

MONTANA NURSES ASSOCIATION
HB605 – AN ACT REVISING THE LAW RELATED TO MEDICAL ASSISTANTS
BUSINESS and LABOR COMMITTEE
SUPPORT TESTIMONY
February 19, 2006 – Room 172

Representative Mendenhall and Members of the Committee;

The Montana Nurses Association has a distinguished record of placing demands on both nursing practice and those who provide patient care of many types, with one overriding goal: that of ASSURING PATIENT SAFETY. Whenever there is disagreement between two or more bodies, such as those between nursing and medicine, it is common for people to explain away the core issue as an argument surrounding “turf”. Today, I want to review the reasons that MNA and Representative Keane have brought HB 605 before you – it is a bill whose intent is not to protect turf but rather to restore safe patient care and to preserve the legislative process.

The origin of the bill in question was HB321 introduced in the 2003 legislature. The basis of this legislation, according to General Council for the MMA, “came as a result of action taken by the Board of Nursing (BON), which had issued cease and desist orders to medical assistants performing tasks delegated to them by their employing physician.” As a member of the BON at the time I was surprised that this could be the basis of legislative action, so I looked into the numbers. The following information was verified through the Prosecuting Attorney for the BON in 2003:

“We have records going back to FY 96. There have been 16 cease and desist orders in those 8 years. I broke them into categories for your information:

- 7 were issued to CNAs who were giving injections or otherwise exceeding their scope of practice
- 3 were issued to unlicensed persons in physician's offices who were giving injections
- 2 were issued to persons licensed in other states who did not have a Montana license and were using the title of nurse
- 2 were issued to nurse imposters (Ms. Campbell and her daughter)
- 1 was issued to a nurse with a suspended license who was continuing to use the title
- 1 was issued for unknown reasons “

Of the three cease & desist orders given to unlicensed persons in physician's offices, I am personally aware that 2 of those complaints were made by members of the public who felt that they, or their family members, had suffered harm based on care provided by unlicensed persons performing advanced procedures. I would ask: what should the Board of Nursing have done? The complaints were investigated, evaluated, and it was determined that there had been a violation of the Nurse Practice Act. The BON, like all healthcare boards, exists solely to protect the public. One would have to ask why any healthcare Board did not exercise their duty to do the same.

Despite this knowledge, the bill went forward and gained legislative approval. It ultimately contained statutory language requiring the BOME to:
“adopt guidelines by administrative rule for:

- a) the performance of administrative and clinical tasks by a medical assistant
- (2)(c) ensuring minimum educational requirements for the medical assistant”

Over the next three years, MNA participated in the Rule- making process, offering input into language which would conform to the legislative directives and promote public safety. In October of 2005, the Proposed Rules were stopped because the attorney from Legal Services felt those Rules did not meet MAPA requirements. Throughout this long process there has been a failure to develop Rules that met legislative intent and that would serve to protect the public; the reason that the BOME exists. When the Rulemaking continued along the same pathway, MNA took the matter to the Economic Affairs Interim Committee in October 2005 and February 2006. The Rules ultimately published in March 2006, over dissent, had NO minimum standards for education (in fact, there was not agreement that Medical Assistants needed to be high school graduates) – and grossly expanded medical assistant’s roles.

Another marked alteration that brings us before you, was a deliberate change from that originally presented in HB 321 (which had focused on allowing medical assistants to give injections, specifically immunizations and allergy testing) to the performance of sophisticated, advanced procedures, not “technical tasks”. MNA sought to have the performance of high risk procedures and advanced medication administration prohibited, yet the BOME allowed it. In fact, according to the current Rules, unlicensed individuals, with no consistent educational preparation or national competency standards required, can perform conscious sedation monitoring and administer intravenous fluids and intravenous medications. The performance of these particular procedures is considered high risk with significant patient safety considerations requiring advanced patient assessment and intervention (i.e.: the practice of nursing). National standards for conscious sedation state that the medical provider performing the procedure MAY NOT also be responsible for monitoring the patient. In fact, often the level of sedation provided causes patients to lose control of their airway and requires not only skilled nursing assessment and intervention but an Anesthesia Provider in attendance as well as skilled Respiratory Therapists. Of interest, LPNs, who have received standardized training and national certification and licensure, are not allowed to perform these same procedures due to their high complexity and potential for patient harm. Standards are not variable. These advanced procedures are CLEARLY not tasks. They are fraught with complications. These procedures must be eliminated from these Rules.

