Montana Nurses' Association
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To: Honorable Chairman Jim Keane and Members of the Interim Economic Affairs Committee
Re: MAR 24-156-62 New Rule I
Date: 2/10/06
From: Eve Franklin MSN RN Executive Director Montana Nurses Association

I am here to request action by the Economic Interim Affairs Committee to request that the committee convey in writing to the Board of Medical Examiners (BOME) and the Department of Labor and Industry dissatisfaction with the scope of the rules developed for HB 321 initially enacted in 2003.

The legislative history of HB 321 is as follows:

In the 2003 session t the Montana Nurses" Association (MNA) did not oppose the bill, working instead with the proponents to craft language that they felt would create parameters for the safe use of medical assistants in Montana. MNA recognizes that medical assisting is a recognized job function with a legitimate set of duties that have a standardized body of knowledge. There are approved and accredited programs that prepare medical assistants here in Montana. Both the Billings College of Technology and the Great Falls campus of the MSU-Bozeman College of Technology offer such a curriculum. The curriculum assures that those who complete the program have a basic set of skills and grasp significant health care concepts such as patient confidentiality and asepsis, and that they can be performed consistently at a accepted community standard. This is to achieve what we all are interested in: safe patient care.

MNA took the position that with the parameters of rule making in place the BOME would have the direction to write rules that made Montana law reasonably consistent with the standards of performance accepted at the national level for the scope of practice of medical assisting. The legislature supported that direction and the Montana Medical Association (MMA) the major proponent of HB 321 acquiesced. Thus one of the most significant amendments read:

THE BOARD SHALL ADOPT RULE REQUIRING ONSITE SUPERVISION OF A MEDICAL ASSISTANT BY A PHYSICIAN OR PODIATRIST FOR INVASIVE PROCEDURES, ADMINISTRATION OF MEDICATION, OR ALLERGY TESTING.

AND

ENSURING MIMIMUM EDUCATIONAL REQUIREMENTS FOR THE MEDICAL ASSISTANTS

A reasonable person reading these statutory directives would assume that the BOME would develop meaningful rules creating a scope of practice and educational standards. This has not yet occurred.

The rules for HB321 have had a tortuous history. The first set of rules were noticed November 22, 2003. They were met with significant opposition from members of the Montana Nurses' Association and some consumer organizations. In addition, a number of legislators who sat on the House Human Services Committee and Senate Public Health including Rep. Nancy Rice-Fritz, Rep. Kathleen Galvin-Halcro, and Senator Trudi Schmidt offered opposition stating that they believed the rules did not meet legislative intent.

Legislative attorney Bart Campbell in his role as rule reviewer testified that the rules did indeed expand the legislative intent: At that time he pointed to two issues (1) inclusion in rules of the physician assistants as one of the individuals who could be designated to delegate and supervise the MA (2) the parroting of legislative language that did not provide adequate guidance for implementation. He testified in November 2003 that the rules did not meet MAPA standards. In response, the rules were withdrawn for further work.

The BOME has continued work on the rules. MNA, AARP, as well as legislators have appeared during work sessions and offered testimony at subsequent rules hearings. The BOME made changes to the rules to satisfy the specific certain concerns expressed by the Legislative attorney. However, the concrete suggestions that were made to help the Board develop a legitimate scope of activities for medical assisting have not been incorporated into the rulemaking.

I strongly maintain that despite the revisions that have been made the current rules still defy legislative intent. Legislators believed that with the passage of HB321 they were "clarifying" the role of medical assistants. They were led to believe that this legislation was geared specifically to the traditional office setting where a physician in a limited, non acute, office setting would be able to use a medical assistant in the conventional and highly circumscribed role. They did not believe they were expanding the role of MA's to be engaged in complex clinical activities. The legislature did not believe it was expanding the use of unlicensed workers in acute care settings such as emergency departments or short- stay surgery

In the article, McCarty, Micheal N "The Lawful Scope of Medical Assistant Practice" AMT (American Association of Medical Assistants) Events (March 2003).
Mr. McCarty, who is chief counsel for the American Association of Medical Assistants, describes duties more consistent with what the public would perceive as "routine clinical tasks".

