

BEFORE THE BOARD OF NURSING  
DEPARTMENT OF LABOR AND INDUSTRY  
STATE OF MONTANA

In the matter of the amendment	)	NOTICE OF AMENDMENT,
of ARM 8.32.301, 8.32.305,	)	ADOPTION AND REPEAL
8.32.306, 8.32.402, 8.32.405,	)	
8.32.412, 8.32.413, 8.32.1501,	)	
8.32.1502, 8.32.1505, 8.32.1506,	)	
8.32.1509, 8.32.1510, the adoption	)	
of new rules I (8.32.417), II	)	
(8.32.1410), III (8.32.1411), and	)	
IV (8.32.1412), related to	)	
probationary licenses, standards	)	
of practice for advanced practice	)	
registered nurses, standards	)	
related to the advanced practice	)	
of registered nurses, and	)	
standards related to nurses as	)	
members of the nursing profession,	)	
and the repeal of ARM 8.32.1507,	)	
method of referral, all pertaining	)	
to nursing matters	)	

TO: All Concerned Persons

1. On July 25, 2002, The Department of Labor and Industry published notice of the proposed amendment, adoption and repeal of the above-stated rules at page 1952 of the 2002 Montana Administrative Register, Issue Number 14.

2. A public hearing was held in Helena on August 23, 2002. Members of the public appeared and commented during the public hearing. Written comments were also received prior to the closing of the comment period.

3. The Board of Nursing (Board) has thoroughly considered all comments made and the Board's responses are as follows:

8.32.301 NURSE PRACTITIONER PRACTICE

Comment 1: Dana Hillyer, Cathleen Simensen, Eve Franklin, Catherine Caniparoli and Teresa Henry stated that they do not believe "interdependent" is appropriate for APRN practice. They believe it connotes physician supervision, and that has never been a part of nurse practitioner practice in Montana.

Response 1: The Board agrees with the commenters and has voted to delete the term, "interdependent" and to adopt language that says independent and/or collaborative.

Comment 2: Pam Peterson stated that assessment should include assessing psychological problems. This must be a part of APRN practice as depression is so common in primary care. Subsection

(1)(b)(ii) should include ordering and interpreting results of diagnostic tests and procedures because APRNs must be able to order tests. There should be a clause that includes treatment with medications if the APRN has prescriptive authority.

Response 2: The Board agrees to add "diagnostic tests" to (1)(b)(i). The Board believes that adding a clause stating that APRNs may administer medication if they have prescriptive authority would be redundant and unnecessary, as this language is in the rules for prescriptive authority.

Comment 3: Practitioner Humphrey objected to replacing the term "independent" in current rules to "interdependent."

Response 3: The Board believes that the APRN practice is independent. The current definition did not have the word "independent" in it. The original proposed change would have added "independent and interdependent." The Board has voted to amend the rule to include the phrase "independent and/or collaborative" and "interdependent" will not be used.

Comment 4: Several commenters [Sami Butler (Montana Nurses Association), Carla Gibson, Winifred Carson (American Nurses Association), Arlys Williams, Casey Blumenthal (Montana Hospital Association), Sharon Androes, and Shawn Shanahan] suggested the following substitutions in language: "collaborative" for "interdependent"; "facilitating" for "providing"; and "referring" for "recognition".

Response 4: The Board agrees with the commenters on the use of "collaborative" and "facilitating." However, the Board believes that because all practitioners must refer clients to other appropriate providers when necessary, "referring" will not be changed to "recognition". The practitioner has a responsibility for recognizing when to refer clients to others.

Comment 5: Casey Blumenthal (Montana Hospital Association) suggested removing the word "compliance" from (1)(b)(iv) since a practitioner can never assure patient compliance.

Response 5: The Board agrees with the comment and will change the language to "promote their understanding of and compliance with therapeutic regimes".

Comment 6: Bart Campbell, staff attorney for the Economic Affairs Interim Committee, asked the Board if this proposed amendment expands the scope of nurse practitioner (NP) practice.