Every citizen deserves competent care. When physicians wanted medical assistants to expand their range of actions into medication administration, specifically allergy testing and immunization injections, they agreed to establish minimum educational standards. The addition of intramuscular, subcutaneous, and intradermal injection of medications demands a defined educational preparation and competency testing and system development that decreases the possibility of error. Every other entity that administers medications is required to have specific training: doctors, nurses, RT, pharmacists,

pharmacology technicians and medication assistants. Why is it not required for medical assistants who are asked to administer medication? We must demand that standardized education and competency testing be performed for the safety of Montana citizens.

I work in an office setting with certified and registered medical assistants. They are an integral part of the patient care team and have invested in their education in order to achieve a level of competency that makes them valuable in today's workforce. Medical assistant programs are standardized and qualify graduates to apply for and achieve national certification. These courses, lasting between 6-18 months, spend a fair amount of time on front office procedures (phone, billing, scheduling, coding) as well as training in medical screening like vital signs, assisting the physician with equipment and minor procedures and performing tasks under the direction of the physician. Thus in HB 605, we have proposed graduation from a medical assistant program that allows individuals to achieve a national certification.

If the legislature is to be sure that their careful deliberations are carried out, they must stop this gross expansion beyond the authority granted. Having to propose legislation for another health occupation is not a comfortable undertaking. However, as health care professionals and patient advocates, MNA cannot sit back and watch the rights of patients to have appropriate, safe health care by competent providers, be trampled. Attached to your packet of information is the front page from the February 12th, 2007 AMA News – here the editors decry the practice of non-physicians who expand their scope of practice through rulemaking instead of through the legislative process. We submit to you that this is exactly what was accomplished in existing Rules developed by the BOME.

The proposed Statute before you, HB 605, is fashioned after other State's statutes guiding medical assistants. It grants some medication administration as discussed in 2003 yet prohibits advanced procedures and guarantees a minimum level of education to address public safety concerns. Please protect Montana's citizens and the legislative process by passing HB 605.

For Montana Patients;



Kim A. Powell APRN

Attachment: AMA News
Definitions
Economic Affairs Interim Committee Minutes (pertinent pages only)
37-3-104 Medical Assistants- guidelines & 24.156.640 MA Rules 3-31-06



Economic Affairs Interim Committee

59th Montana Legislature

PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
FAX (406) 444-3036

SENATE MEMBERS
DONALD STEINBEISSER--Vice Chair
JOHN BRUEGGEMAN
VICKI COCCHIARELLA
KEN HANSEN

HOUSE MEMBERS
JIM KEANE--Chair
DAVE GALLIK
TOM MCGILLVRAY
MIKE MILBURN

COMMITTEE STAFF
PATRICIA MURDO, Lead Staff
BART CAMPBELL, Staff Attorney
DAWN FIELD, Secretary

MINUTES

October 28, 2005

Room 102, State Capitol
Helena, Montana

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Committee tapes are on file in the offices of the Legislative Services Division. Exhibits for this meeting are available upon request. Legislative Council policy requires a charge of 15 cents a page for copies of the document.

COMMITTEE MEMBERS PRESENT

REP. JIM KEANE, Chair
SEN. DONALD STEINBEISSER, Vice Chair

SEN. JOHN BRUEGGEMAN
SEN. VICKI COCCHIARELLA

REP. DAVE GALLIK
REP. TOM MCGILLVRAY
REP. MIKE MILBURN

COMMITTEE MEMBERS ABSENT

SEN. KEN HANSEN

STAFF PRESENT

PATRICIA MURDO, Lead Staff
BART CAMPBELL, Staff Attorney
DAWN FIELD, Secretary

AGENDA & VISITORS LIST

Agenda, Attachment #1.
Visitors' list, Attachment #2.



Montana Nurses' Association

104 Broadway, Suite G2 • Helena, MT 59601 • 406/442-6710 • 406/442-1841 Fax

10/28/05

Dear Chairman Keane and Honorable Committee Members:
Interim Economic Affairs Committee

I would like to draw your attention to the following rules-→ MAR 24-156-62 which were developed by the Board of Medical Examiners (BOME) for the implementation of House Bill 321 passed by the 2003 session. These rules are to be noticed November 17, 2005. I have followed the Board of Medical Examiner's decision making process, attended the rules development discussions and reviewed their outcomes. I sadly, conclude that the rules do not meet the basic requirement of implementing the legislative intent nor do they fulfill the basic obligation which is to protect public safety.

These rules have had a somewhat torturous history as they were noticed once previously in November 2003. At that time they were found to be inadequate in that they exceeded the scope of the legislation, did not address some of the issues in statute that required rules and therefore did not meet the requirements for administrative rule development. The BOME recalled the rules after definitive review by the legal staff of the Interim Committee on Economic Affairs.

