MINUTES OF THE MEETING
HUMAN SERVICES SUBCOMMITTEE
MONTANA STATE
HOUSE OF REPRESENTATIVES

January 10, 1985

Start Tape 3, Side B

The meeting of the Human Services Subcommittee was called to order by Chairman Cal Winslow on January 10, 1985 at 8:00 a.m. in Room 108 of the State Capitol building.

ROLL CALL: All members were present.

GENERAL: Chairman Winslow opened the meeting by explaining Friday's meeting is cancelled due to the Long Range Planning Subcommittee Public Hearing at 8:00 a.m. on that day.

Mr. George Fenner read a brief introduction to the Health Services and Medical Facilities Administration Division of DHES (Exhibit 1).

Dr. Bill Haggberg, Chief of the Dental/Health Education Bureau gave a presentation on his bureau activities (Exhibit 2). There has been a savings of $18,000 since 1971 in the dental health program of the Flathead and Anaconda dental projects with fewer children treated. The bureau is asking $30,000 from total Block Grant monies. A question was directed to Dr. Haggberg if he would mind the monies coming through reimbursement fees from the counties because of the limitation of where the Block Grant goes. Dr. Haggberg indicated he didn't mind.

Mr. Robert Moon spoke on the Health Education-Risk Reduction Project (Exhibit 3). The project is asking for a modified budget amendment of $12,000 for special projects that Montana has been chosen to administer. The project is asking for $50,000 out of the Preventive Health Block Grant.

Testimony was heard from Mr. Charles Briggs, State Agent Coordinator for the Governor. He spoke on the importance of assisting senior citizens in health promotion and modifying their lifestyle, thereby taking responsibility of their own lives.

Mr. Bob Johnson, Director of the Lewis & Clark County Health Department, supported Mr. Moon's project request.

Mr. Jim Foley, Director of the Health Systems Agency for the State of Montana, spoke on the concern of health care costs and the importance of people becoming more involved in health prevention. He said he strongly supports the project's budget request.

Dr. Sidney Pratt, Chief of the Clinical Programs Bureau, introduced the five supervisors of the programs under the bureau (Exhibit 4). Dr. Pratt discussed the organizational chart for the Health Services and Medical Facilities Division of the DHES (Exhibit 5).

MONTANA PERINATAL PROGRAM (MPP)

Dr. Don Espelin discussed a brief history of the Improved Pregnancy Outcome Project (IPO). Dr. Espelin stressed the high expense of taking care of a premature infant and the regionalization of medical care in giving highly technical care to premature infants all over Montana. In addition, education is needed for those physicians and nurses in small towns. Dr. Espelin outlined the problems the MPP has become involved in the following activities:

1) Virginia Outreach Project
2) South Carolina Outreach Project
3) Preterm labor prevention
4) Fetal Alcohol Syndrome (FAS) prevention
5) Preconceptual planning and counseling
6) Health Mothers, Healthy Babies (HmHb) coalition
7) High Risk Registry

Chairman Winslow pointed out that if the funding is taken from the Maternal-Child Health (MCH) Block Grant, an impact would be felt from the local counties.

HANDICAPPED CHILDREN'S SERVICES (HCS)

Sharon Pettit discussed the HCS program (Exhibit 7). The major concerns facing HCS in relation to the proposed budget are:

1) Transport - Removed from HCS budget. Destroys regionalization concept in Montana.

2) Cleft Lip/Palate - The $52,500 would permit HCS to expand to cover more than the initial closure. Treatment begins in early birth and often continues into early adulthood.

END OF TAPE 4; SIDE A

At this point of the meeting, LFA Peter Blouke gave to all members of the committee a handout (Exhibit 8) listing all the bureau budget requests and the type of funding.

TUMOR REGISTRY PROGRAM

(4:B:020) Carol Snyder discussed the Tumor Registry Program, which provides uniform reporting of cancer information (Exhibit 9). Her comments concerning the proposed budget:

1) $2,250 for the costs of a maintenance contract for the proposed computer system. Without this, there will be no maintenance agreement for the system.

2) $1,000 to cover the costs of publishing the biennial, state-wide cancer report for the central registry; therefore,

no cancer statistics for Montana.

Questions were asked as to who is required to report cases of cancer reported. The hospitals are the only sources that require reporting of cancer cases. It was noted the Registry is missing approximately 35 percent of cancer cases because they are not being treated by the hospitals.

SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

(4:B:170) Dave Thomas discussed a brief summary of the WIC program (Exhibit 10), at which time he presented budget modifications for the WIC program. Funded from USDA to meet program deficiencies, USDA recommended and provided additional funding in four areas:

1) Add two additional staff to meet deficiencies;
2) To maintain monthly workcase load;
3) Increase food package dollar amounts;
4) Contract for design and use of data system.

CHILD NUTRITION PROGRAM

(4:B:330) Peggy Baraby discussed the Child Nutrition Program (Exhibit 11). The budget modification they are requesting:

1) .5 FTE to maintain current full-time program supervisor;
2) Increase in grants to local programs.

Questions were asked concerning the .5 FTE request. There is a specific dollar amount limit that the state can use for administration. The program's administration funds are set; they can't be exceeded.

NURSING BUREAU

(4:B:432) Maxine Ferguson indicated the Nursing Bureau includes five major programs: Community Nursing, Communicable Disease, Venereal Disease Control, Childhood Immunization, and Family Planning, each with a preventative health emphasis. She outlined the objectives of the Nursing Administration and Operations (Exhibit 12) and also discussed the Nursing Bureau's Modified Request (Exhibit 13).

Childhood Immunization Program/Venereal Disease Control Program

(4:B:614) Richard Nelson presented his discussion of the program (Exhibit 14).

END OF TAPE 4, SIDE B

Communicable Disease Control Program

(5:A:053) Judith Gedrose discussed the Communicable Disease Control Program (Exhibit 15).

A question was directed towards the rabies vaccine program. There was a concern over how many shots are required and is it still as painful as it was before in past years.

Family Planning

(5:A:159) Suzanne Nybo discussed the overview of the Statewide Family Planning Program (Exhibit 16).

Further testimony was submitted by Anne Brodsky, who spoke on behalf of the Women's Lobbyist Fund (WLF) (Exhibit 17). WLF recommends restoring the Preventive Health Block Grant appropriations to at least the current level in the budget for FY 86 and FY 87; and that the Family Planning Program continues to be staffed with 4.5 FTE's, as it is now staffed; and the regular budget modification request of .5 FTE nurse for additional services.

Questions were asked concerning the notification of receiving Title X monies.

(5:A:335) Questions were asked by several committee members concerning the location of Family Planning buildings. Ms. Nybo gave to each committee member a letter that Chairman Winslow requested everyone on the committee have concerning the Yellowstone Valley Women's Clinic and Planned Parenthood in Billings (Exhibit 18). Discussion followed.

(5:B:058) There being no further business before the committee, the meeting was adjourned at 11:05 a.m.

CAL WINSLOW, Chairman

CW/cj

1-10-85
Exhibit 1

January, 1985

Health Services and Medical Facilities Administration

Mr. Chairman, Senators and Representatives of the Committee, my name is George Fenner. I am Division Administrator for the Health Services and Medical Facilities Division.

This Division was created in July, 1983, combining the Health Services Programs in the Department into a single division. Prior to July, 1983, there were two divisions with two administrative units. When the health services were consolidated, one administrative unit was eliminated. The remaining unit has continued to be funded by the programs making up the former Hospital and Medical Facilities Division.

The requested administrative unit funding reduces the administrative charges to the Bureaus of Health Planning and Licensing and Certification to the actual amount required by these programs. Adjustment of these administrative charges has been requested by the Federal funding agencies. The recommended funding distribution is based on the actual experience of the Administrative Unit since the 1983 reorganization. This funding structure will be more equitable for the Division programs and will comply with the requirements of the various Federal funding sources.

DAILY ROLL CALL

Human Services Subcommittee

49th LEGISLATIVE SESSION -- 1985

Date 1-10-85

NAME	PRESENT	ABSENT	EXCUSED
Rep. Dorothy Bradley	X		
Sen. Chris Christiaens-Vice Chair	X		
Sen. Richard Manning	X		
Rep. Dennis Rehberg	X		
Sen. Pete Story	X		
Rep. Cal Winslow, Chairman	X		

1-10-85
Exhibit 2

DENTAL/HEALTH EDUCATION BUREAU

DENTAL PROGRAM

January 7, 1985

Chairman Winslow and Committee members, I am Dr. Bill Haggberg, Chief of the Dental/Health Education Bureau. The services presently provided are: dental prevention programs and health education risk reduction programs promoting healthy life styles. The hypertension program was under the bureau's jurisdiction until September 30, 1984. Lack of a new federal mandate coupled with the decision by the 48th state legislature, has caused phasing out of the hypertension program from the Preventive Block Grant.

Dentistry has the finest record of all health professions when it comes to prevention. With this in mind, the dental program should and attempts to provide dental prevention projects for all Montanans.

FACTS

1) The fluoride mouthrinse program has reduced decay by one third (1/3) for participating children in Montana.

2) 36,000 children K-6 are presently participating and the savings in dental treatment is $36/student participating which equals 1,296,000 saved in dental treatment in Montana. Refer to attached Flathead and Anaconda studies.

3) The screening program found 135 children in emergent need of dentistry in these five counties (Silver Bow, Beaverhead, Deer Lodge, Powell, Granite) during the 1982-83 school year. Because the schools have continued with the preventive program only 24 children were needing emergent care throughout the 1983-84 school year in the same counties.

4) SRS dental treatment costs were 2,438,623 in 1983 and 2,227,128 in 1984. This is 211,495 less in 1984. The number of treated cases was 22010.4, 1983, costing 110.79 as compared to 24684.4, 1984, costing 90.22. This is 20.57 less per case in 1984.

In the main, energy has been focused due to staff shortage, to expand the school based prevention program. It is comprised of three phases: dental health education, visual screening, and a voluntary fluoride mouthrinse. Before the previous legislative session, 23 counties and 195 schools participated. At present 48 counties and 400 schools participate in one or all phases of the program. The goal is to have all 56 counties participating by the end of this school year.

The voluntary fluoride mouthrinse presently in 335 schools serving 36,000 children K-6 receives supplies from the bureau. It is estimated that 40,000 K-6 children will be rinsing by the end of this school year. 25,000 children K-6 live in areas where drinking water fluoride levels are a benefit to the dentition. It is essential the bureau provide the supplies for the fluoride rinse, to maintain professional control at a cost efficient level. I refer you to Mr. Ray Hoffman concerning supply budget requests.

Mr. Bob Moon is the manager of the Health Education Risk Reduction program. He has recently completed a comprehensive publication in draft of the 1990 objectives for the entire department of health. He will address the committee following my presentation.

EXPLANATION OF FLATHEAD & ANACONDA DENTAL RESULTS

The first and original Flathead project consisted of dental education, toothbrushing, mouthrinse and treatment. The treatment portion was provided for low income families who were not able to pay for treatment from either private funds or state medicaid reimbursement. This treatment phase was introduced to provide a study of cost saving for treatment for every child in the program.

An explanation of the screening classification for both the Flathead and Anaconda projects is as follows:

Class I - Children who are in emergent need
Class II - Children who visually need dental attention
Class III - Children who visually display no dental problems

In fiscal year 1971-1972, only 1,548 children were screened and 56% visually displayed dental conditions which needed correction. The cost of the total program, which included a salaried hygienist, supplies, and the treatment mentioned was $47,000.

Eight years later, 1979-1980, over three times as many children were screened (5,336). The screening results[1] displayed only 12% of the children needing dental care. This is a 44% reduction over an eight-year period. The cost of the total program again included a salaried hygienist (which was increased from $6,000 in 1979 to $11,500), supplies, and treatment was $29,000.

In the face of the greatest period of inflation our country has ever witnessed, the cost of the program for over three times as many children was reduced $18,000. This program factored out shows that for every dollar spent in the program, thirty-six dollars is saved in dental treatment yearly for every student participating.

It was then necessary to pilot a program leaving the treatment phase out. Anaconda was the selected site. A dental education, toothbrushing and mouthrinse program was implemented in 1975-1976. Classification of screened students was the same as in the Flathead project.

Total children screened in 1975-1976 was 1,182. The resultant children in need was 66%[2]. During last years screening, 1980-1981, 1,057 children were screened and the results showed only 16% of the children visually displayed dental need. This is a total reduction of 50% over a period of five years.

These two projects support, and are used as, promotional data for schools to <u>voluntarily</u> participate statewide in this project.

Plate 1 refers to results of Flathead Project
Plate 2 refers to results of Anaconda Project

PLATE 1

RESULTS OF SCREENING BY YEAR

FLATHEAD CHILDREN'S DENTAL HEALTH PROJECT

1971 - 1972		1972 - 1973		1973 - 1974	
Total Children Screened	1,548	Total Children Screened	2,341	Total Children Screened	2,4[illegible]
Class I 12%	177	Class I 8%	118	Class I 6%	1[illegible]
Class II 44%	676	Class II 39%	604	Class II 33%	8[illegible]
Class III 44%	665	Class III 53%	827	Class III 61%	1,47[illegible]
Grades 1 and 2		Grades 1, 2, and 3		Grades 1, 5, and 6	

1974 - 1975		1975 - 1976		1976 - 1977	
Total Children Screened	4,607	Total Children Screened	5,112	Total Children Screened	4,77[illegible]
Class I 7%		Class I 5%		Class I 4%	1[illegible]
Class II 29%		Class II 24%		Class II 20%	9[illegible]
Class III 64%		Class III 71%		Class III 76%	3,6[illegible]
Grades 1 through 6		Grades 1 through 6		Grades 1 through 6	

1977 - 1978		1978 - 1979		1979 - 1980	
Total Children Screened	4,999	Total Children Screened	5,638	Total Children Screened	5,33[illegible]
Class I 3%	147	Class I 3%	156	Class I 2%	1[illegible]
Class II 16%	807	Class II 13%	750	Class II 10%	5[illegible]
Class III 81%	3,946	Class III 84%	4,732	Class III 88%	4,67[illegible]
Grades 1 through 6		Grades K through 6		Grades K through 6	

PLATE 2

RESULTS OF SCREENING BY YEAR

ANACONDA CHILDREN'S DENTAL HEALTH PROJECT

1975-1976		1976-1977	
Total Children Screened	1,182	Total Children Screened	1,190
Class I 12%		Class I 7%	
Class II 56%		Class II 57%	
Class III 32%		Class III 36%	

1977-1978		1978-1979 (Manpower Change)	
Total Children Screened	1,209	Total Children Screened	1,250
Class I 4%		Class I 1.5%	
Class II 37%		Class II 36%	
Class III 59%		Class III 62.5%	

1980-1981	
Total Children Screened	1,100
Class I 4.2%	
Class II 12.1%	
Class III 83.7%	

CLASS I - Children who are in emergent need
CLASS II - Children who visually need dental attention
CLASS III - Children who visually display no dental problems

Exhibit 3
1-10-85

HEALTH EDUCATION-RISK REDUCTION PROJECT

January, 1985

Chairman Winslow, Senators and Representatives of this Committee, I am Robert Moon, Manager of the Health Education-Risk Reduction Project of the Dental/Health Education Bureau of the Health Services and Medical Facilities Division. The project is totally supported by monies from the Preventive Health Block Grant, and employs one full time employee.

The Health Education-Risk Reduction Project provides a statewide focal point for educational programs which assist Montanans in voluntarily replacing undesireable lifestyle behaviors with those which enhance health. The project is creating a new spirit directed toward educating individuals from pre-schoolers through the elderly to develop a better understanding of the control they can have over their own health status. The purpose is not so much to change the Montana community collectively, as it is to increase awareness of how lifestyle and environmental factors affect health. Specifically, the programs are designed to help individuals stop smoking, moderate their use of alcohol, improve their diet, increase their exercise, manage excess stress, and increase their utilization of seat belts.

