MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By VICE CHAIRMAN BRUCE SIMON, on February 3, 1993, at 3:00 p.m.

ROLL CALL

Members Present:

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

Members Excused: None

Members Absent: None

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

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

Committee Business Summary:
Hearing: HB 229, HB 316
Executive Action: HB 220

HEARING ON HB 229

Opening Statement by Sponsor:

REP. DAN HARRINGTON, House District 68, Butte, said HB 229 is more than a consumer protection bill. This bill protects nursing home residents who are no longer allowed the luxury of shopping. HB 229 mandates that nursing home residents cannot be forced to

use nursing home pharmacies. These senior citizens would be guaranteed the right to choose their own pharmacy. Because nursing home residents are sometimes forced to use the in-home pharmacies, they are subject to price gouging. For example, at the Sage Nursing home in Missoula, residents were charged $8.10 for 60 cc of milk of magnesia. At a retail pharmacy, 360 cc of the same product costs $2.90.

Proponents' Testimony:

Janet Robideau, President, Montana Coalition for Nursing Home Reform (MCNHR) said the coalition believes that all people have a right to be treated with dignity and respect, especially the ones in nursing homes. Residents deserve the right to choose their own pharmacy. The coalition has documentation on admission forms that require the use of an in-house pharmacy in certain nursing homes. Residents are not told that they have a choice. **Ms. Robideau** asked the committee to give HB 229 a Do Pass recommendation.

Doug Blakley, State Ombudsman, Governor's Office on Aging, said current federal law allows nursing home residents to choose their own pharmacy as long as the nursing home facility allows them that choice. If a facility has an admission agreement that states the in-house pharmacy must be used, the resident is precluded from using a community pharmacy. Nursing home facilities want to use the in-house pharmacies for convenience and to make money. He asked the committee to give HB 229 a Do Pass recommendation.

Bill Olsen, American Association of Retired Persons (AARP), said AARP concurs with HB 229.

Bonnie Tippy, Montana State Pharmaceutical Association (MSPA), said Montana citizens deserve the right to choose where they will obtain their pharmaceutical products. **MSPA** supports HB 229. **Ms. Tippy** urged the committee to give HB 229 a Do Pass recommendation.

Cindy Polinsky, United Health Care Workers Union, Riverside Health Care Center, Hillside Manor Nursing Home, Missoula, distributed handouts that listed pharmaceutical cost comparisons between Sage Company and A and C Drugs. Sage Company owns and operates three nursing homes in Missoula. The nursing home in-house pharmacy charges $11.97 for 500 mg of vitamin C; A and C Drug charges $2.80. The in-house pharmacy charges $3.75 for aspirin; A and C charges $2.00. Hillside Manor made $56,834 profit in 1991 in sales of pharmaceuticals. Village Health Care Center made $70,720 profit in sales of pharmaceuticals in 1991. The passage of this bill has the potential to save state taxpayers, nursing home residents, and their guardians, thousands of dollars. In-house pharmacies in nursing homes dominate the market. They have no competition. Encouraging nursing home residents and their guardians to comparison shop will open up

these markets and could potentially bring down the cost of pharmaceuticals. **EXHIBIT 1.**

Lyle Shuttlesworth, Kalispell. Written testimony. **EXHIBIT 2.**

Pam Egan, Executive Director, Montana Family Union. Written testimony. **EXHIBIT 3.**

Darryl Holzer, Montana AFL-CIO, said the AFL-CIO supports HB 229.

Doug Campbell, President, Montana Senior Citizens Association (MSCA), said MSCA supports HB 229.

Dan Shea, Montana Low Income Coalition (MLIC), said MLIC supports HB 229. He urged passage of the bill.

Opponents' Testimony:

Rose Hughes, Executive Director, Montana Health Care Association (MHCA). Written testimony. **EXHIBIT 4.**

Rick Ojala, Administrator, Park Place Health Care Center, Great Falls. Written testimony. **EXHIBIT 5.**

Debra Wilson, Registered Nurse, B,S.N., Kalispell. Written testimony. **EXHIBIT 6.**

Linda Benson, Registered Nurse, Director of Nursing, Brendan House, Kalispell. Written testimony. **EXHIBIT 7.**

Paulette Docktor, Consultant Pharmacist. Written testimony. **EXHIBIT 8.**

Joanne Verlanic-Scherger Director of Nursing, Hillside Manor, Missoula, Written testimony. **EXHIBIT 9.**

Donna Kay Jennings, Registered Nurse, Administrator, Village Health Care Center, Missoula, said she is opposed to HB 229.

Bill McLean, Owner/Operator, Four Nursing Homes, Montana, said his facilities were the first to implement a unit dose system for pharmaceuticals because more than half of the staff's time was spent preparing medications, with a potential of a high rate of error. This method is more costly, but there is savings in labor, and licensed staff are able to give more time to patient care.

Bob Olsen, Montana Hospital Association, said over half the patients in nursing homes are Medicaid clients and there is a different way of reimbursing for pharmaceuticals. Hospitals that operate nursing homes are limited to the direct acquisition costs of those pharmaceuticals and are not allowed any markup upon billing Medicaid. Some over-the-counter drugs made available by a pharmacy are not covered by Medicaid and are chargeable to a

personal fund; others are required to be provided in the room rate. This complicates making a choice for people on Medicaid. Will the patients' right to choose be on a drug by drug basis or on a pharmacy by pharmacy basis? Will patients choose one drug from one pharmacy, choose another from the facility, and another from the hospital? Who is going to guide the patients in making these choices? The ultimate responsibility rests with the nursing home facility. The Board of Pharmacy requires community pharmacists to counsel their patients. There is an exemption for nursing homes that operate a certified pharmaceutical program. Will the community pharmacists who bring drugs to patients in the nursing home be responsible for counseling them, or will the nursing home be responsible? These issues need to be addressed by the Board of Pharmacy before HB 229 is passed.

Informational Testimony:

Denzel Davis, Administrator, Health Facilities Division, Department of Health and Environmental Sciences. Written testimony. **EXHIBIT 10.**

Questions From Committee Members and Responses:

REP. RUSSELL asked **Cindy Polinsky** if community pharmacies would be able to comply with the unit dose system. **Ms. Polinsky** said she knew of several pharmacies in Missoula that supply unit dose pharmaceuticals. These pharmacies also supply twenty-four hour emergency service. In-house pharmacies are often only open part-time. **REP. RUSSELL** asked **Ms. Polinsky** how much the pharmacies charge for unit dosages. **Ms. Polinsky** said the pharmacies she checked on didn't charge for packaging.

REP. DOWELL asked **Debra Wilson** who dispenses the prescription drugs at Brendan House. **Ms. Wilson** said licensed practical nurses and the medical nurses dispense prescription drugs.

REP. SIMON said one of the important services pharmacists provide is consultation to customers about medicines that don't react properly together. **REP. SIMON** asked **Bonnie Tippy** how pharmacists could counsel nursing home residents who buy drugs from several different pharmacies. **Ms. Tippy** said every nursing home is required to have a consultant pharmacist to review the records of patients. **REP. SIMON** said nursing homes wouldn't have contracts with pharmacies chosen by nursing home residents. He asked **Ms. Tippy** if the monitoring of different drugs taken by a patient, for reaction against each other, would be the responsibility of the nursing home and not the individual pharmacies. **Ms. Tippy** said she believed the nursing home would have to take the responsibility for monitoring the medications the patients take.

REP. SIMON asked **Rose Hughes** to comment on the amendment **REP. HARRINGTON** offered. **Ms. Hughes** said the amendment doesn't cover all the issues MHCA has raised. The amendment doesn't address

contract pharmacies, and it doesn't address the policies and standards of nursing homes, that pharmacies chosen by residents need to meet.

REP. SIMON asked **REP. HARRINGTON** if the intent of his amendment was to have pharmacies provide medications within the guidelines of nursing homes. **REP. HARRINGTON** said that was exactly the intent of the amendment. **REP. SIMON** asked **REP. HARRINGTON** in closing, to address the issue of who would be responsible for controlling nursing home residents using a variety of pharmacies for different medications to ensure there wouldn't be adverse reactions due to mixing certain medications. **REP. HARRINGTON** said he would address the issue in closing.

REP. HANSEN asked **Melissa Case, Montana Coalition for Nursing Home Reforms,** to clarify what the residents rights document is. **Ms. Case** said when individuals enters a nursing home, they receive a document explaining their rights as residents. Under item 3, of the document, the right to choose a pharmacy is not clearly stated. The residents need to be clearly aware that they do have a right to choose a pharmacy. HB 229 clarifies the residents rights to choose their own pharmacy.

REP. HANSEN asked **Rose Hughes** if her references to policies and standards were references to federal regulations for pharmacies within the nursing home facilities. **Ms. Hughes** said yes, nursing homes are required to abide by federal regulations in receiving medications, counting, storing, and administering them in a timely manner. Every nursing home facility has policies that cover whether or not the unit dose system will be used, the amount of medication, and twenty-four hour availability of services. These are the issues pharmacies have to agree to in order to deal with the nursing home facility.

REP. BOHLINGER asked **Denzel Davis** to expand on his statement that a conflict might exist with Medicaid and Medicare under the provisions of the bill that relate to the Freedom of Choice Act. **Mr. Davis** said it appears that although residents have rights in nursing homes, their rights may be overridden by the federal regulations which demands and dictates to the facility, the controls for medications.

REP. SAYLES asked **Linda Benson** if federal regulations require the individual packaging of nonprescription drugs, for example, milk of magnesia. **Ms. Benson** said in nursing homes, milk of magnesia is a prescription medicine. **REP. SAYLES** asked **Denzel Davis** if federal regulations required individual packaging. **Mr. Davis** said the federal regulations don't specifically state what dispensing method must be used. **REP. SAYLES** asked **Mr. Davis** why nursing homes couldn't buy some medications, such as vitamin C and milk of magnesia, in volume amounts to save on the cost. **Mr. Davis** said dispensing bulk medications, which would include putting the medications in cups, and making sure the dosage is correct would be a very labor intensive situation.

REP. BARNHART asked **Rose Hughes** if she knew of any nursing home residents that were exercising their rights to choose their own pharmacy. **Ms. Hughes** said there are residents in nursing home facilities around the state that are exercising that right, but not many. **REP. BARNHART** asked **Ms. Hughes** if nursing home facilities encourage residents to choose their own pharmacies. **Ms. Hughes** said she didn't know how many facilities specifically encourage individuals to choose their own pharmacy. Facilities are required by federal law to explain to the residents what their rights mean and encourage them to make choices and decisions.

REP. BERGMAN asked **Melissa Case** if the price gouging at the three nursing homes in Missoula is unique or is it going on in other nursing homes in the state. **Ms. Case** said the problem is not unique to Missoula. The testimony presented by **Ms. Benson,** is only a small portion of evidence that has been gathered. Price gouging goes on in other parts of the state as well. **Ms. Case** said she received a call from a resident who said he/she just paid $8.00 for an eight ounce glass of prune juice. If an individual brings in medication such as vitamin C, that is not in the proper packaging required by the nursing home, there can be an administering fee charged. The legislation does not advocate that nursing home facilities eliminate administering fees for bulk packaged medications brought in by residents or their families. It does allow residents and their families to shop for the best prices.

REP. BERGMAN asked **Rose Hughes** if she agreed with **Ms. Case's** comments. **Ms. Hughes** said she did not. There is nothing in the bill that states how much can be charged for each drug. **Ms. Hughes** said she did not believe the price gouging problem is widespread because she would have heard about it and that hasn't been the case.

REP. SQUIRES asked **Rose Hughes** if patients in nursing homes were allowed to self-administer medications. **Ms. Hughes** said patients are allowed to self-administer medications, but there are certain regulations that need to be adhered to. She suggested **Rick Ojala** respond to the question. **Rick Ojala** said if the patient is mentally capable and the physician orders it, the patient can self-administer medication.

REP. SIMON asked **Rose Hughes** who developed the residents' rights form. **Ms. Hughes** said the form was developed by the Montana Health Care Association. **REP. SIMON** said item 3 of the form doesn't clearly state that residents have the right to choose their own pharmacy and asked **Ms. Hughes** if the form could be changed to more clearly state this right, to which she replied, absolutely.

CHAIRMAN BOHARSKI asked **Rose Hughes** what percent of the nursing home patients in Montana are receiving Medicaid and Medicare. **Ms. Hughes** replied 62 % are receiving Medicaid and approximately

5% to 7% receive Medicare. **CHAIRMAN BOHARSKI** asked **Ms. Hughes** what percent of the remaining 31% of patients were paying through some type of insurance and what percent were paying out-of-pocket. **Ms. Hughes** said she didn't have the statistics, but very few of the patients pay through some type of insurance.

CHAIRMAN BOHARSKI asked **Ms. Hughes** if an administering fee can be charged a patient who orders suppositories from a pharmacy and has them delivered, if the bill goes into effect. **Ms. Hughes** said the pharmacy charge is not included in the nursing staff's administering a drug to a patient. Under the bill, nursing homes cannot charge for anything specifically related to pharmacy charges.

CHAIRMAN BOHARSKI asked **REP. HARRINGTON** if that is the intent of the bill, to which he replied yes. **CHAIRMAN BOHARSKI** asked **REP. HARRINGTON** if the patient can't be assessed for the pharmaceutical fee, how will the costs be recovered. **REP. HARRINGTON** said the cost is covered in the cost of the nursing home.

Closing by Sponsor:

REP. HARRINGTON said HB 229 is necessary. It is just one more step towards guaranteeing the rights of nursing home residents; it's cost effective, and will save residents money.

HEARING ON HB 316

Opening Statement by Sponsor:

REP. COCCHIARELLA said people in nursing homes are not always receiving quality care. In most cases, the reason is 90 out of 100 nursing homes are understaffed. The State of Montana adopted rules to set staffing levels of nursing homes in 1977. Those levels have not been changed since then. These people deserve quality care. There are amendments to the bill that adds the RN back in and takes out the time lines for daytime, evening, and nighttime. **EXHIBIT 11.** The fiscal note is inaccurate. It is less than what the bill will cost.

Proponents' Testimony:

Janet Robideau, Montana Coalition for Nursing Home Reform. Written testimony. **EXHIBIT 12.**

Doug Blakley, State Ombudsman, Governor's Office On Aging. Written testimony. **EXHIBIT 13.**
Betty Meagher, Resident, Riverside Health Care Center, Missoula, said her complaint is her bath days are Wednesdays and Saturdays and if she doesn't request a bath she doesn't get one. **Ms. Meagher** said her roommate had to wait 20 minutes the other day before her room bell was answered because there is not enough help.

Donna Booth, Daughter of Betty Meagher, said her mother has been at Riverside Health Care Center for three years. The patients can't get water delivered to their rooms because of staff shortage. **Ms. Booth** said her mother's baths are scheduled, but sometimes she has to wait until the next day and sometimes it is skipped completely. **Ms. Meagher** has gone without a bath several times for eleven days. Patients have gone without clean clothes because there is not enough staff. It usually takes 20 to 25 minutes for call lights to be answered. One night it took two and one-half hours to answer a call light because the facility was short-staffed. One patient was left in the bathroom for over an hour. Residents don't get their hair combed on a regular basis. **Ms. Booth** said recently she observed eight patients who didn't have on clean clothes and their hair was uncombed. One patient wore the same dress for nine days until **Ms. Booth** told the nurse she needed clean clothes. Nurses do not make sure patients hands are washed before leaving the bathroom and before eating. There is a constant turnover of aides and nurses. This constant change causes residents to be anxious. Aides and nurses have been told they cannot talk to residents about being short of staff. Quality care at the present staff level is not possible.

Barbara Booher, Executive Director, Montana Nurses Association (MNA), said MNA recommends passage of HB 316 as amended.

John Wyman, Montana Coalition for Nursing Home Reform, read a statement from **Genevieve Broughton,** resident at Cascade County Nursing Home (Horizon), Great Falls. **EXHIBIT 14.**

Doug Campbell, Missoula, said he supports HB 229.

Lyle Shuttlesworth, Kalispell, said his mother has been a resident at Heritage Place in Kalispell for eight and one-half months. During that time he said he has observed alzheimer residents wandering into other resident's rooms, which is a danger to bed confined residents, residents wandering out of doors unattended with no coat or hat during 15 degree temperatures, only one medication nurse on duty for forty residents, and residents having to wait two and one-half hours before their call lights are answered. He asked the committee to give HB 316 a Do Pass recommendation.

Louisa Clark, Registered Nurse, Heritage Place, Kalispell. Written testimony. **EXHIBIT 15.**

Brent Fay, Nursing Assistant, Hillside Manor, Missoula. Written testimony. **EXHIBIT 16.**

Cheryl Brewer, Nursing Assistant, Riverside Health Care Center, Missoula. Written testimony. **EXHIBIT 17.**

George Coverdale is in support of HB 316.

Bess Frazen, Montana Coalition for Nursing Home Reform Billings,

said her mother had been in four nursing homes. She suffered embarrassment, degradation, and humiliation. She sat in her own urine; she was tied to a chair; she was drugged; she had her arm pulled out of her shoulder socket; and had a stroke. These things happened because the nursing homes were understaffed. Nursing homes are making tremendous profits at the expense of the helpless elderly.

Alice Campbell, Vice Chair, Montana Coalition for Nursing Home Reform. Written testimony. **EXHIBIT 18.**

Jan Hauley, Registered Nurse, Billings, said the testimony given by residents of nursing homes is true. **Ms. Hauley** supports HB 316.

Melissa Case, Self, is in support of SB 316.

