so long as he/she will die in a "relatively short time" if treatment is not administered. This will allow for withdrawal of ethically ordinary means from otherwise medically stable patients to hasten their deaths, even if the patient could have lived a long time with the continued use of some easily provided form of assistance. For example, a mentally incompetent but otherwise robust diabetic person could be classified as "terminal" under this bill (because his diabetes is not curable and he will die soon without insulin). Then, by one interpretation of the bill, the insulin could be removed, because continuing the insulin would only "prolong dying" (that is, it will only prolong existence in this "terminal condition" albeit for many years).

Our concern is that the bill fails to distinguish between ordinary and extraordinary means of treatment. If a patient is terminal in the more traditional sense of the term--i.e., is dying soon no matter what we do for him or her, we can reasonably conclude that most forms of life-sustaining treatment are useless and therefore morally optional. If a patient needs some treatment to survive, and can live a long time with its provision, we would see a moral obligation to provide this beneficial treatment unless its use imposes grave burdens. Because the proposed legislation covers patients in this latter category and makes no distinction between treatments that are or are not gravely burdensome, it could authorize denial of ordinary means of survival.

We would suggest that the patient is in a "terminal condition" if he or she will die in the immediate future even if life support therapy is utilized. Our second concern arises on page 9 of the bill (Section 6, lines 22-24). In both the 1984 and 1986 statements I referred to earlier, the Bishops' Committee urged the establishment of a strong presumption in favor of hydration and nutrition. The proposed legislation fails to establish such a presumption. The clause on "comfort care", though welcome, does not help solve this issue. The unconscious or otherwise incompetent patients generally singled out for removal of all food and fluids will be seen as incapable of feeling the discomfort of dehydration--and if there is any question, analgesics could be provided during the dehydration process to prevent conflict with the law's "comfort care" requirement. To us the fundamental issue is that nutrition and hydration could be denied by a proxy decisionmaker even in cases where it is morally an ordinary means for sustaining life. Recently, the Pennsylvania Catholic Conference advocated that artificial feeding couldn't be withheld from a person unless they stated in a signed living will document that they didn't want it if they became terminally ill or comatose. I have attached a copy of the Pennsylvania's proposed legislation with my testimony.

Again, the Catholic Conference on the national level has taken a neutral position on living will legislation. However, the Bishops' Pro-Life Committee has set out guidelines to help in the discussion of proposed legislation. This would be our intent here today. I would hope our suggestions to the proposed legislation will be helpful in the discussion of living will legislation as this is a life and death issue for the most helpless members of our society.

11 SECTION 12. NUTRITION AND HYDRATION.

hibit # 10  
18/91 HB 635  
12 (A) PRESUMPTION.--IT IS PRESUMED THAT EVERY INCOMPETENT  
13 PERSON HAS DIRECTED HIS HEALTH CARE PROVIDERS TO PROVIDE HIM  
14 WITH NUTRITION AND HYDRATION TO A DEGREE THAT IS SUFFICIENT TO  
15 SUSTAIN LIFE. THIS PRESUMPTION SHALL NOT APPLY IN ANY OF THE  
16 FOLLOWING CIRCUMSTANCES:

17 (1) IF THE INCOMPETENT PERSON HAS A DECLARATION EXECUTED  
18 PURSUANT TO THE ACT WHICH SPECIFICALLY AUTHORIZED THE  
19 WITHHOLDING OR WITHDRAWAL OF NUTRITION AND HYDRATION AND THE  
20 PERSON HAS A TERMINAL CONDITION OR IS PERMANENTLY  
21 UNCONSCIOUS.

22 (2) IF THE INCOMPETENT PERSON HAS A TERMINAL CONDITION  
23 OR IS PERMANENTLY UNCONSCIOUS AND THE ATTENDING PHYSICIAN  
24 KNOWS, BY CLEAR AND CONVINCING EVIDENCE, THAT THE PERSON  
25 WHILE COMPETENT HAD MADE THE DECISION TO FOREGO NUTRITION AND  
26 HYDRATION OR TO HAVE NUTRITION AND HYDRATION WITHDRAWN,  
27 PROVIDED THAT SUCH DECISION WAS CLEARLY EXPRESSED AND  
28 SPECIFICALLY RELATED TO THE PROVISION OF NUTRITION AND  
29 HYDRATION.

30 (3) IF, IN THE REASONABLE MEDICAL OPINION OF THE

1 ATTENDING PHYSICIAN, THE ADMINISTRATION OF NUTRITION AND  
2 HYDRATION:

3 (I) IS NOT MEDICALLY POSSIBLE;

4 (II) WOULD ITSELF CAUSE SEVERE, INTRACTABLE AND  
5 LONG-LASTING PAIN TO THE INCOMPETENT PERSON;

6 (III) COULD NOT BE PHYSICALLY ASSIMILATED BY THE  
7 INCOMPETENT PERSON; OR

8 (IV) WOULD CAUSE SERIOUS UNCORRECTABLE MEDICAL  
9 COMPLICATIONS.