Response 6: The Board does not believe this amendment is an expansion of scope of practice. The practice of NPs will not change in any way as a result of this revision in rule language, which is proposed for clarity, consistency with other APRNs (the independent language has always been in the Certified Nurse Midwife rules), and congruency with current APRN practice.

8.32.305 EDUCATIONAL REQUIREMENTS AND OTHER QUALIFICATIONS APPLICABLE TO ADVANCED PRACTICE REGISTERED NURSING

Comment 7: Commenters (Cathleen Simensen, Dana Hillyer, Eve Franklin, Catherine Caniparoli and Teresa Henry) stated that the CNS role is not well defined in law. They would like the Board to defer making a decision on a change in CNS practice until the Board gathers more information. Commenters stated that the proposed amendments would narrow CNS practice, and limit the individuals available for rural health care.

Response 7: The Board will permit all currently licensed psychiatric clinical nurse specialists to function in the practitioner role. Those currently licensed as psychiatric CNSs will be covered by a grandfather clause. Subsection (3)(a) will read "Those psychiatric mental health CNSs certified in Montana prior to July 1, 2005 will continue to be recognized in Montana." The Board reviewed substantial research and current nursing practice standards in concluding that most CNS education programs do not prepare the nurse to make medical diagnoses or prescribe pharmacotherapeutic interventions. If the individual is educationally prepared, after July 1, 2005, to make medical diagnoses and prescribe pharmacotherapeutic interventions, he/she would be required to take the Nurse Practitioner certifying examination and would then qualify for APRN nurse practitioner status in Montana and practice as such.

The Board is responsible for ensuring that individuals are competent to practice, and educational preparation is a significant mechanism for obtaining competency, in addition to successfully completing the appropriate national certifying examination.

Comment 8: Winifred Carson, from the American Nurses Association, believes that removing the option of prescriptive authority from CNS practice is not in harmony with the statutory mandate from the legislature. Ms. Carson stated that the legislative intent does not allow the Board to limit CNS practice, and that the Board has not provided statistical data in its reasonable necessity statement to warrant this change.

Response 8: The Board acknowledges the comment. However, the Board cannot address the commenter's concerns regarding "legislative intent" because the commenter did not provide any documentary evidence to support her assertions, nor did she provide the citation to the particular legislative bill for the Board to research and respond. Although the Board does use statistical data in many of the reasonable necessity statements, there is no statutory requirement for doing so.

Comment 9: Pam Peterson, Shawn Shanahan and Cathleen Simensen asked for clarification on what constitutes a subspecialty and what types of documentation show competency. The commenters would also like to know if an APRN approves the plans for competency and questioned why narrowing one's scope is a problem

that needs to be approved by the Board.

Response 9: The Board concludes the change is necessary as APRNs who were educated for a generalist role are now choosing to subspecialize. The Board has had several requests from Family Nurse Practitioners who want to subspecialize. The Board has a responsibility to assure public safety. Providing a plan is a way for the Board to assure the public's safety by acknowledging the APRNs' preparation and competency for the subspeciality practice. The APRN committee, which includes an APRN as a member, will review all requests for subspecialization and make recommendations for approval/non-approval to the full Board.

Comment 10: Barbara Warren (for the American Psychiatric Nurses Association) and Eve Franklin stated that the American Psychiatric Nurses Association supports one body of knowledge for PMH CNSs and NPs. They stated that only one exam for certification is needed and only one title is needed.

Response 10: The Board disagrees and concludes that because two exams are available, there is a difference demonstrated by that fact alone - two examinations for two different purposes. The Board has also reviewed transcripts and program descriptions from several CNS programs that do not include practitioner training, such as pharmacotherapeutics and differential diagnoses necessary for independent practitioner practice.

Comment 11: Commenters Sharon Androes and Shawn Shanahan stated opposition to the "grandfather" language, and requested more specific language stating that current psychiatric CNSs will not lose their status after 2005.

Response 11: The Board agrees to clarify the language and will add specific grandfather language to the rule.

Comment 12: Dana Hillyer stated that the rationale for removing the PMH CNS ability to prescribe is flawed. ANCC has no plans to stop administering the PMH CNS exam and there is no move to eliminate PMH CNS programs. Ms. Hillyer stated that the Board overlooked the historical precedents of the PMH CNS role, and has neglected the current national trends. She believes Montana will be a state of restricted practice.