Wendy Neal, Missoula. Written testimony. **EXHIBIT 19.**

Lillian Addison, Missoula. Written testimony. **EXHIBIT 20.**

Bruce Powsner, Missoula. Written testimony. **EXHIBIT 21.**

Donna Maupin, Libby. Written testimony. **EXHIBIT 22.**

Sharon Harrington and Lucy Pomeroy, Libby. Written testimony. **EXHIBIT 23.**

Teri Nelson, Libby. Written testimony. **EXHIBIT 23.**

Connie Skousen, Missoula Women for Peace, Missoula. Written testimony. **EXHIBIT 24.**

Raymond Gold, Missoula. Written testimony. **EXHIBIT 25.**

Pam Egan, Executive Director, Montana Family Union. Written testimony. **EXHIBIT 26.**

Opponents' Testimony:

Rose Hughes, Executive Director, Montana Health Care Association. Written Testimony. **EXHIBIT 27.**

Rick Ojala, Park Place Health Care Center, Great Falls. Written testimony. **EXHIBIT 28.**

Bob Andersen, Department of Corrections, Human Services said he opposes HB 316 because of the price tag associated with it. The impact to the department is about $400,000 annually. The amendments to HB 316 could triple that amount. The department has been asked to reduce their fiscal year budget by $22,000,000.

Bob Olsen, Montana Hospital Association, said if the committee votes to put more staff in nursing home it will have to vote to put more money in nursing home payment system. There has been criticism that nursing homes are making a profit. Nursing homes shouldn't have to apologize for making a profit. Nursing homes are very conscientious about the care they deliver.

Bob Bonato, Administrator, Colonial Manor, Deer Lodge, said HB 316 will add $40,000 annually to his budget. **Mr. Bonato** said if the state and the residents will accept a two dollar rate increase by the nursing home, he will support the bill.

Connie Thisselle, Administrator, Hillside Manor, Missoula, is opposed to HB 316.

Informational Testimony:

None

Questions From Committee Members and Responses:

REP DOWELL asked **Linda Sandman, Department of Health and Environmental Sciences,** if she had seen an increase in the deficiencies of staffing during surveys of nursing home. **Ms. Sandman** said the department has seen an increase in deficiencies within the last year. Staffing complaints are very common, and come from residents. families of residents, and staff members.

REP. NELSON asked **Bob Bonato** if two out of three patients in nursing homes receive Medicaid. **Mr. Bonato** said about 25% of the patients at Colonial Manor receive Medicaid. The amount varies for each nursing home. Statewide the percentage of patients receiving Medicaid is approximately 60%. **REP. NELSON** asked **Mr. Bonato** if his assumption that private pay patients don't have insurance, and pay for nursing home care with their assets was correct, to which he replied yes. **REP. NELSON** asked **Mr. Bonato** if the cost increase would be shifted to private pay residents if HB 316 passes and there is an increase in staff. **Mr. Bonato** replied if that is the only way to get additional revenue, private pay residents would have a cost increase. They will run out of money sooner, will have to receive Medicaid, and the state will end up incurring the cost.

REP. GRIMES asked **Denzel Davis** if administrative rules address staffing patterns. **Mr. Davis** said there is an existing administrative rule.

REP. GRIMES asked **REP. COCCHIARELLA** if there is a direct correlation between the staffing pattern and Montana's workers compensation claims. **REP. COCCHIARELLA** said staff injury rates in nursing homes are high, and directly related to staffing levels.

REP. MOLNAR asked **REP. COCCHIARELLA** how many states use the number of beds in a nursing home as a criterion for staffing. **REP. COCCHIARELLA** referred **REP. MOLNAR** to the National Nurse Survey. **EXHIBIT 29.**

REP. SQUIRES asked **John Chappuis, Social and Rehabilitation Services,** how much money was raised on the bed tax. **Mr. Chappuis** said the tax was on Medicaid and third party payers only. The first year it was 1.4 million dollars; the second year it doubled. There is a new bed tax proposal for $2.85 per bed the first year and $3.65 per bed the second year. The tax will generate approximately 3.4 million the first year and 5.2 million the second year.

REP. SQUIRES asked **Rose Hughes** how many bed tax dollars went toward staffing nursing homes. **Ms. Hughes** the tax dollars are being used to catch up to what nursing homes were spending two years ago. Bed tax dollars are not for increasing staff.

REP. SIMON asked **REP. COCCHIARELLA** if the staffing level is determined by both occupied and unoccupied beds. The bill doesn't address this. **MS. COCCHIARELLA** said in Montana there is an occupancy rate of about 91%. There was never an intent to have staffing for unoccupied beds. **REP. COCCHIARELLA** said an amendment to the bill on this issue would be acceptable.

REP. SIMON expressed concern that HB 229 addressed lowering the costs for residents by giving them the option of choosing their own pharmacy. HB 316, if implemented, would increase the cost of nursing home care. There is a very serious conflict between the two bills. He asked **Melissa Case** how that conflict can be resolved. **Ms. Case** said she felt nursing home residents would be willing to accept a cost increase for quality care. They are not willing to pay additional money on pharmaceuticals that are overpriced.

REP. RUSSELL asked **Bob Olsen** if nursing homes are ever decertified or put on notice, and what are some of the citings that would institute this. **Mr. Olsen** said if staffing is found to be out of compliance, a corrective action plan is required from the nursing home that responds to the deficiencies. He didn't know of any actual decertifications. **REP. RUSSELL** asked **Mr. Olsen** if nursing home residents have a channel to let their concerns be known when a nursing home is due for recertification. **Mr. Olsen** said nursing home residents are allowed to have their own counsel, and allegations of abuse or deficient care are required to be documented. The ombudsman investigates those incidences and the Department of Health may also investigate the allegations. The nursing homes must keep records that show what has been done to investigate those incidences, and what has been done to rectify them.

REP. RUSSELL asked **Doug Blakley** if he new of any law suits that have been filed against nursing homes by residents because of

inadequate care. **Mr. Blakley** said he had been involved in a few cases where residents have been in the process of pursuing legal action against nursing homes. He said to his knowledge, none of the cases ever actually got to the courts. The majority of residents who have problems of this sort, never bring them to anyone's attention. They are afraid to talk to anyone about them.

REP. BARNHART asked **REP. COCCHIARELLA** if residents and their families are entitled to read the records of investigations at nursing homes. **REP. COCCHIARELLA** said the records are public information and nursing homes must make them available.

CHAIRMAN BOHARSKI said staffing hours used to be based on care giver hours and more staff could be on duty during the busiest times of the day. The proposed staffing method is blocked in evening, day, and night hours. The demands on the staff are probably from 6:00 a.m. to 10:00 a.m., when they are getting residents out of bed and at breakfast time, 11:30 a.m. to 1:30 p.m. for lunch, and during the evening at dinnertime and bedtime. **CHAIRMAN BOHARSKI** asked **REP. COCCHIARELLA** if some extra four hour shifts would be better during the busiest hours rather than having all eight hour shifts. **REP. COCCHIARELLA** said there is never a down time for a CNA on any shift. The bill could be amended to add more staff during the busiest hours. Residents of nursing homes have the right to get out of bed any time of the day they want to and not have to have their meals at a certain time. Nursing homes should be complying with these regulations. This could change the mealtime issue.

CHAIRMAN BOHARSKI asked **Rose Hughes** if the 2.2 million dollars per year to implement the bill is in addition to the executive budget. **Ms. Hughes** said that money is not in the budget. A portion of it is federal funds.

Closing by Sponsor:

REP. COCCHIARELLA said the public needs to know what goes on in nursing homes. There is another bill that deals with that. There needs to be more hands-on time from care givers. It is not right that directors of nursing homes, registered nurses, and licensed practical nurses, spend their time in offices filling out a multitude of forms and duplicating forms that the federal government requires. The bottom line is every nursing home resident deserves quality care, regardless of who pays for their care. **REP. COCCHIARELLA** asked the committee to give HB 316 a Do Pass recommendation.

EXECUTIVE ACTION ON HB 220

Motion: **REP. SIMON MOVED HB 220 DO PASS.**

Motion: **REP. SIMON MOVED HB 220 DO PASS AS AMENDED.**

Discussion: **REP. SIMON** explained the amendments to HB 220 **EXHIBIT 29.**

Vote: Voice vote was taken. Motion **CARRIED** unanimously.

Vote: **HB 220 DO PASS AS AMENDED.**

ADJOURNMENT

Adjournment: The meeting was adjourned at 7:20 p.m.

WILLIAM E. BOHARSKI, Chair

ALYCE RICE, Secretary

WB/ar

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 2-3-93

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

HOUSE STANDING COMMITTEE REPORT

February 4, 1993

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 220 (first reading copy -- white) do pass as amended .

Signed: Wm E Boharski
Bill Boharski, Chair

And, that such amendments read:

1. Title, line 7.
Following: "50-16-704"
Insert: ", 50-16-705"

2. Page 1.
Following: line 15
Insert: "(2) "Designated officer" means the person whose name is on record with the department as designated by an emergency services provider as the intermediary between the provider and health care facilities for purposes of reporting an unprotected exposure to an infectious disease."

Renumber: subsequent subsections

3. Page 2, line 1.
Strike: "designated by department rule as"

4. Page 2, line 2.
Following: "exposure"
Insert: ", including the diseases of human immunodeficiency virus, hepatitis B, hepatitis C, hepatitis D, communicable pulmonary tuberculosis, meningococcal meningitis, herpes simplex virus, tetanus, and other diseases that may be designated by department rule

Committee Vote:
Yes ___, No ___.

5. Page 2, lines 5 through 10.
Following: "means" on line 5
Insert: ":(a)"
Following: "exposure" on line 5
Strike: the remainder of line 5 through "patient" on line 10
Insert: "to infectious agents, such as bodily fluids;
(b) exposure through inhalation or percutaneous inoculation;
(c) nonbarrier-protected contact with an open wound, nonintact skin, or mucous membrane; or
(d) contact with other potentially infected materials designated by department rule"

6. Page 2, line 14.
Following: "~~disease~~"
Insert: "to disease"

7. Page 3, line 3.
Strike: "highest ranking"
Insert: "designated"

8. Page 3, lines 4 and 5.
Strike: "the exposure to the infectious disease"
Insert: "those matters required by 50-16-703(2)"

9. Page 3, line 5.
Following: "The"
Insert: "designated"

10. Page 4, line 1.
Following: "facility"
Insert: "within 24 hours"

11. Page 4, line 10.
Strike: ":"

12. Page 4, line 11.
Strike: "(a)"
Strike: "highest ranking"
Insert: "designated"

13. Page 4, lines 12 and 13.

Strike: "; or" on line 12 through remainder of line 13
Insert: "who suffered the unprotected exposure."

14. Page 4, line 15.
Strike: "may have"
Insert: "has"

15. Page 5, line 7.
Strike: "or"
Following: "physician"
Insert: ", or the designated officer of an organization employing an emergency services provider"

16. Page 5, line 11.
Strike: "suspected"
Insert: "who filed the report"

CUTTING THE COSTS,
WITHOUT CUTTING CORNERS
ON QUALITY CARE

If your loved one is currently living in a nursing home, you understand that the costs involved for quality care are extremely high.

Often, the life savings of our loved ones are drained. They lose valuable property and the dignity that they had in being self reliant.

Frequently, nursing homes run by private companies, like the SAGE Company, add extra costs, in addition to the already steep rates they charge for room and board.

Inflated prices for pharmaceuticals, medical supplies , and physical therapy, add hundreds of dollars to our loved one's monthly bill.

Nursing home residents and guardians are consumers. We can have a voice in how our life savings and tax dollars are spent. We can win the fight for affordable, quality care for our loved ones.

Cutting The Cost Of Quality Care

The first in a series of informational brochures

HILLSIDE MANOR NURSING
RESIDENT SERVICE REVENUE
YEARS ENDED DECEMBER 31,

	1991	1990
DAILY RESIDENT SERVICES		
Private	$ 734,213	$ 674,228
Medicare	173,439	149,554
Medicaid	1,260,199	1,293,533
Other third party	18,217	304
TOTAL DAILY SERVICES	$ 2,186,068	$ 2,117,619
ANCILLARY SERVICES		
Physical therapy	$ 24,820	$ 0
Pharmacy	172,174	151,497
Speech therapy	1,916	0
Oxygen	2,595	2,249
Medical supplies	29,884	25,656
Durable medical equipment	33,112	3,530
Occupational therapy	12,880	0
ANCILLARY SERVICES	$ 277,381	$ 182,932
TOTAL RESIDENT SERVICE REVENUE	$ 2,463,449	$ 2,300,551
DISCOUNTS AND ALLOWANCES		
Private	$ (1,765)	$ 51
Medicaid	4,990	101
Medicare	24,735	(4,305)
Other third party	6,827	117
Provision for uncollectible accounts	156	1,755
TOTAL DISCOUNTS AND ALLOWANCES	$ 34,943	$ (2,281)

EXHIBIT 1
DATE 2/3/93
HB 229

HILLSIDE MANOR NURSING
DETAIL OF OPERATING EXPENSE
YEARS ENDED DECEMBER 31,

	1991	1990
SPECIAL SERVICES		
PHYSICAL THERAPY		
Supplies	$ 186	$ 35
Outside contracted services	10,526	0
	$ 10,712	$ 35
PHARMACY		
Salaries and wages	$ 24,926	$ 24,195
Drugs	88,206	83,391
Pharmacy supplies	1,658	0
Outside contracted services	550	0
	$ 115,340	$ 107,586
SPEECH THERAPY		
Outside contracted services	$ 1,176	$ 0
	$ 1,176	$ 0
OXYGEN		
Supplies-oxygen	$ 2,344	$ 914
	$ 2,344	$ 914
MEDICAL SUPPLIES		
Chargeable medical supplies	$ 17,521	$ 17,104
Durable medical equipment--rental	19,354	2,982
	$ 36,875	$ 20,086
OCCUPATIONAL THERAPY		
Supplies	$ 247	$ 0
Outside contracted services	4,884	0
	$ 5,131	$ 0
TOTAL SPECIAL SERVICES	$ 171,578	$ 128,621

EXHIBIT 1
DATE 2/3/93
HB 229

VILLAGE HEALTH CARE CENTER
DETAIL OF OPERATING EXPENSE
YEARS ENDED DECEMBER 31,

	1991	1990
SPECIAL SERVICES		
PHYSICAL THERAPY		
Salaries and wages	$ 5,853	$ 0
Supplies	1,269	0
Outside contracted services	24,638	0
	$ 31,760	$ 0
PHARMACY		
Salaries and wages	$ 42,299	$ 40,792
Drugs	137,063	109,883
Supplies	4,701	0
Outside contracted services	7,700	2,878
	$ 191,763	$ 153,553
SPEECH THERAPY		
Outside contracted services	$ 767	$ 0
	$ 767	$ 0
LABORATORY		
Outside contracted services	$ 40	$ 355
	$ 40	$ 355
OXYGEN		
Outside contracted services	$ 0	$ 25
Supplies-oxygen	2,212	3,451
	$ 2,212	$ 3,476
MEDICAL SUPPLIES		
Salaries and wages	$ 4,833	$ 4,103
Chargeable medical supplies	29,886	19,910
Durable medical equipment--rental	21,701	10,752
	$ 56,420	$ 34,765
OCCUPATIONAL THERAPY		
Supplies	$ 62	$ 0
Outside contracted services	13,984	0
	$ 14,046	$ 0

VILLAGE HEALTH CARE CENTER
RESIDENT SERVICE REVENUE
YEARS ENDED DECEMBER 31,

	1991	1990
DAILY RESIDENT SERVICES		
Private	$ 748,257	$ 885,589
Medicare	295,816	327,256
Medicaid	2,014,501	1,844,510
Other third party	91,799	49,640
TOTAL DAILY SERVICES	$ 3,150,373	$ 3,106,995
ANCILLARY SERVICES		
Physical therapy	$ 80,640	$ 0
Pharmacy	262,483	234,656
Speech therapy	1,050	0
Oxygen	4,425	5,770
Medical supplies	58,758	44,200
Durable medical equipment	34,849	12,953
Occupational therapy	29,765	0
ANCILLARY SERVICES	$ 471,970	$ 297,579
TOTAL RESIDENT SERVICE REVENUE	$ 3,622,343	$ 3,404,574
DISCOUNTS AND ALLOWANCES		
Private	$ 9,843	$ 2,791
Medicaid	11,022	8,568
Medicare	79,859	(11,111)
Other third party	9,621	2,477
Provision for uncollectible accounts	2,166	3,688
TOTAL DISCOUNTS AND ALLOWANCES	$ 112,511	$ 6,413

EXHIBIT 3
DATE 2-3-93
HB 229

The Honorable Bill Boharski and Committee Members:

Dear Sirs,

I am Lyle Shuttlesworth of House District #7 Kalispell, Montana.
For the past eight and one half months my mother, Ellen Shuttlesworth, has been a resident at Heritage Place in Kalispell. My wife, Hannah, and I have visited her an average of five days a week, three hours a visit, during this time. We have observed that there is not adequate help to take proper care of the residents.
Examples:

(1) Up to two hours to answer call light.
(2) Alzheimer's residents wandering into other residents rooms being a danger to bed confined residents.
(3) Nurse station often vacant during meals from 12:00 noon to 2:00 p.m. and from 5:00 p.m. to 7:00 p.m. So there is no one to answer call lights.
(4) Residents wandering out of doors unattended. No coat or hat at 15 degrees. We brought several back inside ourselves.
(5) Some Aids have thirteen full-care residents on an evening shift. One Aid had twenty two residents, eleven full-care, six partial-care, and the rest self-care. This has happened three times in one week. Due to inadequate staffing they do not have anyone they can call out when an Aid calls in sick or has to take a day off for some reason. THEY WORK SHORT!
(6) There is only one Medication Nurse for forty plus residents.

We have had eight and one half months of giving partial care, feeding, giving water, putting her in a wheelchair, and Hannah has even put her on the toilet and bedpan.