The Board of Medical Examiners continued to work on the rules over the past two years. While a modicum of progress was made on issues such as the definition of "office" the core issue of protecting patient safety has not been met. These issues included the following safety mechanisms for the patient that were put in statute by the legislature:

- a delineation of administrative and clinical tasks that are allowed to be delegated by a physician...
- the level of supervision when performing the administrative or clinical tasks
- require adoption of onsite supervision when administering medication, invasive procedures or allergy testing
- ensure performance of tasks is in accordance with good medical practice and the board's guidelines
- ensure that the medical assistant is competent to perform delegated tasks
- ensuring minimal educational requirements

The purpose of public boards in the professional and Occupational Licensing division is first and foremost to protect the health and safety of the public.

We ask that the committee and legal counsel scrutinize the rules. We believe that the rules so not address in any appropriate way the 6 issues listed above. They do not provide for basic patient safety. The legislative intent of the scope of these unlicensed

Economic Affairs Committee Meeting
October 28, 2005

Exhibit #27

health care workers was much more narrow than the rules have allowed for. For example the language in the statute that allows for the performance of "invasive" procedures was envisioned in committee intent to be the administration of injectables WITH CLEARLY DELINEATED TRAINING, PREPARATION AND PERFORMANCE GUIDELINES.

With the current rules, for example, vulnerable and elderly patients will be able to receive chemotherapy, conscious sedation, blood products, or surgical procedures from a health care worker whose training, education, experience must only meet the standard of an "opinion" with no measurable guidelines.

I ask you to review the rules, notice the inherent contradictions within the rules and the compare it to statute. We believe that patient safety demands that the BOME to write specific guidelines, specific tasks, and specific measurable outcomes as the statute requires.

Respectfully,

A handwritten signature in cursive script that reads "Eve Franklin".

Eve Franklin MSN RN
Executive Director

03:20:04 Mr. Campbell said he and Ms. Murdo would review the minutes to make certain the letter contained all of the points discussed by the Committee. SEN. BRUEGGEMAN asked that copies of the draft letter be provided to Committee members.

RULE REVIEW ISSUES

03:20:57 REP. MILBURN said it was brought to his attention that under a Department of Labor rules hearing for HB 249 (EXHIBIT #23), which created the Big Sky Economic Development Fund, that the application for this fund stipulates that there would have to be an increase of at least 10 jobs. He said that the intent of the legislation, as passed by the Legislature, was that there be no stipulation for the number of jobs created. REP. MILBURN asked that the Committee address this. Mr. Campbell said he recalled the discussion and suggested that the Committee allow him to contact the Department of Commerce for discussion and report back to the Committee. He said if the Committee is dissatisfied with the Department's response, an appropriate response could be discussed at a future meeting.

03:24:28 Mr. Poole said there would be no need for Mr. Campbell to contact the Department because this issue had already been addressed by the Department at the rules hearing two weeks previous. He said the Department made the decision to remove the stipulation.

03:25:42 Mr. Campbell said 2-4-302, MCA, passed in 1997, requires an agency, when adopting rules for the first time, that when the substantive work begins on those rules and at the time that notice of adoption is published, that they inform the sponsor of the bill. Mr. Campbell said it has been brought to his attention that the statute is not always being followed. He said individual departments will be contacted and asked to follow the statute and that the State Administration and Veterans' Affairs Interim Committee plans to draft legislation regarding this issue.

03:29:58 **Eve Franklin, Montana Nurses Association**, provided and discussed a packet of information regarding a rules hearing for the licensing of medical assistants scheduled for November 17, 2005:

- HB 321 (EXHIBIT #24) from the 2003 session;
- an October 23, 2003 letter to the Economic Affairs Committee regarding this issue (EXHIBIT #25);
- the rules notice published by the Department for the November 17, 2005, hearing (EXHIBIT #26); and
- a letter from the Montana Nurses' Association to the Committee asking that the rules be scrutinized (EXHIBIT #27).

REP. FRANKLIN said this the rules, as proposed, do not meet the Montana Administrative Procedures Act (MAPA) and that this is not a scope of practice issue but a patient safety issue.

03:34:41 REP. KEANE said this issue be addressed at the next meeting and asked REP. FRANKLIN to continue working with Mr. Campbell.



