MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

MARCH 11, 1985

The meeting of the Public Health, Welfare and Safety Committee was called to order by Chairman Judy Jacobson on Monday, March 8, 1985 in Room 410 of the State Capitol at 12:30.

ROLL CALL: All members were present. However, Senators Towe and Newman arrived late. Karen Renne, staff researcher, was also present.

There were many, many visitors in attendance. See attachments.

CONSIDERATION OF HOUSE BILL 114: Representative Joan Miles of House District 45 in Helena, the sponsor of HB 114, gave a brief resume of the bill. This bill was requested by the Department of Health and Environmental Sciences. HB 114 is an act to generally revise and clarify the laws relating to swimming pools and bathing places; clarifying that the Department of Health and Environmental Sciences may set safety standards for public swimming pools and bathing places; and providing an immediate effective date.

Representative Miles handed out copies of the existing laws. See attachments. This same bill was introduced last session. The laws need to address the safety measures. There seems to be some confusion regarding "safety" in some places in the codes.

Sam Murfitt, representing the Montana Department of Health and Environmental Sciences, stood in support of the bill. Mr. Murfitt stated that safety has always been a major portion of a total swimming pool program throughout the nation. In Montana, safety has been a major portion of the swimming pool program since 1967 when the present law was passed. The law was written with safety included in some sections and not in others. In those sections where the terms "safety" or "safe" were not used, the term "to protect the public health" was substituted. Mr. Murfitt handed in written testimony for the record. See attachments.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Himsl asked if there is a need for this bill. Mr. Murfitt replied that there is a definite need for this legislation.

Ellie Parker, an attorney for the Department of Health, stated that the codes as written are difficult to enforce.

Senator Himsl asked if water slides are affected by this bill. The only way that water slides are affected is by the water quality. The buildling codes division is involved and, therefore, the Department of Health need not be involved other than the quality of the water.

Senator Stephens asked if the Department has a swimming pool expert. Mr. Murfitt replied that he is the one with the expertise regarding swimming pools.

Senator Lynch asked about Chico Hot Springs and the Diamond S Hotel and Pool at Boulder. These are grandfathered in the swimming pool safety standards.

Senator Lynch asked about the cost of this program. There is no cost.

Senator Towe asked the reason for the immediate effective date. Mr. Murfitt replied the reason for the immediate effective date is that being as pool season is coming soon and he would like to see these standards implmented before then.

Senator Hager asked if the university system is under the jurisdiction of the Department. Mr. Murfitt replied that they are indeed under the jurisdiction of the Department and are therefore, regulated by them.

Representative Miles closed.

CONSIDERATION OF HOUSE BILL 783: Representative Joan Miles of House District 45 in Helena, the chief sponsor of House Bill 783, gave a brief resume of the bill. This bill is an act establishing the rights of residents of long-term care facilities; providing that a resident must be informed of his rights; requiring posting of these rights by long-term care facilities; and providing penalties.

This bill was requested by the Department of Social and Rehabilitation Services.

The purpose of this bill is to recognize and establish certain fundamental civil and human rights to which all residents of a long-term care facility are entitled and to provide penalties for violation of these rights.

Doug Blakely, State Ombudsman, stood in support of the bill. He stated that the purpose of the bill is twofold. 1) To extend a comprehensive set of rights to a group of individuals who by nature of mental, physicial or situational factors are in a vulnerable state. 2) To educate both facility personnel and those receiving services in long-term care settings about what their rights are. Mr. Blakely handed in written testimony to the Committee. See attachments.

A letter was submitted to the Committee from Doug Olson, Attorney for the senior's office of Legal and Ombudsman services. See attachments.

Tom Ryan, representing the Montana Senior Citizens Association, stood in support of the bill. He stated that he believes that this is a much need bill for the protection of our senior citizens.

Molly Munro, executive secretary of the Montana Association of Homes for the Aging, stood in support of the bill. She stated that her group wished to go on record in suport of HB 783. HB 783 brings state regulations into conformity with the federal regulations. Their member facilities already have such resident bill of rights posted in their facilities. See attachments.

Wade Wilkinson, representing the Low Income Senior Citizens Association, stood in support of the bill.

Joe Upshaw, representing the Legacy Legislature and also the Association of Retired People, stood in support of the bill.

With no further proponents the chairman called on the opponents.

Rose Skoogs, executive director of the Montana Health Care Association, stated that the Association would support the bill with some amendments. HB 783 reiterates the federal regulations and the interpretive guidelines. They have two general concerns regarding this piece of legislation. Mrs. Skoogs handed in written testimony and also her proposed amendments. See attachments.

With no further opponents, the meeting was opened to a question and answer period from the Committee.

Senator Towe asked Mrs. Skoogs about patients being able to refuse treatment. She stated that her group wants to know that they are free of all liability when a patient refuses treatment of any kind.

Senator Towe asked Mr. Blakely about the door being able to be closed. Mrs. Skoogs stated that this interfers with the facility's ability to take care of its patients and will lead to such absurd practices as knocking on patients' doors and waking them in the middle of the night while doing room checks. In addition, it is impossible to provide an absolute right to each resident to have the door of his room closed if his medical condition allows it, since that does not take into account the medical attention needed by the patient's roommate. Most nursing home patients are in rooms with at least one other person, some are even in four bed wards.

Senator Stephens asked about the 30 days advance written notice of any transfer or discharge. Mrs. Skoogs stated that HB 783 adds the language that reasonable advance notice requires at least 30 days in advance written notice of any interfacility transfer or any discharge, except in the case of emergency as documented by the resident's attending physician in his medical record. This language is too restrictive and is arbitary. There may be circumstances where 5 days is reasonable and others when significantly more than 30 days required.

Representative Miles closed. She stated that this new language has been adopted by 30 other states. The nursing homes amendments were rejected in the hearing in the House.

CONSIDERATION OF HOUSE BILL 817: Representative Les Kitselman of Billings, the chief sponsor of House Bill 817, gave a brief resume of the bill. This bill is an act to provide health insurance coverage to certain persons ineligible for coverage from traditional providers of health care benefits by establishing a Montana Comprehensive Health Association and Plan; to require participation in the Association by each health service corporation, fraternal benefit society; and insurer providing health care benefits in this state; and providing effective dates.

Representative Kitselman handed out some proposed amendments which he felt would make the bill more workable and make for a better bill.

He read a part of a letter from a young single mother in Billings. "I am a single parent of an eleven year old son. In January of 1984, he was diagnosed as having Juvenile Diabetes. The financial impact of the disease is considerable at best and could be catastrophic. I am on a fixed budget and receive no child support whatsoever from his father. An average cost per month for necessities for him is $125. Even a bad case of the flu could require a hospital stay, which I have no idea how I would pay for. Please support HB 817 which would make affordable health insurance available to high risk individuals such as my son. At this point my son is not covered by any health insurance, nor can I find a company that will insure him. I have contacted numerous insurance companies and have not been able to find one that will cover my son, even as a dependent."

Marie Deonier, representing the Montana Association of Health Underwriters, stood in support of the bill. She handed in written testimony to the members of the Committee. See attachments.

Stanlee Dull, executive director of the American Diabetes Association, stood in support of the bill. She handed in written testimony to the Committee for their consideration. See attachments. She also handed in a letter from Marilyn Moore, President of the Montana affiliate of the American Diabetes Association. See attachments.

Elmer Hauken, Montana Association of Life Underwriters, stood in support of the bill as amended. He stated that this is a very necessary bill and one that will not cost the state any money.

Chuck Elke, representing the Montana Physician Service, stood in support of the bill.

Barbara Penner, representing the Montana Heart Association, stood in support of the bill.

Wade Wilkinson, representing the Low Income Senior Citizens Association, stood in support of the concept of the bill. He stated that this is a very positive measure.

Don Allen, representing the Montana Hospital Association, stood in support of the bill.

Jerry Loendorf, representing the Montana Medical Association, stood in support of the bill.

Tanya Ask, representing the Montana Audit Department, stood in support of the bill as amended.

Tom Hager, representing himself as a consumer, stood in support of the bill. He stated that everyone needs a health plan which would take care of them. This is a very necessary bill.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Himsl asked why would people loose their insurance if they moved from the state under this bill. Representative Kitselman stated that since some other nearby states do not have a policy as this, he is concerned that people who live elsewhere would come to Montana and buy the insurance and then move away.

Senator Himsl asked if the cost is known at this time. The cost in unknown at this time, however, it would be like automobile insurance with a share in the coverage and also in the premium. A regulatory board will set up the costs.

Senator Towe asked if this is modeled after the insurance program of another state. It is modeled somewhat after the 1980 North Dakota Insurance program.

Senator Towe asked if one can just go buy this insurance. No, you must be denied coverage by two insurance companies before qualifying for this plan.

Representative Kitselman closed.

CONSIDERATION OF HOUSE BILL 649: Representative Jack Moore of Great Falls, the chief sponsor of House Bill 649, gave a brief resume of the bill. This bill was requested by the Department of Commerce. HB 649 is an act revising for administrative purposes the laws relating to regulation of the practice of denturity.

This is a compromise bill between the dentist and the denturists of Montana. This bill will come under sunset review in two years.

Mona Jamison, Legal Counsel to Governor Schwinden, handed out a proposed amendment. Starting on page 2, line 22, following; "37-4-301."; Insert: "The Governor shall replace one of the three denturists appointed to the initial board with a dentist member, within 60 days of the effective date of this act." She stated that this amendment had been agreed upon by all those working on this bill.

Roger Tippy, representing the Montana Dental Association, stood in support of the bill. He handed in a letter from Dr. W. A. Rader, a Havre dentist and President of the Montana Dental Association. See attachments. Mr. Tippy stated that HB 649 is a good compromise and he urged the Committee to give it a speedy consideration.

Tom Ryan, representing the Montana Senior Citizens Association, stood in support of the bill. He stated that one of the great concerns of the Montana Senior Citizens Association has been Health-Care Cost Containment. They think that HB 649 will add emphasis to their efforts. HB 649 as amended is an attempt by dental providers to reconcile their differences. They agree with the Department of Commerce licensing division that some adjustment in Initiative 97 was needed for administrative purposes. See attachments.

Joe Upshaw, representing the Association of Retired People and also the Legacy Legislature, stood in support of the bill as amended.

Dr. William Haggberg, representing the Department of Health and Environmental Sciences, stood in support of the bill.

Lee Wiser, representing the Board of Denturity, stood in support of the bill as amended and also the governor's amendments.

Wade Wilkinson, representing the Low Income Senior Citizens Association, stood in support of the bill.

Charlie Briggs, representing the Governor's Office, stood in support of the bill as amended. He stated that HB 649 is a workable compromise.

Dr. Ted Beck, a local dentist, stood in support of the bill as amended. He stated that in any legislative action, there must be some compromise so that all concerned can be equally represented. HB 649 as proposed to the Senate, is a compromise but it is a compromise that will allow those who voted for Initiative 97 to have a freedom of choice. There is reasonable representation from the dental community to hopefully ensure

public safety, if properly administered. If this HB is changed in anyway to lessen the control placed on the denturist then the public will most certainly suffer the consequences. Any proposed amendments should only be to strengthen the bill. A dentist needs to serve on the Board of Denturity.

Sam Ryan, representing the Senior Citizens, stood in support of the bill.

With no further proponents, the chairman called on the opponents.

Jeannette S. Buchanan of Columbia Falls, the dental hygienist member of the Board of Dentistry stood in opposition to the bill. She handed in written testimony to the Committee for their review. See attachments.

Dr. Myron Greany of Anaconda, a member of the Board of Dentistry, stood in opposition to the bill. He handed in written testimony to the Committee for their consideration. See attachments.

With no further opponents, the meeting was opened to a question and answer period from the Committee.

Senator Lynch asked when the Governor will be making the appointments to the Board of Denturity. Ms. Jamison stated that the Governor will be making the appointments in the very near future. If in fact, it is before this bill is passed he would appoint as the Initiative called for, and then make the changes after the bill has been passed and sent to the Governor.

Senator Hager asked about the education requirements of a denturist. The present denturists have no specified education at the present time. However, those coming into the profession after passage of this bill will be given certain requirements regarding their education.

Senator Newman asked if there is any denturity school in Montana. No, there are not. Idaho is hoping to have a school in the near future.

Representative Moore closed. The people of Montana passed Initiative 97 and it will become law. This bill is a good compromise to clear up some of the problem areas. He urged the Committee to give the bill favorable consideration and also the amendments.

The Committee took a recess at 3:00 to go into floor session of the Senate. They reconvened at 3:30.

CONSIDERATION OF HOUSE BILL 540: Representative Gerry Devlin of House District 25, the chief sponsor of House Bill 540, gave a brief resume of the bill. This bill is an act to establish and fund a child abuse prevention program.

Representative Devlin stated that there is a real need for the state to establish a child abuse prevention program.

JoAnn Peterson, representing the Montana Education Association, stood in support of the bill. She stated that there are four bills this session dealing with child abuse. Of the four bills, Senator Lynch's bill, SB 19, is the most favorable to her Association.

John Madsen, representing the Social and Rehabilitation Services, stood in support of the bill. He stated that the department supports the concept of HB 540 and that there is a real need for a child abuse program.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Lynch asked Representative Devlin if he felt that there was enough funding to bother with in the concept of the bill. Representative Devlin stated that he felt that the fiscal note was wrong and that the funding would probably be much higher.

Senator Stephens compared Senator Lynch's bill with Representative Devlin's bill. The concepts are the same, however, the funding mechanisms are different.

Representative Devlin closed. He stated that he felt something needs to be done in our state to prevent child abuse.

CONSIDERATION OF HOUSE BILL 807: Representative Tom Hannah of House District 86 in Billings, the chief sponsor of House Bill 807, gave a brief resume of the bill. This bill is an act providing for the protection of certain handicapped, injured or otherwise seriously ill children by requiring that they be given medical treatment.

Representative Hannah stated that HB 807 was originally written to be the same as Louisana law. Two basic things are addressed in this bill, that being Down's Syndrome and also Spinal Bifda. He stated that perhaps this bill needs a statement of intent spelling out the intentions of the legislature with HB 807.

He handed in a letter from Dr. Jeffry Strickler, MD., from Helena, Dr. Strickler is chairman of the Montana Chapter of American Academy of Pediatrics. He stated that the American Academy of Pediatrics has worked many years on Baby Doe and is strongly in favor of HB 807. It is a reasoned and reasonable approach to the handling of difficult decisions. In addition, the concept of an infant bioethics committee is consistant with the academy's position. Life and death decisions should be decided according to local mores and should include clergy, lay people, attorneys, as well as parents and physicians.

Norma Harris, representing the Department of Social and Rehabilitation Services, stood in support of the bill. She stated that the department supports the bill as it would clarify responsibilites in what is already being done.

With no further proponents, the chairman called on the opponents. Hearing none, the meeting was opened to a question and answer period from the Committee.

Senator Newman asked Representative Hannah about the word "child" and the word "infant" being used throughout the bill. The word child is anyone under the age of 18, the word infant refers to anyone under one year of age. The word "infant" should be used throughout the bill being as that is what the bill is addressing. He suggested that perhaps some amendments should be drafted.

Representative Hannah closed. He stated that this is a good bill which he would highly recommend to the Committee.

ANNOUNCEMENTS: The next meeting of the Public Health, Welfare and Safety Committee will be held on Wednesday, March 13, 1985 in Room 410 of the State Capitol to consider House Bills 186, 561, 563, 720, 737, and 748

ADJOURN: With no further business the meeting was adjourned.

Judy Jacobson

SENATOR JUDY JACOBSON,
CHAIRMAN

eg

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985 Date 3/11/85

SENATE SEAT #	NAME	PRESENT	ABSENT	EXCUSED
6	SENATOR JUDY JACOBSON, CHAIRMAN	✓		
5	SENATOR J. D. LYNCH, V.CHAIRMAN	✓		
42	SENATOR TOM HAGER	✓		
30	SENATOR MATT HIMSL	✓		
17	SENATOR TED NEWMAN	late		
45	SENATOR BILL NORMAN	✓		
14	SENATOR STAN STEPHENS	✓		
26	SENATOR TOM TOWE	late		

Each day attach to minutes.

DATE ____________

COMMITTEE ON ____________

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Check One: Oppose
TED BECK	MYSELF	649	X	
SAM MURFITT	Mont. Dept Hlth	114	X	
Ellie Parker	"	114	X	
B. J. Greany	Board of Dentistry	649		X
Brian Ruckman	American Diabetes Assoc	817	X	
Joe Upshaw	Am Assn Retired People & Legacy Legislature	649	X	
Joe Upshaw	" "	783	X	
Tom Ryan	M.S.C.A	649	✓	
Tom Ryan	Bill of Rts	783	✓	
E. Reilly	M.S. CA.	649	X	
E. Reilly	M.S CA	783	X	
Norma Harris	SRS	807 783	X	
John Madsen	SRS	540	X	
Charles Brooks	Governor's Office	HB 783 HB 649	X	
Mona Jamison	" "	HB 649	X	
Molly Munro	MONTANA	HB 783	X	
Mark Lee Garrett	Commerce	HB 649	X	
Bruce Rice	Self	HB 649	✓	
Rose Skoog	Montana Health Care Assn	HB 783	Amend	
Dr Jeff Strickler	Academy of Pediatrics	HB 807	✓	
Gerald T Lydell	Mt medical assn	HB 817	✓	
D. Blakley	St Ombudsman	HB 783	Y	
Jo Ann Peterson	MEA	HB 540	✓	
Nancy Nanken	MAAD	HB 817	✓	
Tom Mullaney	MPS Blue Shield	HB 817	✓	

DATE _____

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One: Support	Oppose
Barbara Renner	MT Heart Assoc.	HB817	✓	
LEE WISER	BOARD OF DENTURITRY	HB 649	✓	
Dan Bryan	M.S.C.A.		✓	
Jeanne M SBuchanan	MT Board of Dentistry	HB649		✓
William NAGOBER G	ST Dept of Health	HB 649	✓	
Shirley Miller	Dept of Commerce	HB649	No position	
[illegible]	[illegible]	HB817	✓ [illegible]	
[illegible]	MT. Hosp Ad Assoc	HB817	✓	
[illegible]	STATE Board of Dentistry	HB649	✓	

50-52-302. Department to pay local board for inspection. (1) Before June 30 of each year, the department shall pay to a local board of health, as established under 50-2-104, 50-2-106, or 50-2-107, an amount from the local board inspection fund [account] created by 50-2-108(2) which is for the purpose of inspecting establishments licensed under this chapter; provided, however, that there is a functioning local board of health and that the local board of health, local health officers, and sanitarians assist in the enforcement of the provisions of this chapter and the rules adopted under it.

(2) The funds received by the local board of health shall be deposited with the appropriate local fiscal authority and shall be in addition to the funds appropriated under 50-2-108 through 50-2-114.

History: En. Sec. 215, Ch. 197, L. 1967; amd. Sec. 4, Ch. 383, L. 1973; amd. Sec. 1, Ch. 506, L. 1975; R.C.M. 1947, 69-5604(part); amd. Sec. 7, Ch. 336, L. 1983.