We have had many meetings with staff and management and they tell us Heritage Place is well within staffing regulations. We have also filed complaints with the local State Ombudsman, Susan Kunda.

We also wish to address the Pharmacy Bill, House Bill #229.
The cost of medications administered by Heritage Place, acquired through their affiliate drug store, costs residents three times that which can be purchased at another local drug store. Example: Quinine, 28 pills for $7.76. I can buy 100 pills from a local pharmacy for $8.99. The extra costs are borne by the residents or the taxpayer. So we urge passage of Pharmacy Bill, House Bill #229 and Staffing Bill, House Bill #316

It is my sincere wish for those of you who do not think our elderly deserve these considerations, that you spend your last days living under these current staffing conditions. By the way, my Mother passed away 2 February 1993. This won't help her but it will help others.

STOICK PHARMACY
142 EAST IDAHO
KALISPELL, MT 59901

SHUTTLESWORTH,ELLEN X 04 13 11 51 748 782 1

381779 02 QUININE SULF C 325MG 100 00677012301 051192 071592 X

SWANSON,HARVEY INH 0010114 00 X 28 7.76

STATEMENT

Stoick DRUG
PERSONALIZED SERVICE
P.O. BOX 637
KALISPELL, MONTANA
59903

H-Plaza Bldg.
142 E. Idaho St.
PH. 755-4103

DATE 7-21 19 92

Ellen Shuttlesworth
Lyles Shuttlesworth 102 W Cotton Dr
Kalispell, Mt. 59901

BALANCE FORWARD							
	WEEK 1	WEEK 2	WEEK 3	WEEK 4	TOTAL	CHARGE	BALANCE
Rx 381-779		7/15/92				7.76	
6/11 Quinine Sulf						7.76	
denied by							
Medicaid							15.52

Tripper's Printing
Stoick-State

EXHIBIT 2
DATE 2/3/93
HB 229

EXHIBIT 2
DATE 2/3/93
LHB 229

STOICK PHARMACY
142 EAST IDAHO
KALISPELL, MT 59901

SHUTTLESWORTH, ELLEN X 04 13 11 51 748 782 1

382225 01 GUIAFENESIN 100MG/5ML 120 00000000182 052692 060192 X

SWANSON, HARVEY INH 0010114 00 X 480 9.95

382225 02 GUIAFENESIN 100MG/5ML 120 00000000182 052692 061792 X

SWANSON, HARVEY INH 0010114 00 X 480 9.95

382882 EAR-WAX TREATMENT DROP 15 00536300094 061792 X

SWANSON, HARVEY INH 0010114 00 X 15 4.95

Medicaid write out prop. / CS-2

STATEMENT
Stoick DRUG
PERSONALIZED SERVICE
PO. BOX 637
KALISPELL, MONTANA
59903

H-Plaza Bldg.
142 E. Idaho St.
PH. 755-4103

DATE 6/23 19 92

Ellen Shuttlesworth
c/o Kyle Shuttlesworth
1031 Mattingly Rd. Kalispell, Mt. 59901

BALANCE FORWARD	WEEK 1	WEEK 2	WEEK 3	WEEK 4	TOTAL	CHARGE	BALANCE
5127	382882	6/17/92				4.95	
						9.95	
382 3225		6/17/92					
						9.95	
382 3225		6/17/92					
							24.85

Trippet's Printing Stoick-Stats

DATE 2-3-93
HB 229

Montana Family Union
AFL-CIO

110 West 13th Street
P.O. Box 1176
Helena, Montana 59624
406-442-1727

Don Judge
President

Pam Egan
Executive Director

The Associate Membership Program of the Montana State AFL-CIO

TESTIMONY OF PAM EGAN ON HOUSE BILL 229
HOUSE COMMITTEE ON HUMAN SERVICES AND AGING, FEBRUARY 3, 1993

Mr. Chairman, members of the committee, for the record, I am Pam Egan, Executive Director of the Montana Family Union. I am here to testify in support of HB 229.

The right to choose providers is a crucial element in containing the cost of prescription medication.

When consumers are held hostage to nursing home pharmacies, the incentive for pharmacies to price medication competitively disappears. The patient pays the price and the company reaps the profit.

This bill protects the consumer's right to freely choose his or her prescription provider, prevents price gouging by nursing homes, and promotes cost containment in prescription pricing.

The Montana Family Union respectfully urges a favorable recommendation on HB 229.

MONTANA
HEALTH
CARE
ASSOCIATION

36 S. Last Chance Gulch, Suite A · Helena, Montana 59601
Telephone (406) 443-2876 · FAX (406) 443-4614

EXHIBIT 4
DATE 2-3-93
HB 229

HOUSE BILL 229

RESIDENTS' RIGHT TO CHOOSE A PHARMACY

HOUSE HUMAN SERVICES & AGING COMMITTEE

FEBRUARY 3, 1993

For the record, I am Rose Hughes, Executive Director of the Montana Health Care Association, an association that represents approximately 80 of Montana's 96 nursing homes.

This legislation amends the Montana residents' rights act to specifically include the right to "obtain prescription drugs or other medicines from a pharmacy of the resident's choice." It further provides that no fee may be charged for "administering a prescription drug or other medicine to a resident who has obtained the drug or medicine from a pharmacy other than the pharmacy operated by the facility."

This legislation appears to confer an absolute right to choose a pharmacy without regard to whether the pharmacy is able to meet the facility's standards and policies with respect to the way drugs are handled in the facility.

We oppose this bill, based on the following:

1. ***Residents currently have a right to choose a pharmacy, as long as that pharmacy meets the facility's standards and policies with respect to pharmacy services.*** We believe this is reasonable. Under federal laws and regulations governing Montana nursing facilities, facilities are responsible for insuring that pharmacy services are provided in a safe and appropriate manner. Because facilities are responsible and liable for all pharmacy services provided in their facilities, they must have the right to set standards which pharmacies must follow if they wish to provide services to the facility and its residents.

2. ***Use of unit dose systems.*** The bill as written would appear to preclude specification of unit dose systems by facilities, since residents would have the right to choose pharmacies that are unable to provide drugs in unit dose. The main advantage of using a unit dose system is that they result in fewer drug errors. These systems are also widely accepted as being very cost effective.

3. ***Administrative and handling fees.*** The bill prohibits the charge of any administrative or other fee for handling drugs brought in from an outside pharmacy. A packaging or other fee may be appropriate when the facility's pharmacist must provide unit dose packaging or other services not provided by the resident's pharmacist.

4. ***Unnecessary time and paperwork.*** This bill is not necessary, since residents already have a right to choose a pharmacy that meets appropriate standards set by the facility for

pharmacy services. However, because this legislation is added to the Montana residents' rights law, if this bill passes, resident rights forms and posters will have to be changed to include this newly specified right. Also, facilities will be required to provide every resident and every employee with a written copy of the new residents rights, explain the change to them, and have all residents and employees sign a form to acknowledge receipt of the written rights. In some cases, physicians must be involved to determine whether individual residents understand their rights, and in other cases a family member or other authorized representative will have to be involved to receive and sign for the rights on behalf of a resident.

There are nearly 7,000 nursing home residents in this state and approximately 5,000 employees. Imagine the time and expense involved in dealing with 12,000 people who must receive, understand, and sign for the new forms! This would be appropriate if this were an important new right or if we had major problems in this area, but that simply isn't the case. Residents already have this right with appropriate exceptions. Please say "no" to this unnecessary legislation and allow our staff to provide patient care instead of shuffling all this paper.

We urge you to vote "do not pass" on HB 229.

Thank you for the opportunity to be heard.

EXHIBIT 4
DATE 2/3/93
HB 229

EXHIBIT 5
DATE 2-3-93
HB 229

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME Rick Ojala BILL NO. 229

ADDRESS P.O. Box 5001 6.F. MT. DATE 2/3/93

WHOM DO YOU REPRESENT? Park Place 59403 Health Care Ctr.

SUPPORT _____ OPPOSE ✓ AMEND _____

COMMENTS: This addition to Residents Rights is not necessary, as this right already exists in OBRA Fed. law. If this additional language is added there are several additional requirements that would need to be added to meet the requirements under State - Federal and OBRA Law. Before an outside Pharmacy could meet the required services of a resident Copy of Form and Specifics are attached. Also a Facility needs to be able to charge a fee for repackaging drugs into the 30 day blister packs most Facilitys use.

HR:1991
CS15

EXHIBIT 6
DATE 2-3-93
HB 229

FEBRUARY 2, 1993

TO: HOUSE HUMAN SERVICES AND AGING COMMITTEE

FROM: DEBORAH M. WILSON, R.N., B.S.N.
ASSISTANT DIRECTOR OF NURSING SERVICES
BRENDAN HOUSE SKILLED NURSING FACILITY

RE: HOUSE BILL NUMBER 229

DEAR COMMITTEE MEMBERS,

IT IS WITH GREAT CONCERN THAT I COME BEFORE YOU TODAY TO DISCUSS AN ISSUE THAT IS VERY IMPORTANT TO ME. IN MY TIME AS THE ASSISTANT DIRECTOR OF NURSING SERVICES OF BRENDAN HOUSE SNF, I HAVE BECOME KEENLY IN TUNED TO THE QUALITY OF CARE THAT ANY ELDERLY MONTANAN (ANY MONTANAN THAT NEEDS TO BE A RESIDENT OF A NURSING FACILITY) RIGHTFULLY DESERVES. IT IS WITH THAT THOUGHT IN MIND THAT I BEGIN EACH DAY.

WHEN I BEGAN READING HB NO. 229, IT APPEARED TO BE ANOTHER LEGISLATIVE STEP TO MANDATE BASICALLY NECESSARY RIGHTS FOR THOSE RESIDENTS IN A SKILLED NURSING FACILITY. I MIGHT ADD THAT THESE RIGHTS ARE THE EVERYDAY, NOT OUT OF THE ORDINARY RIGHTS OUR RESIDENTS ENJOY EACH DAY. IT WAS ONLY WHEN I REACHED PAGE 4, SECTION (N), LINE 7, DID I BECOME APPREHENSIVE. IT IS THIS APPREHENSION AND MY GENUINE CONCERN FOR NURSING FACILITY RESIDENTS ALL OVER THE STATE OF MONTANA THAT PROMPTED ME TO MAKE A FOUR HOUR TRIP TO EXPLAIN TO YOU SOME OF MY FEARS RELATED TO THIS PARTICULAR PART OF HB NO. 229.

BEFORE PROCEEDING I WOULD LIKE TO LET YOU KNOW THAT ANY RESIDENT THAT ENTERS BRENDAN HOUSE HAS THE OPTION OF CHOOSING THEIR OWN PHARMACY, PROVIDED THAT THE PHARMACY THEY CHOOSE IS ABLE TO DISPENSE MEDICATION WITHIN THE GUIDELINES OF OUR FACILITY'S STANDARDS. PLEASE KEEP IN MIND THAT EACH FACILITY HAS THE RIGHT/ OBLIGATION TO PROVIDE MEDICATIONS IN THE SAFEST POSSIBLE WAY. OUR PARTICULAR BELIEF IS THAT THE SAFEST WAY FOR THIS TO HAPPEN IS THROUGH THE UNIT DOSE SYSTEM: WHICH MEANS THAT EACH DOSE IS INDIVIDUALLY PACKAGED.

AT THIS POINT, I WILL OUTLINE SOME PERTINENT POINTS THAT I WOULD LIKE YOU TO CONSIDER BEFORE LEGISLATING SOMETHING THAT HAS THE POTENTIAL FOR DOING EXACTLY THE OPPOSITE OF WHAT YOU INTEND TO ACCOMPLISH.

WHEN I DECIDE TO MODIFY SOMETHING AT WORK, NO MATTER WHAT IT IS, THERE ARE SEVERAL THINGS THAT I CONSIDER. THREE OF THESE CONSIDERATIONS ARE COST, SAFETY, AND PRACTICALITY.

IN RETROSPECT, MY PRIMARY CONCERN IS SAFETY. WHEN YOU CONSIDER THAT THE AVERAGE RESIDENT IN THE NURSING HOME HAS 6-10 SCHEDULED MEDICATIONS IN A 24 HOUR TIME PERIOD AND THAT WE HAVE 88 RESIDENTS, NO ONE CAN OR WOULD WANT TO OVERLOOK THE ISSUE OF SAFETY. AS I EXPLAINED BEFORE, WE BELIEVE THAT THE SAFEST, MOST COST EFFECTIVE MEANS OF ADMINISTERING MEDICATION IS THROUGH THE UNIT DOSE SYSTEM. IN ADDITION TO THIS TYPE OF ADMINISTRATION, BY FAR THE MAJORITY OF OUR MEDICATIONS COME FROM ONE PHARMACY. THIS ALLOWS FOR THE PHARMACY INVOLVED TO CHECK FOR DRUG INTERACTIONS WITH OTHER MEDICATIONS THAT PARTICULAR RESIDENT MAY BE ON; AND TO ENSURE THAT THE APPROPRIATE MEDICATION IS INVOLVED. AT OUR FACILITY, BY USING THE UNIT DOSE SYSTEM, OUR MEDICATIONS ACTUALLY GO THROUGH THREE CHECKS BEFORE THE NURSE EVEN SEES THEM. THE OTHER PROBLEM THAT I SEE IS IN AN EMERGENCY SITUATION... WHO WOULD RESPOND AND HOW LONG WOULD IT TAKE THEM? HEART ATTACKS, SEIZURES, CONGESTIVE HEART FAILURE, CARDIAC ARREST...THESE SITUATIONS WILL NOT WAIT UNTIL A PHARMACIST CAN GET TO HIS STORE. NOT TO MENTION IF THE RESIDENT CHOSE A PHARMACY OUT OF TOWN.

MY NEXT CONCERN IS THE PRACTICALITY. IN SKILLED NURSING FACILITIES, OR AT LEAST IN OURS, THE RESIDENTS HAVE MANY MORE ACUTE NEEDS THAT MAY ARISE. THIS COULD MEAN SEVERAL CHANGES IN MEDICATIONS IN A 24 HOUR PERIOD. I AM NOT SURE THAT PHARMACIES WOULD LIKE TO MAKE THAT MANY TRIPS TO A FACILITY AND CERTAINLY NOT IN A TIMELY MANNER. ANOTHER CONCERN THAT THE NURSING FACILITIES SHARE IS THAT OF RENOVATION. WE HAVE VERY COMPACT AND EFFICIENT MEDICATION CARTS TO TAKE FROM ROOM TO ROOM; IF THIS BILL GOES INTO EFFECT THERE WILL CERTAINLY NEED TO BE SOME OTHER ARRANGEMENTS MADE. IN ADDITION TO THIS A PHARMACIST WILL HAVE TO BE AVAILABLE AT ALL TIMES AND BE ABLE TO CHECK EACH AND EVERY MEDICATION THAT IS BROUGHT INTO THE FACILITY TO ENSURE THAT IT IS THE PROPER MEDICATION.

ALL THESE LEAD ME TO MY FINAL POINT...COST TO THE RESIDENT. ALTHOUGH THIS BILL DOES NOT ALLOCATE ANY ADDITIONAL FUNDING FOR THESE CHANGES, IT CERTAINLY DOES NOT MEAN THOSE CHANGES WILL NOT COST THE FACILITY AND THE RESIDENT IN ONE WAY OR ANOTHER. THESE "COSTS" COULD BE ANYWHERE FROM TAKING THE NURSE AWAY FROM THE RESIDENT'S BEDSIDE IN ORDER TO SEE THAT A PHARMACY WILL BE THERE TO DELIVER MEDICATIONS, TO FORCING THE FACILITY TO WAIT A YEAR TO GET NEW FURNISHINGS FOR THE RESIDENTS DAY ROOM IN ORDER TO PAY THE PHARMACIST TO COUNT EACH AND EVERY MEDICATION THAT IS BROUGHT IN TO THE FACILITY.

AFTER CAREFUL CONSIDERATION OF THE NEGATIVE EFFECTS THAT HB 229 WILL HAVE ON THE NURSING HOME RESIDENTS OF MONTANA, I ENCOURAGE YOU TO DELETE PAGE 4, SECTION (N).

EXHIBIT 7
DATE 2-3-93
HB 229

February 3, 1993
To: House Human Services and Aging Committee
Re: HB 229
From: Linda Benson, RN
Director of Nursing
Brendan House
Kalispell, MT

As a Registered Nurse, and Director of Nursing of a Skilled Nursing Facility, HB229 raises concerns for me with regard to its affect on quality of resident care.

This legislation does not protect the Standard of Care, as facilities would have no control over medications being sent to the facility. As you know, facilities are mandated by Federal Regulations to provide and protect, that Standard of Care for **all** residents.

There is, already, a regulation in effect which "allows residents to choose a pharmacy, as long as that pharmacy meets the facility's **standards** and policies with respect to pharmacy services." In a facility such as Brendan House the Unit Dose system is a **standard** which greatly reduces medication errors. Since not all pharmacies can provide Unit Dose, the safety of residents would be in jeopardy. All medications sent in forms other than Unit Dose would have to be reidentified and repackaged in Unit dose form in order to assure this standard of care. This certainly would not be a cost-effective system.

Past experience, in my nursing practice, has proven that allowing many pharmacies to provide perscription medications, to a facility resulted in:

A. Medications not being readily available, since they were not always delivered in a timely manner.
B. Prescriptions needed to be refilled at different times, causing increased workload for the nursing staff, in order to monitor the times for individual refills, and assuring they were delivered, as requested.
C. Narcotics were being sent through the postal system-an extremely unsafe practice.

Under our current system, our medications are stocked on a daily basis, again, allowing for fewer medication errors, due to a system of three checks to assure correct medication and dosage.

Not all pharmacies can provide 24 hr. availability of medications. What would we do in an emergency situation?