Response 12: The Board disagrees and concludes that because two exams are available, there is a difference. The Board has also reviewed transcripts from several CNS programs that do not include practitioner preparation.

Comment 13: Sami Butler (Montana Nurses Association) and Carla Gibson suggested inserting "medical" in ARM 8.32.305(3) to make it consistent with (4).

Response 13: The Board agrees to change the rule to read

"utilize medical diagnosis and treatment, proof of education related to medical diagnosing, treating and managing of psychiatric patients."

Comment 14: Susan Bodurtha stated that the American Nurses Credentialing Center will continue to administer the psychiatric CNS exam. She also suggested adopting rule language similar to that in Oregon, where the board evaluates each CNS application for licensure, and makes a decision on individual qualifications.

Response 14: The Board reviewed the Oregon rule language and found it more restrictive than that of Montana. Oregon requires protocols and does not support independent practice.

Comment 15: R. M. Scott Purol stated that he and his colleagues have studied neuropharmacology, psychopharmacology, neuropsychopharmacology, and psychoneuropharmacophysiology. He stated that the roles of the psychiatric NP and CNS are the same. He stated that Psychiatric CNSs have additional training in marriage and group therapy.

Response 15: The Board appreciates the commenter's input. The Board disagrees that PMH NP and CNS roles are interchangeable, since the educational preparation differs, as do the certifying examinations. Also, both components are necessary for the Board to establish basic, essential competence for an APRN specialty.

Comment 16: Shawn Shanahan asked how the Board defines "medical treatments" aside from prescribing.

Response 16: There are a number of medical treatments that the APRN could perform, depending on the patient's diagnosis and socio-medical history. Those treatments include psychotherapy, counseling, bio-feedback, and/or anger management, to name four examples. The appropriateness of any given treatment modality must be evaluated by the APRN at each visit with the patient.

8.32.306 APPLICATION FOR RECOGNITION, 8.32.402 LICENSURE BY EXAMINATION, and 8.32.405 LICENSURE BY ENDORSEMENT

Comment 17: The Montana Nurses Association supports the proposed amendments.

Response 17: The Board appreciates the support of the proposed amendments.

8.32.412 INACTIVE STATUS

No comments were received on this proposed amendment.

8.32.413 CONDUCT OF NURSES

Comment 18: Casey Blumenthal, Montana Hospital Association,  
23-12/12/02 Montana Administrative Register

stated that notifying the Board office of an address change within 10 days is an unreasonable expectation during such a chaotic time.

Response 18: All Montana professional and occupational licensing boards have this statement on the licenses they issue. The Board will not penalize a nurse for submitting an address change prior to a move, or within 15 days of the move, however notifying the appropriate licensing board is a professional responsibility. The Board suggests pre-move notification in order to avoid the problem cited by the commenter.

8.32.1501 PRESCRIPTIVE AUTHORITY FOR ADVANCED PRACTICE REGISTERED NURSES NURSE PRACTITIONERS, CERTIFIED REGISTERED NURSE ANESTHETISTS AND CERTIFIED NURSE MIDWIVES

Comment 19: Shawn Shanahan strongly supported the proposed changes in (3). She stated that the changes would enable APRNs to better serve clients and particularly indigent clients.

Response 19: The Board appreciates the commenter's support.

Comment 20: Cathleen Simensen stated that the title should not be changed since CNSs are APRNs.

Response 20: The Board agrees that the catchphrase may be misleading, and therefore the catchphrase will be changed to "PRESCRIPTIVE AUTHORITY FOR ELIGIBLE APRNs". The change in (2)(b) will reflect the fact that current PMH CNSs may have prescriptive authority.

Comment 21: Shawn Shanahan suggested that grandfather language be included for existing CNSs.

Response 21: The Board agrees and will add grandfather language.