PO BOX 201706
Helena, MT 59620-1706
(406) 444-3064
FAX (406) 444-3036

Economic Affairs Interim Committee

59th Montana Legislature

SENATE MEMBERS

DONALD STEINBEISSER--Vice Chair
JOHN BRUEGGEMAN
VICKI COCCHIARELLA
KEN HANSEN

HOUSE MEMBERS

JIM KEANE--Chair
DAVE GALLIK
TOM MCGILLVRAY
MIKE MILBURN

COMMITTEE STAFF

PATRICIA MURDO, Lead Staff
BART CAMPBELL, Staff Attorney
DAWN FIELD, Secretary

MINUTES

February 10, 2006

Room 102, State Capitol
Helena, Montana

Please note: These are summary minutes. Testimony and discussion are paraphrased and condensed. Committee tapes are on file in the offices of the Legislative Services Division. **Exhibits for this meeting are available upon request. Legislative Council policy requires a charge of 15 cents a page for copies of the document.**

COMMITTEE MEMBERS PRESENT

REP. JIM KEANE, Chair
SEN. DONALD STEINBEISSER, Vice Chair

SEN. VICKI COCCHIARELLA
SEN. KEN HANSEN

REP. DAVE GALLIK
REP. MIKE MILBURN

COMMITTEE MEMBERS EXCUSED

SEN. JOHN BRUEGGEMAN
REP. TOM MCGILLVRAY

STAFF PRESENT

PATRICIA MURDO, Lead Staff
BART CAMPBELL, Staff Attorney
DAWN FIELD, Secretary

AGENDA & VISITOR'S LIST

Agenda, Attachment #1.
Visitors' list, Attachment #2.

and related several factors that may be problematic. He noted that \$22 million had been taken from Old Fund reserves by the Legislature in 2003 and moved to the general fund. The loss of reserves could result in a large amount of money needed to make the Old Fund whole.

RULE ON MEDICAL ASSISTANTS

Bart Campbell, Staff Attorney, LSD, said the crux of the controversy is over what the scope of practice of a medical assistant should be. Mr. Campbell provided some history of the issue:

- HB 321 was passed in the 2003 legislature.
- The Board of Medical Examiners (BOME) proposed rules for implementation of HB 321 in 2003. At that time, Mr. Campbell testified that the proposed rules did not meet requirements of the Montana Administrative Procedure Act (MAPA) and objections were also heard from the Montana Nurses Association (MNA).
- The rule was withdrawn at that time and no further action was taken.
- The BOME recently renoticed proposed rules.
- Mr. Campbell has reviewed the proposed rules and has determined that they are compliant with MAPA requirements.
- The MNA has voiced strenuous objections to the proposed rules.
- Mr. Campbell has held discussions with Eve Franklin, Executive Director, MNA, regarding the MNA's concerns.
- The BOME has postponed the hearing in order to address all concerns.
- The Committee has the option of doing nothing, submitting comments to the BOME, or drafting another bill to address this issue legislatively in 2007.

REP. KEANE asked what the role of the Committee would be if the BOME adopts the rules before the 2007 Legislature. Mr. Campbell said that MAPA allows for a rule to be challenged if it does not meet legislative intent or was adopted improperly. He said it is his opinion that these proposed rules do meet MAPA requirements and that there are not solid grounds for a challenge because of that. Mr. Campbell said his recommendation would be to address this issue in the 2007 legislature.

SEN. COCCHIARELLA related a past situation in which the Revenue and Transportation Interim Committee unanimously objected to a proposed rule by the Department of Transportation and that as a result, the Department withdrew the rule. She suggested that the Economic Affairs Committee take the same action.

REP. KEANE asked what record of legislative intent exists. Mr. Campbell said that the minutes of the hearing are the record and in this case, not a lot was said regarding intent.

Anne O'Leary, Counsel, BOME, pointed out that MAPA requirements have a precise time limit set for public comment and that the public comment period regarding these proposed rules closed on November 25, 2005.

Eve Franklin, Executive Director, Montana Nurses Association, stated that she is appearing before the Committee as the Executive Director of MNA and not as a legislator. She discussed a packet of documents regarding the MNA's objections to the BOME's proposed rules for implementation of HB 321, including the minutes from the legislative committee hearings (EXHIBIT #32). It is MNA's contention that legislative intent has been breached and that the legislators who voted for HB 321 believed that a medical assistant would perform only basic

types of tasks. The BOME proposed rules contain substantive changes in the interpretation of the language of HB 321. MNA's concern is that the tasks allowed by the proposed rules are not clinical tasks, but significant medical procedures and the proposal presents a public health issue. Ms. Franklin asked the Committee to indicate to BOME that the Committee agrees that legislative intent has been expanded. Ms. Franklin said that the MNA will ask the Committee to draft legislation addressing their concerns if the BOME ignores MNA's concerns.

TAPE 5 - SIDE A

Ms. O'Leary, BME Counsel, made a statement regarding HB 321. She said it is her understanding that when it was first introduced by the Montana Medical Association (MMA) in the 2003 Legislature, there was no "laundry list" attached to the bill draft. The purpose of the bill was to allow doctors in rural Montana towns to train and supervise trusted employees to perform various tasks in the capacity of a medical assistant. The threat of malpractice is a very real concern to physicians and could be a determining factor in how a doctor would choose and train a medical assistant for his practice.