Brendan House consistently monitors the cost of medications, overall to provide medications in the most cost-effective manner possible. Under this Bill the facility is not allowed to charge any fees for handling drugs provided by other pharmacies. Changing our medication administration system, monitoring for refills, repackaging of medications to Unit Dose form would all be very costly to the facility, while there is not a method for facilities to recoup these additional costs. The funds to cover these expenses would very likely need to be taken from other areas of resident care.

Thank you for your consideration. I hope that, when casting your vote you, will keep in mind the negative effects that HB229 would have on the quality of resident care in long term care facilities.

EXHIBIT 8
DATE 2-3-93
HB 229

February 3, 1993

To: Whom it may concern:
Re: House Bill 229

I am a consultant pharmacist for long term care facilites. I currently provide services for four nursing homes. I have been practicing for ten years.

My duties include insuring safe and correct administration of medications. To this end the drug distribution systems in three of my nursing homes have converted from vial distribution system to unit system. This change occurred in 1983 in two of the facilities and was initiated in the third facility upon opening. (The fourth facility had unit dose system in place.) Unit dose systems were developed in hospital sites to insure safer (more error free) administration of medications. Long term care facilities in the last fifteen years have come to realize that the unit dose system is also the safest method for their use.

The reasons for the change of systems to unit dose is multiple. The vial system lends itself to medication administration errors due to the fact there are no ways to check for omitted or excessive administration. The vial system also has no safe guards against contamination and pilferage. The unit dose system with its "individual" packaging provides a system that prohibits pilferage and contamination and a mechanism to be able to double check administration accuracy.

It is necessary that the facility insure the most secure and accurate medication distribution system available. To this end we require all medications administered in our facilities to be dispensed in unit dose packaging. We do not allow combinations of systems simply due to the fact accuracy and consistency will be lost.

To insure the timely administration of medications we also require that the pharmacies providing service to our facilities provide twenty four hour emergency service.

Therefore for a pharmacy to provide service the pharmacy must dispense in unit dose packaging and provide twenty four hour emergency service.

Sincerely,
Paulette Docktor

Paulette Docktor, RPh
Consultant Pharmacist

Basic Approaches to Drug Distribution

K. Scott Carruthers

Several systems used for dispensing and administering medications in nursing homes and other long term care facilities are described.

For many years a simple vial system, identical to prescription vials dispensed from most community pharmacies, has been used in long term care facilities. More advanced systems have been modifications of unit-dose systems originally developed in acute-care institutions; these provide improved accountability, better drug control, and less chance of medication error. Adaptations of the unit-dose system developed for nursing homes include the punch-card system, also known as "bingo" cards. Punch cards may be provided on a random basis to nursing homes or for preset cycles (usually monthly). The cards may be organized by patient or time of administration. Some multiple-dose punch cards are used for self-administration by patients.

Pharmacists practicing in nursing homes have a variety of basic types of drug-distribution systems from which to choose. These systems differ in many ways, including staff time that must be devoted to dispense, deliver, and set up medications, staff time required to administer the drugs, number of medication errors associated with each system, and cost of required materials and equipment.

In this article I will describe the basic elements associated with several approaches to drug-distribution systems: vial, unit dose, modified unit dose, and systematized unit dose methods. Future Tools of the Trade articles in *TCP* will analyze some of these systems in more detail.

Vial Method

For many years a common method of dispensing, storing, and administering medications in a long term care facility has been the "pill in the vial" method. The medications are dispensed in vials and labeled in the traditional manner, as they have long been dispensed in community-based pharmacies.

Medications are stored in a small room at the facility that has an area of shelving subdivided into small cubicles, usually one cubicle for each patient or bed in the facility.

The traditional system has served the needs of the facility well for many years and provides, at least, a method of dispensing and storing medications that identifies each medication ordered by drug and patient.

In the traditional system the nurse prepares oral solid doses for administration by placing the doses to be given in a soufflé cup for each patient. Usually a small card (med-card) is used to identify the medication in the cup and is color coded for the administration time.

This system works fairly well, but it can present some very fundamental problems. The nurses may rely on the med-cards to prepare doses; unfortunately the cards are not always updated as the physician's orders change. The cards are sometimes mixed up or overlooked, which means that patients potentially receive the wrong medication or incorrectly receive none at all. On occasion, the cups may be spilled and doses from one cup may be mixed with others. Medications are prepared in a medication room (away from patient-care areas), which removes the nurse from the patients for one hour or more. An improvement of this system has been to store the medications in a mobile drug-storage cart that easily can be moved to the patient's bedside or into visible patient-care areas.

With the vial type of system, the accountability of oral solid doses administered is much more difficult than with unit-dose systems, as the contents of the vial must be removed for counting. The vial system presents additional problems on the timely reordering of the medications as they are consumed.

Unit-Dose Systems

When unit-dose systems were introduced into the acute-care hospital, they offered a wonderful drug-control system that ushered in a new level of patient safety and drug control or accountability impossible to attain with bulk or vial systems.

This system provides each dose individually packaged and identified by drug name, strength, and expiration date, among other identifying information. This system works well with oral solid dosage forms, liquids, injectables, and other products.

The medications are stored in a medication cart or a mobile medication room that can be taken to the patient's bedside. In addition to improved safety and control, the system places the nurse in the patient-care area during the entire medication-administration procedure.

Doses are prepared by pharmacy personnel, freeing the nurse's time for more nursing procedures that may be required for the patient. Usually a 24-hour supply is dispensed by the pharmacy and new supplies are sent to the nursing unit daily.

The unit-dose system, with some modification, has been used very successfully in the long term care facility. Some unit-dose systems for long term care facilities have been developed that provide a 24-, 48-, or 72-hour supply of medications. Other systems provide up to a full month's supply of medications in unit-dose packages. Most of these systems use unit-dose packaging for oral solid dosage forms only; liquid medications and injectable products are not often provided in unit-dose packages.

Unfortunately, in most states the various third-party programs that fund the care of patients in the long term care setting have not provided a level of reimbursement that allows a pharmacist to provide unit-dose packages in the same way that acute-care hospitals provide this system (no more than a 24-hour supply, all dosage forms, all

doses premeasured by pharmacy personnel).

Modified Unit-Dose Systems

In the late 1960s, a new system was developed by Richard Berman, president emeritus of ASCP. This new system embraced most of the principles of the unit-dose system for oral solid dosage forms, but in a multiple-day format that was affordable within reimbursement levels.

The system became known by many terms; punch card and "bingo" card are the most common. It uses a cardboard outer "container" and a see-through blister that holds the medication with a foil or foil and paper backing. The container is heat sealed and, in effect, has packaged each dose in an individual unit within a "container" that may hold up to 90 doses. The doses are simply pushed or "punched out" of the blister at administration time.

Since the early days of the punch card, several manufacturers have developed a variety of packaging materials and systems using the basic punch-card concept. Blister materials are available that meet the United States Pharmacopeia standards established for unit-dose packaging.

Systematizing Modified Unit-Dose Systems

Over the years, pharmacists, working closely with their customers and suppliers, have developed many unique variations of the punch card itself, using various materials, graphics, and cart designs to enhance the overall effectiveness of this type of drug-distribution system.

Commercial versions provide packaging materials, packaging equipment, medication carts, and a variety of forms, storage containers, and in-service training materials. The user may purchase all or part of a system from one or more sources, depending on the needs of the pharmacy and the nursing home.

Various types of punch-card systems offer several different dispensing formats. Each variation has specific characteristics based on the type of equipment used, graphics on the cards themselves, and style of cart used as outlined below.

Random-Fill System: In this variation, orders are filled in punch cards, usually for a 30-day supply. Facilities order refills for routine and p.r.n. doses on a random (as needed) basis. The accountability is more difficult than in other variations and may not be better than with the vial system. The doses are individually sealed. The caregiver or nurse simply reorders when the supply reaches a predetermined level. Each prescription is ordered and reordered independently of the other medications the patient may be receiving. As with most punch-card systems, the cards are stored in a mobile medication cart that can be taken to the patient's bedside.

Cycle-Fill Systems: Medications are dispensed in quantities corresponding to the number of days in a given month (28-31 days). Cycle fills can be used in conjunction with patient-pass or time-pass methods. Cycle-fill systems provide for filling of all routine, oral solid dosage forms at the same time each month (cycle) for all patients in a given facility. The cycle-fill system allows the pharmacy to "even out" and predict, with some degree of accuracy, workload. Cycle fill with time pass offers the facility optimal control with a punch-card system. Problems can be pinpointed to shift and day of occurrence.

In addition, a well-organized cycle-fill system provides a direct copy of the physician's order as the refill or reordering document. This enables the pharmacist to perform a partial drug-regimen review during the cycle-fill process. Some basic screening of the patient's drug therapy can be accomplished, thereby providing additional pharmacist time in the facility for direct clinical interactions with patients.

Storage For Punch-Card Systems: Unit-dose packages using punch cards are stored in one of three ways: by patient, by time of administration, or in multiple-dose packages (usually for self-administration). The basic storage method used in most punch-card systems is the patient-pass method, sometimes called a section pass. Each medication is dispensed and stored in 30-day quantities, with each dose administered from a single card. Cards are stored in a section of the cart by patient, usually in the order that the nurse will follow during the administration of medications. Some variations use a smaller card or dispense less than a 30-day supply. Overall, this is probably the easiest system for the pharmacy and the least costly of the punch-card systems. Random-fill or cycle-fill systems of packaging may be used with this variation.

In a time-pass system, medications, dispensed in a 30-day quantity, are subdivided into a card for each administration time. For example, a medication to be administered four times a day for a 30-day period has four separate cards of 30 doses each. To enhance this method, the cards can be color coded as to the specific time of day and stored in the medication cart by patient and by administration time. More cards are used in this system, and more labor time by the pharmacy is required for each prescription. In addition, more storage space in the medication cart is required. Advantages are that the time-pass variation provides an additional measure of control. Problems can be pinpointed to the day and time of occurrence.

In some settings, such as home-care or residential-care facilities in which the patients administer their own medications or the caregiver is a nonhealth-care professional, a multiple-dose punch card may be appropriate. This is basically a time-pass, cycle-fill system, except that all doses for a given day at a given time are packaged into a single bubble or blister. The caregiver simply "punches out" the blister from the appropriate patient's card for that day and time (usually a meal or bedtime). In effect, the bubble is the old soufflé cup, prepared by a pharmacist, hermetically sealed, and packaged and labeled in such a way that increases the potential for the right drugs to be given to the right patient at the right time. In my experience, this variation is very difficult for the dispensing operation in a skilled-nursing or intermediate-care facility.

Summary

Traditional vial systems leave a lot to be desired in terms of drug control, accountability, and patient safety in the long term care setting. Many very good alternatives exist, such as unit-dose and modified unit-dose systems.

Reimbursement plays a dominant role in the selection of a system to be used in long term care facilities. Only a few state Medicaid programs have reimbursement rates that encourage unit-dose systems.

In my experience, the punch-card system of modified unit dose is economically viable for long term care. This system has the required flexibility, allowing the pharmacist to design a dispensing and administration method that can be "tailor-made" for an individual facility's needs. □

K. Scott Carruthers, Pharm.D., is Vice President of Operations for HealthCare Network, a diversified health-care company in Anaheim, California. He is president of the California State Board of Pharmacy and Region V director of ASCP.

Address for Reprints: K. Scott Carruthers, Pharm.D., FASCP, 1440 South State College Blvd., 5J, Anaheim, CA 92806.

EXHIBIT 9
DATE 2-3-93
HB 229

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME Joanne Verlanic-Scherger **BILL NO.** 229

ADDRESS 432 Washington Missoula MT **DATE** 2/3/93

WHOM DO YOU REPRESENT? Hillside Manor NH

SUPPORT _____ **OPPOSE** ✓ **AMEND** _____

COMMENTS: It is necessary to use some form of unit dose packaging of medications to assure the nurse may provide safe medication administration to residents. The resident is free to use any community pharmacy which is able to package into the system used by the NH. The NH pharmacy will re-package medications from another pharmacy for a dispensing fee. ~~Fee~~ It is necessary for a licensed pharmacist to repackage. The fee covers this charge as well as a charge for the packaging supplies.

HR:1991
CS15

EXHIBIT 10
DATE 2-3-93
HB 316

HEALTH FACILITIES DIVISION

HUMAN SERVICES & AGING Committee
Chairman: Bill Boharski
House Bill 316

Chairman Boharski members of the committee for the record my name is Denzel Davis, Administrator of the Health Facilities Division, Department of Health and Environmental Sciences.

Long-term Care providers are regulated by two separate and distinct sets of regulations; CFR 42 483 is the Medicare and Medicaid conditions of participation for Skilled Nursing Facilities and Nursing Facilities and State Licensure regulations for Long-Term Care Facilities are contained in the Montana Code Title 50 Chapter 5 and the Administrative Rules of Montana Chapter 16, Sub-Chapter 3.

The Certification Bureau is responsible for survey and certification and enforcement activities for Medicare and Medicaid conditions of participation for health care providers as provided for by Sections 1864 and 1874 of the Social Security Act.
The Licensure Bureau is responsible for licensure, survey and enforcement of Skilled Nursing Facilities MCA Title 50 Chapter 5 and ARM Sub-Chapter 3.

Medicaid/Medicare Regulations:
I have enclosed for the committee review; CFR 42 483.30 Nursing Services, and the survey interpretive guidelines.
Tag number F353-A Nursing Services, and Tag number 354 Sufficient Staff.

Guidance to Surveyors.
The determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. The ability to meet the requirements of 483.13 Resident Behavior and Facility Practices, 483.20 Resident Assessment, and 483.25 Quality of Care.

Except for licensed staff noted above, the determining factor in sufficiency of staff will be the ability of the facility to provide needed care for residents. Deficiency's concerning staffing are cited when deficits are identified caused by insufficient quality and quantity of staff. If however, inadequate staff (either number or category) presents a clear threat to resident care, even when adverse effects have not occurred, or there is a lack of residents reaching their highest practicable level of well-being, a deficiency could be cited.

State Regulations:
I have enclosed for the committee,s review ARM 16.32.361 MINIMUM STANDARDS FOR A SKILLED NURSING CARE FACILITY FOR EACH 24 HOUR PERIOD--STAFFING. and the staffing table.
The table indicates an absolute minimum staffing pattern and states "Even with this staffing it would be difficult." "Therefore it is recommended that the quality and quality of staffing should be determined by the administrator in consultation with his director of nursing". The decision as to the number of staff needed (by category) should be based on the nursing needs of the residents and should reflect the current concepts of restorative and geriatric care.

As you can see both the Federal and current State regulations places the responsibility for determining the staffing required (number and category) on the facility and both regulations operate on the premise that facility staffing levels are set to meet the needs of the residents.

The Licensure Bureau has prepared a fiscal note that is an estimate of the cost associated to perform survey, investigate complaints and enforce HB 316.

and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

(i) Except when waived under paragraph (c) of this section, licensed nurses; and

(ii) Other nursing personnel.

(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

(b) *Registered nurse.* (1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(2) Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.

(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(c) *Nursing facilities: Waiver of requirement to provide licensed nurses on a 24-hour basis.* To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—

(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;

(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;

(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;

(4) A waiver granted under the conditions listed in paragraph (c) of this section is subject to annual State review;

(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;

(6) The State agency granting a waiver of such requirements provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(d) *SNFs: Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.*

(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;

(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

(iii) The facility either—

(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period, or

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;

(iv) The Secretary provides notice of the waiver to the State long term care ombudsman (established under section 307(a)(12) of the Older American Act of 1965) and the protection and advocacy system in the State for the mentally ill and mentally retarded; and

(v) The facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (d)(1) of this section is subject to annual renewal by the Secretary.

§ 483.35 Dietary services.

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

(a) *Staffing.* The facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

(1) If a qualified dietitian is not employed full-time, the facility must designate a person to serve as the director of food service who receives frequently scheduled consultation from a qualified dietitian.

(2) A qualified dietitian is one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs.

(b) *Sufficient staff.* The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

(c) *Menus and nutritional adequacy.* Menus must—

(1) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

(2) Be prepared in advance; and

(3) Be followed.

(d) *Food.* Each resident receives and the facility provides—

(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

(2) Food that is palatable, attractive, and at the proper temperature;

(3) Food prepared in a form designed to meet individual needs; and

(4) Substitutes offered of similar nutritive value to residents who refuse food served.

(e) *Therapeutic diets.* Therapeutic diets must be prescribed by the attending physician.

(f) *Frequency of meals.* (1) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

(2) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided in (4) below.

(3) The facility must offer snacks at bedtime daily.

(4) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

(g) *Assistive devices.* The facility must provide special eating equipment and utensils for residents who need them.

(h) *Sanitary conditions.* The facility must—

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Paragraph deleted

§ 483.25 Quality of care.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) *Activities of daily living.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to—

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) *Vision and hearing.* To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident—

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

* deleted "medical"

(c) *Pressure sores.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) *Urinary Incontinence.* Based on the resident's comprehensive assessment, the facility must ensure that—

deleted repetitive paragraph

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) *Range of motion.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Mental is new

(f) *Mental and Psychosocial functioning.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and revised

(2) A resident whose assessment did not reveal a mental or psychosocial new adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) *Naso-gastric tubes.* Based on the comprehensive assessment of a resident, the facility must ensure that—

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.

(h) *Accidents.* The facility must ensure that—

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) *Nutrition.* Based on a resident's comprehensive assessment, the facility must ensure that a resident—

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) *Hydration.* The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) *Special needs.* The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and (was podiatric)

(8) Prostheses.

(l) *Unnecessary drug*—(1) *General.* Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for its use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above. new

(2) *Antipsychotic Drugs.* Based on a comprehensive assessment of a resident, the facility must ensure that—

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and new

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. deletes "drug holiday" was "program"

(m) *Medication Errors*—The facility must ensure that—

(1) It is free of medication error rates of five percent or greater; and (was "significant")

(2) Residents are free of any significant medication errors.