Comment 22: Casey Blumenthal, of the Montana Hospital Association, opposed excluding the CNS from obtaining prescriptive authority. The commenter suggested providing another forum whereby CNSs could have an interactive dialogue with the Board on this issue. The commenter feels that prohibiting CNSs from obtaining prescriptive authority limits their practice unnecessarily.

Response 22: The Board does not believe that the non-psychiatric mental health CNS role is one of a practitioner. Non-psychiatric mental health CNSs have never sought prescriptive authority in Montana and their educational preparation would not support it.

Comment 23: Sami Butler, of the Montana Nurses Association, asked the Board to delay action on ARM 8.32.305, and to seek more input from CNSs. If the Board chooses not to delay, the

commenter asks the Board to allow CNSs to obtain prescriptive authority after additional education and competency evaluation.

Response 23: The Board ensured notice for all subcommittee meetings, and provided telephone conference lines for those who could not attend. The information was also available on-line and in the Board newsletters. Notices for the specific rule changes were also mailed to every APRN, which significantly exceeded the notice requirements of the Montana Administrative Procedure Act.

If a CNS obtains additional education and competencies, the individual should then be able to take the appropriate practitioner examination required for independent practice and prescriptive authority.

Comment 24: Dana Hillyer stated that PMH CNSs have the needed pharmacokinetic and differential diagnosis training that the Board believes is necessary.

Response 24: The American Nurses Credentialing Center certification catalog outlines the requirements for PMH CNS certification. A master's in the area of PMH CNS is not required. Thus, there is no guarantee of specific master's level course in the field of specialty which addresses the pharmacokinetics and differential diagnosis required for independent prescribing and diagnosing of psychiatric disorders. This rule pertains to individuals who obtain certification after July 1, 2005, and not to currently licensed psychiatric CNSs.

Comment 25: Winifred Carson, American Nurses Association, suggested that there is no legislative intent to limit CNS practice by denying prescriptive authority. A suggestion was made to require proof of a course in pharmacology instead.

Response 25: The Board concludes that because there are two distinct exams, there are two distinct practices. Requiring a course in pharmacology would not guarantee that the individual was tested by the credentialing body on that information.

Comment 26: The American Psychiatric Nurses Association, Barbara Warren, and Eve Franklin stated that there is one body of knowledge and one scope of practice for all APRNs who treat psychiatric clients.

Response 26: The Board disagrees as outlined in previous responses.

Comment 27: Shawn Shanahan asked the Board to investigate the impact of this change on clients.

Response 27: The Board believes there will be no impact on clients because there will be no change in the health care delivery system. Those PMH CNSs with prescriptive authority, who were recognized in Montana before July 1, 2005, will be

covered by a grandfather clause.

Comment 28: Merton Johnson, Barbara Lundemo, Richard Kirschke and Ronald Freund opposed requiring CRNAs to have prescriptive authority. They believe it is not a national requirement, and that the practice of administering anesthesia and ordering pre-operative medications is not prescribing. Having prescriptive authority will not improve their practice. The commenters stated that the DEA defines the practice of nurse anesthesia as the administration of controlled substances and not prescribing. They do not believe they dispense medications or administer prescription drugs to prevent illness.

Response 28: The Board agrees with the commenters and has changed its position after review of substantial data. The Board will strike the requirement for prescriptive authority, except when the CRNA is prescribing medications to be filled outside the facility, clinic or office and to be taken while not under the direct care of the CRNA.

Comment 29: Ronald Freund and Thomas Schultz (Montana Society for Nurse Anesthetists) stated that the Board based its decision on a comment from the Executive Director and the counsel of the Board of Pharmacy, and the Executive Director has since retracted her opinion and stated she was acting on her own when rendering this opinion. The American Association of Nurse Anesthetists does not believe prescriptive authority is required for anesthesia practice. The DEA defines the practice of anesthesia as administering and not prescribing.

Response 29: The Board agrees and will strike the requirement for prescriptive authority.

Comment 30: Becky Deschamps, Executive Director for the Board of Pharmacy, stated that her opinion on whether CRNAs need prescriptive authority was simply her personal opinion at the time. The Board of Pharmacy never discussed it. Since her original statement, she has changed her opinion on whether CRNAs are prescribing when they give anesthesia.