Influencing individual behavior presents a formidable challenge. Yet, the need for individuals to take greater responsibility for their own health has become more and more evident. Public health efforts of the past were basically one-dimensional, but effective with infectious diseases and sanitation. The individual could basically take a passive while others took care of the problem. This model does not lend itself to today's conditions--heart disease, cancer, stroke, lung disease. Research has linked lifestyle heavily to these diseases. This makes prevention and health promotion all the more important!

The Health Education-Risk Reduction Project has its major components:

1) "Healthy Montanans: 1990 Perspectives" - 1984 statewide health policy to promote health and prevent disease. Two hundred fifty-six (256) objectives have been formulated in the areas of health promotion, health protection, and health services to provide priority programming.

2) Behavioral Risk Surveillance - serving as one of twenty states nationwide in providing a monthly surveillance of 99 Montanans to provide state specific prevalence data on personal health behaviors.

3) Health Promotion Mini-Grants - a series of carefully evaluated health promotion demonstration projects is being proposed in settings as schools, hospitals, worksites, and community agencies. These projects will not focus on specific diseases nor involve persons already under care, but rather are designed to encourage and help individuals to adopt and maintain lifelong positive health behaviors and self care practices.

4) Rocky Mountain School Health Conference - a jointly sponsored statewide model for promotion of school health development in Montana schools.

5) "Making Health Promotion/Education Work" - practical workshops to demonstrate how to develop an effective health promotion model, employing community change models.

6) Health Risk Appraisal System - serves as a state focal point for the Centers for Disease Control to assure effective use of a health promotion tool.

The program is continuing to work in cooperation with local health departments, hospitals, insurance companies, federal and state agencies, universities, voluntary health organizations, health clubs, senior centers, civic groups, health planning systems, and similar programs who are developing and implementing health education-risk reduction programs statewide. Health promotion has become everybody's business and justifiably so.

In conclusion, I would be happy to respond to any questions that you may have. Budgetary questions should be directed to Mr. Hoffman.

FACT SHEET

WHY HEALTH PROMOTION AND DISEASE PREVENTION

There is a growing belief that further improvements in the health of Montanans will be achieved through a commitment to prevent disease and to promote health. This belief is based on the following facts:

-- Degenerative diseases (such as heart disease, cancer, and stroke) cause about 75 percent of all deaths in Montana.

-- Accidents are the most frequent cause of death among persons between the ages of one and forty in Montana. Most accidents can be prevented.

-- Environmental hazards contribute to many of our serious health problems. Many environmental hazards can be controlled.

-- Unhealthy habits (e.g., smoking, overeating) play a major role in the development of chronic diseases among middle-age Montanans. Habits can be changed.

HEALTH RISKS

Each year hundreds of thousands of Americans die before their time. For example, every year:

— 350,000 Americans die from diseases that are directly linked with cigarette smoking--heart disease, lung cancer, emphysema, among others;

— 100,000 Americans die in accidents--half of them on highways; and

— 200,000 deaths (including many accidents) nationwide are related in some way to the misuse of alcohol.

In Montana, in 1983, the following occurred:

— 2,241 Montanans died of heart disease accounting for 34 percent of all deaths;

— 1,350 Montanans died of cancer, about 20 percent of all deaths; and

— Cardiovascular disease (stroke) was responsible for 519 Montana deaths.

Source: Health Montanans; 1990 Perspectives, SDHES, 1984
Montana Vital Statistics, Bureau of Records and Statistics, SDHES, 1983

HEALTH STRATEGIES

Health strategies to promote health and prevent disease include:

-- Health Promotion/Health Education--smoking cessation, alcohol and drug abuse reduction, improved nutrition, exercise and fitness, stress control, weight control/obesity, and accidents.

— Health Protection--environmental protection, occupational safety and health, accident control, community water supply fluoridation, and infectious agent control.

— Preventive Health Services--family planning, pregnancy and infant care, immunizations, sexually transmissible disease services, and hypertension control.

CONTRIBUTING FACTORS OF MORTALITY: LIFE YEARS LOST BEFORE AGE 65

— 50 percent lifestyle
— 20 percent environment
-- 20 percent human biology
— 10 percent health care system

CAUSES OF DEATH

	Risk Factors
Heart Disease	smoking*, high blood pressure, elevated serum cholesterol* (diet), lack of exercise, diabetes, stress, obesity
Cancer	smoking*, worksite carcinogens*, environmental carcinogens*, alcohol, diet, medications, infectious agents
Stroke	hypertension*, smoking*, elevated blood cholesteral*, stress
Accidents	alcohol*, drug abuse*, speed*, no seat belts*, smoking (fires), product design, handgun availibility, roadway design
Homicide	stress*, handgun availability*, alcohol
Suicide	stress*, alcohol, drug abuse
Cirrhosis of liver	alcohol*
Influenza/Pneumonia	smoking*, alcohol, vaccination status
Diabetes	obesity*, diet

Exhibit 4
1-10-85

Chairman Winslow and members of the Joint Appropriations Subcommittee on Human Services;

I am Dr. Sidney Pratt, Chief, Clinical Programs Bureau, Health Services and Medical Facilities Division of the State Department of Health and Environmental Sciences. I am here to introduce the supervisors of the five programs included in the Bureau:

Dr. Donald Espelin, Medical Director of the Montana Perinatal Program

Sharon Pettit, Supervisor of the Handicapped Children Services Program

Carol Snyder, Supervisor of the Tumor Registry Program

David Thomas, Supervisor of the Supplemental Food Program for Women, Infant, and Children (WIC)

Peggy Baraby, Supervisor of the Child Nutrition Program

Before presenting them I would like to discuss the budget requests for the Clinical Bureau Administration. Three FTE's are assigned to administration:

1) One Public Health Nutrition Consultant who is responsible for state-wide nutrition consultation which includes integration of nutrition services into all other Division programs; liaison and consultation to non-state-agency nutrition organizations, State Nutrition Council, Montana Dietetics Association and Association of State and Territorial Public Health Nutrition Directors, and supervision of those other nutritionists assigned to Bureau programs (WIC and Child Nutrition).

2)One Administrative Clerk

3)One Bureau Chief

In addition to exercising administrative responsibilities over the various Bureau programs, the bureau chief is the medical director for the Handicapped Children Services Program (including the Cleft Palate Program), the Tumor Registry Program, the Family Planning Program and the WIC and Child Nutrition Programs.

One major specific program activity that is the full responsibility of the Clinical Programs Bureau Administration is the Inborn Errors of Metabolism Program. This is a statutory mandate which became effective with the passage of SB 128 in 1965 to screen all newborns for hereditary metabolic disorders which lead to profound irreversible mental retardation if not detected and treated in the immediate post-natal period. Montana screens for six metabolic disorders: phenylketonuria (PKU), congenital hypothyroidism, galactosemia, homocystinuria, tyrosinemia and maple syrup urine disease.

Since 1975 Montana has contracted with the Oregon Public Health Laboratory as part of a northwest regional program to perform these six screening tests. Through November, 1984, a total of 149,923 screens have been performed. Budget planning and request for FY 1986 and FY 1987 is based on an anticipated 15,000 births per year at $4.40 per screen. There were a total of 14,054 resident births in 1983 (Montana Vital Statistics, Bureau of Records and Statistics, 1983, page 17).

Of the anticipated 15,000 births and screens it is anticipated that there would be a 20% rescreen required because of reported marginal or low levels. The serious clinical consequences of misdiagnosis mandate repeating questionable levels. Thus a total of $79,200 (15,000 births X $4.40 + 3,000 X $4.40) is felt necessary to comply with the law and maintain a creditable program. This request is merely to pay for the actual costs of the tests as performed by the Oregon Public Health Laboratory. All additional expenses of program operation are borne by the Administrative budget per se - personnel, office supplies, postage, reporting to all hospitals and attending physicians, etc.

One additional important component of this program is now being developed. It is now recognized that former PKU female babies who have developed normally because of controlled diet are now in the reproductive age. The majority of these have not been maintained on a controlled diet. If they become pregnant without having returned to

their special diet and dietary substitutes, they stand a very good chance of having affected offspring. And so a concerted tracking effort is now starting to locate all former PKU patients in order to prevent as much as possible these untoward pregnancy outcomes. We are doing this not only independently in Montana but also by participating in a National Maternal PKU Collaborative Study.

I would be pleased to respond to any questions at this time or later at the pleasure of the chairman.

Exhibit 5
1-10-85

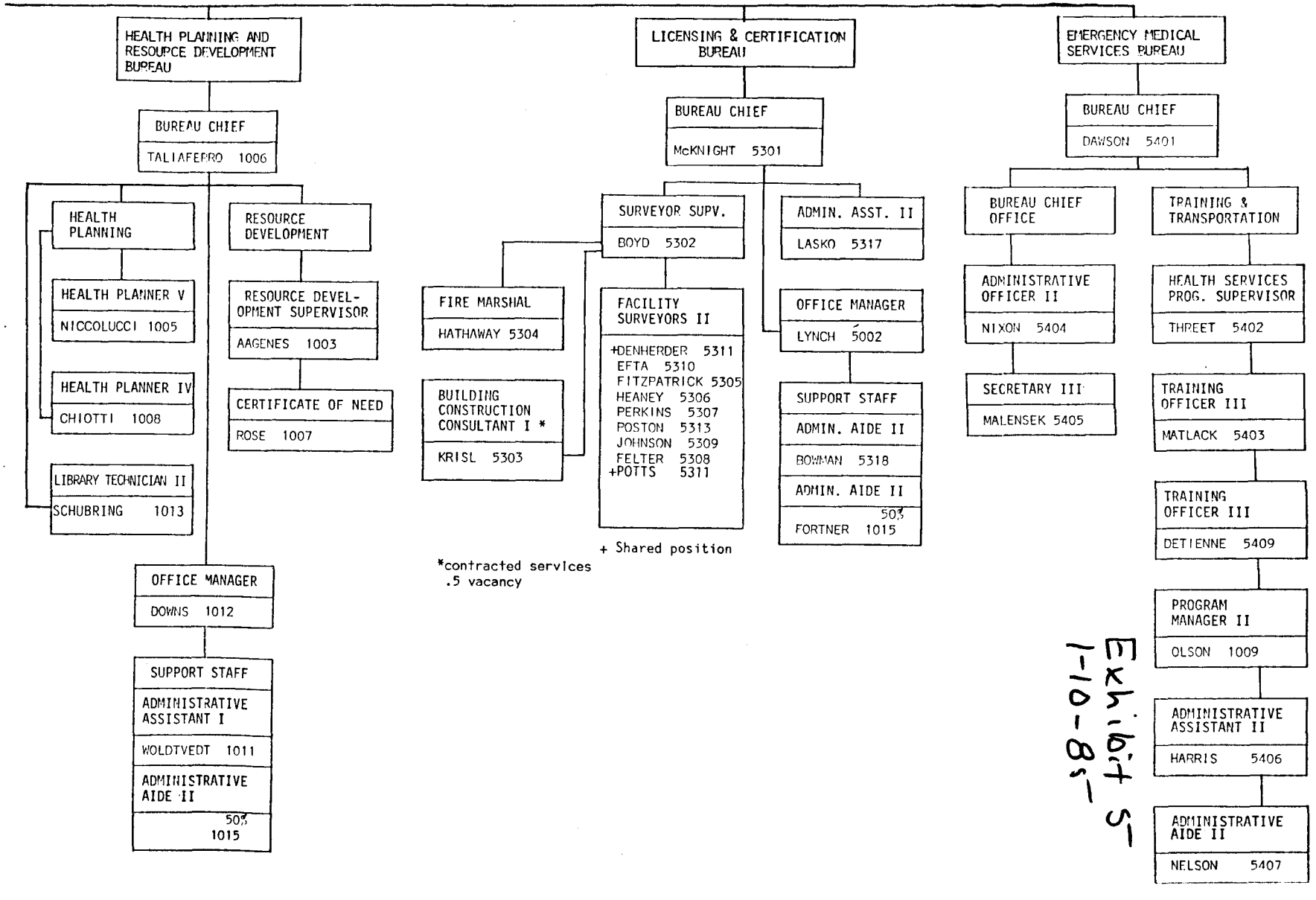
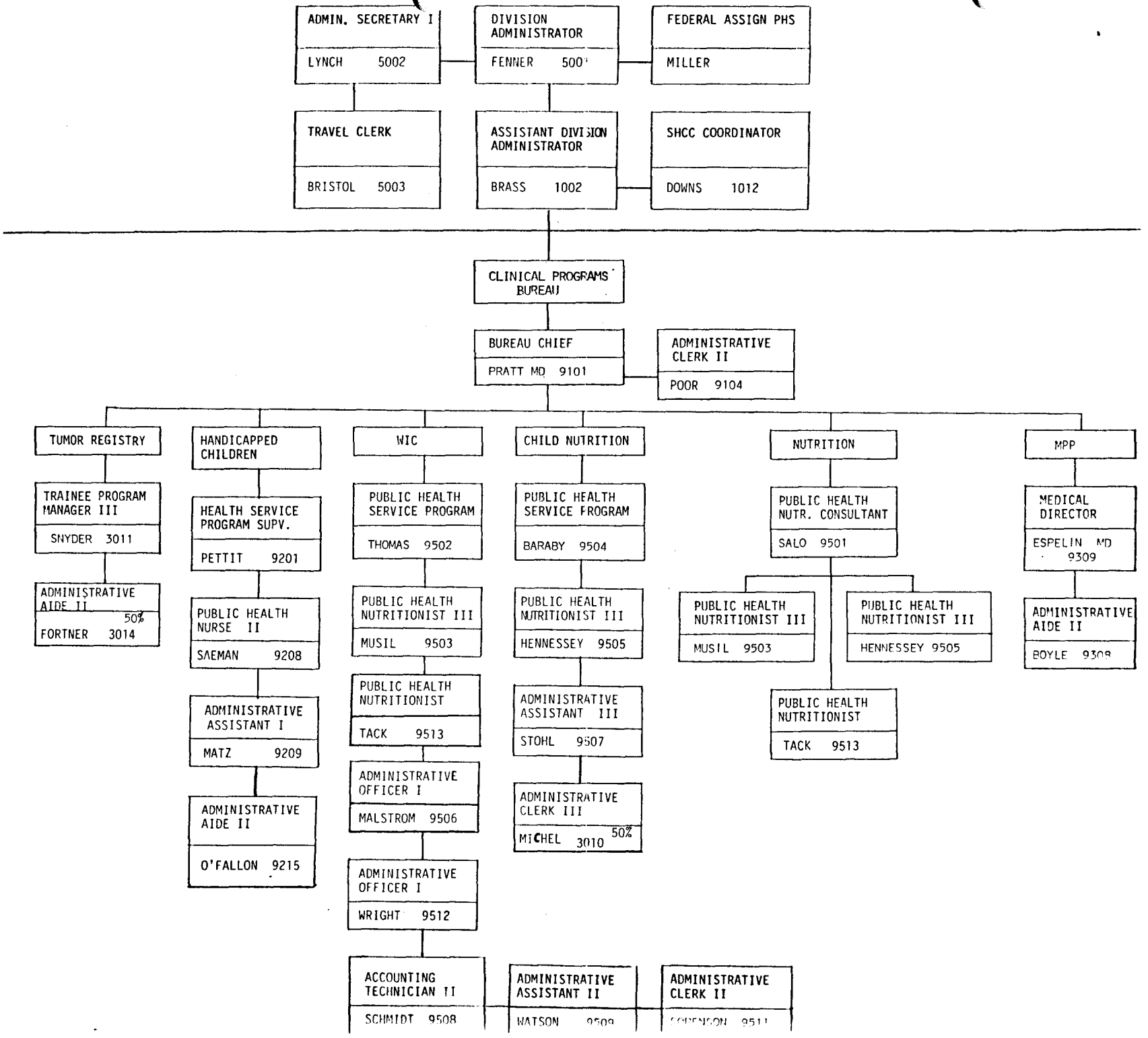