§§ 483.28 and 483.29 [Removed]

4. Sections 483.28 and 483.29 are removed.

5. In Subpart B, §§ 483.30, 483.35, 483.40, 483.45, 483.55, 483.60, 483.65, 483.70 and 483.75 are revised as follows:

§ 483.30 Nursing services.

The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,

holiday is a form of dose reduction, it is not necessarily "gradual."

Others stated that drug holidays are not well defined in the regulations and that gradual dose reduction is the concept that we should capture in these regulations. Several other commenters stated that behavioral programming is not appropriate for use with demented residents because it depends on reservoirs of memory which they do not have. The key to dealing with demented residents, commenters state, is a change in the "environment," including physical environment and staff behavior.

Response: We agree with the commenters who want to delete the requirement for drug holidays, and have done so. We also agree with the commenters who would like to change the term "behavioral programming." We have changed this term to "behavioral interventions," which can include changed staff behavior toward residents but can also mean behavioral programming for those clients for which this is an appropriate intervention.

Comment: With regard to medication errors in § 483.25(m), a number of commenters wanted "significant" defined. Three commenters, representing both consumer and provider groups, specifically suggested that significant medication error rates should not exceed five percent.

Response: Regarding a facility's responsibility to prevent significant error rates, we have modified § 483.25(m) to state that facilities may not have error rates of five percent or greater. This definition has been used in interpretive guidelines by HCFA since May of 1984 (appendix N, part 2 State Operations Manual Transmittal No. 165). It is used as a measure of a facility's drug distribution system, which encompasses the entire spectrum of ordering, transcribing, dispensing, preparing, and administering drugs to residents. It has enabled HCFA to establish an outcome measure for the entire process of drug distribution in long-term care facilities. HCFA does not regulate who may prescribe, dispense, or administer drugs. HCFA does not regulate what type of drug distribution system must be used (e.g., unit dose, floor stock). HCFA has only minimal requirements for drug labeling and no requirement as to how an individual administering drugs must go about preparing drugs for administration. HCFA has left a facility free to create and manage its own system in any way it sees fit as long as it does not make "significant" medication errors and has an overall medication error rate of less than five percent.

The impact this outcome-oriented standard has had on facilities has been very positive. Historically, facilities would correct various perceived defects in the drug distribution system when they were faulted by surveyors. These corrections had little to do with medication error rates, as judged by a medication error rate study HCFA conducted in 1980 (Medication Errors in Nursing Homes and Hospitals; Am. J. Hosp. Pharm., 1982; 39:987–91). In May, 1984, when HCFA began applying this five percent error rate, facilities began to examine their systems of drug distribution, the staff that operate the systems, the pharmacies that provide the drugs, and myriad other issues in order to reduce medication error rates. Anecdotal data indicate that medication error rates are falling as a result of this policy.

Since medication errors vary in their significance (e.g., from significant errors such as a double dose of a potent cardiac drug like digoxin to a small error in the dose of an antacid like milk of magnesia), we have based sanctions on two different criteria. First, if a facility has a significant medication error, then it is sanctioned. This policy satisfies consumers, who maintain that a five percent tolerance in medication errors is too lenient and that one medication error could be disastrous for a resident. Second, a facility is sanctioned if it has an error rate of five percent or greater. This satisfies providers who maintain that there must be some tolerance of errors because all systems have some errors. The five percent limit on medication errors applies to both significant and non-significant errors. When a facility experiences a five percent or greater medication error rate, even if all errors are insignificant, it is a sign that the system has flaws that may eventually lead to a significant, perhaps disastrous error.

A significant medication error is judged by a surveyor, using factors which have been described in interpretive guidelines since May 1984. The three factors are: (1) Drug category. Did the error involve a drug that could result in serious consequences for the resident? (2) Resident condition. Was the resident compromised in such a way that he or she could not easily recover from the error? (3) Frequency of error. Is there any evidence that the error occurred more than once? Using these criteria, an example of a significant medication error might be as follows: A resident received twice the correct dose of digoxin, a potentially toxic drug. The resident already had a slow pulse rate, which the drug would further lower. The error occurred three times last week.

Summary of Changes to § 483.25

As a result of our evaluation of comments, in addition to minor editorial changes, we are making the following changes:

- In § 483.25(d), we are removing paragraph (d)(1) as redundant and redesignating the following two paragraphs.
- In § 483.25(f), we are clarifying terminology to emphasize that the requirements concern mental and psychosocial functioning and to require treatment and services to correct the assessed problem.
- In § 483.25(k), we have revised "podiatric" care to "foot" care to remove emphasis on who may provide the proper treatment.
- In § 483.25(l)(1), we define unnecessary drug and add a provision that each resident's drug regimen must be adequately monitored. In paragraph (1)(2)(a), concerning antipsychotic drugs, we added a requirement that the need for an antipsychotic drug be diagnosed and documented in the clinical record. We also deleted, as suggested, the requirement for drug holidays.
- In § 483.25(m), we require that facilities ensure medication error rates are below five percent.

Section 483.28 Nursing Services—Skilled Nursing Facilities and Section 483.29 Nursing Services—Intermediate Care Facilities

These two sections contain requirements effective through September 30, 1990. They were established in the February 2, 1989 rule, which, initially was to be effective August 1, 1989. As described elsewhere in this preamble, the effective date of the rule is now October 1, 1990. Accordingly, we are deleting them as out-of-date.

Section 483.30 Nursing Services

Summary of Provisions

Section 483.30 specifies that the facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and pyschological well-being of each resident, as determined by resident assessments and individual plans of care. Sections 483.30 (a) and (b) specify need for sufficient staff and for a registered nurse.

Section 483.30(c) provides for waiver of the requirement that a facility provide a registered nurse for at least 8 hours a day, 7 days a week, and licensed nurses

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on a 24-hour basis to the extent that a facility is unable to meet these requirements. Section 483.30(c) also specifies that the State agency granting a waiver of the requirements provides notice of the waiver to the State long term care ombudsman and the protection and advocacy system in the State for the mentally ill and mentally retarded.

Section 483.30(d) provides for waiver of the requirement to provide service of a registered nurse, for more than 40 hours a week. Sections 483.30 (c) and (d) also specify that the facility that is granted such a waiver notifies residents of the facility and members of their immediate families.

Comments and Responses

Comment: Several commenters objected to the requirement that facilities requesting waivers must demonstrate that they are offering wages at the community prevailing rate for nursing facilities.

Response: The words "offering wages at the community prevailing rate for nursing facilities" are taken verbatim from sections 1819(b)(4)(C) and 1919(b)(4)(C) of the Act. We therefore are not altering the requirement.

Comment: Several commenters suggested that HCFA has not provided enough regulatory guidance to facilities on the exact criteria that will be used in implementing the waiver requirements.

Response: HCFA is currently in the process of developing a proposed rule to address these issues. There will be an opportunity for public comment on the proposed criteria before the final rule is developed.

Summary of Changes to § 483.30

We are making the appropriate changes to § 483.30(c) as required by OBRA '90 to specify that a State may waiver 24-hour nursing service if the facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section.

We are adding § 483.30(c)(6) as required by section 4801(e)(5)(D)(iv) of OBRA '90 to specify that the State agency granting a waiver of the requirements provides notice of the waiver to the State long term care ombudsman and the protection and advocacy system in the State for the mentally ill and mentally retarded.

We are adding § 483.30(c)(7) as required by section 4801(e)(5)(D)(v) of OBRA '90 to specify that the nursing facility that is granted such a waiver by a State notifies residents of the facility and members of their immediate families

We are adding § 483.30(d)(iv) as required by sections 4801(e)(5)(D)(v) and 4008(e)(v) of OBRA '90 to specify that the facility that is granted a waiver notifies residents of the facility and members of their immediate families.

We are also making minor editorial changes to delete unnecessary dates.

Section 483.35 Dietary Service

Summary of Provisions

Section 483.35 requires that a facility must provide each resident with a nourishing palatable, well-balanced diet including modified and specially prescribed diets.

Section 483.35(a) requires that a facility must employ a qualified dietitian either full-time, part-time, or on a consultant basis.

Section 483.35(b) requires that a facility must employ sufficient support personnel competent to carry out the functions of the dietary services.

Section 483.35(d) specifies the requirements of the facility for food preparation and service for each resident.

Section 483.35(f) specifies the facility must provide each resident at least three meals daily, at regular times comparable to normal mealtimes in the community.

Comments and Responses

Comment: There were approximately 40 comments addressing the dietary services requirements. The majority of these comments opposed staffing qualifications at § 483.25 (a)(1) and (a)(2). Many of these commenters opposed the general personnel qualifications which allowed a dietitian to be qualified on the basis of education, training, or experience. They opposed this provision for the following reasons:

- Nonspecific requirements could lead to qualifying individuals without required preparation.
- There is a correlation within certain States between the levels of dietary deficiency among residents and the State's dietitian qualifications requirements.
- Dietitians are educated in the fields of physiology and disease processes, thus they are able to make appropriate recommendations relative to diet to physicians as needed.
- A general definition of dietitian opens the way for health care providers to utilize individuals who may have marginally related educational background such as certification as dietary managers or dietary technicians with inadequate skills in identifying nutrition care problems and appropriate nutrition care intervention.

Response: We recognize that section 4801(d) of OBRA '90 provides, in part, that any regulation promulgated by the Secretary after OBRA '87 with respect to dietary services shall include requirements that are at least as stringent as the requirements in effect prior to the enactment of OBRA '87. We believe, however, that the new rules are at least as stringent as those in effect prior to OBRA '87. In fact, the United States District Court for the District of Columbia specifically concluded that the standards appearing in the final rule are at least as stringent as those in existence prior to the enactment of OBRA '87. See *Gray Panthers Advocacy Committee, et al.* v. *Sullivan*, Civil Action No. 89–0605–NHJ (D.D.C. Sept. 17, 1990). Our objective in these rules is to focus on outcome as recommended by the IoM report. With the previous regulation, there was no assurance that each resident was receiving nutritious or quality meals. Under these rules, since high quality services are the standard, this weakness has been alleviated.

Accordingly, current regulations at 42 CFR 405.1101 allow individuals other than a qualified dietitian to manage or direct the dietary services whereas the final rule at § 483.35(a) requires the facility to employ a qualified dietitian either full-time, part-time, or on a consultant basis. We have retained the language which permits an individual to qualify as a dietitian either through registration by the Commission on Dietetic Registration of the American Dietetic Association (ADA) or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs because we believe that there are some individuals not registered by the ADA who are appropriate for employment as dietitians. However, the survey guidelines contain a list of the specific experience requirements that persons not registered by the ADA must meet, a number of which are specific to the needs of geriatric and physically impaired persons and to health care institutional settings. Additionally, the objective of the final rule is to require that the dietetic services assure that the meals meet the nutritional and special dietary needs of each resident and that services meet "professional standards of quality." This is in keeping with the emphasis of the final rule which focuses on outcome, not process, thus avoiding undue reliance on staff qualifications. Also, we have added requirements to the regulation within the resident assessment section at § 483.20(b)(2)(v)

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TAG NUMBER	REGULATION	GUIDANCE TO SURVEYORS
F353-A	§483.30 Nursing services. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.	Survey Procedures and Probes: §483.30 Fully review requirements of nursing services during an extended survey or when a waiver of RN and/or licensed nurse (RN/LPN) staffing has been requested or granted. Except as licensed nursing personnel are specifically required by the regulation (e.g., an RN for 8 consecutive hours a day, 7 days a week), the determination of sufficient staff will be made based on the staff's ability to provide needed care to residents that enable them to reach their highest practicable physical, mental and psychosocial well-being. The ability to meet the requirements of §§483.13, 483.20 and 483.25 determines sufficiency of nurse staffing.
[redacted]	(a) Sufficient staff.	Interpretive Guidelines: §483.30(a) and (b) At a minimum, staff means licensed nurses (RNs and/or LPNs/LVNs), and nurse aides. Nurse aides must meet the training and competency requirements described in §483.75(e). Except for licensed staff noted above, the determining factor in sufficiency of staff will be the ability of the facility to provide needed care for residents. A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff. If, however, inadequate staff (either the number or category) presents a clear threat to resident care, even when adverse effects have not occurred, or there is a lack of residents reaching their highest practicable level of well-being, cite this as a deficiency. Provide specific documentation of the threat. Survey Procedures and Probes: §483.30(a) and (b) Determine nurse staffing sufficiency for each unit: o Is there adequate staff to meet direct care needs, assessments, planning, evaluation, supervision? o Do work loads for direct care staff appear reasonable? o Do residents, family, and ombudsmen report insufficient staff to meet resident needs? o Are staff responsive to residents' needs for assistance, and call bells answered promptly? o Do residents have difficulty in locating a staff member when the need arises, or do call bells go unanswered? o Do residents call out repeatedly for assistance? o Are residents, who are unable to call for help, checked frequently (e.g., each half hour) for safety, comfort, positioning, and to offer fluids and provision of care? o Are identified care problems associated with a specific unit or tour of duty? o Is there a licensed nurse that serves as a charge nurse (e.g., supervises the provision of resident care) on each tour of duty (if facility does not have a waiver of this requirement)? o What does the charge nurse do to correct problems in nurse staff performance? o Does the facility have the services of an RN available 8 consecutive hours a day, 7 days a week (if this requirement has not been waived)?
F354	(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (c) of this section, licensed nurses; and (ii) Other nursing personnel.	
F355	(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	
[redacted]	(b) Registered nurse.	
F356	(1) Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.	

16.32.360 MINIMUM STANDARDS FOR A SKILLED AND SKILLED/INTERMEDIATE CARE FACILITY -- GENERAL REQUIREMENTS A skilled nursing care facility shall comply with the Conditions of Participation for Skilled Nursing Facilities as set forth in 42 CFR 405, Subpart K. An intermediate care facility shall comply with the requirements set forth in 42 CFR 442, Subparts E and F. A copy of the cited rules is available at the department. (History: Sec. 50-5-103, 50-5-404 MCA; IMP, Sec. 50-5-103, 50-5-204, 50-5-404 MCA; NEW, 1980 MAR p. 1587, Eff. 6/13/80.)

16.32.361 MINIMUM STANDARDS FOR A SKILLED NURSING CARE FACILITY FOR EACH 24 HOUR PERIOD -- STAFFING (1) The following table indicates an absolute minimum staffing pattern below which an acceptable level of care and safety cannot be maintained. Even with this staffing it would be difficult. Therefore, it is recommended that the quantity and quality of staffing should be determined by the administrator in consultation with his director of nursing. This decision should be based on the nursing needs of the patients and should reflect the current concepts of restorative and geriatric care. (History: Sec. 50-5-103, 50-5-404 MCA; IMP, Sec. 50-5-103, 50-5-204, 50-5-404 MCA; Eff. 12/31/72.)

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In Terms Of Hours Of Service Furnished By Each Category Of Personnel

No. of Beds Licenced	DAY			EVENINGS			NIGHTS		
	R.N.* Hours	L.P.N. Hours	Aide** Hours	R.N. Hours	L.P.N. Hours	Aide** Hours	R.N. Hours	L.P.N. Hours	Aide** Hours
4-8	8	0	0	0	8	0	0	8	0
9-15	8	0	4	0	8	0	0	8	0
16-20	8	0	8	0	8	4	0	8	0
21-25	8	0	12	0	8	8	0	8	4
26-30	8	0	16	0	8	8	0	8	8
31-35	8	0	20	0	8	12	0	8	8
36-40	8	0	24	0	8	16	0	8	8
41-45***	8	8	28	0	8	16	0	8	12
46-50	8	8	32	0	8	20	0	8	16
51-55	8	8	36	8	0	24	0	8	16
56-60	8	8	40	8	0	24	0	8	16
61-65	8	8	44	8	0	28	0	8	20
66-70	8	8	48	8	0	32	0	8	24
71-75	8	8	52	8	0	32	8	0	24
76-80	8	16	48	8	8	32	8	0	24
81-85	8	16	52	8	8	32	8	8	20
86-90	8	16	56	8	8	32	8	8	24
91-95	16	16	52	8	8	36	8	8	24
96-100	16	16	56	8	8	40	8	8	24

Staffing of homes with more than 100 beds will be given individual consideration.

*The two relief shifts could be provided by an L.P.N. up to 40 beds.
**The term "aide" includes orderlies.
***In a home of 41 beds or more, one R.N. in this pattern is to be the full-time director of nursing service.

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Amendment
HB316

Section 1
Line 13-25

0-59 Beds	60-119 Beds	120-up Beds
	Daytime	
1DON	1DON	1DON
1RN coord.	1RN coord.	1Rn coord.
		1LPN - per 30 beds
1DCGT per 8 beds	1 DCG per 8 beds	1DCG per 8 beds
	Evening	
1RN	1RN	1RN
		1LPN - per 45 beds
1DCG per 12 beds	1DCG per 12 beds	1DCG per 12 beds
	Night	
1RN	1RN	1RN
		1LPN per 60 beds
1DCg per 15 beds	1DCG per 15 beds	1DCG per 15 beds

EXHIBIT 12
DATE 2-3-93
HB 316

MR CHAIRMAN , MEMBERS OF THE COMMITTEE, FOR THE RECORD MY NAME IS JANET ROBIDEAU. I AM THE PRESIDENT OF THE MONTANA COALITION FOR NURSING HOME REFORM. I AM HERE TODAY IN SUPPORT OF H.B 316. I WILL BEGIN WITH A SHORT EXPLANATION OF THE COALITION AND MOVE ON TO THE CRUX OF THE LEGISLATION.