Compiler's Comments

1983 Amendment: In (1), substituted "the local board inspection fund created by 50-2-108(2)" for "any general fund appropriation to the department".

Commissioner Correction: The bracketed word "account" in (1) was added by the Code Commissioner to use the correct name of the fund account created by 50-2-108(2).

CHAPTER 53

PUBLIC SWIMMING POOLS AND SWIMMING AREAS

Part 1 — General Provisions

Section
50-53-101. Purpose of regulation.
50-53-102. Definitions.
50-53-103. Duties of department.
50-53-104. Powers of health officers.
50-53-105. Publication of inspection reports.
50-53-106. Duties of pool operators.
50-53-107. Pool operation to be sanitary, healthful, and safe — when lifeguard not required.
50-53-108. Unauthorized construction or operation a public nuisance.
50-53-109. Violation of chapter a misdemeanor.

Part 1

General Provisions

Part Cross-References

Plans to bear professional seal, 18-2-122.

50-53-101. Purpose of regulation. It is the public policy of this state to regulate public swimming pools and public bathing places to protect public health. ← "safety" left out

History: En. Sec. 201, Ch. 197, L. 1967; R.C.M. 1947, 69-5501.

50-53-102. Definitions. As used in this chapter, unless the context clearly indicates otherwise, the following definitions apply:

(1) "Board" means the board of health and environmental sciences, provided for in 2-15-2104.

(2) "Department" means the department of health and environmental sciences, provided for in Title 2, chapter 15, part 21.

(3) "Person" means a person, firm, partnership, corporation, organization, the state, or any political subdivision of the state.

(4) "Public bathing place" means a body of water with bathhouses and related appurtenances operated for the public.

(5) "Public swimming pool" means an artificial pool and bathhouses and related appurtenances for swimming, bathing, or wading, including natural hot water pools. The term does not include:

(a) swimming pools located on private property used for swimming or bathing only by the owner, members of his family, or their invited guests; or

(b) medicinal hot water baths for individual use.

History: Ap. p. Sec. 202, Ch. 197, L. 1967; amd. Sec. 24, Ch. 187, L. 1977; Sec. 69-5502, R.C.M. 1947; (1), (2)En. Sec. 2, Ch. 197, L. 1967; amd. Sec. 28, Ch. 349, L. 1974; Sec. 69-4102, R.C.M. 1947; R.C.M. 1947, 69-4102(1), (2), 69-5502.

50-53-103. Duties of department. (1) The department shall adopt rules for sanitation in public swimming pools and public bathing places to protect public health.

(2) The department shall supervise the sanitation of public swimming pools and public bathing places.

History: En. Secs. 203, 204, Ch. 197, L. 1967; amd. Secs. 104, 109, Ch. 349, L. 1974; R.C.M. 1947, 69-5503, 69-5504.

Cross-References

Rules for facilities at hotels and motels, 50-51-103.

50-53-104. Powers of health officers. Authorized employees of the department and local boards of health may:

(1) at reasonable times inspect public swimming pools and public bathing places to determine if provisions of this chapter and rules of the department are being violated;

(2) request an injunction from the district court to enjoin actions in violation of this chapter or rules adopted by the department;

(3) bring actions to abate nuisances maintained in violation of this chapter in the manner provided by law for the summary abatement of other public nuisances;

(4) enforce rules adopted by the department.

History: En. Sec. 205, Ch. 197, L. 1967; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-5505.

50-53-105. Publication of inspection reports. The department may publish reports of inspections authorized by 50-53-104(1).

History: En. Sec. 206, Ch. 197, L. 1967; R.C.M. 1947, 69-5506.

50-53-106. Duties of pool operators. Each person operating a public swimming pool or public bathing place shall:

(1) operate the pool or public bathing place in a sanitary and safe manner;

(2) keep records of public health and safety information required by the department;

(3) furnish information to the department on forms prescribed by it.

History: En. Sec. 208, Ch. 197, L. 1967; R.C.M. 1947, 69-5508.

50-53-107. Pool operation to be sanitary, healthful, and safe — when lifeguard not required. (1) Public swimming pools and public bathing places, including pool structures, methods of operation, source of water supply, methods of water purification, lifesaving apparatus, safety measures for bathers, and personal cleanliness measures for bathers, shall be sanitary, healthful, and safe.

(2) A lifeguard is not required for a privately owned public swimming pool if:

(a) a sign is prominently displayed on the swimming pool premises with the words "No lifeguard is on duty" or words of substantially the same meaning; and

(b) one individual per shift is on the premises, accessible to the pool, and currently certified as competent in:

(i) basic water safety measures by the American red cross; and

(ii) cardiopulmonary resuscitation by either the American red cross or the American heart association.

History: En. Sec. 209, Ch. 197, L. 1967; R.C.M. 1947, 69-5509; amd. Sec. 1, Ch. 302, L. 1983.

Compiler's Comments

1983 Amendment: Inserted (2).

50-53-108. Unauthorized construction or operation a public nuisance. The construction or operation of a public swimming pool or public bathing place contrary to the provisions of this chapter or rules adopted by the department under the provisions of this chapter is a public nuisance and dangerous to public health.

History: En. Sec. 210, Ch. 197, L. 1967; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-5510.

50-53-109. Violation of chapter a misdemeanor. A person who violates this chapter or rules adopted by the department under the provisions of this chapter is guilty of a misdemeanor and upon conviction is punishable by a fine of not less than $25 or more than $500, imprisonment for not more than 6 months, or both. Each day that a violation continues is a separate violation.

History: En. Sec. 211, Ch. 197, L. 1967; amd. Sec. 107, Ch. 349, L. 1974; R.C.M. 1947, 69-5511.

CHAPTERS 54 THROUGH 59

RESERVED

CHAPTER 60

BUILDING CONSTRUCTION STANDARDS

Part 1 — General Provisions

Section

Hotel Motel law

Chapter Cross-References
Public swimming pools, Title 50, ch. 53.
Fire safety in public buildings, Title 50, ch. 61.
Hotelkeepers' liens, Title 71, ch. 3, part 14.

Part 1
General Provisions

50-51-101. Purpose of regulation. It is hereby found and declared that the public welfare requires control and regulation of the operation of establishments providing lodging space accommodations, as defined in 50-51-102 hereof, and the control, inspection, and regulation of persons engaged therein in order to prevent or eliminate unsanitary and unhealthful conditions and practices, which conditions and practices may endanger public health. It is further found and declared that the regulation of establishments providing lodging space accommodations as above outlined is in the interest of social well-being and the health and safety of the state and all of its people.

History: En. Sec. 1, Ch. 18, L. 1967; amd. Sec. 1, Ch. 485, L. 1973; R.C.M. 1947, 34-301.

50-51-102. Definitions. Unless the context requires otherwise, in this chapter the following definitions apply:

(1) "Board" means board of health and environmental sciences.

(2) "Department" means the department of health and environmental sciences.

(3) "Hotel" or "motel" includes a building or structure kept, used, maintained as, advertised as, or held out to the public to be a hotel, motel, inn, motor court, tourist court, public lodging house, or place where sleeping accommodations are furnished for a fee to transient guests, with or without meals.

(4) "Person" includes an individual, partnership, corporation, association, county, municipality, cooperative group, or other entity engaged in the business of operating, owning, or offering the services of a hotel, motel, tourist home, retirement home, or roominghouse.

(5) "Roominghouse", "boardinghouse", or "retirement home" means buildings in which separate sleeping rooms are rented providing sleeping accommodations for three or more persons on a weekly, semimonthly, monthly, or permanent basis, whether or not meals or central kitchens are provided but without separated cooking facilities or kitchens within each room, and whose occupants do not need professional nursing or personal-care services provided by the facility.

(6) "Tourist home" means an establishment or premises where sleeping accommodations are furnished to transient guests for hire or rent on a daily

or weekly rental basis in a private home when the accommodations are offered for hire or rent for the use of the traveling public.

(7) "Transient guest" means a guest for only a brief stay, such as the traveling public.

History: En. Sec. 2, Ch. 18, L. 1967; amd. Sec. 2, Ch. 485, L. 1973; amd. Sec. 1, Ch. 325, L. 1977; R.C.M. 1947, 34-302; amd. Sec. 8, Ch. 597, L. 1983.

Compiler's Comments

1983 Amendment: Near beginning of (5), after "Roominghouse" inserted "boardinghouse"; at end of (5) after "nursing" deleted "services on a full-time basis" and inserted "or personal-care services provided by the facility".

50-51-103. Department authorized to adopt rules. The department may adopt and enforce rules to preserve the public health and safety. These rules shall relate to construction, furnishings, housekeeping, personnel, sanitary facilities and controls, water supply, sewerage and sewage disposal system, refuse collection and disposal, registration and supervision, and fire and life safety code.

History: En. Sec. 6, Ch. 18, L. 1967; amd. Sec. 5, Ch. 485, L. 1973; R.C.M. 1947, 34-306(a).

50-51-104. Cooperative agreements authorized. The department is hereby authorized to enter into cooperative agreements with any of the state agencies or political subdivisions for the purpose of carrying out the provisions of this chapter or any part thereof.

History: En. Sec. 6, Ch. 18, L. 1967; amd. Sec. 5, Ch. 485, L. 1973; R.C.M. 1947, 34-306(b).

50-51-105. County attorney to prosecute violations. When the department furnishes evidence to the county attorney of a county in this state, the county attorney shall prosecute any person, firm, or corporation violating this chapter or a rule effective under this chapter.

History: En. Sec. 5, Ch. 18, L. 1967; amd. Sec. 7, Ch. 349, L. 1974; amd. Sec. 2, Ch. 505, L. 1975; R.C.M. 1947, 34-305(5).

50-51-106. Violation of chapter a misdemeanor. Any person violating any provision of this chapter or regulation made hereunder, except 50-51-107, is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine of not less than $50 or more than $100 for the first offense and not less than $75 or more than $200 for the second offense and for the third and subsequent offenses not less than $200 and by imprisonment in the county jail not to exceed 90 days.

History: En. Sec. 9, Ch. 18, L. 1967; R.C.M. 1947, 34-309; amd. Sec. 18, Ch. 37, L. 1979.

50-51-107. Provision of nursing services or personal-care services by the facility prohibited. (1) Hotels, motels, boardinghouses, roominghouses, or similar accommodations may not provide professional nursing services or personal-care services. A resident of a hotel, motel, boardinghouse, roominghouse, or similar accommodation may have personal-care, medical, or nursing-related services provided for him in such facility by a third-party provider.

(2) Whenever a complaint is filed with the department that a person in need of professional nursing services is residing in a roominghouse or other

> The department [of health and environmental sciences] may adopt and enforce rules to preserve the public health and safety. These rules shall relate to construction, furnishings, housekeeping, personnel, sanitary facilities and controls, water supply, sewerage and sewage disposal system, refuse collection and disposal, registration and supervision, and fire and life safety code. (Emphasis added.)

This statute expressly delegates to the Department the authority to adopt rules concerning construction standards for hotels or motels relating to safety. If a hotel or motel provides a swimming pool for the use of its guests, that swimming pool must comply with any rules specifying construction standards adopted by the Department pursuant to section 50-51-103. The Department has adopted such a rule. ARM 16.10.618 states:

> The construction and operation of any swimming pool, hot bath, mineral bath, or public swimming place in connection with any hotel, motel, or tourist home shall be in accordance with Title 50, Chapter 53, MCA and department rules regarding the construction and operation of swimming pools.

Because this rule was adopted under the expressly delegated authority of section 50-51-103, MCA, it has the force of law. See § 2-4-102(11)(a), MCA. Thus, the same rules concerning construction standards for safety which are interpretive only in their application to public swimming pools generally, have the force of law as applied to hotel, motel, or tourist home swimming pools.

THEREFORE, IT IS MY OPINION:

1. The statutes in Title 50, Chapter 53, MCA, concerning public swimming pools, apply to health club swimming pools.

2. Title 50, Chapter 53, MCA, authorizes the Department of Health and Environmental Sciences to adopt interpretive rules concerning construction standards relating to safety for public swimming pools generally.

3. Section 50-51-103, MCA, authorizes the Department of Health and Environmental Sciences to adopt legislative rules, having the force of law, concerning construction standards relating to safety for swimming pools operated in connection with hotels, motels or tourist homes.

Very truly yours,

MIKE GREELY
Attorney General

Proposed amendment to HB 114 as introduced:

1. Page 2, line 19.
Following: "~~(1)~~"
Insert: "(1)"

2. Page 2, Line 24
Following: [redacted] "~~7~~"
Insert: "(2) Any rule that is a building regulation as defined in 50-60-101 is effective only when the department of administration approves it and files it with the secretary of state as part of the state building code pursuant to 50-60-204."

NAME: SAMUEL J. MURPHY DATE: 3-11-85

ADDRESS: Helena Mt

PHONE: 444-2823

REPRESENTING WHOM? Mont Dept Hlth.

APPEARING ON WHICH PROPOSAL: HB 141

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: See attachments

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

INFORMATION RELATIVE TO H.B. 114

Historically, safety has been a major portion of a total swimming pool program throughout the nation.

In Montana, safety has been a major portion of the swimming pool program since 1967 when the present law was passed. The law was written with safety included in some sections and not in others. In those sections where the terms "safety" or "safe" were not used, the term "to protect the public health" was substituted.

Rules were adopted pursuant to the law and both safety and sanitation were addressed.

The purpose of this bill is therefore to clarify those sections where the term "to protect public health" is used instead of the terms "safe" or "safety" and to make those sections consistent with the rest of the law.

Some of the items which would be covered under the "safety" heading are as follows: improper bottom slope, inadequate depth for diving, absence of shallow end, lighting, underwater protrusions, no pool decking, warning signs or other life saving apparatus, depth markings, fencing, pool water clarity, etc.

In many cases safety and sanitation aspects of swimming pool design, maintenance and operation are interrelated. For example, water clarity (which can be a safety problem) is maintained by proper balancing of water chemistry (chlorine, pH, etc.) which in turn inhibits bacterial growth and the transmission or spread of disease.

Swimming pool safety rules are supported and recommended by the swimming pool industry and expected by the general public utilizing public swimming facilities.

From Federal Regs.

CURRENT PATIENTS' RIGHTS NOW BEING USED

Medicare/Medicaid Rights (part of conditions of participation)

(k) Standard: Patients' rights. The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205 (j) of the Social Security Act, and Subpart Q of 20 CFR Part 404, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures. These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:

(1) Is fully informed, as evidenced by the patient's written acknowledgment, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;

(2) Is fully informed, prior to or at the time of admission and during stay of services available in the facility, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;

(3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;

(4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for non-payment of his stay (except as prohibited by titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in his medical record;

(5) Is encouraged and assisted throughout his period of stay, to exercise his rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to facility staff and/or outside representatives of his choice, free from restraint, interference, coercion, discrimination, or reprisal;

(6) May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law;

(7) Is free from mental and physical abuse, and free from chemical and (except in emergencies) physical restraints except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to himself or to others;

(8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

(9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care of his personal needs;

(10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

(11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);

(12) May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

(13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

(14) If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

All rights and responsibilities specified in paragraphs (k) (1) through (4) of this section - as they pertain to (i) a patient adjudicated incompetent in accordance with State law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who exhibits a communication barrier - devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (except when the facility itself is representative payee) selected pursuant to section 205(j) of the Social Security Act and Subpart Q of 20 CFR Part 404.

SENIORS' OFFICE

LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

Feb. 5, 1985

TO: Representative Joan Miles

FROM: Doug Blakley, LTCO DOB

RE: Residents Right Bill

Additions from Interpretive Guidelines and other states

Information herein deals with the specitic sections of the Bill of Rights, and discuss those areas that are highlighted in green in the attached copy of the bill.

(3) Guidelines talk of resident involvement in care planning and alternative courses of care and treatment. Resident preference about alternatives "should be elicited and considered in deciding on the plan of care". Skilled nursing home guidelines do specifically state ability to refuse treatment. Intermedicate care (ICF) resident rights give residents the "opportunity to refuse treatment" but the guidelines do not expand on this. Proposed federal rights of 1980 included the right to refuse treatment.
Other states with similar language in their resident rights bills: Language in the bill paterned after Florida and Colorado; MN, OH, NJ, DE, MD, LA, NY, RI, WA, ND also mention this specifically.

(4) Reasonable discharge is not specifically defined, though resident involvement is included "far enough in advance that he may make his wishes known and participate in planning for the move". The proposed federal guidelines allowed for 30 days in any involuntary transfer. Most residents who pose a problem to a facility that they are unable to handle do so over a period of time. Facilities should be working with the attending physician on controlling or alleviating the problem well in advance of any discharge or transfer. This is especially true in cases where some mental or behavioral problem exists. Cases of medical necessity which would require movement from skilled to intermediate care or vice-versa, could be done via the emergency procedures and would include the attending physician as a safeguard against indiscriminate actions.
Other states: Language patterned after the Minnesota law; MN, FL, ND, NJ, DE, CN, IL, MD all have 30 day requirements; NH has a 21 day requirement; WA has a 15 day requirement; NC has a 5 day requirement. Medicaid requires a 30 day notice before transfer when a facility is decertified. The Superior Court of Washington ruled that a 30 day requirement is necessary.

(7) All additions (restraints for convenience of staff, confinement to locked room, and documentation of emergency use of restraints) are in the interpretive guidelines.
Other states: Language patterned after Ohio and Interpretive Guidelines; NJ, IL, FL have similar language.

(8) Resident rights for access to records is included in guidelines. Proposed federal regulations included this in the regulations itself.
Other states: Patterned after Ohio.

(13) In guidelines, property is to be kept in a safe location which is convenient to residents. Facility is required to inform residents of facilities responsibility for maintaining clothing and possessions. Facilities have responsibility for identifying and recording items at admissions that they retain for safekeeping. Residents need to be aware of what happens in the case of loss or theft of items not specifically retained by the facility so they can either have them retained by the facility or leave them with someone outside the facility. Theft of articles is a constant problem. Thefts are often trivialized, discounted, or explained away by ageist stereotypes of elderly forgetfulness, incompetence.
Other states: Patterned after Illinois language.

(15) Telephones are included under the guidelines for section (1) as are visits. There has been no reported problems with restricted visiting hours, so we have no recommended minimum visiting hours as some states have. Proposed federal regulations specifically included telephone rights.
Other states: Patterned after Ohio language; NJ, MN, FL, KY NJ,DE, WI have similar language.

(16) Not specifically mentioned in any of the guidelines dealing with privacy. Proposed federal guidelines included this provision.
Other states: Patterned after Ohio language; MN, FL, DE, MD, Il have similar language.

(17) ICF resident rights guidelines mention resident councils as a method of involving residents in the exercising of their rights, but goes no further. Several states have mandated that all nursing homes have councils. We wanted that decision to rest with the residents and family members. The proposed federal regulations included the right to organize councils.
Other states: Patterned after the Minnesota law; CN, FL, ME NY have similar language; CO, IN, IL have mandatory council requirements.