Ms. O'Leary said that when the rules were noticed in 2003, there were over 174 letters submitted, most of which objected to the proposed rules; and that the BOME withdrew the rules at that time to address the concerns. There were only 58 comments submitted this time, with 21 of them supporting the adoption of the rules.

Pat Melby, General Counsel, Montana Medical Association (MMA), explained that the request for HB 321 came as a result of action taken by the Board of Nursing (BON), which had issued cease and desist orders to medical assistants performing tasks delegated to them by their employing physician. The intent of the MMA was to acknowledge that this type of work was going on in physicians' offices and to stop the BON from interfering with the daily operations of a physician's office by telling medical assistants what they could and couldn't do. This bill was not intended to be a limitation on what a medical assistant could do, but rather to provide guidelines for physicians in the supervision and the delegation of tasks to medical assistants. The MMA would strongly resist any attempt to turn this bill into a limitation on what a medical assistant can and can't do under the guidance of their employing physician.

Dr. Kurt Kubicka, Montana Board of Medical Examiners, Montana Medical Association, agreed with the points made by Mr. Melby regarding HB 321 and said that it is a critical tool for rural physicians. The rule has been carefully scrutinized. He said that the ultimate responsibility lies with the physician. This rule would allow for delegation of duties by a physician, when appropriate. BOME feels that it can do no more to revise the rules and stay consistent with what it feels the legislative intent of HB 321 was.

SEN. COCCHIARELLA asked if BOME has identified limits as to what a medical assistant will or will not be allowed to do. Dr. Kubicka said any physician who employs a medical assistant must be responsible and reasonable in assigning tasks to the assistants and that the proposed rules will not give carte blanche permission for medical assistants to perform tasks they are not qualified to do.

SEN. COCCHIARELLA said that public safety must be the top priority of the Committee and that she is concerned that patients will make the assumption that anyone who assists with their medical care is a trained or certified nurse or physician. Dr. Kubicka said that in most cases, a

nurse is the person providing the services but that there are instances where a degree in nursing is not necessary, such as the recording of a patient's vital signs or weight.

SEN. COCCHIARELLA said Ms. O'Leary's comments about the proposed rules concerned her because it made it appear as if she were lobbying the Committee for a certain position on this issue. She asked Ms. O'Leary to justify her position, as an attorney for the Department of Labor, and explain why she is advocating for these rules when the BOME has not yet made its final position. Ms. O'Leary said she wasn't lobbying but simply reporting the facts surrounding the last hearing. She also pointed out that in the new proposed rules, new language requires that the supervising physician or podiatrist "shall inform patients" when a medical assistant is seeing them and "shall ensure that assigned tasks are provided in the context of an appropriate physician-patient relationship". Ms. O'Leary also discussed the types of tasks that would be permissible under the new rules.

REP. KEANE stated that as a member of the Business and Labor Committee that heard the bill during the 2005 session, he does know the legislative intent of HB 321. He said that the House Committee had asked for assurance from stakeholders that this issue would not create a turf war, that the assurance was given, and the bill was passed out of the Committee with an 18-0 vote. He expressed his frustration that a turf battle appears to be occurring in spite of the efforts of the House Committee. He moved that the Economic Affairs Committee send a letter to the Board of Medical Examiners requesting that the Board not implement any proposed rules unless both parties - BOME and MNA - are satisfied with the language, and if the Board chooses to adopt the rules without consensus, that the Economic Affairs Committee will likely consider legislative action in 2007.

REP. MILBURN asked to clarify the motion to say "all parties" instead of both parties and said he was uncertain if it was possible for all parties to agree. REP. KEANE said it can happen, if the parties choose to work together. He said he would sponsor the bill himself if there was no cooperation.

REP. KEANE said before BOME implements the proposed rules, both the proponents and opponents must agree on the language. The motion passed on a 8 - 0 voice vote, with REP. KEANE voting "aye" with REP. GALLIK's proxy and REP. MILBURN voting "aye" with SEN. STEINBEISSER's and REP. MCGILLVRAY's proxy. SEN. HANSEN noted that his daughter is a medical assistant and that he has some concerns about this issue. He hopes that the problems can be resolved.

RULE REVIEW - BART CAMPBELL

Mr. Campbell said that he sent out a summary of the proposed rules and that with the exception of the issue just discussed, none of the proposed rules are problematic. He said he is monitoring a proposed rule regarding elevator mechanics and an issue relating to the Electrical Board and would update the Committee if needed.