THE MONTANA COALITION FOR NURSING HOME REFORM BEGAN IN 1989 WITH THE APPEARANCE OF OBRA, A FEDERAL MANDATE TO DEAL WITH NURSING HOME INADEQUACIES. SINCE 1989, THE COALITION HAS WORKED TO ADDRESS THE CONCERNS OF NURSING HOME STAFF, RESIDENTS AND RESIDENTS' FAMILIES IN MONTANA.

AFTER HEARING THE FRUSTRATIONS OF CARE-GIVERS AND RESIDENTS, THE COALITION DEVELOPED LEGISLATION THAT ADDRESSES THESE PROBLEMS.

THE COMPLAINT WE HEAR TIME AFTER TIME FROM GROUP AFTER GROUP IS INSUFFICIENT STAFFING. BECAUSE OF LOW STAFFING, LESS THAN QUALITY CARE IS BEING DELIVERED IN NURSING HOMES.

FEDERAL LAW MANDATES THAT A LICENSED NURSE MUST BE ON DUTY 24 HOURS A DAY. A REGISTERED NURSE MUST BE ON DUTY FOR A LEAST 8 HOURS A DAY. THE LAW ALSO MANDATES THAT A DIRECTOR OF NURSING BE PRESENT

TO SUPERVISE STAFF.

THERE ARE NO FEDERAL LAWS THAT ADDRESS MINIMUM STAFFING RATIOS FOR UNLICENSED STAFF. THESE DIRECT CAREGIVERS PROVIDE 90% OF THE HANDS-ON CARE RESIDENTS RECEIVE (IMPROVING THE QUALITY OF CARE IN NURSING HOMES; 1986, PG10)

AS WE ALL KNOW, HEALTH CARE IS EXPENSIVE. CORPORATIONS HOLD DOWN COSTS BY EMPLOYING CERTIFIED NURSING ASSISTANTS, WHO OCCUPY THE LOWEST RUNG OF THE HEALTH CARE HIERARCHY, RECEIVE RELATIVELY LITTLE TRAINING AND ARE INADEQUATELY SUPERVISED. CNAS ARE REQUIRED TO CARE FOR MORE RESIDENTS THAN THEY CAN SERVE. BECAUSE OF THESE FRUSTRATIONS, A VERY HIGH TURNOVER RATE OF SOMETIMES OVER 100% EXISTS AMONG CNAS.

ADEQUATE STAFFING DOES NOT GUARANTEE GOOD CARE, IF THE WORKERS AREN'T RECEIVING GOOD TRAINING AND SUPERVISION. BUT, GOOD CARE IS NOT POSSIBLE WITH OUT ADEQUATE STAFFING.(NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE: NOV 1990)

AS I SAID, FEDERAL LEGISLATION MANDATES SOME NUMBERS FOR PROFESSIONAL STAFF. IT IS A STATE ADMINISTRATIVE RULE, THOUGH, THAT

DICTATES CNA STAFFING. HB316 PROPOSES TO UPDATE THIS LAW PASSED IN 1977.

THE ADMINISTRATIVE RULE STATES THAT "THE FOLLOWING TABLE INDICATES AN ABSOLUTE MINIMUM STAFFING PATTERN BELOW WHICH AN ACCEPTABLE LEVEL OF CARE AND SAFETY CANNOT BE MAINTAINED. EVEN WITH THIS STAFFING IT WOULD BE DIFFICULT."

ACCORDING TO A HEALTH CARE FINANCING ADMINISTRATION SURVEY, 88% OF NURSING HOMES NATIONWIDE NEED ADDITIONAL STAFF. THIS IS CERTAINLY TRUE IN MONTANA. WE ARE NO LONGER LIVING IN 1977. WE SHOULD NOT OPERATE NURSING HOMES UNDER A 1977 RULE.

MORE AND MORE OF OUR SENIORS ARE GOING TO NURSING HOMES. WITH THE INCREASE IN RESIDENTS, THE MONTANA COALITION FOR NURSING HOME REFORM FEELS IT IS NOT ONLY APPROPRIATE, BUT NECESSARY, TO INCREASE THE NUMBER OF STAFF ON HAND TO CARE FOR THE EVER INCREASING NUMBER OF RESIDENTS.

IN THE STUDY DONE BY THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE IT WAS DISCOVERED THAT DIRECT CAREGIVER STAFFING WAS INADEQUATE ACROSS THE COUNTRY. EIGHTY EIGHT PERCENT

OF THE NURSING HOMES DID NOT MEET THE CNA PROPOSED STANDARD. THE AVERAGE SHORTAGE WAS 13.7 CNA'S PER HOME.

THE COMMITTEE ALSO DISCOVERED MORE NURSES WOULD BE REQUIRED. MONTANA IS NOT AN EXCEPTION. ON THE CONTRARY, MONTANA WAS DISCOVERED TO HAVE SERIOUS DEFICIENCIES. ACCORDING TO THE NATIONAL COMMITTEE'S STUDY, 90 OUT 100 NURSING HOMES IN MONTANA WERE FOUND TO BE IN NEED OF MORE NURSE AIDES.

WE UNDERSTAND THAT COSTLY PROPOSALS CANNOT BE ADDRESSED AT THE LEGISLATURE UNLESS WHAT IS PROPOSED IS AN INVESTMENT.

THIS IS AN INVESTMENT IN QUALITY CARE, IN OUR ELDERLY, AND IN COST-SAVINGS.

HIGHER LEVELS OF STAFFING WILL SAVE BOTH THE STATE AND THE NURSING HOMES MONEY. (THE NATIONAL NURSE SURVEY 1992)

WORKER TURNOVER IN HOMES WILL DROP, WHICH WILL RESULT IN LOW-TRAINING COSTS AND OTHER PRICE TAGS ASSOCIATED WITH HIGH TURNOVER. ADVERTISING COSTS ALONE WILL DROP DRAMATICALLY.

MONTANA WILL SAVE MONEY WITH THIS INVESTMENT IN SEVERAL ARENAS. ADEQUATE STAFFING WILL RESULT IN LOWER-INJURY RATES FOR THESE

WORKERS, WHICH REDUCES THE IMPACT ON WORKERS COMPENSATION. GOOD CARE WILL RESULT IN HEALTHIER PATIENTS, WHICH ADDS UP TO SAVINGS IN MEDICAID COSTS. HB316 WOULD ALSO MAKE THE INDUSTRY ACCOUNTABLE TO THE STATE. THAT WILL RESULT IN COST SAVINGS.

CURRENTLY, STAFFING LEVELS ARE DANGEROUSLY LOW, WHICH RESULTS IN MORE INJURIES. THESE INJURIES COST THE STATE MONEY.

CAN WE AFFORD THIS? I DON'T THINK SO.

A STUDY DONE BY THE SERVICE EMPLOYEES INTERNATIONAL UNION FOUND THAT LOW STAFFING LEVELS HARM RESIDENTS AS WELL AS THEIR CARE GIVERS. SERIOUS ACCIDENTS AND ERRORS DUE TO SHORT STAFFING ARE ON THE INCREASE. NURSES HAVE ALSO REPORTED THAT HALF OF THESE INCIDENTS GO UNREPORTED. INJURIES RESULTING IN A NEED FOR MEDICAL CARE COST SOMEONE MONEY. THAT SOMEONE IS THE MONTANA TAXPAYER.

SHORT STAFFING IS A MAJOR FACTOR IN ERRORS AND INJURIES. THE NATIONAL NURSE SURVEY ASKED HOW OFTEN POOR STAFFING CAUSED PATIENT CARE PROBLEMS: 35% SAY LACK OF STAFF OFTEN OR ALWAYS LEADS TO LAPSES IN INFECTION CONTROL; 29% SAY SHORT STAFFING LEADS TO MORE PATIENT FALLS. THE SURVEY DOCUMENTS THAT LONG-TERM CARE FACILITIES

ARE WORKING SHORT STAFFED AND INADEQUATE STAFFING IS DAMAGING PATIENTS.

POOR QUALITY CARE AND SHORT STAFFING IS SIMPLY TOO EXPENSIVE TO CONTINUE.

THE EFFECT OF SHORT STAFFING ON CAREGIVERS HAS STARTLING RAMIFICATIONS ON NURSES AND THEIR SUPPORT STAFF. BACK INJURIES AND DISORDERS ARE TWICE THE RATE FOUND IN THE GENERAL POPULATION. NEARLY HALF OF THE NATIONAL NURSE SURVEY RESPONDENTS STATED THAT ON-THE-JOB INJURIES ARE OFTEN DUE TO SHORT STAFFING. NINETEEN PERCENT REPORT CHRONIC FATIGUE AS COMPARED TO 8% OF OTHER WORKERS. TWENTY-EIGHT PERCENT REPORT BACK AND SPINE PAIN COMPARED TO 11% NATIONALLY.

THE SURVEY FOUND THAT CAREGIVERS WHO WORK UNDERSTAFFED REPORT A MUCH HIGHER RATE OF STRESS AND STRESS-RELATED INJURIES.

WITH THESE NUMBERS, THE WORKERS COMPENSATION FUND WILL EXPECT RELIEF IF HB316 IS PASSED.

IT IS WITHIN THE POWER OF THIS LEGISLATURE TO MAKE THE INVESTMENT IN QUALITY CARE. IT IS WITHIN THE POWER OF THIS LEGISLATURE TO

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ENSURE THAT THOSE INDIVIDUALS LIVING IN MONTANA'S NURSING HOMES RECEIVE THE QUALITY CARE THEY DESERVE.

THESE PEOPLE, OUR ELDERS, DESERVE TO BE TREATED WITH DIGNITY AND RESPECT. CARE GIVERS WHO DEVOTE THEMSELVES TO CARING FOR OUR NURSING HOME RESIDENTS DESERVE NOTHING LESS.

WE SHOULD NOT PUT A PRICE TAG ON HUMAN LIVES - BUT THE PRICE TAG WE'RE ADVOCATING WILL RESULT IN SAVINGS.

QUALITY CARE SHOULD BE A GIVEN.

NURSING HOME WORKERS SHOULD FEEL CONFIDENT THAT THERE WILL BE ENOUGH STAFF TO MAINTAIN A HIGH STANDARD OF CARE DELIVERY, AND ENOUGH STAFF TO AVOID INJURY.

RESIDENTS, WORKERS, FAMILY MEMBERS, THE NURSING HOME INDUSTRY, AND YOU SHOULD SUPPORT THIS LEGISLATION, WHICH IS AN INVESTMENT IN CLEANING UP THE MESS IN MONTANA'S NURSING HOMES.

HAVE THE COURAGE TO HOLD THE INDUSTRY ACCOUNTABLE. HAVE THE COURAGE TO REDUCE WORKER INJURY AND TURNOVER. HAVE THE COURAGE TO FIND MEDICAID SAVINGS. HAVE THE COURAGE TO MAKE THIS INVESTMENT.

HAVE THE COURAGE TO GIVE HB316 A DO PASS RECOMMENDATION.

EXHIBIT 13
DATE 2-3-93
HB 316

GOVERNOR'S OFFICE ON AGING

MARC RACICOT, GOVERNOR

(406) 444-3111

STATE OF MONTANA

PO BOX 200801
HELENA, MONTANA 59620-0801

February 3, 1993

TO: House Human Services and Aging Committee

FROM: Doug Blakley, State Ombudsman

RE: In support of HB 316 - Nursing Home Staffing Bill

As the head of the State Long-Term Care Ombudsman Program, our program receives and assists residents in resolving complaints regarding their care in the State's long-term care facilities. One of the most frequent complaints we encounter pertains to understaffing and its direct results: residents who receive inadequate levels of care in such areas as assistance to the bathroom, with eating, dressing, bathing, grooming, etc.

For us as ombudsmen, these are some of our most frustration complaints, since there are no easy solutions to the problems. The burden of proof is on consumers and regulators to prove inadequate levels of care, so that regulatory agencies can force increases. This is a very arduous and time consuming process. If understaffing does exist, residents suffer in the mean time.

The issue of staffing is an extremely complex one. Many factors can contribute to residents failing to receive adequate levels of care. A vary of different tools are used to attempt to ensure sufficient staff. Because of its complexity, no state has developed perfect system. All are struggling with the issue.

The bill before you today attempts to address one aspect of the problem: the facility that makes the absolute minimums set by the state their maximum staffing level. Its levels are not exorbitant. It alone will not address all the problems of understaffing. What it does is target the worst of the offenders. Its attempts to set a bottom floor limit below which no facility can go. The bill updates what all admit is an outmoded tool to ensure minimum compliance.

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HB 366

February 2, 1993
Great Falls, Montana

"You can tell them that they just don't have enough help to tend the residents when we need help. This morning, I waited an hour for breakfast, and I left. They brought the tray to the room, but I was so upset that I couldn't eat. Several times, I called for help in the bathroom, and I was a mess when they finally came. At times, I have to wait up to forty-five minutes before help comes I don't blame the girls. They can't be all over at once. I thought that slave days were over."

The testimony of Mrs. Genevieve Broughton,
a resident at Cascade County Nursing home (Horizon)
in Great Falls, Montana

Dear Honorable Bill Boharski and Committee Members

EXHIBIT NO. 13
DATE 2-3-93
316

My name is Louisa Clark. I am a Registered Nurse working at Heritage Place in Kalispell. Currently approximately 90 residents reside there.

The main problem I see in working at the Nursing Home is not enough licensed personnel and nurses' aides to give even close to adequate nursing care. With the increased acuity level of residents, especially the terminally ill, residents with IV therapy, tube feedings, etc., hands-on nursing personnel are spread too thin. This produces a problem of always trying to "catch-up". Most of the time, we as nurses can't "catch-up"; and thus, residents & their families suffer through lack of care.

For example, I administer medications and do treatments for forty residents. Last week, I was confronted with a situation in which I had to start an IV on a resident who was terminally ill, and later died on the beginning of the next shift. By the time I received the physician's order, collected supplies for the IV, started the IV, comforted the family, and assessed the resident's pain level and tolerance to titrating the Morphine, two hours had lapsed. Who observed and assessed the other 39 residents? Intermittently, no one. Why? Because the nurses' aides were in the dining room, helping to feed, which left the most critical residents, who are bed-ridden, on the Unit basically unsupervised. This frightens me tremendously. Where is the Director of Nursing? In the office, being a manager. Where is the Quality Assurance Nurse? Down on a new wing which has just opened up and needs supervision. Where is the charge nurse? Taking orders from doctors, doing paperwork, and also playing "catch up!" Where is the resident? Your loved one? No telling. Maybe slipping in urine and no one around to help? Maybe trying to press "his" or "her" call light, but is too weak to press? Maybe being assaulted by an Alzheimer's

We need improvements. Yes! We needs "hands-on" personnel who are not over-loaded and not bombarded with paperwork, to care for residents.

I support Bill 316. However, I do not agree with increasing nurses' aide & resident ratios, without increasing licensed personnel and resident ratios. Why? Because, in my opinion, licensed personnel ratios also need to be increased to supervise nurses' aides, to deal with IV therapy, care of the terminally ill, residents with tube feedings, and residents with dementia. These are, in my assessment, the most time-consuming areas of resident care. The above areas do require licensed personnel to supervise, not just nurses' aides.

Also, I want to mention that the cost is great to everyone, especially the tax payer, when not enough staffing is provided. For example, workmen's Compensation injuries increase. Nurses' aides tell me, that they lifted because they had been waiting & waiting for help for so long with no response, that they "took a chance", only later to be faced with a back injury. Also turnover of employees increase. A new employee is faced with coming to work without enough staffing, day after day. They keep trying to "catch-up," and they keep failing, no matter how organized they try to be, and so they resign. This situation of burn-out and turnover for the employer and eventually the taxpayer, becomes costly. Then the employer has to spend money orienting and reorienting new employees. Thus, residents also suffer, because they don't experience Continuity of care. It becomes a ~~vicious~~ vicious cycle. This is not to also mention lawsuits from unnecessary hospitalizations because of falls, assaults, over-looked care to name a few All related to lack of staffing.

The reasons for supporting Bill 316 are too many to count.

Thankyou for your time.

[illegible] RN

EXHIBIT 16
DATE 2-3-93
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Mr. Chairman & Members of the committee,

My name is Brent Fay and I'am a Nursing Assistant at Hillside Manor in Missoula. I've been a C.N.A. for almost 5 years now. [redacted] This is about H.B. 316. Anyone who has watched the daily operation of a nursing home knows that it's not the Doctors, or Administrators who provide most of the hands on personal care to the residents: it's the NURSING ASSISTANTS. With the expanding elderly population, and the ever increasing range of illnesses like: cancer, Alzheimers, and AIDS., the type of care we provide is increasingly becoming more sophisticated. With the elderly expanding, and with more people becoming afflicted with these diseases, thus to, the amount of people to take care of them, must increase also. I've seen what happens in a facility when there is short staffing and it's not a rosey picture. There are to many inequities in Montana Nursing Homes, and the people who pay high exorburant prices deserve and should expect more. Poor care and resident neglect is often the result of UNDERSTAFFING. Not only do the residents suffer but the staff as well. According to a 1991 national study by the "National Committee to Preserve Social Security and Medicare", 92 oout of 100 Montana nursing homes are understaffed. I can tell you what happens when working short in a nursing home. Morale doesn't go up, quality of care doesn't go up. People are left lying in there own urine and bowel movement. People don't get turned every 2 hours, like there suppose to be. (and this is a violation of the law now on the books)
People don't bathed on their scheduled day. (when working short) No rehab gets done and personal neglect is almost non existant. There is a lack of feeding assistance. It is not uncommon for 3 aides to feed about 12 residents. Food gets cold when there isn't enough staff. When working short and residents have to lie in their own urine and waste, it eats away at there skin and this how some bed sores start. (When I approach the D.O.N. and administrator about this problem they offer a blanket of denial.) I would like to tell you about this Nursing Assistant that used to work at Hillside Manor. His name was Paul Taylor and he had a uncle at the Village Health Care Center in Missoula. Paul when he visited his uncle he worked the rooms voluntarily. Paul said that there was "call lights on all over the hall, but could find no aides." Paul cleaned his uncle and roommate and answered several call lights. "I tried to find an aide but couldn't." On Feb. 29 only 5 of the 11 required aides worked the day shift. (this is at Hillside Manor)
I would just say that before you come to a determination that you think about the last time that you were in a nursing home. The smell of urine and waste is not a very pretty smell. That is because that people are not getting changed on a regular basis. If you haven't been in a nursing home at all I suggest that you go visit one. Not all nursing homes are bad, because there are some good ones in Montana. But the ones that are not and nothing is done about it is a sad commentary about the system and how they are staffed. When you walk into a nursing home and find no aide and someone is crying for help, or that maybe someone has fallen out onto the floor and busted their hip because there was not enough help on the hall. Think about the family's and how they fell when they walk into the home that they have there loved one in, and find them between the siderails and maybe even fractured their leg. All of this because there is not enough help. The people who work in these places do so because they like to. When people go to there supervisors and tell them that there is a problem and nobody will listen to them then something else has to happen. People that have worked hard all there life and then they must go to a nursing home for one reason or a nother find that there life savings gone to pay for services that are poor and even inadequate. They should get there monies worth, and the person who owns the home should not be gouging these poor people for all there worth. IN 1991 the legislature jsut gave the nursing homes in Montana the biggest amount of money in the states history. These homes are claiming that they are losing money at of about the rate of $8 a day. If you kill this bill then I would like to invite all of you to the nursing home I work at to work in there with me when we are working short. But you have to certified first. Think about the people that going to be put in jepardy by not having enough staff to do the job the proper way. Think about the people that counting on you to do the right thing for them and their families.