Our contention is that in the rules that were noticed and heard Nov 17th 2005 by the board are contrary to the legislative intent. Legislators were led to believe that HB321 was a straightforward clarification of the ability to perform lower level clinical tasks: vital signs, administrative and clerical duties. It was implied that the most complex situation

potentially being blood drawing or injections (invasive procedures) if there was on site supervision. However, through the rulemaking process the rules explicitly expand the role of this unlicensed worker from routine office tasks to being used in settings with fragile, unstable patients --- performing complex procedures that require significant assessment activities, a specialized body of knowledge, and a high degree of sophistication and skill. They specifically give the MA "license" to be involved in sensitive clinical situations such as "monitoring conscious sedation" and "administration of blood products". These are clearly not **tasks, nor are they routine.**

As support for this position, I refer to testimony from Pat Melby, the MMA lobbyist and main proponent of the measure from the minutes of the HB321 Senate Public Health, Welfare and safety Committee hearing February 21, 2003. The verbatim text of the hearing is as follows:

HB 321 was brought for the purpose of clarifying delegation of clinical tasks by physicians to medical assistants who worked in their offices. Medical assistants (MA) were unlicensed health care workers who worked in physician's offices and provided a variety of tasks for the physicians, many of them administrative, such as assisting with the billing, paperwork, keeping medical records, and filing. They assist in obtaining patient history, preparing a patient for an examination, procedures of treatment, preparing and administering medications and immunizations, maintaining records for that and coordinating patient care with other health care providers. Medical assistants were used across the country and certification was available for medical assistants from the national association of medical assistants. They had to meet certain qualifications for that purpose. Physicians believe that under current law the delegation of immunizations (was appropriate for physicians) however the Board of Nursing had issued cease and desist orders for MA's...*who were administering medication and giving injections. (this measure) basically provided the BOME provide guidelines for the performance of clinical tasks by MA's including the administration of medication...the caveat (in the House Committee amendment) was the addition of an requirement to have on sight supervision of the medical assistant by the physician for invasive procedures, med administration, or allergy testing. The physician was also responsible for ensuring that the MA was competent to perform the clinical tasks and meet the requirements of the guidelines...*

Mr Melby goes on to reiterate his original point:

The purpose of the bill was to first, define what a medical assistant was, which was an unlicensed health care worker who functioned under the supervision of a physician and could perform administrative and clinical tasks. Mr. Melby said the substantial part of the bill was in Section 5 on last page, which basically provided the BOME provide guidelines for the performance of administrative office duties and clinical tasks by MA's, including the administration of medication.

In her closing Rep. Younkin again, creates the impression for legislators that office based physicians practicing in Bozeman, who had used MA's for many years simply wanted to

clarify the role of the MA's to *"continue"* the current use in these limited settings. There is no indication that legislative intent included the legitimizing of the use of the untrained person in surgery, monitoring blood products, IV drug administration of sedatives or in acute care settings.

The next serious issue that interacts with the role expansion is that of the educational background of the MA. The statutory language explicitly states that the BOME would set minimum educational standards. All discussion points to the legislative understanding that the BOME these educational standards would include a standardized body of knowledge that could be measured. Mr. Melby's remarks refer to the fact that *"certification was available for medical assistants from the National Association of Medical Assistants. They had to meet certain qualifications for that purpose"* Through this discussion legislators are certainly given the impression that an earnest effort would be made to design meaningful educational standards. This has not as yet been accomplished.

There is an Orwellian use of language in the rules that essentially negates legislative intent. See New Rule I page 1883:
Sub section (7) (a):
The language states that an MA cannot be assigned the following tasks: and goes on to provide a laundry list of complex clinical activities (giving the impression that the they are complying with legislative intent to have MA's scope be limited to **routine, clinical tasks** as outlined in Mr. Melby's testimony.)... but goes on to state the caveat **unless** it is under the onsite supervision of a physician. Defacto, an entire body of **skills** not **tasks** requiring assessment, cognition, and judgement are able to be assigned to an MA that were never envisioned in the legislative intent. **This includes invasive procedures in which human tissue is cut human tissue is cut or altered by mechanical or energy forms, including electrical or laser energy or ionizing radiation.** I do not believe the legislature ever envisioned such a scenario in which MA's would be involved in performing laser surgery, radiation treatments, or traditional surgery at any level of supervison.

Subsection (7) © & (d):
The language states the following tasks may not be assigned...**conscious sedation, administration of blood products, IV medications** (again, giving the impression that they are setting a limit and complying with the spirit of the legislation which is to set parameters) but goes on to state the caveat **unless** under direct supervision. This is a loophole you can drive a HUM VEE through. Again, it creates a defacto body of acceptable clinical activities never envisioned by the legislature at <u>any</u> level of supervison.

Subsection (6):
The language states an MA **must** be a graduate of an accredited program...(giving the impression that the BOME is actively interested in ensuring minimum education requirements as is consistent with statute) but goes on to state the caveat that the individual does not need to meet any requirement but simply the opinion of one

physician. There is no measurable community standard that protects the public other than opinion of one individual physician.

In summary, I am asking the committee write an objection to the rules based on the documentation that the rules expand legislative intent. It is a matter of public safety; the primary role of the BOME to define for the public safe medical assisting practice and to make clear to the public what they can expect in a medical assistant who is attending them.