Exhibit 5
1-10-85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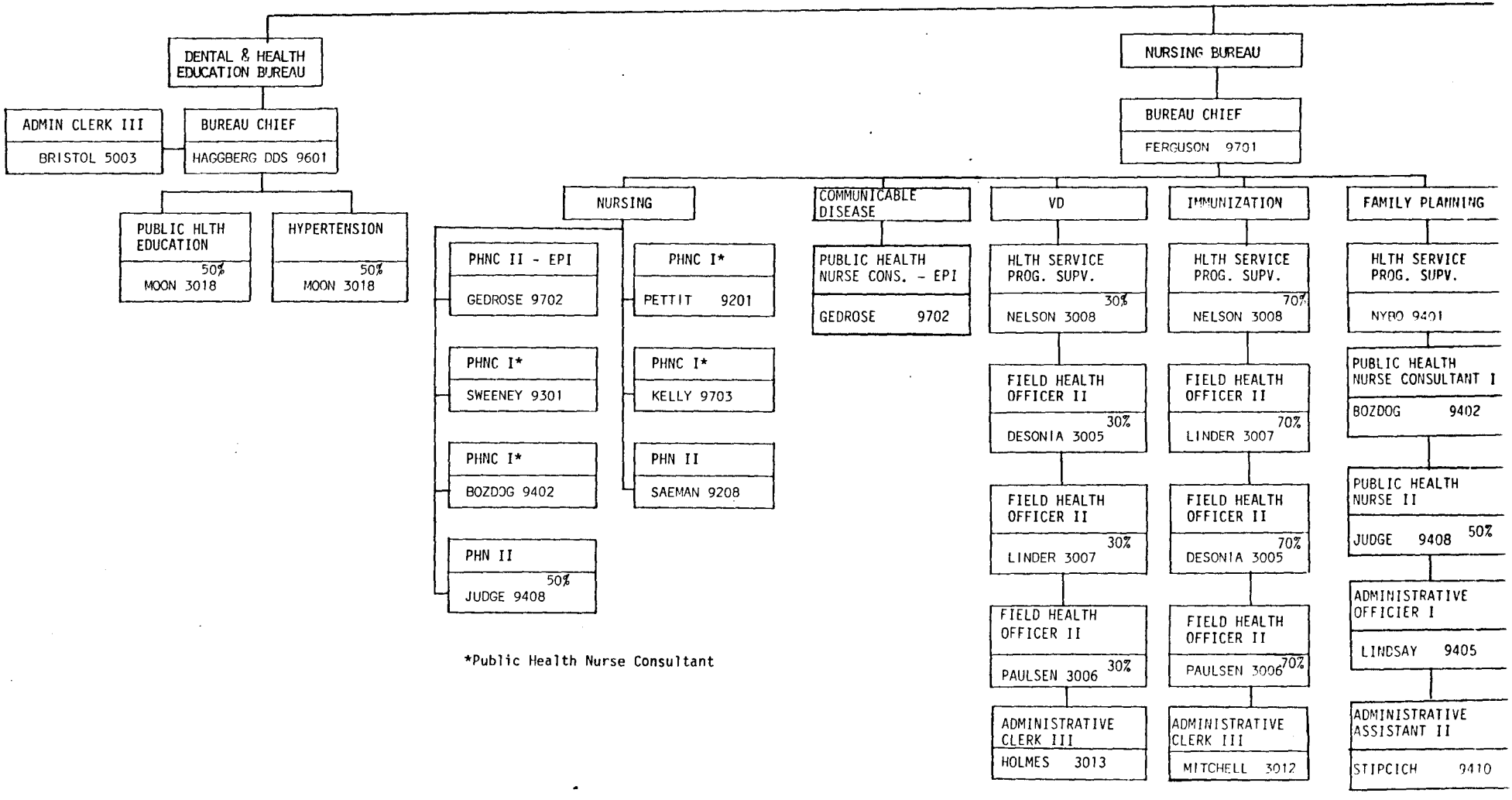
DIVISION ADMINISTRATOR
FENNER 5001
FEDERAL ASSIGN PHS
MILLER
TRAVEL CLERK
BRISTOL 5003
ASSISTANT DIVISION ADMINISTRATOR
BRASS 1002
SHCC COORDINATOR
DOWNS 1012
CLINICAL PROGRAMS BUREAU
BUREAU CHIEF
PRATT MD 9101
ADMINISTRATIVE CLERK II
POOR 9104
TUMOR REGISTRY
TRAINEE PROGRAM MANAGER III
SNYDER 3011
ADMINISTRATIVE AIDE II
FORTNER 3014 50%
HANDICAPPED CHILDREN
HEALTH SERVICE PROGRAM SUPV.
PETTIT 9201
PUBLIC HEALTH NURSE II
SAEMAN 9208
ADMINISTRATIVE ASSISTANT I
MATZ 9209
ADMINISTRATIVE AIDE II
O'FALLON 9215
WIC
PUBLIC HEALTH SERVICE PROGRAM
THOMAS 9502
PUBLIC HEALTH NUTRITIONIST III
MUSIL 9503
PUBLIC HEALTH NUTRITIONIST
TACK 9513
ADMINISTRATIVE OFFICER I
MALSTROM 9506
ADMINISTRATIVE OFFICER I
WRIGHT 9512
ACCOUNTING TECHNICIAN II
SCHMIDT 9508
ADMINISTRATIVE ASSISTANT II
WATSON 9509
ADMINISTRATIVE CLERK II
CHILD NUTRITION
PUBLIC HEALTH SERVICE PROGRAM
BARABY 9504
PUBLIC HEALTH NUTRITIONIST III
HENNESSEY 9505
ADMINISTRATIVE ASSISTANT III
STOHL 9507
ADMINISTRATIVE CLERK III
MICHEL 3010 50%
NUTRITION
PUBLIC HEALTH NUTR. CONSULTANT
SALO 9501
PUBLIC HEALTH NUTRITIONIST III
MUSIL 9503
PUBLIC HEALTH NUTRITIONIST III
HENNESSEY 9505
PUBLIC HEALTH NUTRITIONIST
TACK 9513
MPP
MEDICAL DIRECTOR
ESPELIN MD 9309
ADMINISTRATIVE AIDE II
BOYLE 9308



*Public Health Nurse Consultant

Exhibit 6
1-10-85

MONTANA PERINATAL PROGRAM - TESTIMONY

January, 1985

Chairman Winslow, Senators and Representatives of the Committee, I am Don Espelin, Medical Director of the Montana Perinatal Program (MPP) for the DHES.

When I came on board in June, 1983, Dr. Drynan charged me to run the Improved Pregnancy Outcome Project (IPO) through its fifth year and to improve the outcome of pregnancies in the State of Montana. In reviewing the existing IPO, it became apparent that many of its goals, such as the organization of regional medical care, transport system and educational efforts had been met. The IPO concept then was rapidly becoming outmoded and restrictive. The development of the Montana Perinatal Program changed significantly the programs' role in health care in Montana. In an effort to move beyond the crisis care of the very expensive medical problems the MPP has become involved in the following activities:

1. Virginia Outreach Project (VOP)
2. South Carolina Outreach Project
3. Preterm labor prevention
4. Fetal Alcohol Syndrome (FAS) prevention
5. Preconceptual planning and counseling
6. Healthy Mothers, Healthy Babies (HmHb) coalition
7. High Risk Registry

The MPP is a statewide professional and public education program designed to address the need in the state to provide quality perinatal care. This is accomplished by close coordination with private health care providers and private organizations, such as, March of Dimes (MOD) and Healthy Mothers, Healthy Babies. Staff expertise is used in a consultative role with these organizations. Projects are directed toward the following goals:

- Prevent birth defects and mental retardation.
- Reduce the impact of birth defects and mental retardation by appropriate early intervention.
- Prevent premature births.
- Assess needs of the State in perinatal health.

Inter-agency cooperation is fostered and promoted through my efforts as a member of the Developmental Disabilities Planning Advisory Council (DDPAC) and the Inter-Agency Planning Forum (IAPF).

The Virginia Outreach Project (VOP) is a self-taught educational experience mainly for Level I hospitals, designed to raise the level of care in the nurseries. This is sponsored by the MPP and directed and monitored by the MPP and Level II nurseries. To date, 750 health care providers have been impacted with another 250 on tap.

The South Carolina Project is much the same as VOP, however, its area of impact will be in OB care. This will be coupled with the MOD Preterm Labor Prevention Module. This has been started in Missoula Community Hospital. The preterm labor prevention pilot project for Missoula county is in the late planning stage. The goal here is to reduce the prematurity rate by 50 percent.

Fetal Alcohol Syndrome prevention is obvious. FAS accounts for one-tenth of our mental retardation and cleft palates. FAS also contributes to congenital heart disease and is the most common birth defect. FAS IS 100% PREVENTABLE.

Preconceptual planning, etc., is included in preterm labor prevention. We are now getting to second generation PKUs and prematures. A host of other medical problems such as diabetes enters into this concept.

High risk registry is important for Health Planning, DDPAC and SRS, and DHES, etc., to allow us to plan intelligently for future care.

Healthy Mothers, Healthy Babies is a 60 member national, private coalition to promote the same goals as MPP. We have been instrumental in starting a Montana coalition to aid us with the interface that is necessary to maximize our efforts in dealing with the private sector.

As a state we can be proud of our achievements made in the arena of improved medical care of the newly born infants and their mothers. Our New Born Mortality Rate of 5.9 in 1981 was the sixth best in the nation. The Infant Mortality Rate is also improving. The rate of 9.0/1000 live births for 1983 exceeds federal objectives for 1990. Sadly, the rate of prematurity (rate of 5.6/100) has not changed over the past decade. Prematurity is the leading contributor to New Born Mortality Rate. There are 200,000 women of reproductive age in Montana, 10,000 of which are adolescents under 18 years of age. There were 14,054 live births in 1983. Seven hundred eighty-eight (788) of these were prematures under 2500 grams (5lbs. 8oz.). Of these 200,000 women, one-third of them smoked and worse, one-third of them drank alcoholic beverages. One hundred twenty-six (126) infants died before their first birthday. We are faced then with an obvious challenge.

My goal of reducing prematurity by 50 percent means a savings in health care dollars of 10 million short term and 40 million long term. I do not consider this goal overly ambitious.

I wish to discuss one other problem connected with this issue of prenatal care. It is long term and it is vital to our well being. Level III centers in our neighboring states are starting to refuse our no-pay and/or poor pay patients. This means that these patients must stay in Montana for high level care. This is all right as long as the patients are in our Level II centers such as Missoula, Great Falls, Billings or Butte, as these centers can deliver Level III medical care. However, sooner or later the Level II hospitals will no longer be able to absorb the debts of these

no-pay patients and they will refuse to take them from the Level I hospitals. When this happens, the newborn mortality rate will skyrocket.

If you share my concern over these infants who cannot speak for themselves, then it is readily apparent why prevention of premature babies is such an important issue.

If it pleases you, please address budget questions to Mr. Ray Hoffman.

I thank you for your indulgence and will try to answer any programmatic questions.

MONTANA PERINATAL PROGRAM

January, 1985

DEFINITIONS

ABORTION - A legal act or operation intended to terminate a pregnancy without live birth, which is reported to the Department.

FETAL DEATH - the birth of a fetus after 20 weeks of gestation which shows no evidence of life after complete birth (this is, no action of the heart, breathing, or movement of voluntary muscles).

INFANT DEATH - the death of a person under one year of age.

LIVE BIRTH - birth of a child who shows evidence of life after complete birth. Evidence of life includes heart action, breathing, or movement of voluntary muscles.

NEONATAL DEATH - the death of an infant under 28 days of age.

PERINATAL DEATHS - are those occurring around the time of birth. They are made up of the sum of registered fetal deaths and neonatal deaths.

PERINATAL MORTALITY RATE - relates the number of fetal deaths plus neonatal deaths to the number of deliveries (fetal deaths plus live births). It is calculated as follows:

$$\text{Perinatal mortality rate} = \frac{\text{Annual number of fetal deaths plus neonatal deaths}}{\text{Annual number of fetal deaths plus live births}} \times 1{,}000$$

PREMATURE (IMMATURE) INFANT - a live-born infant with a birth weight of five pounds eight ounces (2,500 grams) or less.

RESIDENCE - for deaths, this refers to the usual residence of the decedent. For births and fetal deaths, it refers to the usual residence of the mother.