SB 133 UPDATE

Mr. Campbell updated the Committee regarding the status of SB 133. He reviewed a letter from Evan Barrett, Governor's Office of Economic Development (EXHIBIT #33), and said that he does not agree with the Governor's opinion regarding SB 133. Mr. Campbell said the bill was

Montana Code Annotated 2005

[Previous Section](#) [MCA Contents](#) [Part Contents](#) [Search](#) [Help](#) [Next Section](#)

37-3-104. Medical assistants -- guidelines. (1) The board shall adopt guidelines by administrative rule for:

(a) the performance of administrative and clinical tasks by a medical assistant that are allowed to be delegated by a physician or podiatrist, including the administration of medications; and

(b) the level of physician or podiatrist supervision required for a medical assistant when performing specified administrative and clinical tasks delegated by a physician or podiatrist. However, the board shall adopt a rule requiring onsite supervision of a medical assistant by a physician or podiatrist for invasive procedures, administration of medication, or allergy testing.

(2) The physician or podiatrist who is supervising the medical assistant is responsible for:

(a) ensuring that the medical assistant is competent to perform clinical tasks and meets the requirements of the guidelines;

(b) ensuring that the performance of the clinical tasks by the medical assistant is in accordance with the board's guidelines and good medical practice; and

(c) ensuring minimum educational requirements for the medical assistant.

(3) The board may hold the supervising physician or podiatrist responsible in accordance with [37-1-410](#) or [37-3-323](#) for any acts of or omissions by the medical assistant acting in the ordinary course and scope of the assigned duties.

History: En. Sec. 5, Ch. 85, L. 2003.

Provided by Montana Legislative Services

24.156.640 MEDICAL ASSISTANT (1) For the purpose of this rule, the following definitions apply:

(a) "Direct supervision" means the supervisor is within audible and visible reach of the person being supervised.

(b) "Office" means a location that a physician or podiatrist designates as the physician's or podiatrist's office, but excludes acute care or long term care facilities. However, the physician or podiatrist may utilize a building which houses an emergency room, acute care, or long term care facility for scheduled services.

(c) "Onsite supervision" means the supervisor is in the facility and quickly available to the person being supervised.

(d) "Supervision" means accepting responsibility for, and overseeing the medical services of, a medical assistant by telephone, radio or in person as frequently as necessary considering the location, nature of practice and experience of the medical assistant.

(2) Medical assistants shall work under the supervision of a Montana-licensed physician or podiatrist who is responsible for assigning administrative and clinical tasks to the medical assistant relating to the physician or podiatrist's practice of medicine.

(3) Physician or podiatrist supervision shall be active and continuous but does not require the physical presence of the supervising physician or podiatrist at the time and place that services are rendered so long as the physician or podiatrist is available for consultation, except that physician or podiatrist supervision shall be onsite when a medical assistant performs:

- (a) invasive procedures;
- (b) administers medicine; or
- (c) performs allergy testing.

(4) The supervising physician or podiatrist is responsible for determining the competency of a medical assistant to perform the administrative and clinical tasks assigned to the medical assistant. Assigned tasks must be consistent with the supervising physician or podiatrist's education, training, experience, and active practice. Assigned tasks must be the type that a reasonable and prudent physician (or podiatrist) would find within the scope of sound medical judgment to assign. Assigned tasks, other than those tasks enumerated in 37-3-104(1)(b), MCA, shall be routine, technical tasks for which the medical assistant has been appropriately trained. A physician (or podiatrist) may only assign tasks that the physician (or podiatrist) is qualified to perform and tasks that the physician (or podiatrist) has not been legally restricted from performing. Any tasks performed by the medical assistant will be held to the same standard that is applied to the supervising physician or podiatrist.

(a) Assigned tasks cannot be subsequently assigned to another party by the medical assistant.

(5) The supervising physician or podiatrist's office shall ensure that patients are informed when a medical assistant is seeing them and shall ensure that assigned tasks are provided in the context of an appropriate physician/patient relationship. A medical assistant shall wear a name badge that includes the title "medical assistant".

(6) A medical assistant must be a graduate of an accredited medical assisting program or possess experience, training or education sufficient, in the supervising physician or podiatrist's opinion, to perform assigned duties responsibly, safely and conscientiously. It is the responsibility of the physician (or podiatrist) to ensure that the medical assistant has the necessary education, training or experience to perform the assigned task.