Response 30: The Board appreciates the comment and has voted to change the proposed language. This opinion is consistent with that of the Drug Enforcement Administration.

Comment 31: Merton Johnson and Barbara Lundemo stated that there is not a problem with physicians signing orders for CNRAs. They wondered where did all this start and what is the reason for proposing this rule now.

Response 31: The Board will not require prescriptive authority for those CRNAs working in a hospital or facility setting when a separate prescription is written for the patient to take home.

Because the practice is independent, the CRNA with prescriptive authority should not have a physician sign



prescriptions that will be filled outside the facility. The rule is being proposed now as a result of general rule review. The Board currently has no requirement that a physician signs off any orders or prescriptions for an APRN, though some facilities require this as a condition of privileging and credentialing.

Comment 32: Richard Kirschke stated that requiring CRNAs to have prescriptive authority would limit the number of CRNAs who will come to Montana for locum tenens coverage.

Response 32: The Board does not believe that this change would have limited locum tenens employment relationships, but has voted to strike the requirement for prescriptive authority.

Comment 33: Merton Johnson and Barbara Lundemo asked whether RNs and LPNs in a facility need prescriptive authority to receive prescription samples.

Response 33: Only APRNs may have prescriptive authority. RNs and LPNs cannot sign for or dispense prescription samples. If this is occurring, it should be reported to the Board office.

Comment 34: Thomas Schultz (Montana Society for Nurse Anesthetists) stated that if CRNA practice is tied to licensure, and a CRNA loses prescriptive authority, that CRNA would be unable to practice. The commenter believes that the rule as proposed would be inconsistent with other parts of the laws and rules for nursing, but did not state in which way.

Response 34: The Board agrees with the commenter and will strike the requirement for prescriptive authority.

Comment 35: Sami Butler (Montana Nurses Association) and Thomas Schultz (Montana Society for Nurse Anesthetists) asked the Board to reexamine the issue of mandatory prescriptive authority for CRNAs since the language is inconsistent with a national movement.

Response 35: The Board agrees with the commenters and will strike the requirement for prescriptive authority.

#### 8.32.1502 DEFINITIONS

Comment 36: Arlys Williams asked why the peer reviewer must have prescriptive authority. If a person has independent practice but does not have prescriptive authority, that practitioner should also be aware of treatment modalities. Will sending charts out to other APRNs raise new concerns with the Health Insurance Portability and Accountability Act of 1996? Will the travel encountered be prohibitive?

Response 36: All practitioners should be aware of treatment modalities within their scopes of practice. However, if a

licensee has not been approved for prescriptive authority, that licensee may not function as a peer reviewer for an APRN with prescriptive authority. The concept of a peer reviewer is a person who has a similar practice. Records may or may not be sent out for review. That decision remains with the licensee. There are no HIPPA regulations that prohibit this. Names and identifiers may be redacted before records are sent out. The Board does not have control over travel required for peer review, but it believes that peer review is necessary given the independent nature and scope of APRN practice.

8.32.1505 PRESCRIBING PRACTICES

Comment 37: Shawn Shanahan strongly supported the proposed changes in (2)(a) through (g), stating that they will streamline provision of care and improve efficiency. Cathleen Simensen supports the changes in (2)(a) through (h).

Response 37: The Board appreciates the support for these proposed amendments.

Comment 38: Cathleen Simensen argued that the line regarding local anesthetics should be retained.

Response 38: Administration of local anesthetics is in the RN rules, and is redundant and unnecessary in the APRN rules.

8.32.1506 SPECIAL LIMITATIONS RELATED TO THE PRESCRIBING OF CONTROLLED SUBSTANCES

Comment 39: Pam Peterson believes that having to send a written authorization for a refill of a controlled substance is already addressed and allowed by state law in some cases. She would like the requirement to be dropped.

Response 39: Faxed prescriptions are acceptable. This was not a proposed change, so it cannot be addressed in this notice.

8.32.1509 TERMINATION OF PRESCRIPTIVE AUTHORITY

No comments were received regarding the proposed amendment.