(18) Self discharge not mentioned in Interpretive Guidelines.
Other states: Patterned after the New Jersey and Illinois language; KY has similar language.

SENIORS' OFFICE
LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

March 11, 1985

TO: Members of the Senate Public Health, Welfare and Safety Committee

FROM: Doug Blakley, State Ombudsman

RE: HB 783 Long-term Care Residents Bill of Rights

Why a Bill of Rights is needed

The Bill's purpose is twofold:

1. to extend a comprehensive set of rights to a group of individuals who by nature of mental, physical or situational factors are in a vulnerable state
2. to educate both facility personnel and those receiving services in long-term care settings about what their rights are.

Rights are usually developed to provide a balance between a stronger and a weaker group. Residents in long-term care settings definitely fall into the latter group. Advanced age, declining capabilities, and institutionalization are factors that contribute to the vulnerability of residents.

While many facilities may extend most of the rights included in the Bill at the present time, it is important that they be extended to all. Many facilities may not be aware of the additional requirements spelled out in the Interpretive Guidelines for the current federal requirements for Skilled and Intermediate Care facilities. Additionally, those areas that in the past have been unclear or not covered in the federal regulations have been calrified or included in the present bill.

Setting all the pertinent requirements into one readily available document and having it available to all involved in long-term care increases knowledge about requirements and should lessen those situations were rights are abridged because of lack of knowledge. It also allows those receiving care to be more aware of what their rights are.

Bill development process

Since the federal Skilled Care Bill of Rights required for participation and reimbursement in the Medicare and Medicaid programs is the most widely used bill of rights, it was used as the basis for the State Bill of Rights. The proposed 1980 federal additions to the federal requirements and approximately 30 resident rights bills from other states were reviewed during the development process. Problems that were identified by the Ombudsman Program were also taken into consideration. Additions were then incorporated into the existing Skilled Care requirements to make their implementation easier for facilities. Thus, the current fourteen standards appear at the start of the bill. Additions were made to sections (3), (4), (7), (8), and (13). The remaining sections are new and are based on other state laws and the Interpretive Guidelines.

AN EQUAL OPPORTUNITY EMPLOYER

publications & graphics

SENIORS' OFFICE
LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATE

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

Feb. 5, 1985

TO: Representative Joan Miles

FROM: Doug Blakley, LTCO DB

RE: Residents Right Bill

Additions from Interpretive Guidelines and other states

Information herein deals with the specitic sections of the Bill of Rights, and discuss those areas that are highlighted in green in the attached copy of the bill.

(3) Guidelines talk of resident involvement in care planning and alternative courses of care and treatment. Resident preference about alternatives "should be elicited and considered in deciding on the plan of care". Skilled nursing home guidelines do specifically state ability to refuse treatment. Intermedicate care (ICF) resident rights give residents the "opportunity to refuse treatment" but the guidelines do not expand on this. Proposed federal rights of 1980 included the right to refuse treatment.
Other states with similar language in their resident rights bills: Language in the bill paterned after Florida and Colorado; MN, OH, NJ, DE, MD, LA, NY, RI, WA, ND also mention this specificall.

(4) Reasonable discharge is not specifically defined, though resident involvement is included "far enough in advance that he may make his wishes known and participate in planning for the move". The proposed federal guidelines allowed for 30 days in any involuntary transfer. Most residents who pose a problem to a facility that they are unable to handle do so over a period of time. Facilities should be working with the attending physician on controlling or alleviating the problem well in advance of any discharge or transfer. This is especially true in cases where some mental or behavioral problem exists. Cases of medical necessity which would require movement from skilled to intermediate care or vice-versa, could be done via the emergency procedures and would include the attending physician as a safeguard against indiscriminate actions.
Other states: Language patterned after the Minnesota law; MN, FL, ND, NJ, DE, CN, IL, MD all have 30 day requirements; NH has a 21 day requirement; WA has a 15 day requirement; NC has a 5 day requirement. Medicaid requires a 30 day notice before transfer when a facility is decertified. The Superior Court of Washington ruled that a 30 day requirement is necessary.

(7) All additions (restraints for convenience of staff, confinement to locked room, and documentation of emergency use of restraints) are in the interpretive guidelines.
Other states: Language patterned after Ohio and Interpretive Guidelines; NJ, IL, FL have similar language.

(8) Resident rights for access to records is included in guidelines. Proposed federal regulations included this in the regulations itself.
Other states: Patterned after Ohio.

(13) In guidelines, property is to be kept in a safe location which is convenient to residents. Facility is required to inform residents of facilities responsibility for maintaining clothing and possessions. Facilities have responsibility for identifying and recording items at admissions that they retain for safekeeping. Residents need to be aware of what happens in the case of loss or theft of items not specifically retained by the facility so they can either have them retained by the facility or leave them with someone outside the facility. Theft of articles is a constant problem. Thefts are often trivialized, discounted, or explained away by ageist stereotypes of elderly forgetfulness, incompetence.
Other states: Patterned after Illinois language.

(15) Telephones are included under the guidelines for section (1) as are visits. There has been no reported problems with restricted visiting hours, so we have no recommended minimum visiting hours as some states have. Proposed federal regulations specifically included telephone rights.
Other states: Patterned after Ohio language; NJ, MN, FL, KY NJ,DE, WI have similar language.

(16) Not specifically mentioned in any of the guidelines dealing with privacy. Proposed federal guidelines included this provision.
Other states: Patterned after Ohio language; MN, FL, DE, MD, IL have similar language.

(17) ICF resident rights guidelines mention resident councils as a method of involving residents in the exercising of their rights, but goes no further. Several states have mandated that all nursing homes have councils. We wanted that decision to rest with the residents and family members. The proposed federal regulations included the right to organize councils.
Other states: Patterned after the Minnesota law; CN, FL, ME NY have similar language; CO, IN, IL have mandatory council requirements.

(18) Self discharge not mentioned in Interpretive Guidelines.
Other states: Patterned after the New Jersey and Illinois language; KY has similar language.

SENIORS' OFFICE
LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

March 11, 1985

Senate Committe on Public Health
49th Legislative Session
Montana Legislature
State Capitol
Helena, Montana 59620

re: House Bill 783
Residents' Bill of Rights

Dear Chairman Jacobson & Committee:

I serve as the attorney for Doug Blakley, the State Long-term Care Ombudsman and I wish to go on record in support of House Bill 783, the Nursing Home Resident's Bill of Rights, which is sponsored by Rep. Joan Miles. I am unable to personally appear before you today but would like to express my support for this Bill while requesting that you consider accepting an amendment to one section of the Bill, Section 7.

If you will note this section as it passed the House it was amended substantially on the House floor to the effect that unless the Senate re-inserts the language that was striken or similar language, it may not be financially feasible for the average resident or his or her family to file a claim. For example, a resident may believe that he has been injured as a result of a facility abridging his rights guaranteed in this bill. The amount of damage may amount to $500 but it will cost him $1000 to hire an attorney to file his suit and bring the issue to trial. As the bill now stands, the resident may win his lawsuit and receive the damages to which he is due but as a result of not being able to recover from the facility his court costs and attorney fees, the client is now in debt.

I would urge your Committee to report this Bill favorably out of Committee with an amendment allowing the prevailing party in a lawsuit under this act, be it the resident or the facility, to recover their costs and reasonable attorney's fees from the other party. In addition, I would urge you to re-insert the language that was in the original bill that the remedies in the bill are in addition to any other legal or administrative sanctions that may apply.

publications & graphics

AN EQUAL OPPORTUNITY EMPLOYER

Some of the rights of residents that are enumerated within this Bill are specifically recognized under federal and state licensure regulations adopted by the federal Department of Health and Human Services and the Montana Department of Health and Environmental Sciences' Licensing and Certification Bureau. It is important not to foreclose these agencies as a result of this Bill from imposing licensing sanctions against facilities that violate rights that are recognized here as well as in their licensing regualtions. By including the language["The remedies provided in this section are in addition to any other legal or administrative remedies available."] the public and the facilities should be on notice that non-compliance with some of these rights may also result in administrative sanctions affecting the facility's license.

Thank you for your consideration of these amendments which I believe will make the Bill more effective in encouraging the recognition of nursing home residents' rights. I have included the amendments that I am recommending on a separate page which is attached to this letter.

Sincerely,

Douglas B. Olson
Attorney
Seniors' Office of Legal &
Ombudsman Services

Attachment
cc: Rep. Joan Miles

Amendments to House Bill 783
Residents' Bill of Rights
Proposed by Doug Olson, Attorney for
State Long-term Care Ombudsman
Submitted to Senate Public Health Committee
March 11, 1985

1. Page 8, line 23
Following: "available."
Insert:"THE ACTION MAY BE BROUGHT IN THE DISTRICT COURT TO ENFORCE SUCH RIGHTS AND RECOVER DAMAGES FOR ANY DEPRIVATION OR INFRINGEMENT OF THE RIGHTS OF RESIDENTS. THE JUDGE IN HIS DISCRETION MAY AWARD TO THE PREVAILING PARTY REASONABLE ATTORNEY FEES AND COSTS OF THE ACTION. THE REMDEDIES PROVIDED IN THIS SECTION ARE IN ADDITION TO ANY OTHER LEGAL OR ADMINISTRATIVE REMEDIES AVAILABLE."

NAME: Molly Munro DATE: 3/11/85

ADDRESS: Helena

PHONE: 443-1185

REPRESENTING WHOM? Mont. Association of Homes for Aging

APPEARING ON WHICH PROPOSAL: HB 783

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

MONTANA
ASSOCIATION OF HOMES FOR THE AGING

715 NORTH FEE
P.O. BOX 5774
HELENA, MT 59604

(406) 443-1185

March 11, 1985

TESTIMONY BEFORE THE SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

RE: HB 783 (Miles)

BY: Molly Munro, Executive Secretary

The Montana Association of Homes for the Aging wishes to go on record in support of HB 783.

HB 783 brings state regulations into conformity with the federal regulations. Our member facilities already have such resident bills of rights posted in their facilities.

We urge your support of HB 783.

mhca
MONTANA HEALTH CARE ASSOCIATION

34 So. Last Chance Mall, No. 1
Helena, Montana 59601
Telephone: 406-443-2876

STATEMENT OF THE MONTANA HEALTH CARE ASSOCIATION

on

HOUSE BILL 783 - RESIDENTS' BILL OF RIGHTS

before the

SENATE PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

March 11, 1985

For the record, I am Rose Skoog, Executive Director of the Montana Health Care Association, an organization representing 60 skilled and intermediate care facilities--both proprietary and non-proprietary--throughout the state of Montana.

As a representative of two-thirds of all of the skilled and intermediate care facilities in this state--whether operated for profit or non-profit, whether county owned or operated, or whether a combination facility attached to a hospital--we support House Bill 783 as a statement of the rights already enjoyed by residents and patients in our facilities. Largely, the rights detailed in this legislation are already guaranteed to all citizens under the U.S. and Montana Constitutions. In addition, such rights are already guaranteed to residents of our facilities by two separate bills of rights--one for residents of intermediate care facilities, and one for residents of skilled nursing facilities--both mandated by the federal government for participation in the Medicaid and Medicare programs. All nursing homes in this state participate in at least one of those programs and are, therefore, covered by these bills of rights.

In addition to the regulations detailing these rights, the U.S. Dept. of Health and Human Services has developed extensive "interpretive guidelines" detailing what facilities are expected to do in order to be deemed in compliance with the federal regulations relating to patients' rights. Nursing homes have been covered by these laws since 1974.

Nursing homes support the establishment of the federal bill of rights in state law as a public policy statement of the commitment of each of us to insure that the frail elderly in our facilities continue to enjoy the basic human rights guaranteed to all citizens.

House Bill 783, in most instances, reiterates the federal regulations and the interpretive guidelines. However, we have two general concerns about this legislation and are seeking amendments to address those concerns. The concerns are:

1. In certain respects, HB 783 goes beyond setting out general policy with respect to rights of patients, and in fact restricts the discretion of the professionals responsible for the care of the residents--such as the attending physician, licensed nurses, and licensed nursing home administrators. A statement of rights, such as this, should serve as a guideline and reminder that patients in our facilities do not lose any of their rights as citizens simply because they can no longer independently care for themselves. It should not, however, assert hard and fast, black and white rules and prohibitions applicable in all sets of circumstances--because many sets of circumstances we come in contact with in our facilities cannot be foreseen and accounted for in such rules.

2. Our second concern with HB 783 is that it goes beyond being instructive and creates new enforcement mechanisms and penalties which are unnecessary and inappropriate.

PROPOSED AMENDMENTS

1. <u>Section 6(4), page 4, relating to transfer and discharge of residents.</u> The first two sentences in this section are the same as the federal language. However, the last sentence is new and goes beyond the federal requirement, setting an absolute standard that is inappropriate.

This right states that "each resident has the right to be transferred or discharged only for medical reasons, for his welfare or that of other patients, or for nonpayment of his stay," and "...to be given reasonable advance notice to ensure orderly transfer or discharge."

HB 783 adds the language:

"Reasonable advance notice requires at least 30 days' advanced written notice of any interfacility transfer or any discharge, except in the case of emergency as documented by the resident's attending physician in his medical record."

We feel this language is too restrictive and is arbitrary. There may be circumstances where 5 days is reasonable and others where significantly more than 30 days is required. We should remember that patients are not discharged and transferred out of nursing homes without consulting social workers, discharge planners--and most importantly, the attending physician. If all of these people, in their professional judgment, feel that a patient should be transferred or discharged with less than 30 days notice and have done everything necessary and possible to insure a smooth transition, why should state law supersede that judgment?

The federal government has interpreted "reasonable advance notice" in a manner consistent with good patient care and the use of professional judgment. Their interpretive guideline on this subject states:

"Reasonable advance notice means that the decision to transfer or discharge a patient must be discussed with him and that he be told the reasons for it and alternatives available far enough in advance that he may make his wishes known and participate in the planning for the move."

We ask that you amend HB 783 to insert the federal definition of "reasonable advance notice" in place of the 30-day requirement.

This will give the facility the flexibility to deal with the day to day problems it encounters in caring for its patients. Thirty days' notice is not always appropriate and not always in the best interests of other patients in the facility. Behavior problems and the like can become severe quickly and the facility and attending physician need to be able to respond. We question whether these situations will qualify as "emergencies" even though they might be serious and require quick response.

2. <u>Section 6 (16), page 7, relating to right to have door closed.</u> This section is totally new and provides:

"Each resident has the right to have the door of his room closed and not opened by the facility's staff without knocking prior to opening, except in the case of emergency or unless medically contraindicated, as documented in his medical record by his attending physician."

Clearly, residents should have a right to private visits with spouse, family and others; to have personal needs attended to in privacy; and to engage in other activities in privacy.

Three other rights provide for these circumstances. They are:

a. Number 9, which provides that "each resident has the right to be treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs."

b. Number 11, which provides that "each resident may associate and communicate privately with persons of his choice and may send and receive his personal mail unopened..."

c. Number 14, which provides that "each resident has the right of privacy for visits with his spouse..."; and

d. Number 15, which provides that "each resident has the right to reasonable access to a telephone for private communications and to have private visits at any reasonable hour."

The federal interpretive guidelines with respect to these enumerated rights are attached for you information. Your review of these guidelines will attest that ample provision is made to insure privacy while recognizing the patients in skilled and intermediate care facilities require care, protection and vigilance by facility staff in meeting their needs.

This section of HB 783 goes beyond what is prudent in a health care facility. It interferes with the facility's ability to take care of its patients and will lead to such absurd practices as knocking on patients doors and waking them in the middle of the night while doing room checks. In addition, it is impossible to provide an absolute right to each resident to have the door of his room closed if his medical condition allows it, since that does not take into account the medical condition of the patient's room mate. Most nursing home patients are in rooms with at least one other person; some are even in four bed wards.

We ask that HB 783 be amended to delete subsection (16) of section 6. Privacy rights are provided in a more responsible manner in other sections of the bill.

3. <u>Sections 7 and 8, pages 8 and 9, relating to enforcement and penalties</u>.

Section 7(1) should be amended to read as follows:

"(1) The long term care ombudsman shall investigate and seek to resolve, and refer to state and local authorities when appropriate, complaints alleging that a facility has violated a resident's right recognized under this act."

Section 7(2) and the whole of Section 8 should be deleted in their entirety. These sections create a cause of action against a long term care facility for any violation of the bill of rights and establishes a civil fine for any such violation.

There is no provision that the violation be serious, that it be intentional, or that the facility have a history of violations of patients rights. Any violation which can be proven creates a cause of action and attaches a fine of not less than $50 nor more than $2,000.

An example would be a new nurse's aide opening a closed door without knocking. Even if the aide was not yet aware of the requirement to knock, and even if she didn't interrupt a private conversation or otherwise harm the patient, the fact that she entered the room without knocking would be a violation and the patient or patient's family could bring a lawsuit under this legislation. In addition, if the patient could simply prove that the incident occurred, the facility would be subject to a fine of not less than $50 nor more than $2,000. If that aide walked through 10 closed doors that day without knocking, the facility would be liable for at least $500 in penalties.

Another example would be a violation of Section 6(3) relating to the right to be fully informed, by a physician, of his medical condition and to participate in the planning of his medical treatment. Here is a situation where this legislation gives a patient the right to sue the facility because a physician--not the facility--failed to inform the patient of his medical condition or to involve him in planning his treatment. A facility has a clear obligation to treat a patient according to physician's orders, yet doing so if the physician has not adequately informed the patient and solicited the patient's participation will subject the facility to penalties under this act.

Long term care residents whose rights have been violated do have recourse--without these sections of this legislation. Residents of nursing homes possess all the legal rights of people residing outside of facilities. They are possessed of the right to seek redress for wrongs through the use of the judicial system.

The type of violation and the extent of the damages will determine what kind of action is filed. If the violation involves a civil right, a civil rights action may be filed. If it involves a breach of a provision in the facility's contract with the patient, the patient can file a contract action. Tort actions for negligence, intentional tort and strict liability are all avenues of redress open to patients of nursing homes.

In addition, the Dept. of Health and Environmental Sciences has the ability to take action against the license of a facility that makes a practice of violating patients' rights. The Department is responsible for insuring that facilities have established policies regarding patients' rights, that facilities have posted such rights and made them available to patients, that facilities have fully trained and informed their staff about the rights of patients, and that patients' rights are in fact enforced in the facilities. This is a standard for licensure and certification of facilities.

Facilities in this state care for some 6,000 patients--365 days a year. That's over 2,000,000 patient days of care each year. Staff of these facilities come in contact with patients a minimum of 8 or 10 times a day--that's a minimum of 20,000,000 staff/patient contacts each year. To make it an offense and create a cause of action and penalty for every transgression an individual staff member makes with an individual patient--no matter how minor--is inappropriate.

In summary, our facilities are very much aware of the rights guaranteed our patients by state and federal laws, regulations, and Constitutions, and they have an excellent record of insuring those rights to their patients. We welcome a restatement of these rights in state law; but we do hope the legislation ultimately adopted with respect to these rights serves to enhance the well being of our residents and does not tie the hands of and improperly penalize the care givers responsible for the difficult day to day decisions made in our facilities.