(7) The following tasks may not be assigned to a medical assistant:

(a) any invasive procedures, including injections other than immunizations, in which human tissue is cut or altered by mechanical or energy forms, including electrical or laser energy or ionizing radiation, unless under the onsite supervision of a physician or podiatrist;

(b) care of an in-patient admitted to an acute care hospital facility licensed by DPHHS;

(c) conscious sedation monitoring, unless under the direct supervision of a physician or podiatrist;

(d) administering fluids or medications through an IV, unless under the direct supervision of a physician or podiatrist; and

(e) administering blood products by IV.

(8) Health care providers licensed in this state or any other jurisdiction whose licenses have been restricted, suspended, revoked or voluntarily relinquished in lieu of discipline are prohibited from working in a physician or podiatrist's office as an unlicensed medical assistant. (History: 37-3-104, 37-3-203, MCA; IMP, 37-3-104, MCA; NEW, 2006 MAR p. 759, Eff. 3/24/06.)

Subchapter 7 reserved

24.156.640 MEDICAL ASSISTANT (1) For the purpose of this rule, the following definitions apply:

(a) "Direct supervision" means the supervisor is within audible and visible reach of the person being supervised.

(b) "Office" means a location that a physician or podiatrist designates as the physician's or podiatrist's office, but excludes acute care or long term care facilities. However, the physician or podiatrist may utilize a building which houses an emergency room, acute care, or long term care facility for scheduled services.

(c) "Onsite supervision" means the supervisor is in the facility and quickly available to the person being supervised.

(d) "Supervision" means accepting responsibility for, and overseeing the medical services of, a medical assistant by telephone, radio or in person as frequently as necessary considering the location, nature of practice and experience of the medical assistant.

(2) Medical assistants shall work under the supervision of a Montana-licensed physician or podiatrist who is responsible for assigning administrative and clinical tasks to the medical assistant relating to the physician or podiatrist's practice of medicine.

(3) Physician or podiatrist supervision shall be active and continuous but does not require the physical presence of the supervising physician or podiatrist at the time and place that services are rendered so long as the physician or podiatrist is available for consultation, except that physician or podiatrist supervision shall be onsite when a medical assistant performs:

- (a) invasive procedures;
- (b) administers medicine; or
- (c) performs allergy testing.

(4) The supervising physician or podiatrist is responsible for determining the competency of a medical assistant to perform the administrative and clinical tasks assigned to the medical assistant. Assigned tasks must be consistent with the supervising physician or podiatrist's education, training, experience, and active practice. Assigned tasks must be the type that a reasonable and prudent physician (or podiatrist) would find within the scope of sound medical judgment to assign. Assigned tasks, other than those tasks enumerated in 37-3-104(1)(b), MCA, shall be routine, technical tasks for which the medical assistant has been appropriately trained. A physician (or podiatrist) may only assign tasks that the physician (or podiatrist) is qualified to perform and tasks that the physician (or podiatrist) has not been legally restricted from performing. Any tasks performed by the medical assistant will be held to the same standard that is applied to the supervising physician or podiatrist.

(a) Assigned tasks cannot be subsequently assigned to another party by the medical assistant.

(16) "Nursing assessment" means an ongoing process of determining nursing care needs based upon collection and interpretation of data relevant to the health status of the patient.

(17) "Nursing judgment" means the intellectual process that a nurse exercises in forming an opinion and reaching a clinical decision based upon analysis of the evidence or data.

(18) "Nursing student" means a person currently enrolled and studying in a state nursing board-approved or state nursing commission-approved nursing education program.

(a) Enrollment includes all periods of regularly planned educational programs and all school scheduled vacations and holidays.

(b) Enrollment does not include any leaves of absence or withdrawals from the nursing program, or enrollment solely in academic nonnursing course work.

(19) "Nursing task" means an activity that requires judgment, analysis, or decision-making based on nursing knowledge or expertise and one that may change based on the individual client or situation.

(20) "Pharmacology course" means a nursing course that introduces the student to the basic principles of pharmacology in nursing practice and the skills necessary to safely administer medications. Students will be able to demonstrate accurate dosage calculations, correct medication administration, knowledge of drug classifications and therapeutic and nursing implications of medication administration.

(21) "Stable" means a state of health in which the prognosis indicates little, if any, immediate change.

(22) "Supervision" means the provision of guidance or direction, evaluation and follow-up by the licensed nurse for accomplishment of a nursing task delegated to a UAP.

(23) "Unlicensed assistive person" or "UAP" means any person, regardless of title, who is not a licensed nurse and who functions in an assistive role to the nurse and receives delegation of nursing tasks and assignment of other tasks from a nurse. (History: Sec. 37-1-131, 37-8-202, MCA; IMP, Sec. 37-1-131, 37-8-202, MCA; NEW, 2005 MAR p. 1291, Eff. 7/1/05.)