8.32.1510 RENEWAL OF PRESCRIPTIVE AUTHORITY

Comment 40: Richard Krischke, Catherine Caniparoli, and Cathleen Simensen believe that 10 hours of continuing education (CE) is burdensome. They state the current requirement of 6 hours for two years is sufficient, and they believe that it will be a hardship for APRNs to find an additional 2 hours of CE per year.

Response 40: The Board concludes that pharmacotherapeutics change so rapidly that the independent practitioner needs to obtain considerable continuing education to be a safe

practitioner. Online courses are plentiful and this is a minimal requirement when compared to other states and the level of independence afforded Montana's APRNs.

Comment 41: Dana Hillyer stated that CE requirements are confusing and that the Board should clearly define how many units will be required.

Response 41: Forty hours will be required to renew APRN status every two years. An additional 10 hours in pharmacology will be required if the licensee is also renewing prescriptive authority. The new language may be clearer when the new rules are in regular format.

NEW RULE I (8.32.417) PROBATIONARY LICENSES AND NEW RULE II (8.32.1410) PURPOSE OF STANDARDS OF PRACTICE FOR THE ADVANCED PRACTICE REGISTERED NURSE

No comments were received on these proposed new rules.

NEW RULE III (8.32.1411) STANDARDS RELATED TO THE ADVANCED PRACTICE REGISTERED NURSE'S RESPONSIBILITY TO APPLY THE NURSING PROCESS

Comment 42: Arlys Williams suggested adding "the APRNs" before nursing practice so that medical research may also be used. Will the APRN need to document the priorities of care for each visit? Will each encounter's dictation need to specify how treatment will be evaluated? She suggested that (1)(d) needs to be reworded since documenting all aspects of health status is not done at every visit. How does one check to know if her peer has an unencumbered license?

Response 42: The Board concludes that the ability to use medical research in practice is covered in (1). The APRN needs to document care according to standards of practice. Uniform national language may be used to address health status. Anyone can check the status of a licensee by calling the Board office or using the web site.

Comment 43: Sharon Androes opposes "across the board protocols and documentation." She sees this as increased and unnecessary paperwork that will reduce the time available for patients.

Response 43: The Board made changes based on current national APRN standards of practice and a thorough understanding of APRN roles and practice.

Comment 44: Sami Butler (Montana Nurses' Association) and Carla Gibson suggested adding "families, communities and populations." The commenters also suggested adding "other disciplines" to the science based evidence clause in (1)(a)(ii) and deleting "all" from (1)(d) and inserting "identified."

Response 44: The Board agrees and has deleted "nursing" in (1)(a)(ii), and has deleted "all" and inserted "identified" in (1)(d). The Board will address the other comment in a future rule change by defining "client" to include individuals, families, groups and populations, as this is the Board's intent. This intent is consistent with current nursing literature, research and textbooks.

NEW RULE IV (8.32.1412) STANDARDS RELATED TO THE ADVANCED PRACTICE REGISTERED NURSE'S RESPONSIBILITY

Comment 45: Dana Hillyer objected to the peer and physician reviewers having to sign a notarized statement attesting to the fact that they had reviewed the APRN's records. She stated that all requirements for renewal should be in a list so that there are no hidden requirements.

Response 45: The Board concludes that the notarized statement is not a hardship. Requirements will be in a list sent to all APRNs. The Board concludes that peer review is important in that it demonstrates a desire to substantiate one's practice patterns, offers opportunity for improvement, and is consistent with independent practice responsibilities.

Comment 46: Janet Winne stated that the referral process language is unclear. Will the APRN be required to maintain a list? She also would like all requirements for renewal be spelled out in New Rule IV.

Response 46: Referral information is obtained at the time of application. It is updated when the APRN files a change in practice. Requirements will be in a list sent to all APRNs.

Additional Comments on Rulemaking Process:

Comment 47: Eve Franklin, RN, commented about the Board's process of conducting hearings and gathering information. Ms. Franklin stated that Board members have a duty to listen to their constituency. Office staff advised a licensee against contacting individual Board members directly, as it would violate the open meeting law. Ms. Franklin believes that this is not a violation of the open meeting law, and believes the Board should communicate with anyone who wants to express an opinion.