Source: Records and Statistics, SDHES, 1983

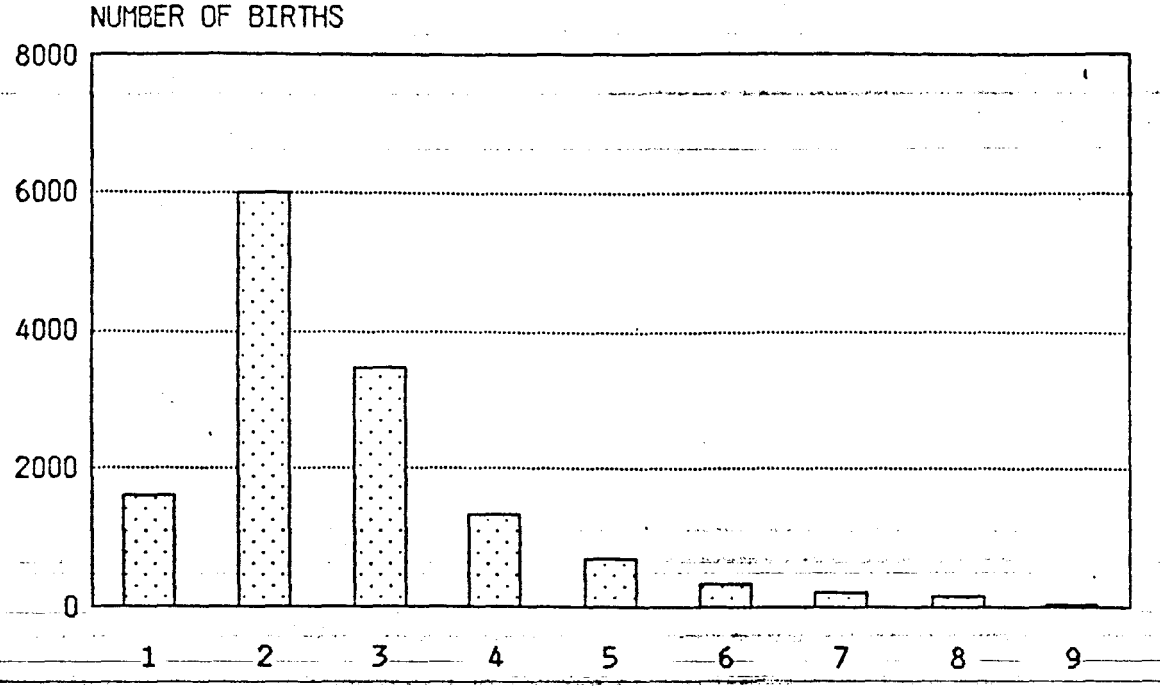
MONTANA PERINATAL PROGRAM

TRANSPORTS

FFY 83

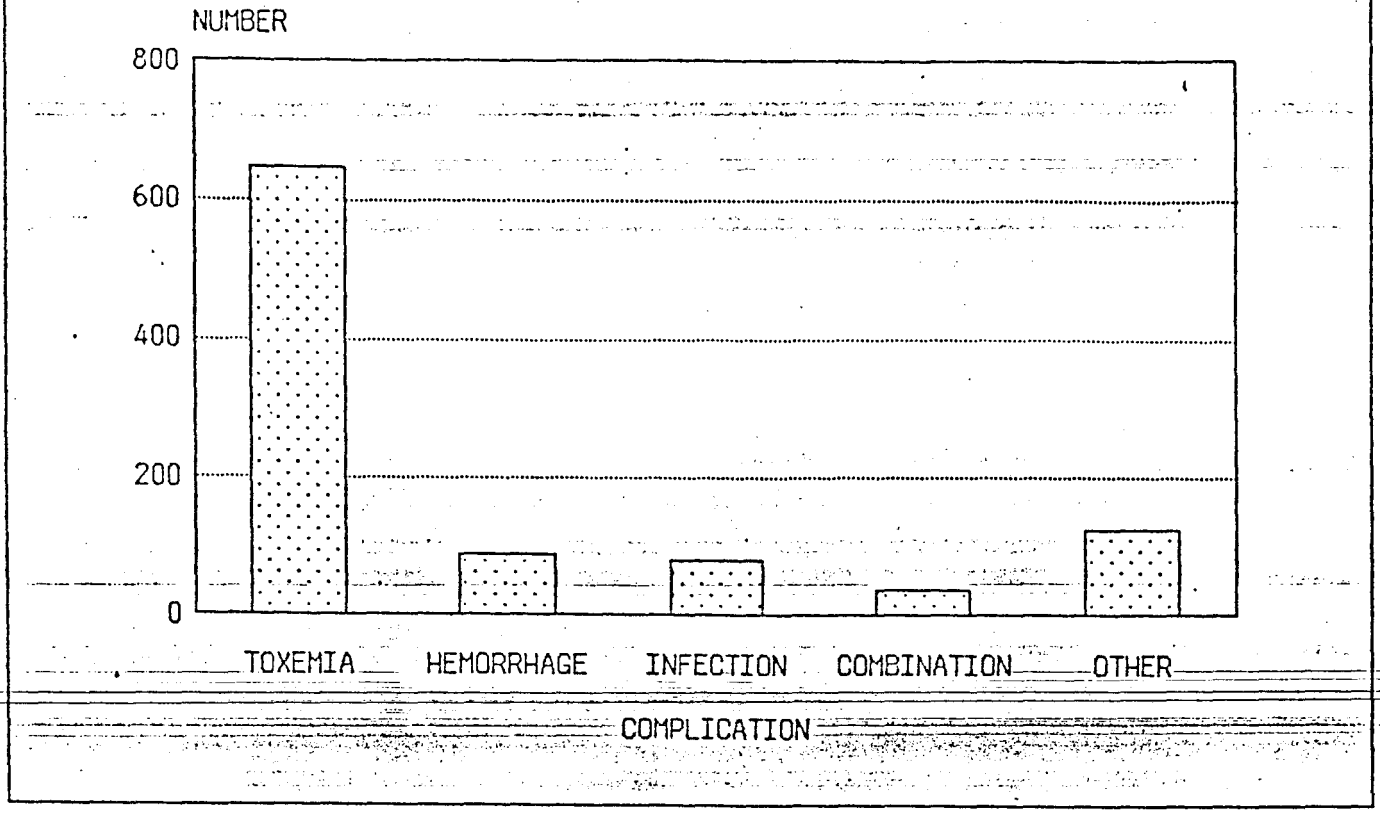
	# Patients	# Transports	Level of Care			
			I-I	I-II	I-III	II-III
Maternal	149	153	2	134	8	9
Newborn	233	249	0	131	18	72

MONTH PRENATAL CARE BEGAN:
MONTANA, 1983



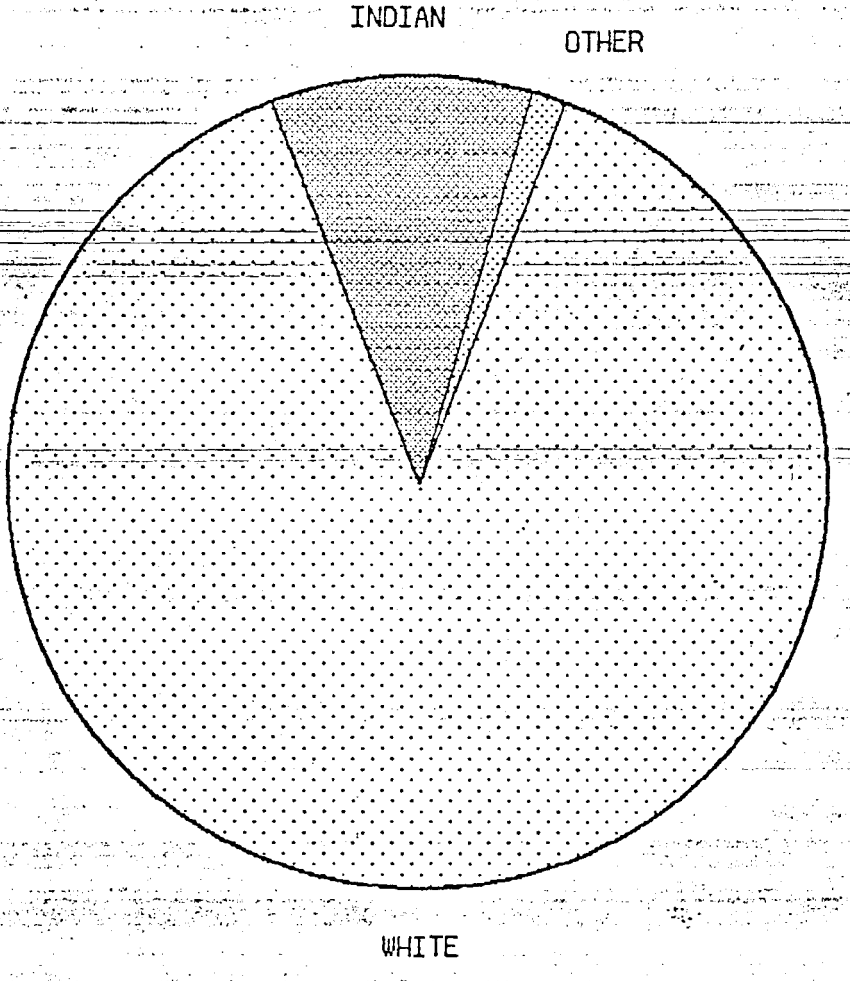
NO CARE = 83; NOT STATED = 59

COMPLICATIONS OF PREGNANCY:
MONTANA RESIDENTS, 1983

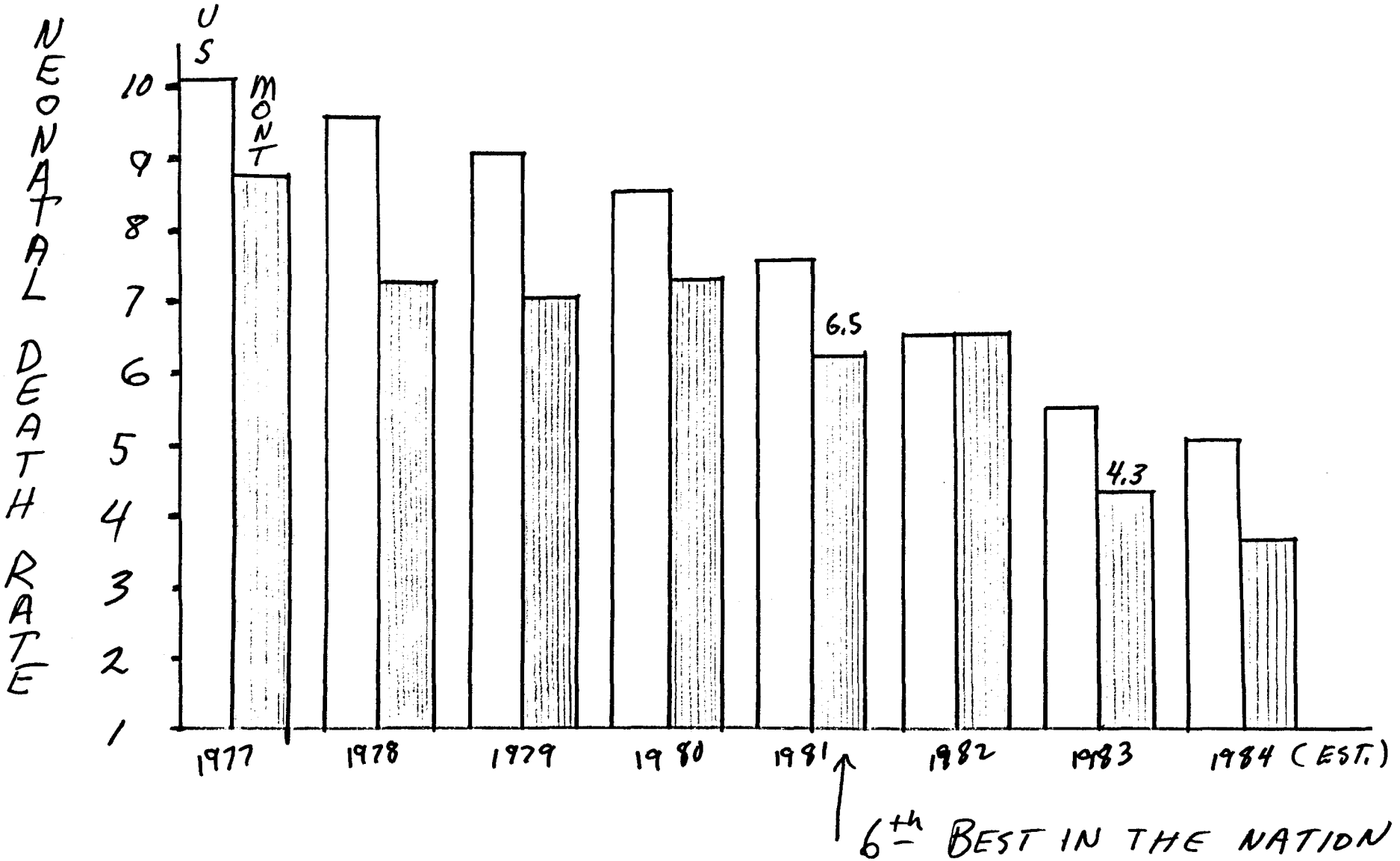


RESIDENT LIVE BIRTHS BY RACE:

MONTANA, 1983



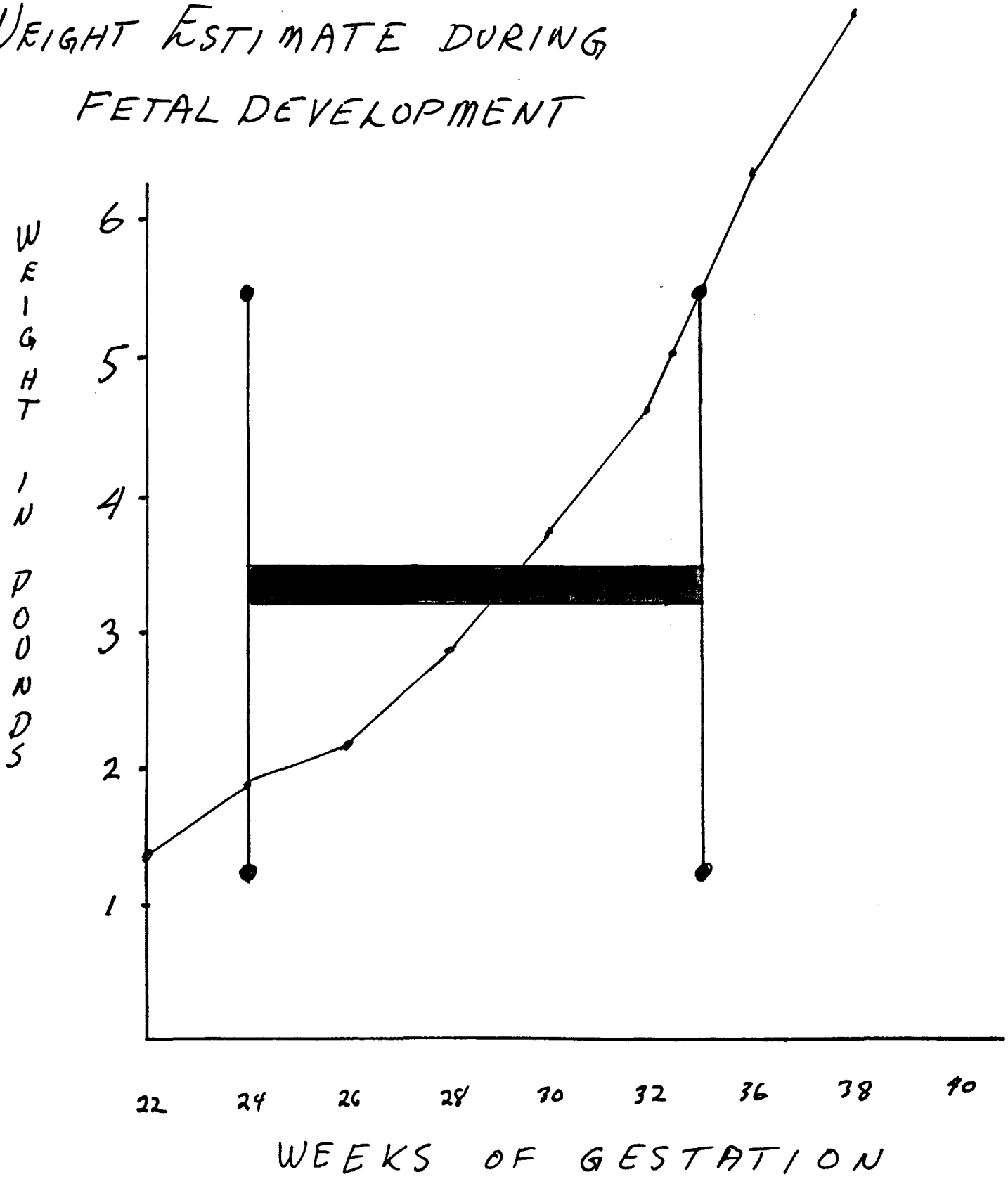
NEONATAL DEATH RATES
1977 - 1984



DEATH RATE IS PER 1000 BIRTHS

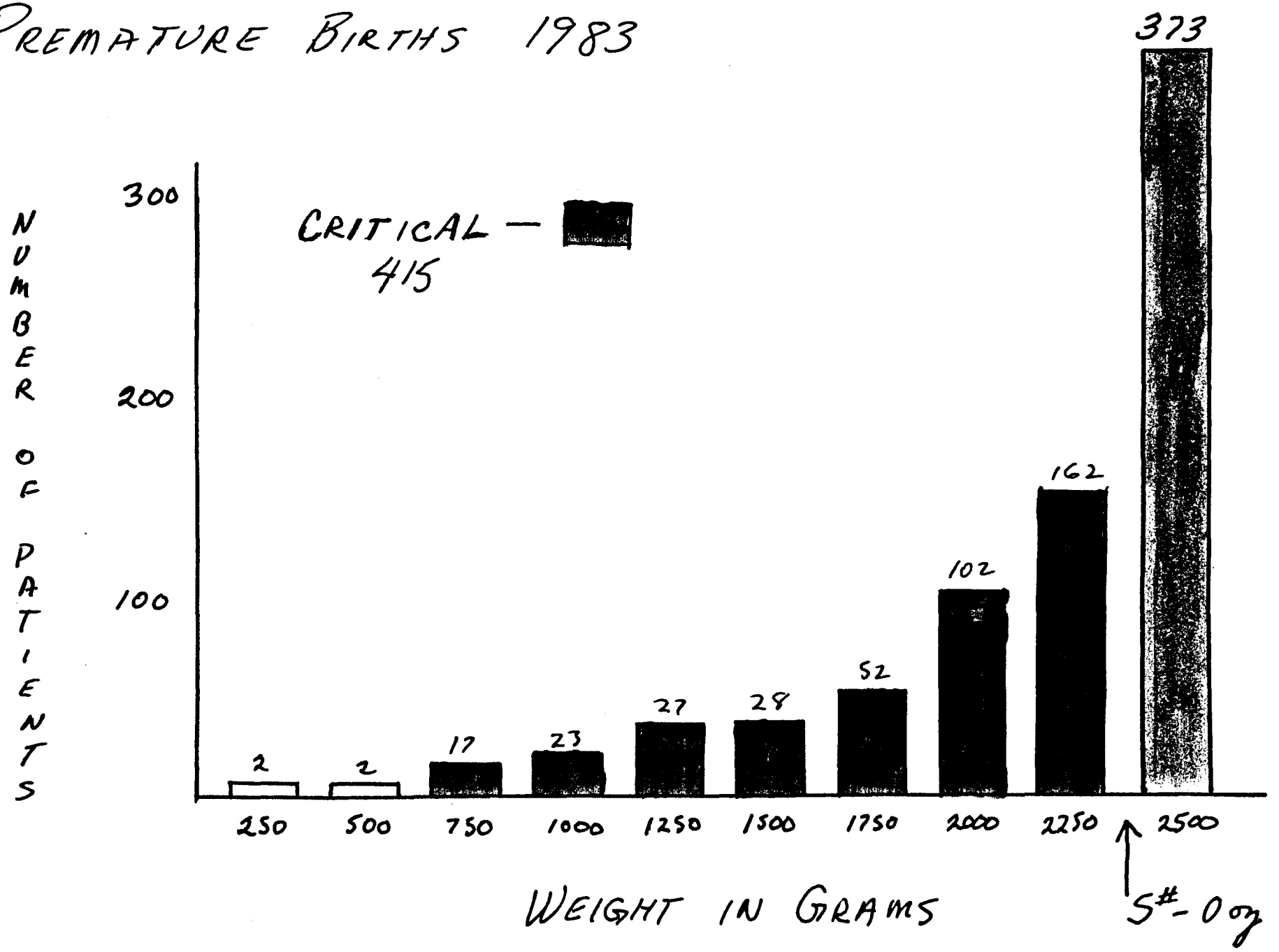
SOURCE: RECORDS & STATISTICS DHES 1984

WEIGHT ESTIMATE DURING FETAL DEVELOPMENT



SOURCE: MOORE- THE DEVELOPING HUMAN 2nd Ed, SANDERS, 1977

PREMATURE BIRTHS 1983



SOURCE: 1983 BUREAU OF RECORDS & STATISTICS

FETAL ALCOHOL SYNDROME

January, 1985

BIRTHS

— 14,000 live births in Montana
  90 percent White (12,600)
  10 percent Native American (1,400)

CAUSE AND EFFECT

— Significantly decreased birth weight has been observed among children born to women who averaged only one ounce of alcohol per day during pregnancy.