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Mr. Chairman, members of the committee.

My name is Cheryl Brewer. I am a certified nursing assistant at Riverside Health Care Center in Missoula. I have been a nursing assistant for over ~~eight~~ 10 years and have worked in several nursing homes.

I'm here today to ask you to support House Bill 316.

As a CNA, I see first-hand, everyday, how hard it is to provide quality care to nursing home residents. There is so much I could tell you about the negative impact of short-staffing, but in the interest of time, I will focus on one point only.

You will hear today from the nursing home industry that they do staff at appropriate levels, or at least, that they schedule enough staff. You will hear from them that it is us, as CNAs, who call in sick or absent and cause the short-staffing problem.

Well personally, I think this is the wrong view to take about this problem. If not enough workers are there, on the floor, to do the job, then obviously the nursing homes are not scheduling enough people to work.

We just can't meet all the new requirements of OBRA, the Nursing Home Reform Act, without more staff. We physically can't honor residents rights to have choices, to engage in activities, and to have daily, rehabilitative therapy, without more staff.

It is true that CNAs have a high call-in and a high turn-over rate, and it is true that this affects quality of care.

So why doesn't the nursing home industry join us in seeking solutions to this problem?

We believe that CNAs experience burn out because of the physically, mentally and emotionally taxing nature of our work. We also believe that when a person is paid minimum wage, provided little or no benefits, and treated with no dignity or respect at work, your incentive to be a model employee diminishes.

We're here today because we want to improve the quality of care we are able to deliver to Montana's elderly citizens.

Please help us by supporting this bill.

Thank you.

EXHIBIT 18
DATE 2-3-93
HB 316

2/2/93

CHAIRMAN BOHARSKI AND MEMBERS OF THE COMMITTEE. MY NAME IS ALICE CAMPBELL, I LIVE IN MISSOULA AND I AM VICE-CHAIR OF THE MONTANA COALITION FOR NURSING HOME REFORM. I AM HERE TO TESTIFY IN SUPPORT OF HOUSE BILL 316. I WOULD LIKE TO RELATE SOME INCIDENTS OF NEGLECT, CAUSED BY UNDERSTAFFING, THAT OCCURED WHILE MY MOTHER WAS A RESIDENT AT HILLSIDE MANOR IN MISSOULA.

MY MOTHER FELL AND BROKE HER HIP WHILE TAKING HERSELF TO THE BATHROOM. HER DOCTOR'S INSTRUCTIONS WERE THAT SHE SHOULD NOT GO TO THE BATHROOM UNASSISTED, BUT AFTER WAITING A CONSIDERABLE TIME FOR HELP SHE ATTEMPTED TO TAKE HERSELF. WE WERE NOT INFORMED OF THE ACCIDENT UNTIL THE NEXT MORNING. MANY TIMES I WOULD CHECK TO SEE HOW LONG IT TOOK TO HAVE A LIGHT ANSWERED. AFTER WAITING SOME TIME I WOULD GO OUT TO THE DESK TO CHECK BUT NO ONE WOULD BE THERE. I WOULD GO DOWN EACH HALLWAY BUT NO ONE WOULD BE AVAILABLE AND THE BOARD AT THE DESK WOULD BE FILLED WITH RED LIGHTS. MY MOTHER WOULD SAY, "THEY ARE NOT COMING,THEY NEVER DO". AT OTHER TIMES THEY SEEMED TO HAVE MORE HELP AND THE RESPONSE WOULD BE QUICKER.

THE AIDES ALWAYS SEEMED TO BE RUSHING FROM ONE ROOM TO ANOTHER, TRYING TO CARE FOR THE PATIENTS AS BEST THEY COULD WITH LIMITED HELP. I AM SURE IT WAS ALWAYS GOING OVER AND OVER IN THEIR MINDS WHICH PATIENTS NEEDED THEIR ATTENTION FIRST DUE TO THEIR INDIVIDUAL CIRCUMSTANCES. I HAVE HAD AIDES RELATE INCIDENTS TO ME OF BEING THE ONLY PERSON RESPONSIBLE FOR AS MANY AS EIGHTEEN PATIENTS ON THE MORNING SHIFT. THAT MEANT GETTING THEM UP, TOILETING OR CHANGING, DRESSING AND HOPEFULLY BEING ABLE TO WASH BEFORE BREAKFAST. BATHTIME, WHAT A DIFFICULT TIME FOR THOSE

UNABLE TO SPEAK FOR THEMSELVES. THEY WERE LINED UP WITH JUST A BATH BLANKET WRAPPED AROUND THEM, WAITING THEIR TURN. AN AIDE RUSHING TO GET THEM IN AND OUT OF THE BATH WHILE TRYING TO GIVE THEM A LITTLE INDIVIDUAL ATTENTION, SUCH AS APPLYING LOTION TO THEIR DRY SKIN. MANY WOULD BE WAITING FOR AS MUCH AS AN HOUR AFTER WE ARRIVED.

LASTLY, I WISH TO EXPRESS THE FEELING OF ANGER AND FRUSTRATION MY SISTER AND I FELT THE DAY WE ARRIVED TO FIND OUR MOTHER WITH TWO BLACK EYES AND A BADLY BRUISED NOSE. WHEN WE ASKED WHAT HAD HAPPENED SHE SAID, "THEY BROKE MY NOSE WHEN THEY WERE BATHING ME." WHEN ASKING AT THE DESK WHAT HAD HAPPENED WE WERE TOLD THAT SHE WAS NOT STRAPPED IN WHILE BEING GIVEN HER BATH AND FELL. TWO PEOPLE SHOULD HAVE BEEN PERFORMING THE TASK BUT BECAUSE OF A SHORTAGE OF HELP ONLY ONE WAS AVAILABLE. I KNOW THAT MANY OF THE ACCIDENTS I KNOW OF AND HAVE BEEN TOLD ABOUT OCCUR BECAUSE OF UNDERSTAFFING. I FEEL THAT THE UNDERPAID AND OVERWORKED AIDES AT THESE HOMES DO THE BEST THEY CAN UNDER DIFFICULT CIRCUMSTANCES. THE MAIN CONCERN OF THE FOR-PROFIT NURSING HOMES IS FOR THE BOTTOM LINE DOLLAR, NOT CONCERN FOR THE PATIENTS. PROFIT AT THE EXPENSE OF THE DIGNITY AND WELL BEING OF THE UNFORTUNATE ELDERLY IS NOT ACCEPTABLE. STAFFING REQUIREMENTS MUST BE ADEQUATE AND ENFORCED.

EXHIBIT 19
DATE 2-3-93
HB 316

Rep. Vicki Cocchiarella
Capitol Station
Helena, Montana 59620
Re: House Bill 316

My Dad is gone now. It has been a year. He was taken from a Missoula nursing home to Community Hospital where my family and I had to make a choice of where we wanted him to spend the last 35 hours of his life. We chose the hospital where he could die with dignity, quality care, and adequate staffing.

My father was a severely dehydrated man when he was taken from the Hillside Nursing Home to the hospital. I feel that the only reason any attention was paid to him that morning was because I phoned the Director of Nursing earlier that same morning, making her aware of the condition I found him in at eight p.m. the evening before.

My father's health had continued to deteriorate during the last month of his life. Numerous times my family and I told the staff that he was "losing weight, didn't look well and was very weak." Responses to those concerns were met with "he had been sick, we can't make him eat, and he had lost that much weight before."

How many times was there adequate staffing to take time to stay with him to see that he ate his meals before his food became cold and unappetizing, or to see that he was gettin enough liquids. He would beg to be put to bed when he wasn't feeling well, and it would be hours before someone had time to do it. He would beg to be taken to the bathroom. Again it would be hours before the staff would get around to it and so he would have to sit in wet and soiled clothing.

My father's story is not unique. For the sake of our loved ones I urge each and every one of you to support H.B. 316 so that they may recieve the care and attention they so richly deserve.

kSincerely,

Wendy Neal

Wendy Neal
8635 Pheasant St.
Missoula, Mt 59802

EXHIBIT 20
DATE 2-3-93
HB 316

Rep. Vicki Cocchiarella
Capitol Station
Helena, Montana 59620
Re: House Bill 316

I regret not being able to attend this hearing so I am hoping my message will be heard. I have been a member of the Montana Coalition for Nursing Home Reform for two years and sincerely hope that this is a Wake Up Call for the State of Montana to move forward and take action. Conditions in Montana's nursing homes must be changed so loved ones who have to be placed there can receive the Quality Care they deserve. For too long, many nursing home residents have suffered because of Low Staffing and too few state inspections.

My husband was a resident for two years in a Missoula nursing home. He had Alzheimer's and as time passed we saw more and more evidence of low staffing and the care he recieved became less and less adaquate. The care he required, such as exercise, help with walking (because his cane had been taken away and he had been restrained in a wheelchair). Fewer baths were given. There was no help for toileting as was promised and many, many times he was left wet and soiled. His hands and nails were seldom cleaned and he was tied to hall railings. No one seemed to know why, and it should not have been necessary when he was already restrained in his wheelchair. His diet was not closely watched when he lost weight and he was seldom given water to drink and became severely dehydrated. Oxygen and inhalers were not always used properly. He waited hours to be put to bed when he was not feeling well. This request was often asked but seldom granted. I was told over and over again by the RN's that there was just not enough help. I strongly believe these needs could have been met if the state inspectors and out-of-state owners had done their job adequately. No out-of-state owners could possibly know what goes on in these nursing homes in Montana. If they did and cared they would have done something a long time ago.

There are many dedicated workers in these nursing homes. Listen to them, for they are the ones who know what is going on, Listen to what they have to say and take Action.

My husband died January 25, 1992 in Community Hospital in Missoula where he spent his last 34 hours. He had finally found Quality Care with Dignity. He deserved much more than the nursing home gave. Please support H.B. 316. My husband's suffering is over, but for those remaining your help is desparately needed.

Sincerely,

Lillian Addison

Lillian Addison
3602 Stephans Ave
Missoula, Mt 59801

EXHIBIT 11
DATE 2-3-93
HB 316

January 18, 1993

House Committee on Human Services and Aging
Support of House Bill 316
Capital Station
Helena Mt

My name is Bruce Powsner. I work at Riverside Health Care Center both as a CNA and as a rehabilitation aide. During the last week of December 1992 after finals were over I was working every day on the floor mornings as a CNA. I' noticed that none of the resorative care usually done by Krystal (weekdays) or Don (weekends) was being done and had not been done since the 15th of December. However, I was not assigned to do any of this until the last day before I went on vacation. (Dec. 30) During this week their were at least three short staffed mornings.

At this time there were 12-14 residents who were supposed to recieve restoritive care, under instruction from the physical therapist, twice daily seven days a week. This restoritive care consists of ambulation (walking) for residents who are able to walk with assistance and range of motion exercises for people with partial paralysis of one side. This is a progressive activity, whereby residents gain increased use of upper and lower limbs, shoulders, hips while for a few residents, these exercises prevent muscle contractions fromdeveloping and possibly permanently reducing their ability to move. To interupt this program for two weeks can cause significant loss of function and independence for certain individuals.

I personnaly think this is a result of short staffing because the two people that were supposed to do this while I was gone simply did not have enough time to do it.

Sincerely,

Bruce Powsner

Bruce Powsner

EXHIBIT 22
DATE 2-3-93
HB 316

House Committee on Human Services and Aging
Capital Station
Helena Mt
Supporting House Bill 316

My Name is Donna, I work at Libby Care Center. I wanted to let yiu know that even when were full staffed we feel understaffed. You don't have time to visit with anyone. Some of them want to start talking and we always feel rushed. You don't have time to have residents rest between breakfast and lunch.

Sometimes call lights stay on for a long time before they get answered because their is so many going off at one time. If we had more staff they would get answered in a timely fashion. Residents don't get to lye down when they want to, they don't get fed before their food turns cold, and we rarely have time to just sit and talk to them.

I think it's sick to see these residents not get the care that they need. That's why I support Bill 316. If we had more staff we would have time to give the care these residents to greatly deserve.

Sincerely,

Donna L. Maupin

EXHIBIT 23
DATE 2-3-93
HB 316

To: THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING
From: Sharon Harrington and Luceta Pomerov-Libby Montana
Date: Feb. 3.1993
Re: Written testimony in support of House Bill 316

On pm. shift at Libby Care Center. there are 11 residents for every CNA to care for. That's when we are fully staffed. As soon as we hit the floor we are changing people. pottying people. we are laying residents down. we answer lights and the bath person bathes people. Even when we are fully staffed. we can't provide people with the care that we would like to. You can't turn them as much as you need to and people get bed sores. You can't take the time for people to dress themselves and you have to hurry through teeth brushing and face washing. You get so busy taking care of people who really need help. that you can't spend time with the people who can take care of themselves. And. again. this is when we are fully staffed.

When we don't have a full staff. which is at least 2-3 times a week. then it's really hard to provide people with the care they need. Often times. we can't get to the call lights on time. People get bathed in a hurry. Sometimes. people don't get enough to eat. Sometimes they are rushed to their activities. Sometimes. if we are short staffed. and we are feeding people.. we have to ignore call lights.

We do 95% of the patient care and even with the state minimum enforced. residents are still neglected. We have no time to give people personal contact. that does not promote a healthy living style. and people get treated like animals. We need more staff on the floor. it is heart breaking to see this happening. What the nursing home industry does not understand is that we love these people. they are like family. and that's a fact.

Sincerly.

Sharon Harrington

Lucy Pomerov

EXHIBIT 23
DATE 2-3-93
HB 316

TO: THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING
FROM: TERI NELSON-LIBBY CARE CENTER CNA
DATE: FEB. 3. 1993
RE: WRITTEN TESTIMONY IN SUPPORT OF HOUSE BILL 316

I work on the day shift at eh Libby Care Center. On a fully staffed day, we have 1 CNA for 8.5 residents. You need to understand that in providing care we deal with many completely helpless people. Some people are terminally ill, that requires taking extra care, turning them frequently so they don't get bed sores because their skin is very fragile, giving them sips of water, checking their vital signs, helping the family cope. People need to understand that the care we provide in a nursing home is to people who are in medical crisis. Emergencies are the rule, not the exception. One minute someone might be eating lunch, the next minute they might be vomiting or passed out. So, even in nursing homes where the ratio is one CNA for every 8 residents, it is very difficult to provide care. In nursing homes that are staffed with one CNA for up to 12 residents.it must be impossible.

People don't understand that we are people's families: Sometimes their real families abandon them, sometimes the families might live out of town, or maybe the resident is the sole survivor. We mean as much to these people as they mean to us. They feel extremely neglected when we can't provide them with enough care.

Alot of these people become disoriented, there needs to be consistency in who provides care. You might do things like dress someone and the next minute they are stark naked. Sometimes people wander outside and its winter in Libby. One time we put a resident to bed and finished our rounds and came back and saw that the man who we had just put to bed had gotten up, went out to the hall buck naked, and pooped all over the hall. We had to clean the whole thing up before we could leave. So we do more then just resident care, sometimes we are even doing housekeeping. When people can't speak, because they have a stroke, we have to interpret what they are saying: Are they speaking in the present or are they fantasizing about the past. So you have to get past the language barrier and figure out if they really do need something or not. We take care of people in their last stages of life. Not only do they deserve high quality care, **they have to have it.**

Signed,
Teri Nelson CNA
Teri Nelson CNA

EXHIBIT 24
DATE 2-3-93
HB 316

Missoula Women for Peace
Branch of Women's International
League for Peace & Freedom

Jeannette Rankin Education Fund
An Association to Promote
the Legacy of Jeannette Rankin

P.O. Box 5823
Missoula, MT 59806

February 3, 1993

The Missoula Women for Peace would like to support both the staffing bill, HB 316 and the Pharmacy bill, HB 229.

The staffing of the nursing homes needs to be matched to OBRA standards on a daily basis, not a monthly basis as it is at present.

How we treat the most vulnerable in our society is a measure of how civilized we are. At present, Montana's nursing homes as a whole fall short.