Thank you for the opportunity to present our views. I would be happy to respond to your questions at the appropriate time.

MEDICARE/MEDICAID OPERATING STANDARDS

Skilled Nursing Facilities

405.1121 GOVERNING BODY AND MANAGEMENT, contd.

h. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each 2 hours in which restraints are employed, except at night; and

i. The practice of locking patients in their rooms or using locked restraints also constitutes physical restraint and must be in conformance with the requirements of the Life Safety Code as well as meet the requirements contained in this standard.

(k)(8) Is assured confidential treatment of his personal and medical records, and may approve or refuse their release to any individual outside the facility, except, in case of his transfer to another health care institution, or as required by law or third-party payment contract;

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. The facility limits access to any medical records to staff and consultants providing professional service to the patient (405.1132(b)). This is not meant to preclude access by representatives of state and federal regulatory agencies.
2. Similar procedures safeguard the confidentiality of patients' personal records (e.g., financial records and social services records 405.1120(c)). Only those personnel concerned with the fiscal affairs of the patients have access to the financial records.
3. Patients may initiate a request to release information contained in their records and charts to anyone they wish, and the facility honors such a request.

(k)(9) Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. Staff display respect for patients when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings.
2. Schedules of daily activities allow maximum flexibility for patients to exercise choice about what they will do and when they will do it. Patients' individual preferences regarding such things as menus, clothing, religious activities, friendships, activity programs, entertainment are elicited and respected by the facility.
3. Patients are examined and treated in a manner that maintains the privacy of their bodies. A closed door or a drawn curtain shields the patient from passers-by. People not involved in the care of the patients are not present without their consent while they are being examined or treated.
4. Privacy of a patient's body also is maintained during toileting, bathing, and other activities of personal hygiene, except as needed for patient safety or assistance.

(k)(10) Is not required to perform services for the facility that are not included for therapeutic purposes in his plan of care;

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. Patients are not used to provide a source of labor for a facility against their will or against their physicians' orders.
2. If the plan of care requires such activities for therapeutic reasons, the plan for these activities is professionally developed and implemented, the therapeutic goals are clearly stated and measurable, the plan is time limited and reviewed at least quarterly.

(k)(11) May associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated (as documented by his physician in his medical record);

©National Health Publishing Corp., 1977

MEDICARE/MEDICAID OPERATING STANDARDS

Skilled Nursing Facilities

405.1121 GOVERNING BODY AND MANAGEMENT, contd.

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. Policies and procedures recognize the needs of patients to have access to and maintain contact with the community of which they are a part and members of that community have access to him.
2. Subject to reasonable scheduling restrictions, visiting policies and procedures permit patients to receive visits from anyone they wish. A particular visitor may be restricted by the facility for one of the following reasons:
   a. The patient refuses to see the visitor.
   b. The patient's physician documents specific reasons why such a visit would be harmful to the patient's health.
   c. The visitor's behavior is unreasonably disruptive of the functioning of the facility (this judgment must be made by the administrator and the reasons are documented). This is not intended to preclude those who, because they advocate administrative changes to protect patient rights, are considered a disruptive influence by the administrator.
3. Decisions to restrict a visitor are reviewed and reevaluated each time the patient's plan of care and medical orders are reviewed by the physician and nursing staff or at the patient's request.
4. Space is provided for patients to receive visitors in reasonable comfort and privacy.
5. Telephones, consistent with ANSI standards (405.1134(c)), are available and accessible for patients to make and receive calls with privacy. Patients who need help are assisted in using the phone. The fact that telephone communication is possible, as well as any restrictions, is made known to patients.
6. Arrangements are made to provide assistance to patients who require help in reading or sending mail.

(k)(12) May meet with, and participate in activities of, social, religious, and community groups at his discretion, unless medically contraindicated (as documented by his physician in his medical record);

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. Patients who wish to meet with or participate in activities of social, religious, or other community groups in or outside of the facility are informed and encouraged and assisted to do so. (405.1131(b)).
2. All patients have the freedom to refuse to participate in these activities.

(k)(13) May retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients, and unless medically contraindicated (as documented by his physician in his medical record); and

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. Patients are permitted to keep reasonable amounts of personal clothing and possessions for their use while in the facility and such personal property is kept in a safe location which is convenient to the patient.
2. Patients are advised, prior to or at admission, of the kinds and amounts of clothing and possessions permitted for personal use, and whether the facility will accept responsibility for maintaining these items (e.g., cleaning and laundry).
3. Any personal clothing or possessions retained by the facility for the patient during his stay is identified and recorded on admission and a receipt given to the patient. The facility is responsible for secure storage of such items, and they are returned to the patient promptly upon request or upon discharge from the facility.

(k)(14) If married, is assured privacy for visits by his/her spouse; if both are inpatients in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record).

©National Health Publishing Corp., 1977

405.1121 GOVERNING BODY AND MANAGEMENT, contd.

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

1. The facility has a method of arranging for privacy in visits between spouses.
2. Spouses who are patients in the same facility are permitted to share a room unless one of their physicians documents in the medical record those specific reasons why such an arrangement would have an adverse effect on the health of the patient.

All rights and responsibilities specified in paragraphs (k) (1) through (4) of this section as they pertain to (a) a patient adjudicated incompetent in accordance with State law, **(b)** a patient who is found, by his physician, to be medically incapable of understanding these rights, or **(c)** a patient who exhibits a communication barrier--**devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee** (except when the facility itself is represenatative payee (selected pursuant to section 205(j) of the Social Security Act and Subpart Q of Part 404 of this chapter. [*Subpart Q of Part 404 deals with the determination by the Social Security Administration of the proper representative of the patient, whether a relative or other person.*]

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, June, 1975*]

The fact that a patient has been adjudicated incompetent, is medically incapable of understanding, or exhibits a communication barrier, does not absolve the facility from advising the patient of these rights to the extent the patient is able to understand them. If the patient is incapable of understanding these rights, the facility advises the guardian or sponsor and acquires a statement indicating an understanding of patients' rights.

(1) Patient care policies. The skilled nursing facility has written patient care policies to govern the continuing skilled nursing care and related medical or other services provided.

(I)(1) The facility has policies, which are **developed by the medical director** or the organized medical staff (see 405.1122), with the advice of (and with provision for review of such policies from time to time, but at least annually, by) a group of professional personnel including one or more physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides. The policies, which are available to admitting physicians, sponsoring agencies, patients, and the public, reflect awareness of, and provision for, meeting the total medical and psychosocial needs of patients, including admission, transfer, and discharge planning; and the range of services available to patients, including frequency of physician visits by each category of patients admitted. These policies also include provisions to protect patients' personal and property rights. Medical records and minutes of staff and committee meetings reflect that patient care is being rendered in accordance with the written patient care policies, and that utilization review committee recommendations regarding the policies are reviewed and necessary steps taken to ensure compliance.

Interpretive Guidelines: [*Issued by HEW's Office of Long Term Care, Nov., 1974*]

Policies guide and limit the activities and decisions of the staff as they fulfill the objectives of the facility. The establishment and enforcement of policies ensures that specific duties or functions are performed accurately and uniformly.

1. The facility has patient care policies for the following areas:
   a. Admission, transfer, and discharge policies, categories of patients accepted and not accepted;
   b. Physician services;

(continued)

©National Health Publishing Corp., 1977

APPENDIX A

SENIORS' OFFICE

LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

ANNUAL STATISTICS

A. RESIDENT CARE (86) 38%

A-1	Inadequate hygiene care	(7)	A-16	Dehydration	
A-2	Bedsores, decubitus ulcers	(2)	A-17	Doctor not called	(1)
A-3	Not dressed	(1)	A-18	Staff attitudes	(6)
A-4	Not turned	(1)	A-19	Staff poorly trained	(7)
A-5	Not walked, exercised	(2)		**Lack/poor quality of:**	
A-6	Improper restraints	(5)	A-20	Restorative nursing	(2)
A-7	Unanswered help calls	(2)	A-21	Rehabilitation (OT,PT,ST)	(2)
A-8	Inadequate supervision of resisent	(3)	A-22	Social Services	
A-9	Kept up too long		A-23	Dental	
A-10	Improper accident procedures	(2)	A-24	Diagnostic	(1)
A-11	Resident falling	(3)	A-25	Activities (leisure, religious)	
A-12	Physical abuse	(18)	A-26	Inadequate care plan	(1)
A-13	Mental abuse	(3)	A-27	Poor medical equipment (wheel-chair, walker, hearing aid, etc.)	(2)
A-14	Verbal abuse	(7)			
A-15	Neglect (specify)	(6)	A-28	clothing in poor condition	(1)
			A-29	Other (specify)	(1)

B. PHYSICIAN SERVICES (4) 2%

B-1	Schedule of visits	(1)	B-5	Not responsive in emergency	
B-2	Billing		B-6	Does not take Medicare/Medicaid	
B-3	Inaccessible, unresponsive	(1)	B-7	Other (specify)	(1)
B-4	Diagnosis, treatment	(1)			

C. MEDICATIONS (10) 4%

C-1	Not given according to orders	(1)	C-4	Shortage	(1)
C-2	Administered by inappropriate staff	(4)	C-5	Given against resident's will	
C-3	Over-sedation	(4)	C-6	Other (specify)	

D. FINANCIAL (4) 2%

D-1	Billing/accounting wrong, denied		D-6	Questionable charges	(1)
D-2	Access to own money denied		D-7	Misuse of personal funds by facility	(2)
D-3	Not informed of charges	(1)	D-8	Deposits, other money not returned	
D-4	Charged for services not rendered		D-9	other (specify)	
D-5	Charges not approved in advance				

E. FOOD/NUTRITION (26) 11.5%

E-1	Cold	(3)	E-8	No water available	(1)
E-2	Unappetizing, little variety	(6)	E-9	Nutritionally poor	(5)
E-3	Choices		E-10	Religious preference not followed	
E-4	Snacks		E-11	Insufficient amount	(2)
E-5	Not assisted in eating	(1)	E-12	Unsanitary	(1)
E-6	Special diet not followed	(3)	E-13	Time span	
E-7	Preferences not considered	(1)	E-14	Lack of utensils	
			E-15	Other (specify)	(3)

ANNUAL STATISTICS CONT.

F. ADMINISTRATIVE (18) 8%

F-1	Understaffing	(8)	F-8	Bed not held	
F-2	Admissions procedures	(2)	F-9	Room changes/assignment	(
F-3	Admission refused due to Medicaid status		F-10	Roommate conflict	
			F-11	Improper use of staff	
F-4	Discharge plans, procedures	(1)	F-12	Medical transportation	
F-5	Improper placement	(2)	F-13	Language barrier (incl. sign lang.)	
F-6	Transfer due to Medicaid status	(1)	F-14	Laundry procedures	(1)
F-7	Other improper transfer	(2)	F-15	Other (specify)	

G. RESIDENT RIGHTS (32) 14%

G-1	Restriction on right to complain		G-14	Denied rights	(
G-2	No grievance procedures		G-15	Visiting hours	
G-3	Religious rights restricted		G-16	Mail opened/not delivered	(1)
G-4	Civil liberties, voting restricted		G-17	No phone privacy	(1)
G-5	Social/community activities restricted	(4)	G-18	Not treated with respect, digni	(6
G-6	Medicaid discrimination other than admission or transfer	(2)	G-19	Physical abuse by other resident	(3
			G-20	Verbal abuse by other resident	
G-7	Religious discrimination		G-21	Use of possessions restricted	
G-8	Race discrimination		G-22	Kept in facility against will	(
G-9	Sex discrimination		G-23	Threats of eviction from facility	(1
G-10	Not informed of condition		G-24	Fear of retaliation by facility	(
G-11	Not informed of rights, policies		G-25	Personal items lost, stolen, or used by others	(
G-12	Confidentiality of records				
G-13	Disallowed access to own records		G-26	Violation of privacy	(1)
			G-27	Denied sharing room w/spouse	
			G-28	Other (specify)	

H. BUILDING, SANITATION, LAUNDRY (12) 5%

H-1	Cleanliness	(1)	H-9	Bed, bedside equipment	(
H-2	Safety factors (exits, fire, railings)	(4)	H-10	Storage space (amount, security)	(1
			H-11	Supplies	
H-3	Offensive odors	(1)	H-12	Heating	(
H-4	Appearance		H-13	Cooling, ventilation	(
H-5	Pests		H-14	Lighting	
H-6	Bathrooms		H-15	Water temperature	
H-7	Linens	(1)	H-16	Outside garbage area	
H-8	Handicap assessibility	(1)	H-17	Other (specify)	

J. NOT AGAINST FACILITY (OTHER PROBLEMS) (35) 15.5%

J-1	Financial (bad debts, exploitation)	(12)	J-7	Insurance	
			J-8	Guardianship, conservatorship, power of attorney	(1
J-2	Medicaid not providing services				
J-3	Medicaid reclassification	(2)	J-9	Family problems	(
J-4	Other Medicaid problem except discrimination	(1)	J-10	Wills	
			J-11	Outside social services agency	
J-5	SSI, Social Security		J-12	Inappropriate placement	(
J-6	Medicare		J-13	Other (specify)	(

PROPOSED AMENDMENTS TO HB 873 - RESIDENTS' RIGHTS

Proposed by the Montana Health Care Association

1. Section 6 (4), page 4, relating to transfer and discharge of residents, lines 17 through 21:

Delete the words: "Reasonable advance notice requires at least 30 days' advanced written notice of any interfacility transfer or any discharge, except in the case of emergency as documented by the resident's attending physician in his medical record."

Insert: "Reasonable advance notice means that the decision to transfer or discharge a patient must be discussed with him and that he be told the reasons for it and alternatives available far enough in advance that he may make his wishes known and participate in the planning for the move."

2. Section 6 (16), page 7, relating to right to have door closed:

Delete subsection (16) in its entirety.

3. Section 7 (1), page 8:

Amend to read as follows: "The long term care ombudsman shall investigate and seek to resolve, and refer to state and local authorities when appropriate, complaints alleging that a facility has violated a resident's rights recognized under this act."

4. Section 7 (2), page 8:

Delete subsection (2) of Section 7 in its entirety.

5. Section 8, pages 8 and 9:

Delete Section 8 in its entirety.

NAME: Marie Dennis DATE: 3/1/05

ADDRESS: 40 Stadium Place, Billings, MT 59102

PHONE: 245-7063 (res) 652-5240 (bus)

REPRESENTING WHOM? Montana Association of Health Underwriters

APPEARING ON WHICH PROPOSAL: HB 817

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: Copy of testimony to be distributed.

We also support & recommend the adoption of the amendment submitted by Kit Elmore.

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

TESTIMONY OF MARIE DEONIER, RHU

ON

HOUSE BILL # 817

"AN ACT TO PROVIDE HEALTH INSURANCE COVERAGE TO CERTAIN PERSONS INELIGIBLE FOR COVERAGE FROM TRADITIONAL PROVIDERS OF HEALTH CARE BENEFITS BY ESTABLISHING A COMPREHENSIVE HEALTH ASSOCIATION AND PLAN; TO REQUIRE PARTICIPATION IN THE ASSOCIATION BY EACH HEALTH SERVCIE CORPORATION, FRATERNAL BENEFIT SOCIETY, AND INSURER PROVIDING HEALTH CARE BENEFITS IN THIS STATE; AND PROVIDING AN EFFECTIVE DATE."

ON BEHALF OF

MONTANA ASSOCIATION OF HEALTH UNDERWRITERS

My name is MARIE DEONIER, RHU (Registered Health Underwriter). I am a member of the Montana Association of Health Underwriters of which I am the current President Elect and Chairman of the Legislative Committee. I am also a memeber of the Montana Association of Life Underwriters, and legislative co-chairman of the Southeastern Montana Association of Life Underwriters.

I am appearing on behalf of the Montana Association of Health Underwriters and myself, an informed insurance agent who is concerned about the health insurance needs of all persons residing in the State of Montana.

Many Montanan's are presently unable to purchase medical insurance because of medical problems such as diabetes, cancer, heart, epilepsy, physical handicaps, lung diseases, cerebral palsy, to name a few.

Most of us here today know or know of someone who would fall into the category of "uninsurable due to medical reasons".

As an insurance agent specializing in the health insurance market I frequently recieve calls from persons who have been

DECLINED BY INSURANCE COMPANIES FOR MEDICAL INSURANCE OR WHO HAVE BEEN ISSUED A POLICY WITH EXCLUSIONS FOR THE CONDITION FOR WHICH THEY NEED THE INSURANCE COVERAGE THE MOST. A TYPICAL EXAMPLE BEING: EXCLUSION OF HEART AND CIRCULATORY SYSTEM FOR A PERSON WHO HAS HAD A HEART ATTACK OR WHO HAS HIGH BLOOD PRESSURE.

IT IS THEREFORE MY FEELING AS A CONCERNED PERSON AND INSURANCE AGENT THAT THERE NEEDS TO BE A WAY TO OFFER MEDICAL INSURANCE COVERAGE TO THESE PERSONS WHICH WILL NOT ONLY OFFER THAT PERSON A MEDICAL INSURANCE POLICY, BUT ONE THAT WILL NOT ISSUE EXCLUSIONS. THEREFORE, THE MONTANA ASSOCIATION OF HEALTH UNDERWRITERS DECIDED TO BACK THIS BILL WHCH IS BEING PRESENTED TO YOU TODAY.

BY MAKING A PLAN OF INSURANCE AVAILABLE TO THESE PEOPLE IT IS POSSIBLE THAT IT WILL PREVENT THOSE SAME PERSONS FROM THE LOSS OF SAVINGS, FAMILY HOME OR FARM DUE TO EXCESSIVE MEDICAL COSTS. UNDER THE CURRENT LAWS, PEOPLE LIKE YOU AND I COULD BE FACED WITH FINANCIAL DEVASTATION FROM MEDICAL BILLS AS WE ARE "TOO WELL OFF TO BE ELIGIBLE FOR MEDICAID OR OTHER GOVERNMENT PLANS". THOSE OF US WHO WANT TO TAKE CARE OF OUR EARTHLY OBLIGATIONS, BUT DUE TO INCREASING MEDICAL COSTS FIND IT INCREASINGLY DIFFICULTY TO DO SO. PASSAGE OF THIS BILL WILL

GREATLY HELP THESE PEOPLE TO BE FREE FROM FINANCIAL WORRIES CAUSED BY HIGH MEDICAL COSTS AND THE UNAVAILABILITY OF MEDICAL INSURANCE TO ASSIST WITH THOSE BILLS.