Ms. Franklin also stated that the hearing process the Board uses is dubious, and although the practice has been consistent for a number of years, she believes it is flawed. Board members should attend every rulemaking hearing. She believes that the Board members do not receive all of the testimony, and that staff filters and editorializes what is given to Board members.

Ms. Franklin also believes that these proposed rules and previous proposed rules were developed by staff, and that staff presented only part of the available information on CNS licensure, education and preparation to the Board.

Response 47: The Board acknowledges Ms. Franklin's comments. The incident in question involved a licensee who wished to discuss testimony with Board members after the close of the comment period. The Board may not accept any further verbal or written testimony once the comment period is closed. On another note, the Board does not have a constituency. The Board serves to protect the public. Licensees are not constituents.

The Board concludes that it is not feasible for all Board members to attend every hearing. Board members are required to be employed in the field of nursing, and to have them attend every hearing would be financially prohibitive for the individual Board members and the Board as a whole. Costs associated with travel, hotels and meals for several rules hearings a year would dramatically increase the Board's budget.

The Board hires a court reporter to accurately document testimony and discussion at every hearing. Board staff does not edit these documents in any way. Furthermore, Board staff meticulously copies all written testimony and other documents received. A copy of all testimony and the transcript from the hearing is mailed to each Board member at least two weeks before they deliberate in an open meeting. Board members believe they have the ability to review written documentation in an objective and thorough manner prior to deliberating at a meeting. They do not believe that it would make a difference to be present at the hearings, and that it could actually cause oral testimony to carry more weight than written testimony. This is unacceptable to the Board, as all testimony, in whatever form, is equally important in the rulemaking process.

A subcommittee initiated work on the rules and considered many sources of information, including the documents cited in testimony from the hearing. The subcommittee then referred the proposed changes to the full Board for consideration and the subsequent filing of the notice. The document produced was not a Board staff document, but rather a document that had the criticism of a Committee, including two NPs, a CNS, two MSNs, an RN, an LPN, and other APRNs who had periodic involvement in the process. Each member researched topics, brought independent information to the table and reviewed each draft.

Comment 48: Dana Hillyer, Dale Mayer, John Honsky, Linda Morrow Torma, Nadine Parker, Rachel Rockafellow, Laurie Glover and Shawn Shanahan asked the Board to delay action until more nurses could submit testimony and stated that the Board did not seek opinions from interested parties and licensees.

Response 48: The Board publicized its meetings in newsletters and on its web site for almost a year. Every APRN also received a copy of the notice of proposed amendment. MAPA was followed, and a sufficient comment period was provided. The Board could not afford to send invitations to each APRN, however Montana Nurses Association representatives were present at every meeting.

4. After consideration of the comments, the Board has

amended ARM 8.32.306, 8.32.402, 8.32.405, 8.32.412, 8.32.1502, 8.32.1505, 8.32.1506, 8.32.1509 and adopted new rules I (8.32.417) and II (8.32.1410), exactly as proposed. The Board has repealed 8.32.1507 exactly as proposed.

5. After consideration of the comments, the Board has amended and adopted the following rules as proposed, with the following changes, stricken matter interlined, new matter underlined:

8.32.301 NURSE PRACTITIONER PRACTICE (1) Nurse practitioner practice means the independent and/or ~~interdependent~~ collaborative management of primary and/or acute health care of individuals, families and communities including:

(a) remains as proposed.

(b) instituting and ~~providing~~ facilitating continuity of health care to clients, including:

(i) ordering durable medical equipment, treatments and modalities, and diagnostic tests;

(ii) and (iii) remain as proposed.

(iv) working with clients to ~~insure~~ promote their understanding of and compliance with therapeutic regimes;

(c) through (f) remain as proposed.

AUTH: 37-8-202, MCA

IMP: 37-8-202, MCA

8.32.305 EDUCATIONAL REQUIREMENTS AND OTHER QUALIFICATIONS APPLICABLE TO ADVANCED PRACTICE REGISTERED NURSING (1) and (2) remain as proposed.