American Medical News

February 12, 2007
VOLUME 50 • NUMBER 6

www.amednews.com

Nonphysicians bypass legislatures, use own boards to expand scope

Legislatures are still the main avenue for change, but at least nine states have seen groups try to alter practice rules through regulatory boards.

MYRLE CROASDALE
AMNEWS STAFF

A growing number of allied health professions seeking scope-of-practice expansion are going through their regulatory boards instead of state legislatures, physician leaders say.

Executives at national groups such as the American Optometric Assn., state groups such as the Texas Podiatric Medical Assn. and other organizations say their boards are amending regulations within their authority

At least 17 nonphysician associations are expected to approach state legislatures this year with expansion of scope proposals.

See chart page 2.

and that their professions are not putting patients at risk. But physicians view the actions as illegal and a threat to patient safety.

"To get a state board to issue an advisory opinion is a quick way to get

[scope changes], and the only way to challenge it is in court, which is expensive," said John B. Neeld Jr., MD, past president of the American Society of Anesthesiologists. "If they get a friendly state board, they're home free. It's a big train that's left the station, and it's gathering momentum."

Oklahoma gained national attention in 2004 when the Oklahoma Board of Examiners in Optometry adopted rules permitting optometrists to perform surgery with a scalpel, a move the state legislature backed with legislation later that year.

The Texas Medical Assn. is in legal battles with the state's chiropractors and podiatrists, whose boards have made regulatory changes the TMA considers scope expansions. At least

Continued on next page

Nonphysicians bypass legislatures, use boards to expand scope

Continued from preceding page
seven other state medical associations are seeing allied health professions pursue scope changes through their boards. Podiatrists, optometrists and certified registered nurse anesthetists are among the most active groups, the medical society leaders said.

William A. Hazel Jr., MD, a member of the American Medical Association Board of Trustees, said allied professionals are overstepping their regulatory authority as they include aspects of medicine into their scope. Those in the allied professions may consider themselves competent to make diagnoses, prescribe drugs or perform invasive procedures, he said. But without a medical degree, they do not have the expertise, said Dr. Hazel.

"The problem with limited license boards expanding their scope is that the hardest thing to know is what you don't know," Dr. Hazel said. "As boards expand the scope of their li-

that have been done only by physicians before."

Allied health professionals making regulatory changes say they are not dodging the lengthy legislative process or the unpredictability of legislators' votes. They say their boards are acting within their legislative mandate to regulate their licenses, which includes interpreting their governing statutes and amending them.

Jason Ray, an attorney for the Texas Chiropractic Assn., which the Texas Medical Assn. has sued, said legislatures commonly give regulatory bodies authority to define parameters in which they have responsibility. "Every regulatory agency that licenses a profession to some extent defines what that scope is going to be."

Most allied health professionals are still more likely to go to state legislatures seeking scope-of-practice expansions. This year, at least 17 nonphysician associations are expected to

states. But the regulatory route is becoming increasingly popular.

In Ohio, Todd Baker, executive director of the Ohio Ophthalmological Society, said optometrists there are using the regulatory process to expand on prescribing legislation passed in 1992. Using this law, he said, the optometric board has been adding drugs to its formulary, such as antivirals for treating shingles involving the eye. "This is the optometric community adding scope by adding new drugs," he said.

The executive director of the Ohio Optometric Assn. said the group does not view it as an expansion.

Elsewhere:

● In New York, nurse anesthetists have asked regulators to create a category of nurse anesthetists that would practice without doctor supervision.

● In Idaho, the Idaho Medical Assn. and Idaho Society of Ophthalmology, along with the medical board, ap-

proposed to include certain eyelid procedures within optometrists' scope.

● In Massachusetts, the state podiatric board, through a regulatory hearing, defined the scope of podiatry to include the ankle and amputation. That occurred after legislative attempts failed. The Massachusetts Medical Society has not decided whether it will pursue legal action.

Meanwhile, the Texas Medical Assn. is appealing an Austin district court decision upholding the podiatric board's action to define the profession's scope to include the ankle. The TMA's case against the chiropractic board for allowing needle electromyography and spinal manipulation under anesthesia is still in pretrial proceedings.

Mark J. Hanna, legal counsel for the Texas Podiatric Medical Assn., and Ray, for the Texas chiropractic board, said their boards were not expanding either profession's scope. ●

Rewiring lives

Excerpts from *Shattered Nerves* explore how new technology might help some people with disabilities operate a computer through brain waves.
In *Professional Issues*, page 10

Cosmetic procedure

The way your office looks can play a role in how patients perceive you as a doctor. Experts offer makeover tips.
In *Business*, page 14

Daily headaches underreported

Continued on next page

Continued on next page