ANOTHER PERSON WHO MAY FIND THEMSELVES LOOKING FOR INSURANCE AND NO PLACE TO FIND IT IS A YOUNG PERSON WHO IS NO LONGER ALBE TO REMAIN ON THE PARENTS PLAN BECAUSE OF AGE OR DEPENDENCY REASONS. SOME OF THESE YOUNG PEOPLE ARE NOT FULLY AWARE OF THE NEED FOR INSURANCE COVERAGE AND DO NOT PURCHASE A PLAN RIGHT AWAY THINKING THAT THEY ARE YOUNG AND HEALTHY AND NOTHING CAN HAPPEN TO THEM ONLY TO FIND THEMSELF THE VICTIM OF AN ACCIDENT OR ILLNESS WHICH LEAVES THEM "UNINSURABLE". SUCH A CASE COMES TO MIND WITH A CLIENT OF MINE: THIS IS A MAN IN HIS EARLY 20S WHO WAS THE VICTIM OF A GUN SHOT WOUND IN WHICH THE MAJOR ARTERY IN HIS LEG WAS DAMAGED RESULTING IN GRAFTING OF THE ARTERY; TO DATE HE HAS UNDERGONE 15 SURGERIES, THE MOST RECENT WITHIN THE PAST 6 MONTHS AND HE WILL BE ON A BLOOD THINNING MEDICATION FOR THE REMAINDER OF HIS LIFE. THIS HUNTING ACCIDENT HAS NOT ONLY LEFT HIM UNINSURABLE, BUT DUE TO HIS UNINSURABILITY, EMPLOYERS ARE RELECTANT TO HIRE HIM AS AN EMPLOYEE, THEREFORE NO GROUP COVERAGE IS AVAILABLE EITHER.

IN CHECKING THE NEED FOR SUCH A PLAN TO TO IMPLEMENTED IN THE STATE OF MONTANA OUR COMMITTEE VISITED WITH VARIOUS ORGANIZATIONS SUCH AS DIABESTES, HEART FUND, CRIPPLED CHILDREN, CANCER SOCIETY, MENTAL HEALTH, MUSCULAR DYSTROPHY, TO NAME A FEW. ALL EXPRESSED A VERY REAL NEED FOR THIS TYPE OF INSURANCE PLAN. FROM INFORMATION GAINED FROM THESE SOURCES IT IS ESTIMATED THAT THERE COULD BE FROM 2,000 TO 5,000 PERSONS IN MONTANA WHO WOULD BE ELIGIBLE FOR COVERAGE UNDER THIS PLAN WHO ARE CURRENTLY NOT COVERED UNDER ANY OTHER FORM OF MEDICAL INSURANCE COVERAGE. IT IS TRUE THAT SOME OF THESE PEOPLE ARE BORDERLINE POVERTY AND POSSIBLY WOULD NOT BE ABLE TO AFFORD THE PREMIUMS FOR ANY POLICY, BUT SOME OF THOSE HAVE INDICATED THEY WOULD RATHER HAVE THE INSURANCE PROTECTION THAN CHANCE LOSING THEIR HOME AND BE FORCED TO GO ON WELFARE OR MEDICAID - THESE ARE PROUD PEOPLE WHO ARE RESPONSIBLE CITIZENS WHO WANT TO BE ABLE TO TAKE CARE OF THEIR OWN OBLIGATIONS IN LIFE. THIS BILL WILL GIVE THEM THAT CHANCE.

ADDITIONAL CHECKING AND COMPARING OF PLANS WAS DONE BY EXAMINING SIMILAR PLANS OFFERED BY OTHER STATES.

IN SUMMARY: UNDER CURRENT INSURANCE PRACTICES IN THE INDIVIDUAL HEALTH INSURANCE MARKETS, AND IN SMALL GROUP PLANS UNDERWRITING FOR CAUSE PREVENTS MANY PERSONS FROM BEING ACCEPTED FOR MEDICAL INSURANCE COVERAGE FOR MEDICAL REASONS. BY MEANS OF THIS BILL, THOSE SAME PERSONS WOULD HAVE A PLAN OF INSURANCE AVAILABEL TO THEM.

WOULDN'T YOU AGREE THAT IT IS FAR BETTER TO OFFER A PLAN OF INSURANCE AVAILABLE TO THIS SPECIAL GROUP OF PEOPLE THAN TO HAVE THEM FINANCIALLY DEVASTATED BY MEDICAL COSTS TO THE POINT THAT THAT PERSON WOULD BE ELIGIBLE FOR MEDICAID AND WELFARE WHICH WOULD IN TURN PLACE A LARGER BURDEN ON THE STATE OF MONTANA?

THE MONTANA ASSOCIATION OF HEALTH UNDERWRITERS AND MYSELF URGE YOU TO CONSIDER THIS BILL AND VOTE FAVORABLY FOR ITS PASSAGE.

PROPOSED AMENDMENTS TO HB 817

1. Title, line 11.
   Following: line 10
   Insert: "INSURANCE ARRANGEMENT,"

2. Page 2, line 18.
   Following: line 17
   Insert: "(6) "Insurance arrangement" means any plan, program, contract, or other arrangement to the extent not exempt from inclusion by virtue of the provisions of the federal employee retirement income security act of 1974 under which one or more employers, unions, or other organizations provide to their employees or members, either directly or indirectly through a trust or a third party administrator, health care services or benefits other than through an insurer."
   Renumber: subsequent subsections

3. Page 3, lines 7 through 14.
   Following: "~~benefits~~" in line 7
   Strike: remainder of line 7 through "INSURER" in line 14
   Insert: "those health benefit plans certified by the commissioner as providing the minimum benefits required by [section 6] or the actuarial equivalent of those benefits"

4. Page 4, line 16.
   Following: "insurers,"
   Insert: "insurance arrangements,"

American Diabetes Association
MONTANA AFFILIATE, INC.

600 Central Plaza • Box 2411 • Great Falls, Montana 59403 • (406) 761-0908

March 11, 1985

The American Diabetes Association, Montana Affiliate, and its members is pleased that the Montana Legislature is considering a bill to guarantee health insurance coverage for the citizens of the state who presently cannot obtain this protection because of current or past illness and disease.

Speaking from our own experience, there are 23,000 persons with diabetes in Montana. Most of these people are in good health, living with daily exercise regimens and an excellent diet. Yet, because they have diabetes, it is impossible for many of them to obtain health insurance coverage. It is our concern that these people will be able to purchase insurance coverage for reasons unrelated to diabetes as well, without facing financial hardship.

Our offices have received many calls from people across the state who are unable to obtain insurance coverage for themselves or their children. A family from Eureka recently called to tell us that they could not obtain health insurance for their 15 year old son even with an offer to pay the premiums one year in advance. It is a common underwriting practice to deny anyone under 35 years of age who has Type I, Juvenile, or Insulin Dependent diabetes.

It is our hope that persons with diabetes and other chronic illnesses may be able to obtain affordable health insurance coverage as a result of this legislation.

Thank you for your consideration of the needs of uninsurable citizens of Montana.

Sincerely,

Stanlee Dull
Executive Director

bz

NAME: Stanlee Duell DATE: 3-11-85

ADDRESS: 135 12th Ave So

PHONE: 761-8770 (H) 761-0908 (Office)

REPRESENTING WHOM? American Diabetes Assn.

APPEARING ON WHICH PROPOSAL: HB 517

DO YOU: SUPPORT? Yes AMEND? _____ OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

American Diabetes Association
MONTANA AFFILIATE, INC.

600 Central Plaza • Box 2411 • Great Falls, Montana 59403 • (406) 761-0908

POOLED RISK HEALTH INSURANCE PLAN

I believe that we should seriously consider this concept. Many people find themselves unable to purchase health insurance due to chronic medical conditions. If we want these individuals to be a productive members of our state then we, the people of the State of Montana, must be willing to make available some type of a health insurance program. Often persons who find themselves in this situation are willing to pay higher premiums but find coverage not available

Most persons can often control their chronic illness but they also need insurance to cover other illnesses or accidents to prevent possible bankruptcy or welfare due to unpaid medical bills.

I would appreciate your consideration on HB 817.

Marilyn F. Moore
President
Montana Affiliate, A.D.A.

PROPOSED AMENDMENTS TO HOUSE BILL 649

Submitted by Mona Jamison, Legal Counsel to Governor Schwinden

1. Page 2, Line 22

Following: "37-4-301."
Insert: "The Governor shall replace one of the three denturists appointed to the initial board with a dentist member, within 60 days of the effective date of this Act."

-End-

Testimony on HB 649

I am Dr. W. A. Rader, a Havre dentist and President of the Montana Dental Association.

I am here today to speak in favor of HB 649 as transmitted to the Senate.

I feel as President of the Montana Dental Association, that it should be noted and clearly indicated to this committee and audience that the M.D.A. is not an advocate of denturism in any form. Historically, dentistry has made great strides in conquering tooth decay, oral pain and reconstruction of damaged mouths. The goals of dentistry in the United States and Montana have been to advance techniques and care for the public, and to completely eliminate diseases of the mouth and teeth. We feel denturism is a reversal of these goals.

Unfortunately, the reality of Initiative 97 is that the electorate has spoken, leaving the M.D.A. to seek the best possible avenues of compromise to promote and protect the health of the public.

TO: Chairman Jacobson and Members of the Committee
FROM: Tom Ryan, Montana Senior Citizens Association
DATE: March 11, 1985
RE: HB 649

One of the great concerns of the Montana Senior Citizens Association has been Health-Care Cost Containment. We think HB 649 will add emphasis to our efforts.

HB 649 as amended is an attempt by dental providers to reconcile their differences. We agreed with the Department of Commerce licensing division that some adjustment in Initiative 97 was needed for administrative purposes.

Montana Senior Citizens Association supports HB 649 as amended.

NAME: LEE WISER DATE: 3-11-85

ADDRESS: 111 No C Street Livingston

PHONE: 222-7665

REPRESENTING WHOM? Board of Dentistry

APPEARING ON WHICH PROPOSAL: HB649

DO YOU: SUPPORT? ✓ AMEND? _____ OPPOSE? _____

COMMENTS: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

NAME: Theodore P. Beck DATE: 3/11/95

ADDRESS: 227 West Lyndale

PHONE: 443-6466

REPRESENTING WHOM? Self

APPEARING ON WHICH PROPOSAL: HB649

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENTS: In any legislation dealing there must be some compromise so that all concerned can be equal represented. HB649 as it applies to the issue is a compromise, but it is a compromise that will allow those who voted for their initiative 97 to have a freedom of choice. There is reasonable protection from the dental community to hopefully ensure the safety if properly administered. If the HB is changed in anyway to lessen the control placed on the dentist then the public will most certainly suffer the consequences not those of us here today

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Feb 19, 1985

oppose HB ~~479~~ 649

I am Jeannette S Buchanon of Columbia Falls Montana. The dental hygienist member of the Board of Dentistry. HB ~~479~~ 649 answers some of my concerns for the health and welbeing of the public relative to the proposed practice of denturity in Montana.

A dental hygienist practices under the direct supervision of a dentist. Our area of expertice is the maintenance of healthy teeth + supporting structures, that is the gums and bone surrounding the teeth. A dental hygienist provides services which basically are preventive in nature.

X-rays are taken for diagnostic purposes. There are two factors here: 1) because of potential hazards from radiation, x-rays must be utilized with a great deal of respect.

2) x-rays are a voluble diagnostic tool. Proper diagnosis requires a great deal of understanding which can only be gained through along educational process as accredited by the Commission on Dental Education.

Any appliance placed in the mouth must be totally precise A partial appliance derives its support from natural teeth + often is distructive to the supporting structures. In many instances, the abutment teeth need to be modified in order to protect them as they hold the partial. Natural teeth which oppose artifical teeth can also be damaged.

To protect these structures, as well as the jaws and the joint, a great deal of knowledge needs to be acquired. I seek support for recognition of accredited education.

Hearing HB649 on March 11, 1985

I am Byron Greany, an Anaconda dentist, serving my third year as part of the seven member Montana Board of Dentistry. I wish to present the unanimously-agreed upon position of our group - a position established when the signature petitions were being circulated for the initiative nearly a year ago. Our position on Initiative 97 has not changed since that time.

Entrusted with protection of the dental health of all Montanans there is absolutely no way we can accept in concept, then or now, a statute licensing a group who will provide health care for Montanans without regard for minimal scientific, biological and clinical training. It is impossible for our Board to rationalize as acceptable, individuals who lack formal training, in some cases not even a high school education, to be grandfathered into a profession that has spent 100 years reaching a pinnacle that provides the worlds best dental health - this is a step backwards.

This same group is on record in their initiative agreeing with our position for requirement of an educational background but it becomes effective only after they have been grandfathered licensure. April 1st of this year, one month from now, this same licensure will require the formal training I have referred to as well as 2 years of internship requirements that the presently appointed Board of Denturitry, to the man, has not attained much less have the applicants they will license and regulate to provide a health care service for Montanans. To our Board of Dentistry it sets two standards of quality care in denturitry, and in addition, a closed shop for those 10 or 15 unqualified technicians lucky enough to be licensed before the door is closed, as per the initiative.

The Board of Dentistry, trying to be realistic to the political whims of pressure groups on the legislature, and recognizing the vote of what we believe was an uninformed electorate, request that if the entire initiative can't be turned down, which we think would be the wise choice, or rigid educational standards as outlined in Initiative 97 be adopted for <u>all</u> denturists, then consider change HB649 with the

following amendments:

1. REMOVE THE PRIVILEGE OF TAKING X-RAYS: The past few years have provided a barrage of literature and proven examples of excessive exposure to various forms of radiation of which dental x-rays is only one type. Without the necessary educational background training for diagnosis of x-rays by individuals is impossible and therefore the exposure of patients to x-ray radiation is unjustified. By their own admission and by definition under the terms of Initiative 97, denturists cannot diagnosis. X-rays are used for diagnosis whether we call it "scanning" or "diagnosing." If x-ray pictures cannot be used by the denturist why allow patients to be exposed to radiation for no reason and why should they pay for a service that does them no good. There is no limitation to the use of x-ray radiation by the denturist, yet he has no reason to take them except to increase cash flow.

2. ELIMINATE THE CONSTRUCTION OF REMOVABLE PARTIAL DENTURES: These appliances are designed with many considerations other than filling spaces of missing teeth - primarily how to extend the longevity of the remaining permanent teeth. The prescription of these appliances is based on the general health of the patient. Local findings of bone support and periodontal conditions of the teeth are most important, not to minimize the condition of the teeth to be used as attachment teeth - do they need fillings, a crown, does their shape need to be changed, rests prepared, etc. These are the things a dentist is trained to ascertain - TECHNICIANS AREN'T! Poorly designed appliances destroy good teeth!!!!

We realize this presentation will undoubtedly confuse the issue but any other position by the Board of Dentistry would be a betrayal of the confidence the Governor and the Senate placed in us when making our appointments to serve Montanans. We hope this testimony will prevail and permit us the satisfaction of protecting the dental health of Montanans in the manner in which we are dedicated.

From Jeffrey H. Strickler MD
Chairman. MT Chapter
American Academy of Pediatrics

Re HB 807

The Am Acad of Pediatrics (has worked many years on Baby Doe.) is strongly in favor of HB 807. It is a reasoned & reasonable approach to the handling of difficult decisions. We recommend a DO PASS.

In addition the concept of an infant bioethics committee as proposed in Rep Hannah's ammendment is consistant with our position. Life & death decisions should be decided according to local mores - and should include clergy, lay people, attorneys as well as parents & physicians.

We recommend approval of the ammendment as proposed.

Thank you

Jeffrey H. Strickler MD

PART B—SERVICES AND TREATMENT FOR DISABLED INFANTS

NEW DEFINITION

42 USC 5102.

SEC. 121. Section 3 of the Act is further amended—

(1) by striking out "this Act the term 'child abuse and neglect' " and inserting in lieu thereof the following: "This Act—

"(1) the term 'child abuse and neglect' ";

(2) by striking out the period at the end thereof and inserting in lieu thereof a semicolon and the word "and"; and

(3) by adding after clause (2) (as added by section 102(3) of this Act) the following new clause:

"(3) the term 'withholding of medically indicated treatment' means the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's or physicians' reasonable medical judgment, (A) the infant is chronically and irreversibly comatose; (B) the provision of such treatment would (i) merely prolong dying, (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or (iii) otherwise be futile in terms of the survival of the infant; or (C) the provision of such treatment would be virtually futile in terms of the survivial of the infant and the treatment itself under such circumstances would be inhumane.".

NEW BASIC STATE GRANT REQUIREMENT

SEC. 122. Section 4(b)(2) of the Act (42 U.S.C. 5103(b)(2)) is amended—

(1) by striking out "and" at the end of clause (I);

(2) by striking out the period at the end of clause (J) and inserting in lieu thereof a semicolon and the word "and"; and

(3) by inserting after clause (J) the following new clause:

Ante, p. 1749.

"(K) within one year after the date of the enactment of the Child Abuse Amendments of 1984, have in place for the purpose of responding to the reporting of medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), procedures or programs, or both (within the State child protective services system), to provide for (i) coordination and consultation with individuals designated by and within appropriate health-care facilities, (ii) prompt notification by individuals designated by and within appropriate health-care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), and (iii) authority, under State law, for the State child protective service system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions.".

ADDITIONAL STATE GRANTS AND ASSISTANCE FOR TRAINING, TECHNICAL ASSISTANCE, AND CLEARINGHOUSE ACTIVITIES

SEC. 123. (a) Section 4 of the Act is further amended by—

42 USC 5103.

(1) redesignating subsection (c) as subsection (d), subsection (d) as subsection (e), and subsection (e) as subsection (f); and

(2) inserting after subsection (b) the following new subsection:

"(c)(1) The Secretary is authorized to make additional grants to the States for the purpose of developing, establishing, and operating or implementing—

Public information.

"(A) the procedures or programs required under clause (K) of subsection (b)(2) of this section;

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Human Development Services

45 CFR Part 1340

Child Abuse and Neglect Prevention and Treatment Program

AGENCY: Office of Human Development Services, HHS.

ACTION: Notice of proposed rulemaking.

SUMMARY: This rule proposes a new basic State grant requirement to implement the Child Abuse Amendments of 1984 (Pub. L. 98–457). As a condition of receiving State grants under the Child Abuse Prevention and Treatment Act, States must establish programs and/or procedures within the State's child protective service system to respond to reports of medical neglect, including reports of the withholding of medically indicated treatment for disabled infants with life-threatening conditions. Other changes in regulations required by these Amendments will be published as a separate NPRM at a later date.

DATE: To ensure consideration, comments must be submitted on or before February 8, 1985.

ADDRESSES: Please address comments to: National Center on Child Abuse & Neglect, U.S. Children's Bureau, HHS, P.O. Box 1182, Washington, D.C. 20013.

It would be helpful if agencies and organizations submitted comments in duplicate. Comments will be available for public inspection in Room 3758, Donohoe Building, 400 Sixth Street, SW., Washington, D.C. 20201, Monday through Friday between the hours of 9:00 a.m. and 4:00 p.m.

FOR FURTHER INFORMATION CONTACT: Jay Olson, (202) 245–2859, or Mary McKeough, (202) 245–2892.

SUPPLEMENTARY INFORMATION:

Background

The Child Abuse Prevention and Treatment Act (Pub. L. 93–247, 42 U.S.C. 5101, *et seq.*) was signed into law in 1974. It established in the Department the National Center on Child Abuse and Neglect. The National Center is located organizationally within the Children's Bureau of the Administration for Children, Youth and Families in the Office of Human Development Services.