(3) Applicants for recognition as a psychiatric CNS shall possess a master's degree in nursing from an accredited nursing education program which prepares the nurse for a psychiatric CNS practice. If the psychiatric CNS plans to ~~diagnose and treat~~ utilize medical diagnosis and treatment, proof of education related to medical diagnosing, treating and managing psychiatric clients shall be provided. This education must integrate pharmacology and clinical practice.

(a) After July 1, 2005, the board will not recognize newly certified psychiatric CNSs who provide medical diagnoses and treatments. Individuals intending to practice in this manner will be required to be certified as psychiatric nurse practitioners. Those psychiatric mental health CNSs certified in Montana prior to July 1, 2005 will continue to be recognized in Montana.

(b) Psychiatric CNSs certified in a state other than Montana prior to July 1, 2005, may be recognized in Montana.

(4) For approval in a subspecialty practice setting, the licensee shall submit documentation of, or a plan for, achievement of competency in the subspecialty area.

(5) remains as proposed.

AUTH: 37-8-202, MCA

IMP: 37-8-202, MCA

8.32.413 CONDUCT OF NURSES (1) through (2)(t) remain as

proposed.

AUTH: ~~37-1-316~~, 37-1-319, 37-8-202, MCA  
IMP: 37-1-316, 37-1-319, 37-8-202, MCA

Reason: Following final review of the proposed rule changes, the Board has determined that it is necessary to remove 37-1-316, MCA, from the authority cites to accurately reflect the source of the Board's rulemaking authority.

8.32.1501 PRESCRIPTIVE AUTHORITY FOR NURSE PRACTITIONERS, CERTIFIED REGISTERED NURSE ANESTHETISTS AND CERTIFIED NURSE MIDWIVES ELIGIBLE APRNS (1) remains as proposed.

(2) An APRN granted prescriptive authority by the board of nursing may prescribe and dispense drugs pursuant to applicable state and federal laws.

(a) ~~Only~~ NPs, CRNAs, and CNMs with unencumbered licenses may hold prescriptive authority.

(b) ~~All CRNAs are required to have Psychiatric CNSs with unencumbered licenses who are certified prior to July 1, 2005, may hold~~ prescriptive authority.

(3) and (4) remain as proposed.

AUTH: 37-8-202, MCA  
IMP: 37-8-202, MCA

NEW RULE III (8.32.1411) STANDARDS RELATED TO THE ADVANCED PRACTICE REGISTERED NURSE'S RESPONSIBILITY TO APPLY THE NURSING PROCESS (1) through (1)(a)(i) remain as proposed.

(ii) utilizing evidence-based research data in ~~nursing~~ practice;

(b) and (c) remain as proposed.

(d) manage and document ~~all~~ identified aspects of the client's health status within the APRN's competencies, scope and practice; and

(e) remains as proposed.

AUTH: ~~37-1-301, 37-8-102~~, 37-1-131, 37-8-202, MCA  
IMP: 37-1-131, 37-8-202, MCA

Reason: Following final review of the proposed rule changes, the Board has determined that it is necessary to amend the authority cites to accurately reflect the source of the Board's rulemaking authority.

NEW RULE IV (8.32.1412) STANDARDS RELATED TO THE ADVANCED PRACTICE REGISTERED NURSE'S RESPONSIBILITIES AS A MEMBER OF THE NURSING PROFESSION (1) remains as proposed.

AUTH: ~~37-1-301, 37-8-102~~, 37-1-131, 37-8-202, MCA  
IMP: 37-1-131, 37-8-202, MCA

Reason: Following final review of the proposed rule changes, the Board has determined that it is necessary to amend the authority cites to accurately reflect the source of the Board's rulemaking authority.

BOARD OF NURSING  
KIM POWELL, RN, MSN, APRN, Chair

/s/ KEVIN BRAUN  
Kevin Braun  
Rule Reviewer

/s/ WENDY KEATING  
Wendy Keating, Commissioner  
DEPARTMENT OF LABOR & INDUSTRY

Certified to the Secretary of State: December 2, 2002.