Respectfully submitted,

Connie Skousen

Connie Skousen, Chair

EXHIBIT 25
DATE 2-3-93
HB 316

January 28, 1993

To: Chairman, Human Services and Aging Committee
From: Raymond Gold, 413 King St., Missoula, MT 59801 Raymond Gold
Re: My support of HB 316

Engaging Montana's nursing home industry in a constructive dialog about the significant issues of nursing home reform has been and will continue to be extremely difficult. Leaders of this industry tend to view any movement toward reform as a threat to their livelihood and control of their organizations. They have successfully fought off any and all efforts within the state to do virtually anything which, from the point of view people like me who have loved ones in nursing homes*, would have the effect of improving the quality of life of nursing home residents. "Virturally anything" includes attempts to legislate more adequate staffing levels, better preparation of staff to do their work, professionalization of nursing home administrators and supervisors, and the like. The few improvements in quality of life of residents which have occurred in recent years have come about as a result of federal legislation which mandated certain requirements, not as a result of anything occurring in Montana alone. It is high time for Montana's legislators to mandate more adequate staffing levels in the state's nursing homes, for the evidence is distressingly clear that nearly all of Montana's nursing homes have been, and are continuing to be, strongly disinclined to add, professionalize, and adequately supervise the personnel needed to insure a good quality of life for nursing home residents.

*My mother, Sarah Gold, age 96, has resided in a Missoula nursing home for five years.

EXHIBIT
DATE 2-3-93
HB 316

Montana Family Union
AFL-CIO

110 West 13th Street
P.O. Box 1176
Helena, Montana 59624
406-442-1727

Don Judge
President

Pam Egan
Executive Director

The Associate Membership Program of the Montana State AFL-CIO

TESTIMONY OF PAM EGAN ON HOUSE BILL 316
HOUSE COMMITTEE ON HUMAN SERVICES AND AGING, FEBRUARY 3, 1993

Mr. Chairman, Members of the committee, I am Pam Egan, Executive Director of the Montana Family Union. I am here today to testify in support of House Bill 316.

This legislation speaks to the needs of two populations of great importance to the members of our organization: Montana health care consumers and Montana workers in low-wage, high-stress occupations.

As a result of the work of the Montana State Council of Hotel Employees and Restaraunt Employees and the Montana Nursing Home Coalition, the plight of both patients and workers in nursing homes has been brought to greater public attention. In fact, reform of nursing home care was identified by the Montana Family Union District 2 Chapter organization as its top priority issue.

When 92 of 100 Montana nursing homes are understaffed, both the patients and the nursing home staff pay the price. The cost to patients is inadequate, rushed health care. The cost to health care workers is an impossible workload in an already over-stressed job.

The only reward goes to nursing homes, in the form of increased profits.

Good health care is a right, not a privilege. It's about caring for people, not about making money. That's the real bottom line.

The Montana Family Union respectfully urges your support for HB 316.

MONTANA
HEALTH
CARE
ASSOCIATION

36 S. Last Chance Gulch, Suite A · Helena, Montana 59601
Telephone (406) 443-2876 · FAX (406) 443-4614

EXHIBIT 27
DATE 2-3-93
HB 316

HOUSE BILL 316

LONG TERM CARE FACILITY STAFFING

HOUSE HUMAN SERVICES & AGING COMMITTEE

FEBRUARY 3, 1993

For the record, I am Rose Hughes, Executive Director of the Montana Health Care Association, an association that represents approximately 80 of Montana's 96 nursing homes.

While we appreciate and understand the desire of the proponents of this bill to provide for additional staff in nursing homes, for a variety of practical and technical reasons we must oppose this legislation.

1. ***Appropriateness of placing staffing patterns in statute.*** We believe it is inappropriate to put staffing patterns in statute. To our knowledge, Montana has no other statute requiring any provider of any service (health or otherwise) to staff at any particular level. If there are to be minimum staffing levels, they should be contained in the rules of the Department of Health and/or the Department of Social and Rehabilitation Services. These agencies both have regulatory authority over nursing homes, and are

the agencies best able to deal with staffing requirements. In fact both agencies have rules on the books dealing with nursing home staffing.

2. ***Current staffing requirements are adequate and based on more appropriate criteria.*** Currently, the Department of SRS requires nursing facilities to participate in a patient assessment system. This system is designed to identify the actual care needs of residents in our facilities and to determine appropriate staffing levels based on these care needs. The staffing requirement generated by this system is called the "patient assessment score" or the "PAS". Facilities are required to staff to their patient assessment score and facilities are subject to substantial monetary penalties if actual staffing falls below 90% of the PAS for two consecutive months. While this system is not perfect, it is far superior to either the matrix in this bill, which is based on number of beds rather than on the care needs of our residents, or to the matrix contained in the Health Department's rules (which is also based on number of beds). We strongly believe that basing staffing on the number of beds in a facility is inappropriate. Why should any facility be required to staff empty beds? And, how does the number of beds tell you anything about the actual care needs of the residents of the facility?

Also, our facilities are required by federal law and regulations to employ adequate numbers and types of staff to meet the care needs of their residents. It is the job of the Department

of Health to inspect our facilities to insure that we are doing this and to respond to complaints. If the Health Department finds serious inadequacies which in any way jeopardize patient care, they have the ability demand correction and ultimately to shut down the facility.

3. ***The "shifts" contained in the bill are confusing.*** The specific shifts listed in the bill are confusing and do not resemble the actual shifts used by nursing homes. The "day" shift is 9 hours long, the "evening" shift is 5 hours long, and the "night" shift is 10 hours long.

4. ***The Director of Nursing Services (DON) is required to work 7 days a week.*** This bill requires the Director of Nursing Services to work seven days a week. Because of the administrative duties attached to the DON position, it is not appropriate to designate more than one DON. It is also inappropriate to ask our DONs to work seven days. Federal law requires facilities of 60 beds or more to employ a full time Director of Nursing. Federal law requires that there be RN coverage 8 hours a day, 7 days a week, and that there be licensed staff (RNs or LPNs) at all times.

5. ***Increased costs.*** This bill will substantially increase the cost of nursing home care for the State Medicaid program and for those who pay for their own care. SRS estimates that this bill will cost the state and federal Medicaid program approximately $2.2 million per year. Based on the number of non-Medicaid days, the bill will cost other payors about $1.3 million per year. These estimates do not include recruiting and training costs. Each new

EXHIBIT 27
DATE 2/3/93
HB 316

nurse aide hired must be provided with 75 hours of training and pass a test. Nursing staff at all levels in hard to find in many parts of the state. We do not believe that either our privately paying residents or the Medicaid program is willing to pay these increased costs. By SRS's own estimates, the current cost of providing a day of nursing home care to Medicaid beneficiaries averages $75.43 per day, while the rate Medicaid reimburses facilities to care for these residents is $67.23. There are no rates increases for nursing homes built into the budget for FY 94 or FY 95. The current nursing home bed tax will have to be increased and expanded to include all patients to fund rate increases for the next biennium and to attempt to close the gap between actual costs and Medicaid rates.

We simply cannot support legislation that increases our services and costs when those who must pay the increased costs are unable or unwilling to pay for current services and costs. Every morning we sit across the hall in the Joint Appropriations Subcommittee on Human Services. We are asked why our costs are going up. Our costs are going up because of new federal laws and regulations which demand that we provide bigger and better services. The bill before you does the same--it mandates more services and increased costs at a time when those footing the bill are demanding cost containment.

We urge you to vote "Do not pass" on HB 316.

Thank you for the opportunity to comment.

EXHIBIT
DATE 2/3/93
LHB 316

In Terms Of Hours Of Service Furnished By Each Category Of Personnel

	DAY			EVENINGS			NIGHTS		
No. of Beds Licensed	R.N.* Hours	L.P.N. Hours	Aide** Hours	R.N. Hours	L.P.N. Hours	Aide** Hours	R.N. Hours	L.P.N. Hours	Aide** Hours
4-8	8	0	0	0	8	0	0	8	0
9-15	8	0	4	0	8	0	0	8	0
16-20	8	0	8	0	8	4	0	8	0
21-25	8	0	12	0	8	8	0	8	4
26-30	8	0	16	0	8	8	0	8	8
31-35	8	0	20	0	8	12	0	8	8
36-40	8	0	24	0	8	16	0	8	8
41-45***	8	8	28	0	8	16	0	8	12
46-50	8	8	32	0	8	20	0	8	16
51-55	8	8	36	8	0	24	0	8	16
56-60	8	8	40	8	0	24	0	8	16
61-65	8	8	44	8	0	28	0	8	20
66-70	8	8	48	8	0	32	0	8	24
71-75	8	8	52	8	0	32	8	0	24
76-80	8	16	48	8	8	32	8	0	24
81-85	8	16	52	8	8	32	8	8	20
86-90	8	16	56	8	8	32	8	8	24
91-95	16	16	52	8	8	36	8	8	24
96-100	16	16	56	8	8	40	8	8	24

Staffing of homes with more than 100 beds will be given individual consideration.

*The two relief shifts could be provided by an L.P.N. up to 40 beds.
**The term "aide" includes orderlies.
***In a home of 41 beds or more one R.N. in this pattern is to be the full-time director of nursing service.

EXHIBIT 28
DATE 2-3-93
HB 316

HOUSE OF REPRESENTATIVES

WITNESS STATEMENT

PLEASE PRINT

NAME Rick Ojala **BILL NO.** 316

ADDRESS P.O. Box 5001 Gf. MT 59403 **DATE** 2/3/93

WHOM DO YOU REPRESENT? Park Place Health Cou Ctr.

SUPPORT _____ **OPPOSE** X **AMEND** _____

COMMENTS: I would like to speak in opposition to the bill for the following reasons. ① The staffing is proposed on beds, does this mean licensed beds or occupied beds? ② Does not take acuity into account. ③ We already have a Patient Assessment System within the Medicaid System which sets staffing for all nursing homes. on a monthly Basis. ④ The Nursing homes in the state are paid on this PAS, and N.H. can not afford to staff Higher. ⑤ The times stated do not match Normal shift Times. in N. Homes.

HR:1991
CS15

February 3, 1993

Exhibit 29 addresses the minimum staffing requirements for nursing homes (HB 316). The original is stored at the Historical Society, 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

EXHIBIT 29
DATE 2-3-93
HB 316

Amendments to House Bill No. 220
First Reading Copy

Requested by Representative Simon
For the Committee on Human services and Aging

Prepared by David S. Niss
February 3, 1993

1. Title, line 7.
Following: "50-16-704"
Insert: ", 50-16-705"

2. Page 1.
Following: line 15
Insert: "(2) "Designated officer" means the person whose name is on record with the department as designated by an emergency services provider as the intermediary between the provider and health care facilities for purposes of reporting an unprotected exposure to an infectious disease."

Renumber: subsequent subsections

3. Page 2, line 1.
Strike: "designated by department rule as"

4. Page 2, line 2.
Following: "exposure"
Insert: ", including the diseases of human immunodeficiency virus, hepatitis B, hepatitis C, hepatitis D, communicable pulmonary tuberculosis, meningococcal meningitis, herpes simplex virus, tetanus, and other diseases that may be designated by department rule

5. Page 2, lines 5 through 10.
Following: "means" on line 5
Insert: ":(a)"
Following: "exposure" on line 5
Strike: the remainder of line 5 through "patient" on line 10
Insert: "to infectious agents, such as bodily fluids;
(b) exposure through inhalation or percutaneous inoculation;
(c) nonbarrier-protected contact with an open wound, nonintact skin, or mucous membrane; or
(d) contact with other potentially infected materials

designated by department rule"

6. Page 2, line 14.
Following: "~~disease~~"
Insert: "to disease"

7. Page 3, line 3.
Strike: "highest ranking"
Insert: "designated"

8. Page 3, lines 4 and 5.
Strike: "the exposure to the infectious disease"
Insert: "those matters required by 50-16-703(2)"

9. Page 3, line 5.
Following: "The"
Insert: "designated"

10. Page 4, line 1.
Following: "facility"
Insert: "within 24 hours"

11. Page 4, line 10.
Strike: ":"

12. Page 4, line 11.
Strike: "(a)"
Strike: "highest ranking"
Insert: "designated"

13. Page 4, lines 12 and 13.
Strike: "; or" on line 12 through remainder of line 13
Insert: "who suffered the unprotected exposure."

14. Page 4, line 15.
Strike: "may have"
Insert: "has"

15. Page 5, line 7.
Strike: "or"
Following: "physician"
Insert: ", or the designated officer of an organization employing an emergency services provider"

16. Page 5, line 11.
Strike: "suspected"
Insert: "who filed the report"

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. HB 229

DATE 2/3/93 SPONSOR(S) Rep. Harrington

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Bill Olson - Helena	AARP	HB 229		✓
Molly Herrin ~~Molly Herrin~~	~~Nursing Home~~ OF Mont Coalition for	HB 229		✓
Rick Ojala	Park Place HCC		✓	
Lori Hughes	MHCA	HB 229	✓	
Bill McCall	Youth Svcs	HB 229	✓	
Denzil C Davis	Health Dept.			
Pam Egan	MTFU	HB 229		✓
Pat Sjulin	Discovery Care		✓	
Charlotte Juli	"		✓	
Al Hanley	Health Dept			✓
Craig Polinsky	UNHWA	229		✓
Deb Wilson	Brendan House SNF	229		
LINDA BENSON	Brendan House SNF	229		

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB229

DATE 2-3 SPONSOR(S) Rep. Harrington

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Darrell Hoczer	Mt. St. AFL-CIO			✓
Bonnie L Tippy	MT ST Pharmaceutical Assn			✓
Doug Blakley	Office on Aging			✓
Janet Robideau	MT Coal. Mur Hm Rel.			✓
Dan Skeg	MLIC			✓
Bob Olsen	MT. Hospital Assn		✓	
Rose Hughes	MT. Health Care		✓	
Bonb Bottom	MT. Nurses Assoc.			✓
Toolie Welker	MT. Alliance for Progressive policy			✓
Jan Hawley	NOW			✓
Terry Minow	MT Ed Health Care Employees			✓
Greg Campbell	MSCA			✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Licensed Services & Agency COMMITTEE BILL NO. HB 316 HB 229

DATE 2-3-93 SPONSOR(S) Rep. Cashmore - Rep Harrington

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Bob Bonato 1100 Texas Deer Lodge	Fun Deer Lodge	316 229	X	
Gerald Butcher	Nursing Home	316 229	X	
Brent Foy	M.C.N.H.I.R.A. United Healthcare Union	316 229		X
Becky Pascarone 208 E. Main MSLA	MT Coalition for Nursing Home	316 229		✓

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. HB316

DATE 2/3/93 SPONSOR(S) Rep. Cocchiarella

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Lois Hove Msla 416 Westview Dr	CNHR	316		X
Doug Campbell Mt Gravel	MSCA	316		X
Bess A. Grainger	Nursing Home Reform	316		X
Jan Hanley	NOW	316		X
Betty Meaghr	CNHR	316		X
Donna Boyd	CNHR	316		X
~~John Wyman~~ John Wyman ~~Connie Boylan~~	Mont. Coalition for Nursing Home Reform	316		X
Alice Campbell	MT " " " "	316		X
Rachelle Malek	CNHR	229 316		X
John H. Hoppe	425 E. Central Ave Msla MT	316		X
Cheryl L. Brewer	Local 427 UNION HERE ~~416 Custer~~ Butte	316		X
CORA LINN	4900 MULLEN RD #3 LOCAL 427	316		X
CAROL COVERDALE	LOCAL 427 ANACONDA	316		X

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services COMMITTEE BILL NO. HB316

DATE 2/3/93 SPONSOR(S) Rep. Cocchiarella

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
M. Brewer 101 Sherwood	NOW			✓
Alexei Carlisle	NOW			✓
Lindi Sandman	DHES			
Rick Ojala	Park Place Health Care		✓	
Pat Sjolie	Discovery Care Centre.		✓	
Claudette Julei	"		✓	
Pam Egan	MTFU	316		✓
				✓
Molly Heerin	MT Nursing Home Reform	316		✓
JUDITH GUSTAFSON - student	MSU COLLEGE OF NURSING	316		
PATRICIA WILHELM - student	MSU COLLEGE OF NURSING	316		
MICHELLE WANDLER - student	MSU COLLEGE OF NURSING	316		
KIM HALL - student	MSU COLLEGE OF NURSING	316		

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services COMMITTEE BILL NO. HB 316

DATE 2-3-93 SPONSOR(S) Rep. Cocchiarella

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Rose Hughes	MHCA		✓
Denzel C James	Health Dept.		
Pat Sinclair	Discovery Care Center		
Bill McCall	Lanti Eyton		✓
Robert Anderson	DCHS		✓
Cindy Blongby	UHCW	✓	
Al Hanly	" "	✓	
Darrell Holzer	mt. st. AFL-CIO	✓	
Doug Baldwin	Office on Aging	✓	
Janet Robideaux	MT Coal. Nur. Hm.	—	
Dan Shea	MLEC		
Bob Olsen	MT Hospital Assn.		✓
Barb Bachich	MT. Nurses Assoc.	✓ As Amended	

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB316

DATE 2-3-93 SPONSOR(S) Rep. Cacchiarelli

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
George Coverdale	427 Local	316		X
Hannah Shuttlesworth	Self	229 316		X
Louisa Clark-	MFT	229 316		X
Lyle Shuttlesworth	Self	229 316		X
Vera McDermott	self	229 316		X
Ron Bergman	Nursing Home industry	229 316	X	
Michael Bergman	Nursing Home Ind	229 316	X	
Paulette Dockter	nursing homes	316 229	X	
Kay Jimmings Missoula	Nursing Homes	316 229	X	
Joanne Ustanis-Doherty	Nursing Homes	316 229	X	
Connie Russell	Nursing Homes	316 229	X	
Barbara Hughes	SELF	316 229		X as ammended
Chris Duncan	Self			X as amended

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