Under this Act, the National Center carries out the following responsibilites:

- Makes grants to States to implement State child abuse and neglect prevention and treatment programs.
- Funds public or nonprofit private organizations to carry out research, demonstration, and service improvement programs and projects designed to prevent, identify and treat child abuse and neglect.
- Collects, analyzes and disseminates information, e.g., compiles and disseminates training materials, prepares an annual summary of recent and on-going research on child abuse and neglect, and maintains an information clearinghouse.
- Assists States and communities in implementing child abuse and neglect programs.
- Coordinates Federal programs and activities, in part through the Advisory Board on Child Abuse and Neglect.

The Act has been extended and amended several times since its passage. Regulations for the State grant and discretionary fund programs are found at 45 CFR Part 1340; the most recent revisions were published on January 28, 1983 (48 FR 3698). The fifty States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, and the Trust Territory of the Pacific Islands are eligible to apply for State grants. Fifty-one of the fifty-seven eligible jurisdictions meet the requirements of the Act and the regulations and currently receive State grant funds. We will refer to these jurisdictions as "States" in this preamble discussion.

In this Notice of Proposed Rulemaking (NPRM), the Department is proposing to implement a major new requirement of Pub. L. 98–457, the Child Abuse Amendments of 1984. This requirement, found in a new clause (k) in section 4(b)(2), mandates that, as a condition of receiving State grant funds under the Act, States must establish programs and/or procedures within the State's child protective service system to prevent instances of medical neglect, including the witholding of medically indicated treatment (including appropriate nutrition, hydration, and medication) from disabled infants with life-threatening conditions. Other changes required in regulations as a result of these Amendments will be published in a separate NPRM.

The amendments add a new program of grants to assist States to meet the requirements of clause (k). In addition, they authorize the Department to fund training, technical assistance, and clearinghouse activities to improve the provisions of services to these infants and their families.

The Child Abuse Amendments of 1984 represent a substantial consensus among many medical, professional, and advocacy organizations that action was needed to adopt protections for disabled infants with life-threatening conditions. This consensus formed the basis for the extensive and cooperative participation in the development of these new statutory requirements, and the development of the "Joint Explanatory Statement By Principal Sponsors Of Compromise Amendment Regarding Services And Treatment For Disabled Infants". (See H.R. Conference Report No. 98–1038, 98th Congress, 2nd Session, 19, 40–4 (1984); *Congressional Record*, H–9805, September 19, 1984.) (These groups include: American Academy of Pediatrics, American Association of Mental Deficiency, American Coalition of Citizens with Disabilities, American College of Obstetricians and Gynecologists, American College of Physicians, American Hospital Association, American Life Lobby, American Nurses Association, Association for Persons with Severe Handicaps, Association for Retarded Citizens, California Association of Children's Hospitals, Catholic Health Association, Christian Action Council, Disability Rights Center, Down's Syndrome Conference, National Association of Children's Hospitals and Related Institutions, National Child Abuse Coalition, National Right to Life Committee, Nurses Association of the American College of Obstetricians and Gynecologists, Operation Real Rights, People First of Nebraska, and Spina-Bifida Association of America.)

In substantial respect, this consensus is an outgrowth of prior efforts to articulate fair and reasonable guidelines to deal with this complex issue, including the landmark "Principles of Treatment of Disabled Infants", issued in 1983 by a broad coalition of leading medical associations and advocacy organizations for the disabled. (*Pediatrics*, vol. 73, no. 4, April 1984, p. 559.). This document stated:

> When medical care is clearly beneficial, it should always be provided. When appropriate medical care is not available, arrangements should be made to transfer the infant to an appropriate medical facility. Considerations such as anticipated or actual limited potential of an individual and present or future lack of available community resources are irrelevant and must not determine the decisions concerning medical care. The individual's medical condition should be the sole focus of the decision. These are very strict standards.
>
> It is ethically and legally justified to withhold medical or surgical procedures which are clearly futile and will only prolong the act of dying. However, supportive care should be provided, including sustenance as medically indicated and relief of pain and

Montana Medical-Legal Panel

2021 Eleventh Avenue, Suite 12, Helena, Montana 59601 — Telephone 443-1110

Stan B
FOR YOUR INFORMATION

March 11, 1985
Monday

M E M O R A N D U M

TO: EACH MEMBER SENATE COMMITTEE ON PUBLIC HEALTH, WELFARE, AND SAFETY - SENATORS: JUDY JACOBSON, CHAIRMAN; J. D. LYNCH, VICE CHAIRMAN; TOM HAGER; MATT HIMSL; TED NEUMAN; BILL NORMAN; STAN STEPHENS; AND TOM TOWE

FROM: G. BRIAN ZINS, EXECUTIVE DIRECTOR

Re: House Bill 738

Dear Senators:

Enclosed is specific information about the operations of the Montana Medical-Legal Panel to include financial and actual proceedings. We are hopeful this information will be very comprehensive and explanatory.

The Panel assessment is based upon claims; by statute, any surplus going towards reduction of a following year assessment. The Panel is very economical in its timely disposition of alleged malpractice claims. It relieves the overburdened court system and allows claimants, without charge, an informal atmosphere of experts to review their allegations.

We would be very happy to respond to any questions and provide any further information.

Your concern is indeed appreciated.

Very best wishes.

GBZ:le

cc: Karen Renne, Legislative Council Staff (W/Enclosures) 2

COPY

CLAIMS BEFORE THE MONTANA MEDICAL-LEGAL PANEL THROUGH 1983

MONTANA MEDICAL LEGAL PANEL
2021 11TH AVE
HELENA, MT 50601

FEBRUARY, 1985

1. INTRODUCTION. The following is a report of closed claims before the Montana Medical Legal Panel from April, 1977 through December, 1983. The report on closed claims thru year 1984 will be available within two months.

All claims of medical malpractice against physicians, hospitals, and long-term care facilities must come before the Panel before proceeding to court.

A separate Panel of three attorneys and three health care providers reviews each claim and renders an advisory decision as to whether there is sufficient evidence of malpractice to warrant a jury trial. The result of the Panel's decision is not binding and the claimant may proceed to court at his or her option.

The Panel is and has been since its inception funded solely by assessments levied on health care providers.

There is no cost associated with filing a claim or obtaining the medical records of the case at hand, which the Panel collects and distributes to the parties.

The goals of the Panel are:

...Prompt encouragement of pre-lawsuit and pre-trial settlement of claims that have merit

...Prompt discouragement of lawsuits and trials of claims without merit

...Reduction of the cost of medical care by lowering the cost of definding claims through prompt resolution

...Reduction and prevention of incidents of malpractice by determining the "who, what, when and where" of malpractice incidents in Montana.

2. NUMBER OF CLAIMS BEFORE THE PANEL

During the period surveyed, there have been 264 claims filed by claimants against 280 physicians, 101 hospitals, and 2 nursing homes.

3. INCREASED CLAIMS BEFORE THE PANEL

At the national level, recent studies have indicated a substantial increase in the number of medical malpractice claims filed in the period 1979 - 1983. Nationwide that increase has been 114%, with the rate of increase at the 26% level in the West. American Medical Association, PROFESSIONAL LIABILITY IN THE 80's, October, 1984.

Increased claim filings has also been experienced by the Panel. From 1981 to 1983, the rate of increase was 140.5%. From 1982 to 1983 the number of claims filed increased by 14.1% and preliminary data for year 1984 indicates the rate of increase from 1983 to 1984 was in excess of 12%:

Year	Number Of Claims Filed
1981	37
1982	78
1983	89

4. EFFECTIVENESS OF THE PANEL. The effectiveness of the Panel can be guaged in terms of the number of claims that are disposed of, with or without settlement to the Claimant, without the necessity of suit or trial. It is the clear-cut cases -- either a clear indication of responsibility on the part of the health care provider or a clear indication of no responsibility -- that are subject to being properly removed from the court system.

A. Substantial Reduction In The Number Of Lawsuits.

During the two-and-one-half year period from July, 1967-December, 1969, there were 57 lawsuits filed against physicians in Montana. This was an average of 23 lawsuits filed per year, and during a period of time when the frequency of claims against physicians was not as great, and at a time when there were fewer physicians.

Of the 383 health care providers who have been brought before the Panel, the results as to 237 of them has been tracked after the claim left the Panel.

Suit has been filed against 82 physicians or at the rate of 12 lawsuits per year. This represents a decrease of nearly 49% in the number of suits filed under circumstances of more claims and more physicians. Stated another way, there were nearly 100% more suits filed in the period before the Panel that after it became operational.

Suit has been filed against 27 hospitals during the period of this report. No earlier comparative figures are available.

B. Substantial Reduction In The Number Of Trials

Prior to implementation of the Panel, there were approximately 8 trials per year in Montana for medical malpractice against physicians. For a period comparable to the Panel's existence, this would indicate an expected 56 trials to have taken place.

Of the 237 physicians surveyed, against whom claims were brought, only 3 cases have gone to trial. This number will increase as the balance of the claims are surveyed, but not markedly. It is anticipated that in the long term, the average number of trials per year will be between 1 and 2.

Of the hospitals surveyed, 1 case had gone to trial.

C. Substantial Increases In Settled Or Withdrawn Claims

The reduction in litigation and lawsuits has been brought about by the substantial numbers of claims which are either settled by payment of money to the claimant, or just not further pursued by the claimant.

Nearly 30% of the claims filed against health care providers have been settled or withdrawn by the claimant before the claim reached the hearing stage at Panel.

Claims against 163 physicians have been withdrawn by the claimant or settled with money to the claimant after the claim has gone thru the Panel. Claims against 60 hospitals and 2 nursing homes have been withdrawn by the claimant or settled with money to the claimant after the claim has gone thru the Panel.

D. High Correlation Between Panel Results And Ultimate Outcome Of The Claim.

The impact of the Panel on the parties can be measured by looking at the relationship between what the Panel recommends and what the ultimate outcome of the claim is.

There exists a high correlation between the unanimous decisions of the Panel and the ultimate outcome of the claim.

Where the Panel held for the Physician, 82% of the Physicians had post-panel outcomes which were favorable. Where the Panel held for the Claimant, 94% of the Claimants had post-panel outcomes which were favorable.

Where the Panel held for the Hospital or Nursing Home, 71% of them had post-panel outcomes which were favorable.

There also exists a high correlation between the recommendation of the Panel and whether suit is or is not later filed.

Where the Panel result was for the Physician, no suit was filed as to 106 Physicians and 35 suits were filed. That is to say, the Panel results were followed 75% of the time as to suit-filing.

Where the Panel result was for the Health Care Facility, no suit was filed as to 46 Hospitals and Nursing Homes and 15 suits were filed. That is to say, the Panel results were followed in excess of 75% of the time.

5. DISPOSITION OF CLAIMS

Depending upon whether Panel results or ultimate results are measured, Claimants were successful as to between 22% -34% of the Physicians brought before the Panel and as to between 19% - 35% of the Health Care Facilities brought before the Panel.

As to claims withdrawn prior to Panel Hearing resulted, claimants received settlement as to 19% of the health care providers involved.

The above data provides support for the conclusion that approximately 3/4 of the claims brought against Physicians, Hospitals, and Nursing Homes do not have sufficient evidence of actual malpractice to warrant a jury trial. On the contrary, the figures also indicate that malpractice sufficient for a jury did exist as to 1/4 of the health care providers.

To the extent that these claims can be disposed of by way of settlement or non-pursuit, all parties are benefited.

	Percentage Of Health Care Providers
Result Favorable To Claimant	
At Panel	
As To Physicians	22.1%
As To Facilities	19.4%
Subsequent To Panel	
As To Physicians	33.7%
As To Facilities	34.9%

6. ADDITIONAL INFORMATION ON CLAIMS BEFORE THE MONTANA MEDICAL LEGAL PANEL

A. Total Claims

During the period surveyed, there have been 264 claims filed by claimants against 280 physicians, 101 hospitals, and 2 nursing homes.

These claims have been against 230 different physicians; 50 of the physicians had more than one claim filed against them. Similarly, 32 different hospitals and nursing homes have had claims filed against them; 8 hospitals have had more than one claim filed against them.

B. Repeated Claims Against Physicians and Hospitals

Physicians with more than one claim against them account for 35.3% of the total claims against physicians. Three physicians have had 4 claims filed against them; five have had 3 claims; and thirty-six have had 2 claims.

Hospitals with more than one claim against them account for 81.6% of the total claims against hospitals. The number of multiple claims against individual hospitals ranges from 2 to 18.

C. Claims Against Physicians By Specialty

The specialties with the highest absolute number of claims against them are: Family practice; General, Thoracic, and Cardiovascular Surgery; Obstetrics and Gynecology; Orthopaedic Surgery; Internal Medicine; and Radiology.

Of these groups, each except Internal Medicine and Radiology have had claims disproportionate to the number of physicians in the specialty.

D. County Of Incident

The counties with the highest frequency of incidents are: Cascade, Flathead, Gallatin, Lewis & Clark, Missoula, Silver Bow, and Yellowstone.

E. Nature Of Panel Votes.

Of the claims which went to hearing involving 300 health care providers, only as to 13 of those providers or 4% did a tie result in the voting. Fully 71% of the voting was by unanimous ballot of the lawyers and providers on the Panel.

The above data provides a strong basis for concluding that the Panel is not weighted one way or the other by the presence of health care providers reviewing the claims along with the attorneys, and that an impartial result is most frequently obtained. Only as to 4% of the claims is is possible for there to have been an attorney-health care provider split, and it may not have even occurred in these instances.

Gerald J. Neely
Counsel To Montana
Medical Legal Panel

APPENDIX OF DATA - Claims Required To Be Heard By Panel - Claims Closed 1979-1983

1. BY PANEL YEAR: Number of Claims Open At the Start of The Year, Filed During The Year, Withdrawn By Settlement or With No Settlement During The Year, Heard During The Year and Open At Year End.

YEAR	OPEN-ST	CLMFILED	WITHDRN	HEARING	OPEN-END
1978	0	5	0	0	5
1979	5	24	4	12	13
1980	13	31	2	24	18
1981	18	37	7	33	15
1982	15	78	12	43	38
1983	38	89	16	62	49
	89	264	41	174	138

2. BY YEAR OF INCIDENT: Number Of Claims Filed In Each Calendar Year

INCDYEAR	YRFL1978	YRFL1979	YRFL1980	YRFL1981	YRFL1982	YRFL1983	Total
1969	0	0	0	0	1	0	1
1975	0	0	0	0	0	1	1
1976	0	0	0	0	0	1	1
1977	4	10	12	7	13	0	46
1978	1	11	7	11	8	4	42
1979	0	3	11	6	17	4	41
1980	0	0	1	12	12	36	61
1981	0	0	0	1	17	21	39
1982	0	0	0	0	10	17	27
1983	0	0	0	0	0	5	5
	5	24	31	37	78	89	264

3. By Calendar Year: Number of Physicians, Hospitals, Other Facilities With Claims, and Total Claims

YEAR	#PCLAIMS	#HCLAIMS	#OFCLAIM	THCPCLMS
1978	6	5	0	11
1979	31	11	0	42
1980	33	15	1	49
1981	53	18	0	71
1982	107	36	1	144
1983	50	16	0	66
	280	101	2	383

4. By Calendar Year: Physicians, Hospitals, And Other Facilities As a Percentage of Total Health Care Providers With Claims

YEAR	%PWTHCLM	%HWTHCLM	%OFWCLM	TOTAL%
1978	54.55	45.45	0.00	100.00
1979	73.81	26.19	0.00	100.00
1980	67.35	30.61	2.04	100.00
1981	74.65	25.35	0.00	100.00
1982	74.31	25.00	0.69	100.00
1983	75.76	24.24	0.00	100.00

5. By Calendar Year: Claims Withdrawn From The Panel As A Percentage of Total Closed Claims; Claims Heard By the Panel

YEAR	WITHDRN	HEARING	#CLOCLMS	AN-CW%CC	CU-CW%CC
1978	0	0	0	0.0	0.0
1979	4	12	16	25.0	25.0
1980	2	24	26	7.69	14.29
1981	7	33	40	17.50	15.85
1982	12	43	55	21.82	18.84
1983	16	62	78	20.51	19.07
	41	174	215		

6. Physicians: Number of Claims By Specialty, Percentage of Each Specialty of Total Physicians, Number In Each Specialty, Claims in Each Specialty As A Percentage of Total Claims

YEAR	SPEC-PHY	SPEC-NUM	TOTALPHY	#PSPWCLM	SPEC%TPH	CLSP%TCL
7883	FP	296	1100	68	26.9000	28.5700
7883	IM	143	1100	19	13.0000	9.29000
7883	GTCS	102	1100	31	9.30000	14.2900
7883	PD	60	1100	7	5.50000	2.50000
7883	P	38	1100	3	3.50000	1.43000
7883	ORS	52	1100	24	4.70000	11.4300
7883	OBG	64	1100	18	5.80000	7.86000
7883	CD	11	1100	4	1.00000	1.43000
7883	AN	47	1100	5	4.30000	2.14000
7883	EM	21	1100	7	1.90000	2.86000
7883	R	56	1100	12	5.10000	5.00000
7883	NS	11	1100	8	1.00000	2.86000
7883	U	29	1100	4	2.60000	1.43000
7883	PTH	31	1100	3	2.80000	1.07000
7883	OPH	46	1100	6	4.20000	2.86000
7883	OTO	25	1100	2	2.30000	0.71000
7883	N	8	1100	4	0.70000	1.43000
7883	DA	20	1100	2	1.80000	0.71000
7883	GE	2	1100	2	0.20000	0.71000
7883	OS	38	1100	1	3.40000	0.36000

7. Same As Above: Number of Different Physicians With Claims Against Them, By Specialty - Alphabetically By Specialty

PHYSPEC	Number of Occurrences
AN	5
CD	4
DA	2
EM	7
FP	68
GE	2
GTCS	31
IM	19
N	4
NS	8
OBG	18
OPH	6
ORS	24
OS	1
OTO	2
P	3
PD	7
PTH	3
R	12
U	4
	230 different physicians

8. Number of Physicians With More Than One Claim Against Them-Repeat Physicians

No. Physicians	No Claims	Total Physicians
36	2	72
5	3	15
3	4	12
181	1	181
		280

Number of Hospitals & Nursing Homes With More Than One Claim Against Them

No. Hospitals & Nursing H	No Claims	Total Hospitals & NH
1	7	7
2	6	12
2	9	18
3	2	6
19	1	19
1	10	10
1	18	18
1	5	5
2	4	8
		103

9. Tally of Claims By Physician County

PHYCOUN	Number of Occurrences
BEAVERHEAD	2
BROADWATER	1
CARBON	2
CASCADE	32
CUSTER	4
DAWSON	3
DEER LODGE	2
FLATHEAD	15
GALLATIN	13
GLACIER	2
HILL	4
LAKE	5
LEWIS & CLARK	16
LIBERTY	3
LINCOLN	1
MISSOULA	32
PHILLIPS	2
PONDERA	1
POWELL	6
RAVALLI	1
RICHLAND	6
ROOSEVELT	2
SANDERS	2
SHERIDAN	2
SILVER BOW	18
STATE: OKLA	1
STATE: WA	1
STILLWATER	1
TETON	1
VALLEY	1
YELLOWSTONE	48