-- Significant increases in spontaneous abortions have been observed following alcohol consumption of as little as one ounce of absolute alcohol twice a week.

— Women who drink heavily are more likely to bear a child with one or more of the birth defects associated with Fetal Alcohol Syndrome.

MONTANA PREVALENCE

-- 1-2/1,000 in White population	12-25 annually
— 100-150/1,000 in Native American population	100-150 annually

COST

— Foster home placement	$14,000 annually
— Boulder placement	$60,000 annually

GOOD NEWS

100 PERCENT PREVENTABLE!!

Healthy Mothers, Healthy Babies

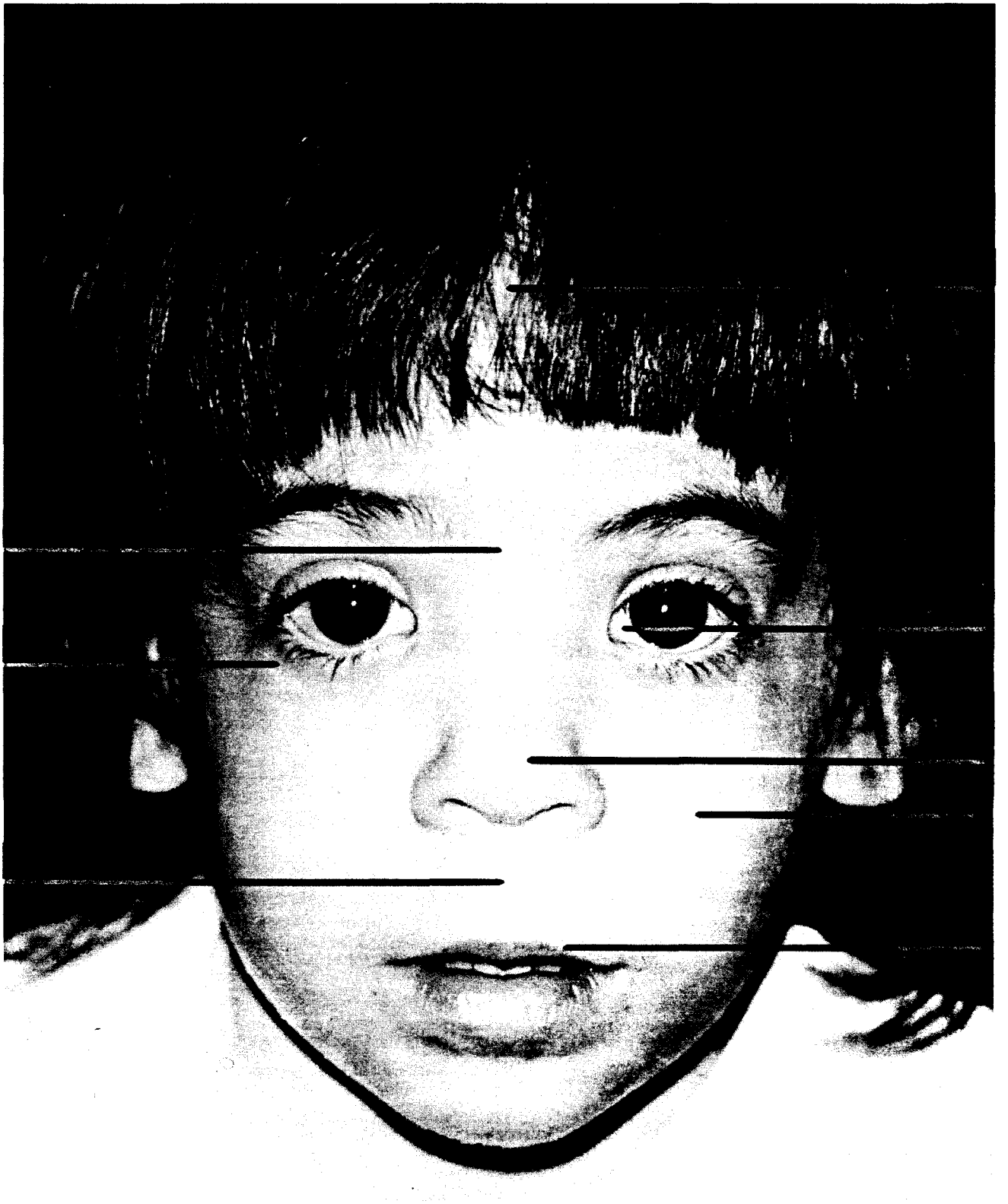
A COALITION FOR PUBLIC EDUCATION TO IMPROVE MATERNAL/INFANT HEALTH

March of Dimes
BIRTH DEFECTS FOUNDATION
1275 Mamaroneck Avenue
White Plains, New York 10605

Nutrition Today®

The World's Most Widely Read Nutrition Journal

Volume 15, Number 5 September/October, 1980



ALCOHOL AND PREGNANCY


Four Years Ago, It Was Touch And Go


Special Babies
Special Care

MONTANA PERINATAL PROGRAM

January 9, 1985

PREMATURITY - Number One Birth Defect (MOD)

Prematures in Montana: 1982: 818

1983: 788

15 years ago 10 percent of 3# 8oz. babies survived, now 90 percent do.

Disabilities:

1500 gms. (3# 5oz.)	10 percent severe 10-15 percent mild to moderate
1000 gms. (2# 3½oz.)	25 percent probably are severe

Survivability (1979):

1# 2oz. to 1# 10oz.	93 percent die
2# 4oz.	64 percent die
2# 12oz.	29 percent die
3# 8oz.	10 percent die
5# 8oz.	most survive

FACT SHEET

UNIVERSITY OF VIRGINIA PERINATAL OUTREACH PROGRAM FOR MONTANA, 1984

Sponsored and Coordinated by the Montana Perinatal Program
State Department of Health and Environmental Sciences
Cogswell Building
Helena, Montana 59620

The University of Virginia Perinatal Outreach Program is a community-based program designed for delivery by a regional perinatal center's outreach team to the community hospitals within their referral area. It is based on the use of self-instructional materials. Participants work through the material at their own pace. The Program allows local personnel to conduct essentially all program activities within the community hospital. The regional center would need to visit only 3 or 4 times during the 10 month duration of the Program. The Program is a multidisciplinary approach allowing physicians, nurses and support personnel to gain information and skills vital to their job responsibilities.

PROGRAM CONTENT:

Fetal Evaluation
- Unit 1. Overview
- Unit 2. Identifying High Risk Pregnancies
- Unit 3. Evaluating Fetal Maturity and Well-Being
- Unit 4. Monitoring the Fetus During Labor and Delivery
  - Skill: Fetal Monitoring

Immediate Newborn Assessment
- Unit 5. Is the Baby Sick?
- Unit 6. Resuscitating the Newborn Infant
  - Skills: Apgar Scoring
    Bag and Mask Ventilation
    Endotracheal Intubation
    Cardiac Massage
    Medication Administration
- Unit 7. Sizing and Determining Gestational Age in Newborn Infants
  - Skill: Dubowitz Assessment

Newborn Care: Concepts and Procedures
- Unit 8. Controlling Temperatures of Sick and At Risk Infants
  - Skills: Operating Radiant Warmers
    Operating Incubators
    Setting Neutral Thermal Environment
- Unit 9. Giving Oxygen to Sick and At Risk Infants
  - Skills: Measurement of Oxygen Concentration
    Heating and Humidifying an Oxygen/Air Mixture
    Mixing Oxygen and Compressed Air
- Unit 10. Identifying and Caring for Infants with Respiratory Distress and Apnea
  - Skill: Continuous Positive Airway Pressure
- Unit 11. Inserting and Using Umbilical Catheters with Sick and At Risk Infants
  - Skill: Inserting Umbilical Catheters
- Unit 12. Identifying and Caring for Infants with Low Blood Pressure
  - Skill: Flush Blood Pressure Measurement

Unit 13. Identifying and Caring for Infants with Hypoglycemia
Skill: Dextrostix Test
Unit 14. Giving IV Therapy to Sick and At Risk Infants
Skill: Starting Peripheral IVs
Unit 15. Feeding Sick and At Risk Infants
Skill: Nasogastric Tube Feedings
Unit 16. Identifying and Caring for Infants with Hyperbilirubinemia
Skill: Exchange Transfusion
Unit 17. Identifying and Caring for Infants with Infections

Complex Newborn Care
Unit 18. Review: Is the Baby Sick? Identifying and Caring for Sick and At Risk Infants
Unit 19. Preparation of the Baby for Transport

CONTINUING EDUCATION CREDITS:

Continuing education credit is available for all programs through the following groups:

Obstetricians: American College of Obstetricians and Gynecologists
Maximum Credit: 25 cognates
Pediatricians: American Medical Association
Maximum Credit: 50 category 1 credits
Family Physicians: American Academy of Family Physicians
Maximum Credit: 50 hours prescribed credit
Registered Nurses: Montana Nurses Association (nationwide recognition by the American Nurses Association)
Maximum Credit: 50 contact hours
Licensed Practical Nurses: National Association for Practical Nurse Education and Service, Inc.
Maximum Credit: 50 contact hours

DEVELOPMENTAL STEPS OF THE EDUCATIONAL PROGRAM:

1.	Initial contact is made by MPP and/or Regional Center	Week 1
2.	Community hospital is visited by Regional Center	Week 4
3.	Community hospital self-inventory is distributed by MPP	Week 12
4.	Community hospital nurse coordinators attend workshop in Regional Center	Week 20
5.	Self-inventories are tallied and summarized by MPP; needs list developed	Week 24
6.	"Kick-off" meeting, inventory feedback, self-instructional program begins	Week 25
7.	Self-instructional books and skills practice proceeds	Week 26 to Week 40
8.	Skills workshop: Cats and cords	Week 33
9.	Final meeting, continuing education credit certificates are awarded	Week 40

Management of high risk and sick infants is monitored for 24 to 36 months via transport feedback by the Regional Center. The basic Virginia Perinatal Program is then repeated as a means of updating staff and training new staff that has been added to the Community Hospital in the interim.

BOOK ORDERING PROCEDURE

The three volume set of self-instructional books may be ordered through the Community Hospital's nurse coordinators. The cost is $45.00 for physicians and $25.00 for nurses.

1-10-85
Exhibit 7

Testimony before the Joint Appropriations Subcommittee on Human Services
January 10, 1985

Chairman Winslow, Senators and Representatives of this Committee, I am Sharon Pettit, Program Supervisor of the Handicapped Children's Services Program of the Clinical Programs Bureau.

Handicapped Children's Services (HCS) is a program concerned with the early detection, intervention, treatment and rehabilitation of children up to age eighteen who have a chronically handicapping condition. The program is funded as part of the Maternal and Child Health Block Grant.

The provision of diagnostic and evaluation services is arranged through interdisciplinary regional centers and teams composed of private health care providers. Treatment services, such as surgery and related hospitalizations, special medications and formulas, braces and other therapies and emergency ambulance transports are purchased as needed from private health care providers.

The diagnostic, evaluation and treatment services are provided for a specific and limited number of diagnostic categories which have good potential for rehabilitation, thus increasing the individual's potential for a productive life.

Financial assistance to cover the costs of care is provided to low income families who are not covered by Medicaid or private insurance. Eligibility criteria for HCS assistance include gross family income compared to 185% of poverty as set by CSA 1984 guidelines, family size, medical condition and the age of the child. All other possible payment resources are explored and utilized before HCS undertakes payment.

But bill payment is only a part of what Handicapped Children's Services does. HCS acts as a family advocate. HCS helps families make arrangements for out-of-state care. HCS helps families find living accommodations when they have to be away from home for long periods of time. HCS helps families coordinate their needs with other community resources. HCS works with families who are having

difficulty with complicated insurance procedures.

HCS organizes and administers a number of special diagnostic and evaluation clinics throughout the State which utilize teams of specialists. HCS generates and monitors the contracts with the team members, organizes and often helps conduct the clinics and is responsible for the post-clinic reporting.

Handicapped Children's Services is also concerned with the long term follow-up of children referred for our services. With that in mind, HCS coordinates referrals with county public health nurses and other resources available in the local community. HCS provides information and educational materials to the public health nurses in an effort to improve and enhance their skills in working with children with handicaps and their families. HCS staff plans to develop a manual of follow-up guidelines for use by the nurses.

The staff members of HCS carry out the daily management of program activities. Medical questions and concerns are referred to the physicians in the Clinical Programs Bureau and, when necessary, to the panel of physicians who serve as the Advisory Committee for HCS.

Mr. Chairman, at your request, I shall be happy to answer any questions you or the committee might have. Dr. Pratt is available also to answer questions having to do with medical issues.

Thank you for your kind attention.

HANDICAPPED CHILDREN'S SERVICES

STATISTICAL REPORT

SFY 84

TYPE OF SERVICE	NUMBER OF CHILDREN		YTD EXPENDITURES
General Medical Payments	94		$ 143,431.77
Cardiac Care	40		115,705.74
Cleft lip/palate	37		72,018.32
Orthopedic Care	68		54,540.17
Out-patient Care	66		9,962.53
Emergency transports (HCS only)	66		38,277.25
	371		433,935.78
		Accrued	20,034.95
		Total YTD	453,970.73

DENIALS OF SERVICE	
Paid by Medicaid or Insurance	67
Paid by SSI	102
Condition not covered by HCS	272
Overincome	35
Over age	3
	479

FIELD CLINICS	
Cleft lip/palate	117
Cardiac	618
Scoliosis	26
Other	242
	1003

1-10-85
Exhibit 8

AGENCY	Program	Level
DHES	Dental	Modified

MOUTHRINSE PROGRAM

	FY 86	
Supplies / Materials	$30,000	

Funding

Maternal & Child Block GRANT. Purchase of supplies and material for a two year period to continue the mouthrinse program. Bulk purchase.

AGENCY	Program	Level
DHES	Nursing	Modified

ENHANCEMENT OF Nursing Staff

	FY86	FY87
Personal Services	#66,717	#66,744
Contracted Services	15,400	15,400
Supplies/Materials	600	600
Communications	1,756	1,420
Travel	6,000	6,000
Rent	1,500	1,500
Equipment	1,600	-0-
Total	$93,573	$91,664

Funding

Preventive Health Block Grant. Hire two additional Nursing and one clerical position for nursing bureau.