10 (4) IF, IN THE REASONABLE MEDICAL OPINION OF THE  
11 ATTENDING PHYSICIAN, THE INCOMPETENT PERSON:

12 (I) IS CHRONICALLY AND IRREVERSIBLY INCOMPETENT; AND

13 (II) IS IN THE FINAL STAGE OF A TERMINAL CONDITION  
14 AND WHOSE DEATH FROM THE UNDERLYING TERMINAL CONDITION IS  
15 IMMINENT, PROVIDED HOWEVER, NUTRITION AND HYDRATION MAY  
16 NOT BE WITHHELD OR WITHDRAWN IF THE INCOMPETENT PERSON  
17 WOULD DIE AS A RESULT OF THE DEPRIVATION OF NUTRITION AND  
18 HYDRATION RATHER THAN FROM THE UNDERLYING TERMINAL  
19 CONDITION.

20 (B) PROHIBITION.--THIS ACT SPECIFICALLY PROHIBITS ANY PERSON  
21 FROM AUTHORIZING THE WITHDRAWAL OR WITHHOLDING OF NUTRITION AND  
22 HYDRATION, AND ANY HEALTH CARE PROVIDER OR OTHER PERSON FROM  
23 WITHDRAWING OR WITHHOLDING NUTRITION OR HYDRATION FROM AN  
24 INCOMPETENT PERSON EXCEPT AS PROVIDED IN THIS ACT.

25 (C) OTHER MEASURES.--NOTHING IN THIS ACT SHALL RELIEVE THE  
26 PHYSICIAN, HEALTH CARE PROVIDER OR HEALTH CARE FACILITY OF THE  
27 OBLIGATION TO PROVIDE OTHER MEASURES DEEMED NECESSARY TO PROVIDE  
28 COMFORT TO A PERSON OR TO ALLEVIATE HIS PAIN REGARDLESS OF  
29 WHETHER A PERSON HAS A TERMINAL CONDITION.

30 Section 12 13. Penalties.

BROWNING, KALECZYC, BERRY & HOVEN, P.C.

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JOHN H. MAYNARD  
JON METROPOULOS  
MARCIA D. MORTON  
LEO S. WARD

TO: Dr. Ken Eden  
Director, Montana Medical  
Association Legislative Committee

FROM: Steve Browning, MHA Counsel

DATE: March 4, 1991

SUBJECT: HB 635 -- Uniform Rights of The Terminally Ill Act

SENATE HEALTH & WELFARE

EXHIBIT NO. 11

DATE 3/18

H BILL NO. 635

I am enclosing a copy of the "Notes and Comments" from the National Conference of Commissioners on Uniform State Laws in connection with the possible adoption of amendments to Montana's Living Will Act (cf. HB 635, introduced by Representative Measure, D. Kalispell). The notes and comments should be of considerable help to you in interpreting the new Montana law if it passes the 1991 Legislature. As you know, HB 635 has passed the Montana House of Representatives, unamended, and is now pending in the Senate Public Health Committee. No hearing has yet been set.

The attached comments were helpful in answering legislators' questions. However, they were also confusing, because the section numbers of the bills do not correspond in all cases. The table below will guide you to the proper sections if you need further interpretation of HB 635. Please call if you have questions.

SECTIONS IN HB 635

SECTIONS OF UNIFORM ACT

1. Short Title	16. same
2. Definitions	1. same
3. Declaration relating to ...	2. same
4. Revocation of declaration ...	4. same
5. Recording determination ...	5. same
6. Treatment of qualified patients	6. same
7. Transfer of patients	8. same
8. Immunities	9. same
9. Effect on insurance	11. similar
10. Penalties	10. same
11. When declaration operative	3. same
12. Consent by others to withholding...	7. same
13. When health care provider may ...	12. same
14. Effect of previous declaration	14. same
15. Codification instructions	No comparable section
16. Effective date	18. same

NATIONAL CONFERENCE OF COMMISSIONERS  
ON UNIFORM STATE LAWS

and by it

APPROVED AND RECOMMENDED FOR ENACTMENT  
IN ALL THE STATES

at its

ANNUAL CONFERENCE  
MEETING IN ITS NINETY-EIGHTH YEAR  
IN KAUAI, HAWAII  
JULY 28 - AUGUST 4, 1989

WITH PREFATORY NOTE AND COMMENTS

Approved by the American Bar Association  
Los Angeles, California, February 13, 1990

P. 1-29

Time 4:30 p.m.

NO


There being


DATE: 2/18/91

COMMITTEE ON Sen. Public Health, Welfare + Safety

HB 620, 635, 713, 831, 862

## VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
DARRYL BRUNO	Institution	831	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Egyl Thomas	American Lung Assn	620	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Kelly Morse	Board of Visitors	713/862	<input checked="" type="checkbox"/>	<input type="checkbox"/>
JANE EDWARDS	Mt. State Hospital	862	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Michael Baggino	Mt. Soc. of Respiratory Care	620	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hank Hudson	Office on Aging, Gov. Office	635/713	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rich Jundy	MT SOCIETY FOR RESPIRATORY CARE	620	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nicholas Wolter	MT SOCIETY RESY Care	620	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rose Hughes	MT. Hlth Care Assn	635	<input checked="" type="checkbox"/>	<input type="checkbox"/>
John Ostrom	MT CATHOLIC CONF	635	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mikes Gippert	C D P M	831	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Steve Brownings	Mt Hosp Assn	635	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Tim Owens	Mt. Hosp Assn	620	<input type="checkbox"/>	<input checked="" type="checkbox"/>

(Please leave prepared statement with Secretary)