10. Closed Claims With Hearings - Nature of Hearing Disposition & Health Care Providers Before Panel

Claim Filed Against Health Care Providers & Dispoosition By Panel	Number
A. Physician(s) & Facility	
Both To Hearing	61
Facility To Hearing Withdrawn With No Settlement As to Physician(s)	2
Physician(s) To Hearing Withdrawn With No Settlement As to Facility	7
B. Physician(s) Alone To Hearing	88
Facility Alone To Hearing	16
	174

11. Closed Claims Without Hearings

Claims Filed Against Health Care Providers And Disposition	Number
A. Against Physician(s) And Facility	
Withdrawn, No Settlement, In Favor of All	9
Withdrawn, Settlement, Against All	3
Withdrawn, No Settlement Against Physician(s), Settlement Against Facility	1
B. Against Physician(s) Only	
Withdrawn, No Settlement Against	19
Withdrawn, Settlement Against	5
C. Against Facility Only	
Withdrawn, Settlement Against	2
Withdrawn, No Settlement Against	2

12. Overall Panel Results

	Number Of Occurrences
A. Claims Involving Physicians	
Result In Favor of Physician	218
Result In Favor of Claimant	62
B. Claims Involving Facilities	
Result In Favor of Hospital	81
Result In Favor of Nursing Home	2
Result In Favor of Claimant Against Hospital	20
	383

13. Panel Votes: Health Care Providers - Talled as to 300 health care providers

Type Vote	Number Health Care Providers
A. Physicians	
Tie	10
Unanimous	
Against HCP	35
For HCP	127
Split	
Against HCP	26
For HCP	24
B. Facilities	
Tie	3
Unanimous	
Against HCP	8
For HCP	43
Split	
Against HCP	6
For HCP	18

13. Post-Panel Disposition: Number Of Health Care Providers Tracked To Date: 237 of 383

		Result Favorable To Claimant	Provider
A. Physicians			
Suit Filed	82		
No Suit Filed	155		
Withdrawn			
Settlement	55	55	
No settlement	108		108
Trial-Appeal Result Undetermined			
For Physician	2		2
For Claimant	1	1	
B. Facilities			
Suit Filed	27		
No Suit Filed	62		
Withdrawn			
Settlement	22	22	
No Settlement	40		40
Trial			
For Facility	1		1
For Patient			

C. Correlation Between Panel Results And Whether Suit Filed

1. Physicians: Suit Filed: Panel Result For

	Number of Occurrences
Claimant	19
Physician	35

2. Physicians: No Suit Filed: Panel Result for

	Number of Occurrences
Claimant	27
Physician	106

3. Facilities: No Suit Filed: Panel Result For

	Number of Occurrences
Claimaint	12
Hospital	44
Nursing Home	2

4. Facilities: Suit Filed: Panel Result For

	Number of Occurrences
Claimant	5
Hospital	15

D. Correlation Between Panel Result and Post-Panel Result: Unanimous Votes of Panel

	Number
Panel For Physician	
Post Panel	
For Physician	54
Against Physician	12
Panel For Claimant	
Post Panel	
For Claimant	16
Against Claimant	1
Panel For Facility	
Post Panel	
For Facility	15
Against Facility	6
Panel Against Facility	
Post Panel	
Against Facility	0
For Claimant	0

14. ASSESSMENT DETERMINATION FOR YEAR 1985

A. BUDGET ASSUMPTIONS

1.	Number of Expected Claims Filed:	122
2.	Number of Expected Hearings:	110
3.	Expected Administrative Expense: (1985 set at $100,552)	$100,552
4.	Expected Prehearing Expense Per Closed Claim: (1983 at $510.27; 1984 approximately $611.97)	$523
5.	Expected Hearing Expense Per HEARING HELD: (1983 at $1,621.55)	$1,622
6.	Expected Interest Rate (e.g. .08) on Invested Money:	0.08
7.	Contingency Fund Desired At End of Year:	$20,000
8.	Physicians To Be Assessed: (1984 at 1084)	1084
9.	Hospital Beds To Be Assessed: (1984 at 3442)	3442
10.	Other Facilities To Be Assessed: (1984 at 31)	31
11.	Current Number Of Open Claims:	40
12.	Expected Assessment Income, Previous Years:	$11,800
13.	Proportion Of The Following As To Total HCP With Claims, All Previous Full Years	
	a. Physicians:	0.7311
	b. Hospitals:	0.2637
	c. Other Facilities:	0.0052

ASSESSMENT	Physicians:	$246
	Each Bed:	$28
	Each Other Facility:	$61

RESULTING IN YEAR-END OPEN CLAIMS OF: 32
AND RESULTING IN YEAR-END CASH ON HAND OF: $0
EXCLUSIVE OF CASH CONTINGENCY OF: $20,000

B. INCOME-EXPENSE STATEMENT BASED ON BUDGET

	ASSESSMENT BUDGET	
INCOME		
Cash On Hand: Start	$63	
Expected Receivables		
Previous Years	$11,800	
Current Year	$347,020	
Interest Income	$7,932	
Total Income		$366,814
EXPENSE		
Administrative	$100,552	
Pre-Hearing	$67,821	
Hearing	$178,441	
Cash Contingency	$20,000	
Total Expense		$366,814
Income In Excess of Expense		$0

C. CURRENT DATA AS BASIS FOR ASSUMPTIONS

Year	Hearing Expense Per Hearing Held	Pre-Hearing Expense Per Closed Claim
1981	$1,626.94	$331.25
1982	$1,674.47	$416.18
1983	$1,547.19	$510.27
Thru Sept 1984	$1,621.55	$611.97
AVERAGE	$1,617.54	$467.42

D. CLAIMS PATTERNS

Year	Number of Claims Filed
1980	31
1981	37
1982	78
1983	89
1984 Est	97
1985	110

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Suite 12 • Helena, Montana 59601

BILLING TO MONTANA MEDICAL-LEGAL PANEL FOR
PERIOD JANUARY 1, 1985 TO DECEMBER 31, 1985

1)	Equipment rental	$ 6,800.00
2)	IBM System 6 and mag card rental	8,400.00
3)	Staff services	62,400.00
4)	Director	14,952.00
5)	Rent & utilities	8,000.00
	DUE	$100,552.00

Notes:

1) Equipment rental includes desks, chairs, filing cabinets, tables, postage equipment, mailing equipment, use of IBM Display Writers, IBM Personal Computer XT, dictation equipment, etc.

2) IBM System 6 & IBM Mag Card typewriter rental is exclusive of maintenance, ribbons, etc.

3) Staff time is computed for 2½ individuals and the availability of multiple secretarial assistance when required. Salaries - $48,710, retirement - $7,306, health insurance - $3,120 and FICA taxes - $3,264.

4) Director at $1,000 per month, part time. Salary - $12,000, retirement - $1,800, health insurance $348 and FICA - $804.

5) Rent and utilities is computed at $8 per foot for 1,000 square feet; no additional charge for conference facilities and additional office space when required.

Note: Payable monthly @ $8,379 per month.

Montana Medical-Legal Panel

2021 Eleventh Avenue, Suite 12, Helena, Montana 59601 — Telephone 443-1110

December, 1984

Dear Health Care Provider:

Enclosed is your assessment for 1985 for the Montana Medical-Legal Panel. Also enclosed are financial and claims data for your information.

Insurance for medical malpractice is based on the number of claims and the dollar impact of amounts paid out. The Panel assessment is based on the number of physicians, hospitals, hospital-related and long-term care facilities brought before the Panel, with hospitals being assessed on a per-bed basis.

The Panel's purposes include:

...The reduction in the number of non-meritorious claims for malpractice going to lawsuit and to trial

...The encouragement of the settlement of those with merit

...The collection of data on the "who, what, when and where" of malpractice claims in Montana, and its use in the reduction of future claims.

It is demonstrable that these goals are being met to a high degree.

Both patients and health care providers presumably benefit in having this type of forum for the airing of patient grievances, especially under circumstances where less time and cost on everyone's part is associated with definitively handling most of the claims.

If you have any questions, please feel free to write and inquire.

Respectfully submitted,

G. Brian Zins, Director
Montana Medical-Legal Panel

GBZ:jt
Enclosures

ASSESSMENT DETERMINATION FOR YEAR 1985

A. BUDGET ASSUMPTIONS

1.	Number of Expected Claims Filed:	122
2.	Number of Expected Hearings:	110
3.	Expected Administrative Expense: (1985 set at $100,552)	$100,55^
4.	Expected Prehearing Expense Per Closed Claim: (1983 at $510.27; 1984 approximately $611.97)	$523
5.	Expected Hearing Expense Per HEARING HELD: (1983 at $1,621.55)	$1,622
6.	Expected Interest Rate (e.g. 8%) on Invested Money:	8%
7.	Contingency Fund Desired at End of Year:	$20,000
8.	Physicians to be Assessed: (1984 at 1084)	1084
9.	Hospital Beds to be Assessed: (1984 3442)	3442
10.	Other Facilities to be Assessed: (1984	31
11.	Current Number of Open Claims:	40
12.	Expected Assessment Income, Previous Years:	$11,800
13.	Proportion of the Following as to Total HCP with Claims	
	a. Physicians:	73.11%
	b. Hospitals:	26.37%
	c. Other Facilities:	52%

ASSESSMENT

a. Physicians:	$246
b. Hospital Bed:	$28
c. Each Other Facility:	$61

RESULTING IN:

Year-end open claims:	32
Year-end cash on hand:	$0
Exclusive of cash contingency:	$20,000

B. INCOME-EXPENSE STATEMENT BASED ON BUDGET

INCOME		
Cash on Hand: Start	$63	
Expected Receivables		
Previous Years	$11,800	
Current Year	$347,020	
Interest Income	$7,932	
Total Income		$366,814
EXPENSE		
Administrative	$100,552	
Pre-Hearing	$67,821	
Hearing	$178,441	
Cash Contingency	$20,000	
Total Expense		$366,814
Income in Excess of Expense		-0-

C. CURRENT DATA AS BASIS FOR ASSUMPTIONS

Year	Hearing Expense Per Hearing Held	Pre-Hearing Expense Per Closed Claim
1981	$1,626.94	$331.25
1982	$1,674.47	$416.18
1983	$1,547.19	$510.27
Thru Sept 1984	$1,621.55	$611.97

D. CLAIMS PATTERNS

Year	Number of Claims Filed
1980	31
1981	37
1982	78
1983	89
1984 Estimate	97
1985 Estimate	122

FROM:

PLACE POSTAGE ON REVERSE SIDE

PLACE
POSTAGE
HERE

MML PANEL

2021 Eleventh Avenue, Suite 12

Helena, MT 59601

MONTANA MEDICAL-LEGAL PANEL ASSESSMENT

1985

PHYSICIANS	HOSPITALS AT	HOSPITAL-RELATED AND
	$28.00 Per Bed,	LONG-TERM CARE FACILITIES
*$246.00 Each		$61.00 Each

Your Hospital $_____

PLEASE REMIT THE APPROPRIATE AMOUNT SHOWN ABOVE AND RETURN IN THIS ENVELOPE.

DUE AND PAYABLE BY MARCH 31, 1985

YOUR CANCELLED CHECK SHALL SERVE AS YOUR RECEIPT.

*If began practice after January 1985, please prorate at $20.50/mo. beginning month of practice through December 1985.

TO EACH HEALTH CARE PROVIDER CONCERNED

This is a statement for your share (as a Montana licensed provider) of the 1985 assessment for operation of the Montana Medical-Legal Panel, as authorized by M.C.A. 27-6-206.

The Panel hears claims against all physicians, hospitals, hospital-related facilities and long-term care facilities involving alleged negligence in providing health care. Such claims cannot be filed in court prior to a Panel decision.

This statement represents your assessment for 1985.

Under M.C.A. 27-6-206(3) the assessment is due and payable by March 31, 1985. Under that statute the Director of the Panel has, upon default of such payments, the same powers as the Department of Professional and Occupational Licensing under M.C.A. 37-3-313.

The Panel has a great potential for the reduction of costs associated with such claims, and hopefully will help to reduce insurance premiums in a greater amount than Panel costs, a savings that could then be passed on to patients.

Thank you.

STATE PUBLISHING CO., HELENA, MONT.

MONTANA MEDICAL - LEGAL PANEL

HELENA, MONTANA

AUDIT REPORT

FOR THE YEARS DECEMBER 31, 1983 AND 1982

TABLE OF CONTENTS

NEWLAND, HORN, CRIPPEN & PECK, P.C.
Certified Public Accountants

212 Missouri Ave.
Deer Lodge, Montana 59722
(406) 846-3733

53 West Broadway
Butte, Montana 59701
(406) 782-1253

16 North Montana
Dillon, Montana 59725
(406) 683-6125

William B. Horn
Robert L. Crippen
Dennis W. Peck

Ronald W. Wagner
Ronald W. Hanni
John F. Burns

Mr. G. Brian Zins
Executive Director
Montana Medical - Legal Panel
2021 Eleventh Ave.
Helena, Montana 59601

We have examined the statement of assets, liabilities and fund balance arising directly from cash transactions of the Montana Medical - Legal Panel as of December 31, 1983 and 1982, and the related statements of revenues collected and expenses disbursed and changes in financial position for the years then ended. Our examination was made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in note 1, the Panel policy is to prepare its financial statements on the basis of cash receipts and disbursements; consequently, certain revenue and the related assets are recognized when received rather than when earned, and certain expenses are recognized when paid rather than when the obligation is incurred. Accordingly, the accompanying financial statements are not intended to present financial position and results of operations in conformity with generally accepted accounting principles.

In our opinion, the financial statements referred to above present fairly the assets, liabilities and fund balance arising from cash transactions of the Montana Medical - Legal Panel at December 31, 1983 and 1982, and the revenue collected and expenses paid and the changes in its financial position for the years then ended, on the basis of accounting described in note 1, which basis has been applied in a manner consistent with that of the preceding year.

Newland, Horn, Crippen & Peck P.C.
NEWLAND, HORN, CRIPPEN & PECK, P.C.
Certified Public Accountants

Dillon, Montana
March 27, 1984

EXHIBIT "A"

MONTANA MEDICAL - LEGAL PANEL
HELENA, MONTANA

STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCE
DECEMBER 31, 1983 AND 1982

ASSETS

	1983	1982
Current assets:		
Cash in bank	$14,837	$16,310
Investments	-0-	2,505
Other receivables	80	-0-
Total current assets	$14,917	$18,815

LIABILITIES AND FUND BALANCE

Current liabilities:		
Notes payable, bank	$ -0-	$80,000
Fund balance:		
Surplus (Exhibit "B")	14,917	(61,185)
Total liabilities and fund balance	$14,917	$18,815

See accompanying notes to financial statements.

EXHIBIT "B"

MONTANA MEDICAL - LEGAL PANEL
HELENA, MONTANA

STATEMENTS OF REVENUES COLLECTED, EXPENSES DISBURSED AND SURPLUS
FOR THE YEARS ENDED DECEMBER 31, 1983 AND 1982

	1983	1982
Assessment fees	$259,698	$ 77,502
Interest income	3,862	2,302
Miscellaneous income	-0-	305
Total income	263,560	80,109
Expenses:		
Printing	1,440	339
Telephone	4,293	2,637
Office supplies	350	823
Postage	7,098	3,393
Xerox	10,568	5,927
Interest expense	4,145	-0-
Medical record and x-ray charges	1,590	1,447
Panelist hearing time	55,712	45,100
Panelist preparation and travel time	22,854	14,923
Panelist travel	17,360	11,979
Panel legal counsel	7,722	5,052
Administrative	50,200	69,225
Miscellaneous	4,126	3,689
Total expenses	187,458	164,534
Net income (loss)	76,102	(84,425)
Surplus January 1st	(61,185)	23,240
Surplus December 31st	$ 14,917	($ 61,185)

See accompanying notes to financial statements.

EXHIBIT "C"

MONTANA MEDICAL - LEGAL PANEL
HELENA, MONTANA

STATEMENTS OF CHANGES IN FINANCIAL POSITION
FOR THE YEARS ENDED DECEMBER 31, 1983 AND 1982

	1983	1982
Working capital used by operations:		
Net income (loss)	$76,102	($84,425)
Increase (decrease) in working capital, as below	$76,102	($84,425)
Changes in working capital by element:		
Increase (decrease) in current assets -		
Cash	($ 1,473)	($ 6,929)
Investments	(2,505)	2,504
Other assets	80	-0-
Total	(3,898)	(4,425)
Increase (decrease) in current liabilities -		
Notes payable, bank	(80,000)	80,000
Increase (decrease) in working capital	$76,102	($84,425)

See accompanying notes to financial statements.

MONTANA MEDICAL - LEGAL PANEL
HELENA, MONTANA

NOTES TO FINANCIAL STATEMENTS
DECEMBER 31, 1983

Note 1: Accounting Policies

Organization: The Panel was established by the "Montana Medical Legal Panel Act", as authorized by Sections 27-6-101 through 27-6-704 M.C.A. The Panel is attached to the Montana Supreme Court for administrative purposes only, except that 2-15-121 (2) does not apply.

Cash basis: The Panel follows the cash basis of accounting whereby items of expense are recognized as cash is expensed and revenues are recognized when cash is received.

Note 2: Accounts Receivable

The Panel, at December 31st, had not as yet received the following fees:

	Physicians	Hospital	Total
1982	$ 600	$ 300	$ 900
1983	15,750	1,800	17,550
Total	$16,350	$2,100	$18,450

Note 3: Accounts Payable

The Panel, at December 31st, had not paid the following bills:

Panel hearing time	$ 80
Panel preparation and travel time	195
Panel travel time	7
Panel, other	630
Medical records	25
Total	$ 937

EXPENDITURES OF THE
MONTANA MEDICAL-LEGAL PANEL
THROUGH 1983

JANUARY 1984

GERALD J. NEELY, ESQ
COUNSEL TO PANEL

EXPENDITURES OF THE

MONTANA MEDICAL-LEGAL PANEL

THROUGH 1983

1. TOTAL EXPENDITURES: 1978-1983

The Panel administration spent $599,727 from 1978 - 1983. These expenditures involved the processing of claims of medical malpractice made against physicians, hospitals, and long-term care facilities.

The Panel is obligatory as a pre-condition to a state court lawsuit as to any claims arising after April 18, 1977. By the consent of all parties, the Panel has heard some claims which occurred prior to that date.

The total expenditures have involved the processing of:

... 295 claims filed before the Panel

.. 67 of which have been withdrawn and fully completed, with or without settlement
.. 178 of which have been heard by a full panel of three lawyers and three health care providers
.. 50 of which are still open and being processed, each having been filed in 1983.