AGENCY	Program	Level
DHES	Family Planning	Modified

ENHANCEMENT OF FAMILY PLANNING PROGRAM

	FY 86	FY 87
Personal Services	$11,649	$11,653

Funding

Preventive Health Block Grant. Continuation of .50 Health Nurse Consultant position for Family Planning Program. Position budget amended in FY 1984.

AGENCY	Program	Level
DHES	Montana Perinatal Program	Modified

	FY86	FY87
F.T.E	3.0	4.0
Personal Services	$90,073	$105,666
Contracted Services	92,100	80,475
Supplies/Materials	11,900	23,900
Communications	3,056	3,303
Travel	4,500	4,500
Rent	2,500	2,500
Repair/Maintenance	70	70
Other	400	400
Total	$204,599	$220,819

Funding

Maternal Child BLOCK GRANT.

AGENCY	PROGRAM	Level
DHES	HCS	Modified

CLEFT PALATE SERVICES

	FY 96	FY 97
Contracted Services	$52,500	$52,500

Funding

Maternal Child Block Grant. For children requiring medical services beyond initial closure of Cleft Lip and Palate.

AGENCY	Program	Level
DHES	Child Nutrition	Modified

ENHANCEMENT of CHILD Nutrition Program

	FY86	FY87
Personal Services	$13,805	$13,811
Grants	200,000	200,000
Total	$213,805	$213,811

Funding

10070 Federal Funds from USDA. Increased Program Manager from half time F.T.E. to full-Time. Provide funding for mandated program Expansion. Budget amendment FY 1984.

AGENCY	Program	Level
DHES	W.I.C.	Modified

ENHANCEMENT OF W.I.C. Program

	FY86	FY87
Personal Services	$ 50,299	$ 50,319
Contracted Services	18,000	18,000
Supplies/Materials	746,000	746,000
Communications	1,000	1,000
Travel	2,400	2,400
Rent	500	500
other	200	200
Total	$818,399	$818,419

Funding

100% Federal Funds from USDA. TO MEET program deficiencies, USDA Recommended and provided additional funding for two positions (Nutritionist, Administrative Officer) and associated operating budget. USDA also provided funding for increased food package costs and additional W.I.C. clients.

Exhibit 9
1-10-85

MONTANA CENTRAL TUMOR REGISTRY
TESTIMONY -- JANUARY, 1985

Chairman Winslow, Members of the Committee, I am Carol Snyder, the program supervisor for the Montana Central Tumor Registry, which is a legislatively mandated program.

Prior to the legislative session of 1979, there had been two previous attempts to establish a central tumor registry, both of which lasted about 18 months and were discontinued due to lack of ongoing funding. As a result, Montana had no valid statistics on the occurrence of cancer in the state or on the survival rates of its victims. In 1979, legislative action approved the development of the Montana Central Tumor Registry to provide uniform reporting of cancer information. Since that time the Registry has collected, abstracted, coded and analyzed cancer information for approximately 8,000 cases in Montana. There are about 300 new cases abstracted and submitted per month from all the hospitals in the state.

The primary goals of the Montana Central Tumor Registry are to:

1. Facilitate the systematic follow-up of cancer patients at regular intervals in order to help save lives by early detection and treatment of local recurrence, recurrence in regional lymph nodes, solitary distant metastases, and additional primary lesions.
2. Provide meaningful feedback to the medical profession regarding cancer in their practice, hospital, state and region.
3. Define areas of further research and planning.
4. Determine statistical facts about early diagnosis, treatment and survival in various malignant diseases in order to help evaluate and formulate educational efforts and improve patient care.

MONTANA CENTRAL TUMOR REGISTRY
TESTIMONY -- JANUARY, 1985

The Montana Central Tumor Registry is a member of the Rocky Mountain Cancer Data Systems (RMCDS) based in Salt Lake City. Membership in RMCDS has allowed Montana to utilize the central data processing capabilities of this system. As a result, the Central Registry distributes monthly and annual reports to all participating hospitals which reflect their cancer patients' experience. In addition, re-examination reports are generated and sent to private physicians, assuring prompt and regular follow-up of all cancer patients in order to detect and treat recurrences, which are so common with this disease. Participation in this regional data system also provides Montana with a link to a nationwide cancer surveillance program, providing vital information for research into the cause, treatment and prevention of cancer.

Currently, registry information is processed by batch system, which means a wait of three to four weeks for processing in order to obtain complete, up-to-date registry information. This year, the Central Registry is requesting purchase of a computer to improve program operation. With this computer, the Registry will be able to provide day-to-day entry, resulting in a more efficient operation. RMCDS will supply the software and technical assistance as well as comparative national and regional statistics.

There is no other statewide program in Montana which coordinates the uniform reporting, data collection and analysis of information on cancer. Given the magnitude of the impact of the disease in Montana, the efforts are invaluable.

MONTANA SUMMARY & SURVIVAL CURVES (STATE) OCT 18, 1984 TABLE 3-A

HOSPITAL ALL
NUMBER OF ADMISSIONS TO THE REGISTRY BY SITE BOTH SEXES (ALL CASES & (+) FLAGGED SITES)

SITE	# OF CASES	300	600	900	1200
162- LUNG	1117	.**********			
174- BREAST FEMALE	955	.*********			
185- PROSTATE	930	.*********			
153- COLON	679	.******			
188- BLADDER	414	.****			
154- RECTUM	302	.***			
182- CORPUS UTERI	300	.***			
*180- CERVIX INSITU	287	.***			
199- UNKNOWN PRIMARY	259	.***			
157- PANCREAS	224	.**			
191*2- BRAIN & CNS	190	.**			
200- LYMPH. NON-HODGKIN	165	.**			
183- OVARY-TUBE-LIGAMEN	152	.**			
189- KIDNEY	140	.*			
151- STOMACH	139	.*			
161- LARYNX	116	.*			
180- CERVIX UTERI	114	.*			
172- MELANOMA SKIN	104	.*			
193- THYROID	90	.*			
169- ACUTE LEUKEMIA	79	.*			
203- MULTIPLE MYELOMA	69	.*			
150- ESOPHAGUS	63	.*			
201- HODGKINS	63	.*			
186- TESTIS	60	.*			
140- TO 148- MOUTH	56	.*			
205- CHRONIC LEUKEMIA	54	.*			
146- TO 9- PHARYNX	51	.*			
184- FEMALE GENITAL	50	.*			
156- GALLBLADDER	42	.*			
141- TONGUE	41	.*			
209- OTHER HEMATOPOIETI	40	.*			
173- SKIN REPORTABLE	40	.*			
*BENIGN (EXCEPT BRAIN)	40	.*			
171- CONNECTIVE TISSUE	39	.*			
152- SMALL INTESTINE	37	.*			
189- OTHER URINARY	34	.*			
155- LIVER	32	.*			
170- BONE	23	.*			
ILL DEF. SITES	22	.*			
190- EYE	20	.*			
140- LIP	19	.*			
142- SALIVARY GLAND	18	.*			
160- NASAL CAVITY-SINUS	16	.*			
187- MALE GENITAL	14	.*			
154- ANUS	13	.*			
164- MEDIASTINUM	13	.*			
194- OTHER END. GL	13	.*			
*173- SKIN NON-MELANOMA	13	.*			
158- PERITONEUM	13	.			
175- BREAST MALE	8	.			
163- PLEURA	6	.			
181- PLACENTA	4	.			

* INDICATES A FLAGGED SITE AND IS NOT INCLUDED IN CERTAIN OTHER TOTAL FIGURES!

Exhibit 10
1-10-85

SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)
January 10, 1985

Chairman Winslow, Senators and Representatives of the Committee: My name is Dave Thomas and I am the Program Coordinator for the Department of Health and Environmental Sciences' Supplemental Food Program for Women, Infants and Children (known as WIC).

The Department's Nutrition Programs seek to improve the nutritional status of pregnant women, infants, children, adolescents, and adults through provision of comprehensive nutrition services to local agencies and communities, and nutrition consultation provided to community health nurses, handicapped children's services, family planning, dental and health promotion/education programs.

WIC is a major component of the Nutrition Programs, serving about 12,053 clients per month in state fiscal year 1984. Approximately 11,916 clients were served in October, 1984, which continues to follow historical patterns of participation. WIC provides low income, pregnant, postpartum, and lactating women, infants and children up to age five, at nutritional risk, with (1) nutrition assessment, education and counseling to improve eating behaviors and reduce nutritional problems; (2) selected foods to supplement diets lacking in nutrients needed during this critical time of growth and development; and (3) access to preventive health programs and referral to private and public health providers. WIC is 100% federally funded.

Mr. Chairman, that concludes my testimony.

CHILD NUTRITION PROGRAM
CHILD CARE FOOD PROGRAM
CLINICAL PROGRAMS BUREAU
HEALTH SERVICES & MEDICAL FACILITIES DIVISION
DEPARTMENT OF HEALTH & ENVIRONMENTAL SCIENCES

Exhibit 11
1-10-85

January 10, 1985

Chairman Winslow, Senators and Representatives of the Committee:

My name is Peggy Baraby, and I am the Program Supervisor for the Child Nutrition Program.

The Department's nutrition programs seek to improve the nutritional status of pregnant women, infants, children, adolescents and adults through provision of comprehensive nutrition services to local agencies and communities, and nutrition consultation provided to community health nurses, handicapped children's services, family planning, dental and health promotion/education programs.

The Child Nutrition Program's goal is "To improve the nutritional status of Montana's children by assuring that meals meeting minimum nutritional requirements will be available to children attending institutions participating in the Child Nutrition Program and by intervention for nutritional health problems identified among these children."

The program was created by Congress in response to the need to provide good nutrition to children in needy areas where there were large numbers of working mothers. The Child Nutrition Program is 100% federal funds.

The Child Nutrition Program provides cash reimbursement for meals, (breakfast, lunch, supper & snacks) meeting specific nutritional requirements which are served to children enrolled in non-profit licensed or approved child care centers, Head Start programs, day care homes, and outside-school-hours programs who participate in the Child Care Food Program. The Program also reimburses local non-profit sponsoring organizations for administrative expense associated with the administration of the Child Nutrition Program in local day care homes.

In addition, the Program provides technical assistance in the areas of Program operations, menu planning, food service, nutrition and nutrition education to participating institutions, their staff and enrolled children.

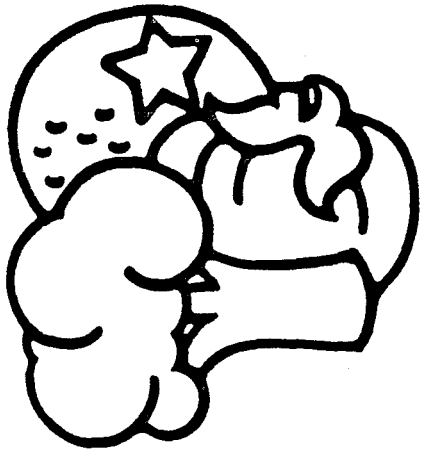
In SFY84 2,990,514 meals were served to the 9,910 enrolled children.

Mr. Chairman that concludes my testimony.

The Child Care Food Program

This day care home or child care center is a participant in the Child Care Food Program (CCFP), a Federal program of the Food and Nutrition Service (FNS), U.S. Department of Agriculture (USDA). It is operated in accordance with USDA policy, which does not permit discrimination because of race, color, national origin, sex, or handicap. If you believe that your child has been treated unfairly in receiving food services for any of these reasons, write immediately to the Secretary of Agriculture, Washington, D.C. 20250. For more information on civil rights, write to the Office of Equal Opportunity, USDA, Washington, D.C. 20250.

The primary goal of the CCFP is to improve the diet of children 12 years of age or younger. (Children 15 and under from families of migrant workers are also eligible, and certain handicapped people regardless of age may receive CCFP meals if they are enrolled in a center or home that serves mostly persons 18 years of age or younger.)



Nutrition is an important part of good health. Proper nutrition is also an important part of a good child care program. Children need well-balanced meals in order to meet their daily energy needs and to help them build strong bodies and minds. Through the CCFP, you can be assured that your child is getting balanced, nutritious meals. As participants in the CCFP, child care organizations may serve up to three meals a day to each child. If three meals are served, at least one of them must be a snack. All of the meals must follow patterns set by USDA.

There are two groups of meal patterns. The first group is for infants up to 12 months. Foods in these patterns vary according to the infant's age. Infants from 4 to 8 months old receive some, but not all, of the foods in the meal pattern below. Infants under 4 months of age are not served solid foods. The second group of patterns is for children over 1 year of age.

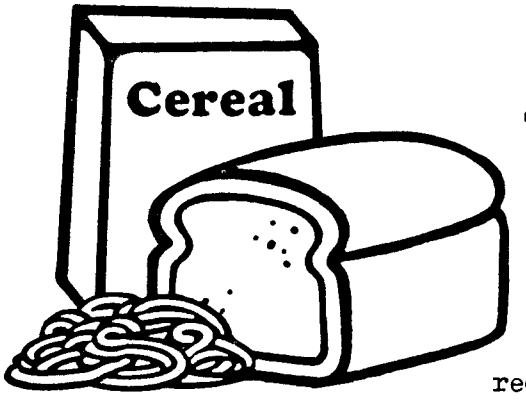
Foods for Babies (8 to 12 months old)

Breakfast	Snack	Lunch and Supper
Infant formula (iron fortified) or whole fluid milk and full-strength fruit juice	Infant formula (iron fortified) or full-strength fruit juice or milk	Infant formula (iron fortified) or whole fluid milk and full-strength fruit juice
Infant cereal (iron fortified)	Enriched or whole-grain bread or cracker-type product (suitable for infants)	Infant cereal (iron fortified) or strained fruit and/or vegetable
		Strained meat, fish, poultry, or egg yolk or cheese or cottage cheese, cheese food, or cheese spread

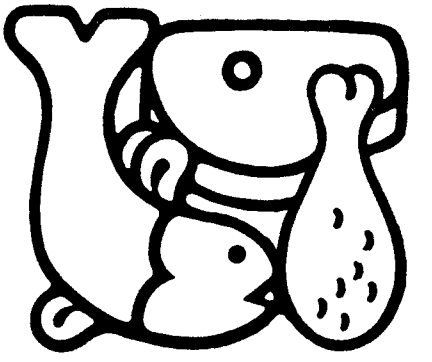
U.S. Department of Agriculture
Food and Nutrition Service
Program Aid Number 1299

Foods for Children

Breakfast	Lunch or Supper	Snack
Milk Juice, fruit, or vegetable Bread or bread alternate	Milk Meat or meat alternate Vegetables and/or fruits Bread or bread alternate	(Serve two of the following four foods. Juice may not be served when milk is served as the only other food.) Milk Meat or meat alternate Fruit, vegetable, or juice Bread or bread alternate



The CCFP gives financial assistance to public and private nonprofit organizations providing licensed or approved nonresidential day care service throughout the country. Organizations participating in the CCFP include, but are not limited to, day care centers, day care homes, and institutions providing day care services for handicapped children. Also, private for-profit centers that receive compensation under Title XX of the Social Security Act for at least 25 percent of the children who are receiving nonresidential day care may qualify as eligible child care institutions. Sponsoring organizations can operate the CCFP in child care centers, outside-school-hours care centers, and family day care homes.



Centers can operate in the program either independently or under the auspices of a sponsoring organization. The sponsoring organization must accept final administrative and financial responsibility for centers and homes under its auspices. Day care homes must participate under a sponsoring organization; they cannot enter the CCFP directly. In most States, the CCFP is administered by the State department of education. In States that do not administer the program, FNS regional offices operate it directly.

Issued October 1981
Slightly revised October 1982

U.S. GOVERNMENT PRINTING OFFICE : 1982 O - 389-210

To the Families of Day Care Children:

Your children are enrolled in a day care center which participates in the Child Care Food Program of the U.S. Department of Agriculture. Through the Program, USDA gives financial assistance to this day care center to serve nutritious meals and snacks.

The Program requires centers to collect family size and income information once a year from their families. The law requires the centers to treat this information confidentially and to protect your right to privacy.

We urge you to cooperate with this request for information so you can benefit from lower child care costs.

Child Nutrition Program
Montana Department of Health
& Environmental Sciences
Cogswell Building
Helena, Montana 59620
Phone (406) 444-4740

The day care center your child attends should provide the types and amounts of food listed below for the meals and snacks they serve your child.

The center's menus should be posted in the center for your information.

FOOD CHART Child Care Food Program

		For required serving amounts for infants up to age 1 year, refer to your handbooks or to program regulations.	AGE 1 up to 3	AGE 3 up to 6	AGE 6 up to 12
BREAKFAST		Fluid Milk	½ cup	¾ cup	1 cup
		Juice or Fruit or Vegetable	¼ cup	½ cup	½ cup
		Bread or Bread Alternate	½ slice*	½ slice*	1 slice*
SNACK (Supplement) Select 2 out of 4 components		Fluid Milk	½ cup	½ cup	1 cup
		Juice or Fruit or Vegetable	½ cup	½ cup	¾ cup
		Meat or Meat Alternate	½ ounce	½ ounce	1 ounce
		Bread or Bread Alternate	½ slice*	½ slice*	1 slice*
LUNCH/ SUPPER		Fluid Milk	½ cup	¾ cup	1 cup
		Meat or Poultry or Fish or	1 ounce	1½ ounces	2 ounces
		Cheese or	1 ounce	1½ ounces	2 ounces
		Egg or	1	1	1
		Cooked Dry Beans and Peas or	¼ cup	⅜ cup	½ cup
		Peanut Butter	2 Tablespoons	3 Tablespoons	4 Tablespoons
		Vegetables and/or Fruits (2 or more)	¼ cup total	½ cup total	¾ cup total
		Bread or Bread Alternate	½ slice*	½ slice*	1 slice*

* or an equivalent serving of an acceptable bread alternate such as cornbread, biscuits, rolls, muffins, etc., made of whole-grain or enriched meal or flour, or a serving of whole-grain or enriched cereal, or a serving of cooked enriched or whole-grain rice or macaroni or other pasta product.

The Child Care Food Program is open to all eligible children regardless of race, age, sex, handicap, color or national origin. If you believe you have been treated unfairly in receiving food services because of race, age, sex, handicap, color or national origin, write immediately to the Secretary of Agriculture, Washington, D.C. 20250

NURSING BUREAU

January, 1985

Exhibit 12
1-10-85

NURSING ADMINISTRATION: NURSING OPERATIONS (Community Nursing Services Program)

Presented by: Maxine Ferguson, Chief, Nursing Bureau

OBJECTIVES Through professional nursing consultation:

Develop and ensure ongoing, viable local programs of community health and school nursing, in concert with local officials, including the professional nursing component of the MCH Block Grant to Counties;

Monitor quality assurance and patient care standards in direct service clinics, such as well-child clinics, including audit activities;

Facilitate the development of quality home health services.

Promote school health services which provide, at least:

- identification of children with health problems which have potential for interfering with learning, and

- modification of the school environment to meet the needs of handicapped children.

STAFF 7.5 FTE professional nurses are currently assigned to the Nursing Bureau. Their areas of responsibility are as follows:

1.0 FTE - Bureau Chief, Nursing Bureau. The Bureau Chief oversees the Bureau programs and operations, serves as Program Manager for the Community Nursing Services Program, and provides generalized nursing consultation to approximately 50 nurses in 15 agencies or locations in South Central Montana. She is also the State School Nurse Consultant, and is designated as the Project Director for the Childhood Immunization and Venereal Disease Control Programs. (Day-to-day operations of these two programs are carried out by a Program Manager.)

2.0 FTE - Community Nursing Services Program. Two nurse consultants provide generalized nursing consultation to approximately 200 nurses in 131 agencies or locations in Eastern, Western, and North Central Montana. Each nurse consultant also provides specialty nursing consultation statewide upon request (and availability) in the areas of maternal-child nursing and home health.

One nurse consultant is based in Corvallis, Montana.

1.0 FTE - Communicable Disease Program. A nurse consultant manages this program, serves as State Epidemiologist, and provides communicable disease consultation statewide. She is also the generalized nursing consultant for approximately 35 nurses in 14 agencies or locations in Central Montana.

1.5 FTE - Family Planning Program. DHHS mandates that these Title X-funded nurses (1.0 FTE nurse consultant and .5 FTE public health nurse) work exclusively with the Title X-funded program and its 15 delegate agencies.

1.0 FTE - Handicapped Children's Services. A public health nurse is designated 100% with HCS, but has been assigned 40% of her time to End Stage Renal Disease (ESRD). When ESRD was assigned to the Department, no administrative dollars were included.

1.0 FTE - Handicapped Children's Services. A nurse consultant serves as Program Manager, and is paid from HCS.

No clerical staff is assigned to the Community Nursing Services Program.

DISCUSSION The majority of public health programs in the State are implemented by professional nurses. The Nursing Bureau provides consultation under authority of MCA 50-1-202, "... (11) provide consultation to school and local community health nurses in the performance of their duties...." Unlike a hospital, with its hierarchy of nursing positions culminating in a "nursing director", nearly 2/3 of the locally employed school nurses and public health nurses work in professional isolation. Non-health persons are usually designated as their supervisors.

The remaining 1/3 nurses are locally employed by larger agencies or school districts, with a designated nurse-supervisor.

Consultation to locally employed nurses is provided according to their needs and the needs of their community or agency. Methods employed by generalized nurse consultants include on-site field visits, workshops, technical assistance in program development, and coordination with other programs and agencies. Program audits, the development or written guidelines and other materials, provision of current information regarding public health and school nursing practice, and other methods are also utilized.

In counties or school districts with no public health or school nursing services, generalized nurse consultants work with local officials and interested citizens in development of these services.

MF/cmb/166

NURSING BUREAU

January, 1985

Exhibit 13
1-10-85

NURSING BUDGET, MODIFIED REQUEST

Presented by: Maxine Ferguson, Chief, Nursing Bureau

The Department is requesting 3.0 additional FTE (2 Nurse Consultants; 1 Clerical Staff) and associated operating costs for the Nursing Bureau to alleviate the workload increases experienced over the past two years. This workload impact was created, at least in part, by:

- program reassignment of nurse consultants
- Federal decisions about use of funds supporting nurse positions
- increased numbers of locally employed community health nurses and school nurses
- increased emphasis on maternal-child nursing, including public health nursing followup of handicapped children, development of well-child services and school nursing services, through the MCH Block Grant to Counties
- increased requests for assistance in the development of community-based and hospital-based home health services

An additional 2 FTE nurse consultants would enable the Nursing Bureau to more adequately and expediently meet requests for consultation, work with local areas in development of services, and ensure that community health and school nursing services provided to people really are services, not just the "illusion of services."

As indicated previously, 2 full-time Nurse Consultants are currently carrying the majority of responsibility for generalized consultation (70% assigned to them; 18% to the Bureau Chief and 12% to the State Epidemiologist). A more manageable percentage of 25% each for 4 full-time nurse consultants could be effected with the additional FTEs, along with reducing the workloads of the Bureau Chief and State Epidemiologist.

No clerical person has been assigned to Nursing Administration, Nursing Operations (Community Nursing Services Program), or the Communicable Disease Program since prior to the Department reorganization and re-creation of the Nursing Bureau

in July, 1983. The FTE clerical person would have primary responsibility in the Communicable Disease Program, effecting the paper tracking, record keeping, and reporting that is necessary in that Program.

/mf

1-10-85
Exhibit 14
~~1-7-85~~
1-10-85

CHILDHOOD IMMUNIZATION PROGRAM / VENEREAL DISEASE CONTROL PROGRAM

TO: Chairman Winslow, Senators and Representatives of this Committee

FROM: M. Richard Nelson

Chairman Winslow, Senators and Representatives of this Committee, I am Richard Nelson and I supervise the Childhood Immunization Program and Venereal Disease Control Program. The staff for these two programs also function as disease investigators for the Communicable Disease Control Program, thus providing a more cost-effective program for all communicable disease activities.

I would first like to speak of the Childhood Immunization Program. This program is primarily federally funded to prevent and control the immunizable diseases of Measles, Rubella (or 3-day measles), Mumps, Polio, Diphtheria, Tetanus and Pertussis (or whooping cough).

The primary activities of this program are:

1. To monitor and assist public and private K-12 schools and day care centers in the implementation of immunization laws and rules.
2. To conduct surveillance and rapid disease control of these vaccine-preventable diseases.
3. To distribute, free-of-charge, and ensure the appropriate use of vaccine for these diseases for adults and children in Montana through local public health care providers. (For FY 84, approximately $60,000 of vaccine was distributed.)
4. To monitor the adverse reactions to these vaccines when they occur.
5. To publicize and promote the need for and importance

of appropriate immunizations for adults, such as employees of hospitals and students in colleges and technical schools.

Due in part to ongoing activities such as those mentioned above, the actual number of reported cases of these diseases are continuing to remain at all-time lows in Montana.

The next program I will address is the V.D. Control Program. This program is for the control and prevention of the sexually transmitted diseases, primarily syphilis and gonorrhea, through support and assistance to locally established V.D. services. It also provides a wide range of program activities in areas of the state where no local services exist.

The primary activities to this program are:

1. To engage in appropriate follow-up activities of reported venereal disease cases to include interviewing cases for their sexual contacts and referral for medical evaluation.
2. To monitor and log the number of diagnosed cases and the follow-up of those cases to ensure for proper medical management.
3. To coordinate V.D. activities between programs within Montana.
4. To coordinate V.D. activities with programs in other states in order to identify and respond quickly to importation of disease into Montana.
5. To provide current technical information regarding

V.D. trends and status to both public and private health care providers through correspondence and in-service training.

6. To provide V.D. education to the general public through requests by civic groups, schools, etc.

Finally, in reference to the staff's function within the communicable disease program, the staff has been trained and is functioning as primary disease investigators for the state communicable disease program. They provide services to all Montana counties, either directly or indirectly, through assistance and/or consultation with local health care providers. These activities are funded by a 20% commitment of general funds to the current level budgets for personal services and travel of the Immunization and V.D. Control programs. These activities help meet the state mandate of communicable disease control needs in Montana.

In conclusion, at the request of the chair, I would be pleased to respond to any questions you may have.

Any budgetary questions will be answered by Mr. Hoffman.

NURSING BUREAU
Communicable Disease Control
Judith Gedrose
January 7, 1985

Exhibit 15
1-10-85

Chairman Winslow, members of the committee: I am Judith Gedrose, State Epidemiologist and coordinator for communicable disease control activities. The general communicable disease control program is within the Nursing Bureau of Health Services and Medical Facilities Division. Statutes concerning communicable disease control are found in Montana Code Annotated, Title 50.

The general communicable disease control program maintains continual surveillance of 43 diseases and 5 syndromes and categories of disease. Investigation of outbreaks and cases is performed to prevent spread of disease in the population. Tuberculosis control comprises approximately one half the program's activities. Rabies prevention in humans is a top priority of the program.

Approximately one quarter of Montana's population will have some type of infectious disease process requiring medical care during any given year. Infectious diseases are designated "reportable" based on two criteria. One, they can spread to others, and two, the outcome of the disease is particularly devastating, such as with rabies. Reportable diseases are beyond the nature of the usual private doctor-patient relationship because of the potential of spread to others.

The uniqueness of general communicable disease control makes the public, public health direct service providers and the private medical community turn to Montana State Department of Health and Environmental Sciences for assistance. During one six-month period at least 125 requests came for assistance from local health departments and private medical care providers. An additional 23 requests for information or assistance came directly from private citizens. The diseases prompting requests for assistance are listed below, with the most frequent being first:

Tuberculosis

Rabies

Salmonellosis

Giardiasis

Hepatitis

Vaccine-preventable, including recommendations for international travel

Schistosomiasis (swimmer's itch)

Head lice

Streptococcal disease outbreaks

Plague

Colorado tick fever

Malaria

Many of the program activities are carried out with the cooperation of other department programs. Immunization and Venereal Disease Control program's staff have travel and personnel costs supplemented by the general fund for this purpose. MSDHES Microbiology Laboratory, Food and Consumer Safety Bureau, Air and Water Quality Bureaus also regularly participate in communicable disease control.

I would be glad to answer questions you may have about communicable disease control activities of MSDHES.

REPORTABLE DISEASES

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

HEALTH SERVICES AND MEDICAL FACILITIES DIVISION

COGSWELL BUILDING **HELENA, MONTANA 59620**

T = Immediately Telephone Case Report X = Report on Confidential Case Report Card	Mail Daily	Mail Within 7 Days	Mail Weekly Numbers Only
Amebiasis		X	
Anthrax	T		
Aquired Immune Deficiency Syndrome		X	
Botulism	T		
Brucellosis		X	
Campylobacter		X	
Chancroid	X		
Chicken Pox			X
Cholera	X		
Chlamydia		X	
Conjunctivitis, epidemic			X
Colorado Tick Fever			X
Diarrheal Disease, outbreaks	X		
Diphtheria	T		
Encephalitis		X	
Giardiasis		X	
Gonococcal Disease	X		
Granuloma Inguinale	X		
Guillain-Barré Syndrome		X	
Hepatitis, A		X	
Hepatitis, B		X	
Hepatitis, Non A—Non B		X	
Hepatitis, unspecified		X	
Herpes, genital		X	
Histoplasmosis		X	
Influenza			X
Legionnaires' Disease		X	
Leprosy		X	
Leptospirosis		X	
Lyme Disease		X	
Lymphogranuloma Venereum	X		
Malaria		X	
Measles (Rubeola)	T		
Meningitis, Bacterial	X		
Meningitis, Viral	X		
Mononucleosis			X
Mumps		X	
Ornithosis (Psittacosis)		X	
Pediculosis (Lice)			X
Pertussis (whooping cough)	X		
Plague	T		
Polio (paralytic & non-paralytic)	X		
Q-fever		X	
Rabies, exposure	T		
Reye's Syndrome		X	
Ringworm, epidemic			X
Rocky Mountain Spotted Fever		X	
Rubella	X		
Salmonellosis		X	
Scabies			X
Shigellosis		X	
Smallpox (including vaccinia)	T		
Streptococcal Disease, outbreak			X
Syphilis	X		
Swimmer's Itch (Schistosomiasis)			X
Tetanus	X		
Trichinosis		X	
Toxic Shock Syndrome		X	
Tuberculosis (all types)		X	
Tularemia		X	
Typhoid	T		
Typhus	X		
Yersinia Enterocolitica		X	
Exotic Diseases, Illness in Foreign Travelers	X		

Report to your local health officer:

Name:_____

Phone:_____

If unable to contact local health officer, contact:
STATE DEPT. OF HEALTH & ENV. SCIENCES
Cogswell Bldg.
Helena, MT 59620

ATTN: Communicable Disease Control

Exhibit 16
1-10-85

TESTIMONY

STATEWIDE FAMILY PLANNING PROGRAM

January 10, 1985

Chairman Winslow, Senators and Representatives of the Committee, I am Suzanne Nybo, Program Manager of the Statewide Family Planning Program. Today I will present an overview of Family Planning and discuss the modified request for a .50 FTE nurse to provide additional services in support of the Program. At the conclusion of my testimony I will be happy to respond to any questions you may have.

The Statewide Family Planning Program is a preventive health program whose goal is to improve the overall reproductive health of Montanans. Services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women and children, particularly through the detection and prevention of cancer and venereal disease with women.
- Reduce the incidence of abortion by preventing unplanned pregnancies.
- Decrease maternal and infant mortality and morbidity.
- Assist couples who want to have children but cannot.
- Prevent unplanned pregnancies (particularly in child abuse and poverty situations).
- Prevent birth defects and mental retardation.
- Assure that more children are "wellborn" by decreasing the incidence of prematurity and birth defects.
- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.
- Assist couples in having the number of children they desire so that every child is intended and loved.

The Department of Health and Environmental Sciences (DHES) contracts with 15 family planning programs in the state to provide services. Each program functions under the medical supervision of a licensed physician. Some of the services offered are: health education, counseling, physical examinations, cervical cancer screening, breast self-exams, pregnancy testing, blood pressure recordings, blood testing, dispensing of contraceptives, screening and treatment for gonorrhea, and referral for other problems.

In SFY 1984, 21,391 persons from every county in the state were served by the program, a 453% increase in caseload since the program's inception in 1972. 81% of all persons served were from low income families. In 1983, it is estimated the 15 family programs prevented 6,266 unplanned pregnancies. These pregnancies would have resulted in 3,973 births, 1,147 abortions, and 1,146 miscarriages. This would have included approximately 119 cases of congenital abnormalities, 119 cases of hypoxic brain damage, 20 cases of chromosomal abnormalities and 266 high-risk premature deliveries.

In SFY 1984, the programs detected and referred for treatment: 730 positive pap smears for cervical cancer; 1,661 cases of anemia; 126 cases of gonorrhea; 1,165 cases of breast diseases or other physical findings (heart, thyroid, etc.); 2,679 cases of vaginal infections; and 430 cases of high blood pressure.

It is widely documented that 1) many low income people do not have equal access to family planning services, and 2) repeated, closely spaced childbearing -- or childbearing that occurs very early or late in life -- often has adverse health, social and economic consequences for mothers and their children and for society. Therefore, a national goal of the program is to assist in making comprehensive voluntary family planning services available to all persons desiring such services with priority on serving persons from low income families.

The objectives of the program are to provide educational, social, and comprehensive medical services necessary to enable individuals to freely determine the number and spacing of their children and to promote the health of mothers and children.

According to the Alan Guttmacher Institute, a corporation for research, policy analysis and public education, family planning has the highest documented benefit/cost ratios of any federally funded health program in the nation. It meets the needs of those who otherwise cannot afford services and could eventually become dependent on government agencies.

- The cost to the government for a mother on welfare and an unplanned child averages $3,348 per year plus food stamps and Medicaid.
- The short-term benefits (savings) to federal, state, and local governments are estimated to be $2 for each dollar invested in family planning.
- The long-term benefits are estimated to be $26 for each dollar invested.

DHES receives Federal Title X funds from the U.S. Department of Health and Human Services, Maternal and Child Health and Preventive Health Block Grant Funds. The block grant funds are directly allocated to the 15 local programs in the state to provide services; no administrative dollars are retained at the state office.

Family Planning's modified request is to add an additional .50 FTE nurse to the program. This position will be responsible for providing program direction and nursing consultation to the 15 local family planning programs.

Again, I would be happy to answer any questions you may have regarding the program. Budget questions should be addressed to Mr. Hoffman.

SN/war-85

MONTANA STATEWIDE FAMILY PLANNING PROJECT

November 23, 1984

In Montana, 21,391 clients were served by programs in SFY 1984. This is a 453% increase in caseload since the program's statewide inception in 1972.

Each program functions under the medical supervision of a licensed physician.

Family Planning meets the needs of those who otherwise cannot afford services and could eventually become dependent on government agencies.

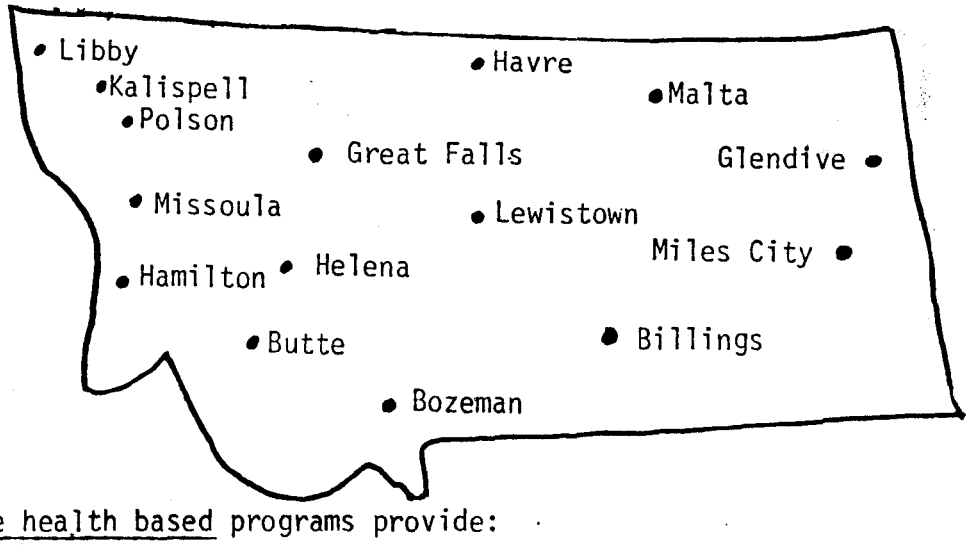
- The cost to the government for a mother on welfare and an unplanned child averages $3,348 per year plus food stamps and Medicaid.
- The average cost per family planning medical encounter is $20.
- The short-term benefits (savings) to federal, state, and local governments are estimated to be $2 for each dollar invested in family planning.
- The long-term benefits are estimated to be $26 for each dollar invested.

Family Planning is a preventive health effort with potential to reduce significantly certain social, psychological and medical problems of women and children. It is characterized by two important aspects:

- Improvement of the health of women and children.
- The acceptance of family planning services must always be the voluntary decision of the individual.

The goal of Montana family planning services is to maintain or improve the reproductive health of Montana people in their reproductive years.

In Montana there are presently 15 family planning clinics. Currently the funding is provided by: Federal Title X, Preventive Health (PH) Block Grant, and Maternal and Child Health (MCH) Block Grant funds through Health Services and Medical Facilities Division of the Montana State Department of Health and Environmental Sciences; third party reimbursement; local funds; and direct fees paid by the clients based on their ability to pay. In addition some counties have elected to utilize MCH block grant funds for Family Planning. Total funds expended in SFY 1984 were $1,760,592.



The preventive health based programs provide:

- counseling in all aspects of family life
- educational services
- physical examinations
- cervical cancer screening
- self-breast exams
- blood tests for anemia, rubella & syphilis
- immunization for rubella
- blood pressure recordings
- urinalysis for sugar and protein
- inter-agency referral for other problems
- dispensation of contraceptives
- screening and treatment for gonorrhea
- pregnancy tests

Family planning services are directed toward the accomplishment of the following major health goals:

- Improve and maintain the emotional and physical health of men, women, and children, particularly through the detection and prevention of cancer and veneral disease with women.
- Prevent birth defects and mental retardation. Mental retardation tends to be associated with prematurity and low birth weight. The Comptroller General's report to Congress on Mental Retardation, 1977, identified family planning programs as an existing program with the ability to make a significant contribution towards reducing the incidence of mental retardation.
- Reduce the incidence of abortion by preventing unplanned pregnancies.
- Assure that more children are "wellborn" be decreasing the incidence of prematurity and birth defects.
- Decrease maternal and infant mortality and morbidity.
- Assist couples who want to have children but cannot.
- Prevent unplanned pregnancies (particularly in child abuse and poverty situations).
- Improve pregnancy outcome by correction of health problems between pregnancies and by proper spacing and timing of pregnancy.
- Assist couples in having the number of children they desire so that every child is intended and loved.

The Need:

- There are an estimated 44,047 women-in-need of subsidized family planning services in Montana.
- About 39% of these women (or 17,359) are being served by the 15 programs. Roughly estimated, an additional 9,317 women-in-need or (21%) are being provided family planning services by physicians.
- This leaves some 17,371 Montana women needing family planning services who are not receiving them. They are at risk for unplanned children.

Accomplishments:

- 81% of the 21,391 clients served in SFY 1984 lived in families with incomes at or below 150% of the CSA poverty level.
- Medical and/or education services were provided by programs to women in all 56 counties in SFY 1984.

In SFY 1984 the 15 programs detected and referred for treatment:

- 730 positive pap smears for cervical cancer
- 1,661 cases of anemia
- 296 abnormal urine chemistry results
- 126 cases of gonorrhea
- 2,679 cases of vaginal infections
- 1,165 cases of breast diseases or other physical findings (heart, thyroid, etc.)
- 430 cases of high blood pressure

MONTANA STATEWIDE FAMILY PLANNING PROJECT

SFY 1984 FUNDS EXPENDED: $1,760,592

(See attached fact sheet for program information)

Family Planning Programs (County)	SFY 1984 Patient Load
Cascade	1,934
Custer	589
Dawson	797
Fergus	365
Flathead	1,043
Gallatin	2,442
Hill	681
Lake	211
Lewis and Clark	1,940
Lincoln	791
Missoula	2,835
Phillips	140
Ravalli	139
Silver Bow	1,445
Yellowstone	6,039
Total	21,391

County (All 56 Counties Served)	SFY 1984 Patient Load
Beaverhead	63
Big Horn	82
Blaine	55
Broadwater	44
Carbon	133
Carter	8
Cascade	1,837
Chouteau	18
Custer	516
Daniels	12
Dawson	500
Deer Lodge	220
Fallon	17
Fergus	312
Flathead	1,047
Gallatin	2,315
Garfield	11

MONTANA STATEWIDE FAMILY PLANNING PROJECT

County (All 56 Counties Served)	SFY 1984 Patient Load
Glacier	14
Golden Valley	15
Granite	26
Hill	608
Jefferson	113
Judith Basin	24
Lake	223
Lewis and Clark	1,799
Liberty	11
Lincoln	783
McCone	29
Madison	26
Meagher	17
Mineral	24
Missoula	2,669
Musselshell	68
Park	61
Petroleum	13
Phillips	151
Pondera	16
Powder River	25
Powell	80
Prairie	19
Ravalli	191
Richland	237
Roosevelt	3
Rosebud	96
Sanders	21
Sheridan	4
Silver Bow	1,096
Stillwater	76
Sweet Grass	7
Teton	25
Toole	13
Treasure	4
Valley	5
Wheatland	39
Wibaux	23
Yellowstone	5,369
Out-of-State	130
Unknown	48
Total	21,391

FAMILY PLANNING PROGRAM

UNPLANNED PREGNANCIES PREVENTED

In 1983, the 15 family planning programs in Montana prevented 6,266 unplanned pregnancies. These pregnancies would have resulted in 3,973 births, 1,147 abortions, and 1,146 miscarriages. This would have included approximately 119 cases of congenital abnormalities, 119 cases of hypoxic brain damage, 20 cases of chromosomal abnormalities and 266 high-risk premature deliveries.

PROGRAM	Pregnancies Prevented	Births Prevented	Abortions Prevented	Miscarriages Prevented
Billings	1,789	1,134	327	328
Bozeman	742	470	136	136
Butte	431	273	79	79
Glendive	238	151	44	43
Great Falls	526	334	96	96
Hamilton	39	25	7	7
Havre	203	129	37	37
Helena	605	383	111	111
Kalispell	239	151	44	44
Lewistown	92	58	17	17
Libby	253	161	46	46
Malta	38	24	7	7
Miles City	187	119	34	34
Missoula	824	522	151	151
Polson	60	39	11	10
STATEWIDE	6,266	3,973	1,147	1,146

SOURCE: Trussell Method Effectiveness Estimates, "Cost versus Effectiveness of Different Birth Control Methods", T. James Trussell

WOMEN'S LOBBYIST FUND

Box 1099
Helena, MT 59624
449-7917

January 10, 1985

Exhibit 17
1-10-85

Mr. Chairman and members of the Subcommittee on Human Services:

My name is Anne Brodsky and I am speaking on behalf of the Women's Lobbyist Fund (WLF). Maintaining family planning funding at least at the current level is an issue of primary importance to the WLF and its constituents.

Family planning services were provided to over 21,000 clients in all 56 Montana counties in FY 84. 81% of the clients served lived in families with incomes at or below 150% of the Community Services Administration poverty level. Family planning is an essential preventative health program that provides Montana citizens with education and medical services in the area of reproductive health.

You have information before you with regard to the importance of these services in preventing unwanted pregnancies and detecting and referring serious medical problems, such as cervical cancer, venereal disease, and breast diseases, among others.

I also point out that family planning has an excellent record of being one of the most cost effective federally-funded health programs in the nation.*

The WLF believes that adequate family planning funding (i.e., maintaining at least the current level of services) is essential for the health and welfare of Montana citizens, and we hope that you consider adequate funding for family planning to be just as high a priority as we do.

With these thoughts in mind, the WLF must bring to your attention some serious problems we see in the proposed executive budget for the family planning program. First, let me remind you that all the money for family planning comes from federal dollars. There are 3 sources of money for this: Title X; Preventive Health Block Grant money; and Maternal and Child Health (MCH) Block Grant money.

The executive budget proposes that MCH Block Grant money be appropriated at roughly the same level in the coming biennium as it has been in the present biennium.

FY 84	FY 86	FY 87	MCH Block Grant
$25, 787	$28,000	$29,000	

However, the Preventive Health Block Grant appropriation under the executive budget contains a reduction of $55,490 in FY 86 and a reduction of $90,889 in FY 87 from FY 84 levels for the family planning program.

FY 84	FY 86	FY 87	PREVENTIVE HEALTH
$203,968	$148,478 ($55,490 less than in FY 84)	$113,079 ($90,889 less than in FY 84)	BLOCK GRANT

The third source of funding for family planning comes from Title X. Currently (FY 85), Montana receives just under $800,000 under Title X ($797,122). In my conversation on January 8, 1985, with the U.S. Department of Health and Human Services' Family Planning Regional Program Consultant in Denver, I was told that Montana can anticipate, at best, the current level of funding ($800,000) for FY 86 from Title X. At worst, that funding could be reduced by $40,000.

The executive budget contains drastic reductions in the Preventive Health Block Grant for the Family Planning Program. The explanation for this is not apparent, particularly if the executive budget intention is to maintain at least the current level of services, if not a modest modification (.5 FTE).

The WLF urges this subcommittee to restore the Preventive Health Block Grant appropriations to at least the current level in the budget for FY 86 and FY 87.

Further, we recommend that the Family Planning Program continue to be staffed with 4.5 FTEs, as it is staffed at present.

The Family Planning Program is vital to Montanans and should be given high priority in the budget process.

* (from page 1) Issues in Brief, The Alan Guttmacher Institute, Wash. D.C., Voume 1, Number 7, May 1981, p.1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Region VIII

Federal Office Building
1961 Stout Street
Denver CO 80294

Exhibit 18
1-10-85

April 9, 1981

John J. Drynan, M.D.
Director
Department of Health and
Environmental Sciences
Cogswell Building
Helena, Montana 59620

Attention: Sidney Pratt, M.D.

Dear Dr. Drynan:

On November 18, 1980, two members of my staff went to Planned Parenthood of Billings, Inc. to ascertain the relationship between that Title X clinic and Yellowstone Valley Women's Clinic and to determine Planned Parenthood of Billings' compliance with the Department's laws and regulations concerning abortion.

There is sufficient and significant separation of functions between Planned Parenthood and the Yellowstone Valley Women's Clinic so that there are absolute assurances that no Title X money is being used in the operation of Yellowstone Valley Women's Clinic. The review concluded that Planned Parenthood of Billings was in complete compliance with Federal laws and regulations concerning abortion.

If you have any questions on this issue, please call me.

Sincerely,

Hilary H. Connor, M.D.
Regional Health Administrator

cc:
Suzanne Nybo

VISITORS' REGISTER

Human Services Sub COMMITTEE

BILL NO. _____ DATE 1-10-85

SPONSOR _____

NAME (please print)	RESIDENCE	SUPPORT	OPPOSE
Tolly Munro MSDH Mont Optometric Assoc.	Helena		
Bill Hagberg		✓	
DENNIS LANG Ass of Local Health Dirs	MISSOULA	✓	✓
Anne Brodsky - WLF	Helena		
Lisa Paulick	Helena		
Gail Klein - WLF	Helena		
Robert Johnson	Helena		
George M Simon	DHES		
WARREN E. BRASS	HELENA		
Jean McCune	Billings		
Donald Hoffman MD	DHES		
Ray Hoffman	DHES		
Mary LaFond	OBPP		
[illegible]	OBPP		
[illegible]	HSA		
JUDITH H CARLSON	HELENA		

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.