2. TOTAL EXPENDITURES: 1983

The 1983 expenditures for the Panel were $187,458 for the processing of:

... 95 claims filed before the Panel in 1983
... 83 closures of claims filed in 1982 and 1983

.. 21 of which were withdrawn and fully completed, with or without settlement
.. 62 of which were heard by a full panel

3. RECENT CHANGES IN TOTAL EXPENDITURES.

A. In Relation to Claims Filed, Closed, and Hearings Held.

Since 1980, total expenditures have increased at a lower rate than the number of claims filed, claims closed, or hearings held:

Category	1980-1983 Percentage Increase
Total Expenditures	97.4%
Claims Filed	163.9%
Claims Closed	159.4%
Hearings Held	148.0%

B. On A Per Claim Closed Basis.

Since 1980, total expenditures on a per claim closed basis have dropped by 23.9%:

	Year		Percentage
	1980	1983	Increase
Per Claim Closed Cost	$2,969	$2,259	(23.9%)

4. ITEM EXPENDITURES: 1978-1983

The Panel Administration spent funds from 1978 - 1983 on the following percentage basis:

Item	Percentage of Total Expenditures
Administration	36.2%
Panelist fees & travel	46.5%
Printing and reproduction	5.0%
Legal	4.9%
Postage	2.3%
Telephone	1.9%
Other	3.2%
	100.0%

Nearly 83% of total expenditures were for the administration of the claims and the panelist fees and travel.

5. RECENT CHANGES IN ITEM EXPENDITURES ON A PER CLAIM CLOSED BASIS.

Since 1980, the item expenditures have increased or decreased as follows, on a per claim closed basis:

Item	Year per closed claim 1980	1983	Percentage Increase
Administration	$1,498	$ 605	(59.6%)
Panelist fees & travel	1,142	1,156	1.2%
Printing and reproduction	69	164	137.7%
Legal	134	93	(30.6%)
Postage	42	84	100.0%
Telephone	47	52	10.6%
Other	37	104	181.1%
Total	$2,969	$2,259	(23.9%)

The cost per claim closed dropped by nearly 24% from 1980 to 1983, primarily as a result of drops in the cost per closed claim for administration and legal fees.

These overall cost reductions were achieved even though the costs associated with the Panel administration's assumption of the cost and responsibility for medical record gathering, reproduction, and distribution increased substantially.

Printing and reproduction and postage alone increased from $111 to $248 per closed claim -- or by 123% -- from 1980 to 1983.

On the assumption that half of one employee's time is now spent on the medical records matter, by eliminating printing of Rules of Procedure from the expenditures, and eliminating the other day-to-day cost of postage and photocopying, it is estimated that the cost per claim of medical record receipt, reproduction, and distribution has increased from approximately $90 per closed claim to $315 per closed claim from 1980 to 1983, a 250% increase:

	Cost per Closed Claim 1980	1983	% Increase
Administration	$ 0	$ 84	--
Reproduction	58	146	152%
Postage	32	85	166%
Total	$ 90	$ 315	250%

Such medical records cost are thus currently about 14% of the total Panel costs.

6. FUTURE PANEL COSTS

A refined estimation of future Panel costs requires assumptions as to the number of claims that will be closed with hearing and without hearing. Also required is an assumption as to the costs of administration and the per closed claim cost of hearings held and the pre-hearing non-administrative costs.

Assuming the closure of 100 claims by hearing and 27 by settlement prior to hearing, without the addition of added staff to handle the added closures, it is estimated that the Panel administration will expend $280,031 in 1984 as follows:

-- Administration, at $516 per closed claim	$ 65,532
-- Pre-hearing costs at $537 per closed claim	68,199
-- Hearing costs at $1,463 per hearing	146,300
	$ 280,031

With the addition of one full time staff member for 10 months of 1984, it is estimated that the annual expenditure will be $290,000.00. Budget expenditures for year 1984 made in 1983 was $290,540.00.

DOLLAR EXPENDITURES OF PANEL BY YEAR: 1979-1983

	1979	1980	1981	1982	1983	Total
Fixed Costs						
Administrative*	$29,223	$47,925	$20,475	$69,225	$50,200	$217,048
Variable Costs						
Panelist Fees**	14,202	29,463	45,584	60,023	78,566	227,838
Panelist Travel***	4,020	7,082	10,392	11,979	17,360	50,833
Printing and Reproduction	2,481	2,218	3,927	7,713	13,598	29,937
Legal	9,093	4,272	3,406	5,052	7,722	29,545
Telephone	915	1,505	2,039	2,637	4,293	11,389
Postage	736	1,334	1,104	3,393	7,098	13,665
Supplies	632	387	562	823	350	2,754
Interest	0	0	0	0	4,145	4,145
Miscellaneous	1,751	796	2,212	3,688	4,126	12,573
Total	$63,053	$94,982	$89,701	$164,533	$187,458	$599,727

NOTES:

* - A substantial portion of the 1981 administrative expenses were paid in 1982.

** - Fees for preparation and hearing time.

*** - Includes fees for time of travel plus cost of travel, board and room

Year 1979 includes nominal expenditures from year 1978.

ITEMS AS A PERCENTAGE OF TOTAL EXPENDITURES BY YEAR, 1979-1983

	1979	1980	1981	1982	1983	Total
Fixed Costs						
Administrative	46.3%	50.5%	22.8%	42.1%	26.7%	36.2%
Variable Costs						
Panelist Fees	22.5%	31.0%	50.8%	36.5%	41.9%	38.0%
Panelist Travel	6.4%	7.5%	11.6%	7.3%	9.3%	8.5%
Printing & Reproduction	3.9%	2.3%	4.4%	4.7%	7.3%	5.0%
Legal	14.4%	4.5%	3.8%	3.1%	4.1%	4.9%
Telephone	1.5%	1.6%	2.3%	1.6%	2.3%	1.9%
Postage	1.2%	1.4%	1.2%	2.1%	3.8%	2.3%
Supplies	1.0%	.4%	.6%	.5%	.2%	.5%
Interest	0.0%	0.0%	0.0%	0.0%	2.2%	.7%
Miscellaneous	2.8%	.8%	2.5%	2.2%	2.2%	2.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

COST PER CLAIM CLOSED: 1979-1983

Year	Total Expenditures	No. Claims Closed	Cost per Claim Closed
1979	$ 63,053	33	$ 1,911
1980	94,983	32	2,968
1981	89,699	40	2,242
1982	164,533	57	2,887
1983	187,537	83	2,259
Total	$ 599,805	245	N/A
Average	$ 119,961	49	$ 2,448

ADMINISTRATIVE COSTS PER CLAIM CLOSED: 1979-1983

Year	Administrative Costs	Claims Closed	Administrative Cost per Claim Closed
1979	$ 29,223	33	$ 886
1980	47,925	32	1,498
1981	20,475	40	519
1982	69,225	57	1,214
1983	50,200	83	605
Total	$217,048	245	
Average	$ 43,410	49	$ 886

NOTE: A substantial portion of the 1981 administrative expenses were not paid until year 1982. Any comparison of changes in expenditure patterns using 1981 or 1982 as a base year must take this factor into account.

NON-ADMINISTRATIVE PRE-HEARING COSTS PER CLAIM CLOSED:

1979-1983

Year	Non-administrative Pre-hearing Costs	Claims Closed	Non-administrative Pre-hearing Costs Per Claim Closed
1979	$ 15,608	33	$ 473
1980	10,512	32	329
1981	13,250	40	331
1982	26,306	57	462
1983	41,332	83	498
Total	$ 107,008	245	
Average	$ 21,402	49	$ 438

NON-ADMINISTRATIVE PRE-HEARING COSTS PER CLAIM CLOSED, BY ITEM: 1979-1983

	COST PER CLAIM CLOSED				
ITEM	1979	1980	1981	1982	1983
Printing and Reproduction	$ 75.18	$ 69.31	$ 98.18	$135.32	$163.83
Legal	275.55	133.50	85.15	88.63	93.04
Telephone	27.73	47.03	50.98	46.26	51.72
Postage	22.30	41.69	27.60	59.53	85.52
Supplies	19.15	12.09	14.05	14.44	4.22
Interest	0.00	0.00	0.00	0.00	49.94
Miscellaneous	53.06	24.88	55.30	64.70	49.71

DIRECT HEARING COSTS PER HEARING: 1979-1983

Year	Direct Hearing Costs	Hearings Held	Direct Hearing Costs Per Hearing Held
1979	$ 18,222	14	$ 1,302
1980	36,545	25	1,462
1981	55,976	33	1,696
1982	72,002	44	1,636
1983	95,926	62	1,547
Total	$ 278,671	178	
Average	$ 55,734	36	$ 1,566

RECENT CHANGES IN TOTAL EXPENDITURES IN RELATION TO CLAIMS FILED, CLOSED AND HEARINGS HELD:

	1980	1983	Percentage Increase
Total Expenditures	$ 94,982	$187,458	97.4%
Claims Filed	36	95	163.9%
Claims Closed	32	83	159.4%
Hearings Held	25	62	148.0%

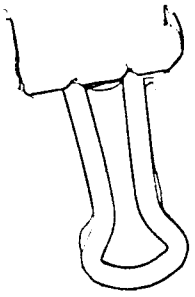
RECENT CHANGES IN EXPENDITURES PER CLAIM CLOSED: 1980 to 1983

	Cost Per Claim Closed 1980	1983	Percentage Increase
Administrative	$ 1,498	$ 605	(59.6%)
Non-Administrative Pre-hearing			
Printing & Reproduction	69	164	137.7%
Legal	135	93	(30.6%)
Telephone	47	52	10.6%
Postage	42	84	100.00%
Supplies	12	4	(66.7%)
Interest	0	50	--
Miscellaneous	25	50	100.0%
Total	329	498	51.4%
Hearing Costs	1,142	1,156	1.2%
TOTAL	$ 2,969	$ 2,259	(23.9%)

NOTE: The above presents hearing costs per claim closed. For purpose of a per-hearing held comparison, the following is appropriate:

1980	1983	Percentage Increase
$1,462	$ 1,547	5.8%

The cost per claim closed for 1980 of $2,969 varies from the $2,968 of the total expenditures divided by total closed claims due to rounding.



Montana Medical Legal Panel

Rules of Procedure

October 1, 1983

STATE PUBLISHING CO., HELENA, MONT.

INTRODUCTION TO PANEL RULES

Should you have a claim to be filed before the Montana Medical Legal Panel, you may request Application and Consent Forms by writing:

Montana Medical Legal Panel
2021 - 11th Avenue, Suite #12
Helena, Montana 59601

It will be helpful if you will provide the date of each alleged occurrence in your correspondence requesting the forms, so that the Panel can determine if the claim is one covered by the Act, or, if occurring prior to April 19, 1977, a claim which under Rule 6 may be submitted to the Panel upon all parties consenting thereto.

For your assistance a timetable outlining the various time requirements of the Rules is presented on page 12.

DISQUALIFICATION
of Panelists
Affidavit stating facts filed with Panel within 15 days of Director's mailing of list of selected Panel members. Rule 10(c).

EXHIBITS
and Documentary evidence
Provided to Director and all other parties no later than 30 days prior to hearing, unless not earlier available, then as soon as available. Rule 14.

HEARING
date
Fixed by Director after receipt of Application by Panel, but no later than 120 days after transmittal of Application by Director to other parties. Rule 12(a).

LAWSUIT
filing of
May not be filed in District or Justice Court before Application to Panel and its decision rendered. Rule 6(b).

SUPPLMENTAL HEARING
Upon Panel request for additional information, no later than 30 days after original hearing. Rule 15(e).

TELEPHONE CONFERENCE
Pre-hearing
At least 5 days before hearing date. Rule 13.

TRANSCRIPTION
of Record, Request
At telephone conference. Rule 13(4).

TIME TABLE FOR LAWYERS IN MONTANA MEDICAL LEGAL PANEL CLAIMS

This Time Table indicates the time for key steps in a claim before the Montana Medical Legal Panel, as provided by the Rules of Procedure. It should be noted by the parties that once a Panel has been selected and the hearing date set, considerable expense to the Panel and delay for the claim are involved in any rescheduling.

ANSWER

to Application

Filed with Panel within 20 days of receipt of claim by health care provider. Rule 7(a).

to Amended Application

Answer deemed Answer to Amended Application, unless Amended Answer filed with Panel within 20 days of receipt of Amended application by health care provider. Rule 7(a).

AMENDMENT

of Application

As a matter of course allowed, within 20 days of receipt of original application by Panel. At request or by authorization of Director or Chairman of Panel, within 20 days of receipt of such request or authorization. If filed with Panel within 30 day period before hearing date, hearing continued not more than 30 days. Rule 6(d)(3).

APPLICATION

Filing of

Filed with Panel prior to filing a complaint in District or Justice Court, Rule 6(b), on form provided by Director. Rule 6(d).

CONSENT FORMS

Claimant filing of

Filed at time of filing application, signed by claimant, on a form provided by the Director, as to all health care providers mentioned. Rule 6(d)(2).

Health Care Provider filing of

Filed at time of providing medical records, signed by Health Care Provider, on a form provided by the Director. Rule 7(b).

CONSULTATION, MEDICAL

Cooperation of Director

Claimant request for Director cooperation in retaining medical consultation made within four weeks of filing of Application. Rule 11.

IN THE SUPREME COURT OF THE STATE OF MONTANA

RE: Rules of Procedure, Montana Medical Legal Panel

ORDER

Section 27-6-204, MCA, authorizes the Director of the Montana Medical Legal Panel, in consultation with the State Bar of Montana and subject to the approval of the Supreme Court, to adopt and publish Rules of Procedure necessary to implement and carry out the duties of the Panel.

The Director of the Panel, after consultation with the State Bar of Montana, having presented proposed Rules to the Court, and the Court exercising its authority to promulgate guidelines for the payment of hourly fees to panelists under Section 27-6-203, MCA:

THEREFORE, IT IS ORDERED THAT effective October 1, 1983, the following are adopted as the Rules of Procedure for the Montana Medical Legal Panel:

RULE 1. Definitions. As used in these Rules:

(a) "Health care provider" means a "physician" or a "health care facility". A "physician" means an individual licensed to practice medicine by the Department of Commerce pursuant to M.C.A. Title 37, Chapter 3. A "health care facility" means a facility, other than a governmental infirmary or any infirmary not staffed by a physician, licensed as a health care facility by the Department of Health and Environmental Sciences pursuant to M.C.A. Title 50, Chapter 5.

(b) "Malpractice claim" means any claim or potential claim against a Health Care Provider for medical treatment, lack of medical treatment or other alleged departure from accepted standards of health care which proximately results in damage to the patient, whether the patient's claim or potential claim sounds in tort or contract, and includes but is not limited to allegations of battery or wrongful death.

(c) "Panel" means the Montana Medical Legal Panel provided for in Section 27-6-104, MCA.

(d) "Act" means the Montana Medical Legal Panel Act as established by Sections 27-6-101 through 27-6-704, MCA.

(e) "Director" means the Director of the Panel.

(f) "Substantial Evidence" is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion, or, stated another way, enough evidence to justify refusal to direct a verdict on a factual issue in jury trial.

RULE 2. Scope of Rules. These Rules apply to all proceedings before the Montana Medical Legal Panel established by the Act.

RULE 3. Purpose of the Panel. The purpose of the Panel is to prevent, where possible, the filing in court of actions against Health Care Providers and their employees for professional liability in situations where the facts do not permit at least a reasonable inference of malpractice and to make possible the fair and equitable disposition of such claims against Health Care Providers as are or reasonably may be well founded.

RULE 4. Fees. No fees or charges are to be levied upon claimants as a precondition to the bringing of a malpractice claim before the Panel.

RULE 5. Representation and Appearance-Counsel. The parties may be represented by counsel in proceedings before the Panel though it shall not be required. If any party chooses to retain legal counsel, such legal counsel shall informally enter his or her appearance with the Director. Thereafter, all communications required by these Rules to be transmitted to a party and all other communications directed to a represented party shall be directed to the appropriate counsel, with a copy to the Director, except that the Notice of Hearing required by Rule 12 shall be provided to all the parties involved and their counsel, if any.

RULE 6. Presentation of Claims.

(a) These Rules shall apply to all malpractice claims arising from a Health Care Provider's acts and/or omissions occurring on or after April 19, 1977; provided however, claims arising prior thereto may be submitted to the Panel upon all parties consenting thereto.

(b) Prior to filing a complaint in any State District or Justice Court in Montana, claimants shall submit a case for consideration of the Panel, and no malpractice claim to which the Act is applicable may be filed in any such court against a Health Care Provider before an application is made to the Panel and its decision rendered.

RULE 18. Compensation of the Panel. All members of the Panel shall be paid a fee of Forty ($40.00) Dollars per hour, up to a maximum of Three Hundred Twenty ($320.00) Dollars per day in which a hearing or part of a hearing is held, for the time spent in hearing claims subject to the approval of the Director and upon presentation of a billing itemizing to the one-tenth (1/10th) of an hour the nature of the services performed and the time involved. Additional compensation for travel time and other services shall be considered by the Director under circumstances including, but not limited to weather or distance.

RULE 19. Additional Authority of Panel. The Panel may provide for the administration of oaths, the receipt of claims filed, the promulgation of forms required by the Act, the issuance of subpoenas in connection with the administration of the Act, and the performance of all other act fairly and effectively administer the Act.

(1) Whether there is substantial evidence that the acts or omissions complained of occurred;

(2) If the answer to (1) is "Yes", whether there is substantial evidence such acts or omissions constitute a departure from the accepted standards of health care;

(3) If the answer to (2) is "Yes", whether there is a reasonable probability that the patient was injured thereby.

(b) All votes of the Panel on the questions for discussion shall be by secret ballot. The decision shall be by a majority vote of those voting members of the Panel who sat on the entire case. The decision shall be communicated in writing to the parties and their attorneys, and a copy thereof shall be retained in the permanent files of the Panel.

(c) The decision shall in every case be signed for the Panel by the chairman and shall contain only the conclusions reached by a majority of its members and shall list the number of members, if any, dissenting therefrom. The majority may briefly explain the reasoning and the basis for their decision, and the dissenters may likewise explain the reason for disagreement.

(d) The report of the Panel is not admissible as evidence in any action subsequently brought in any court of law. A copy of the report shall be sent by the Director to the Health Care Provider's professional licensing board.

(e) Panelists and witnesses are immune from civil liability for all communications, findings, opinions and conclusions made in the course and scope of the duties prescribed by the Act.

(f) The Panel's decision is without administrative or judicial authority and is not binding upon any party. The Panel may, however, recommend an award, approve settlement agreements consented to by the parties and discuss the same and all such approved settlement agreements are binding on the parties.

RULES 17. Travel Expenses. All members of the Panel, the Director, and his staff are entitled to travel expenses incurred while on the business of the Panel, as provided in Sections 2-18-501 through 2-18-503, MCA, but such expenses shall be approved by the Director before payment is made.

(c) Claimants shall submit a case for consideration of the Panel by delivery of an application in writing and signed by the patient and/or his or her attorney, by certified mail, to the office of the Director.

(d) The application, on a form provided by the Director, shall contain the following:

(1) A statement in reasonable detail of the elements of the Health Care Provider's conduct which are believed to constitute a malpractice claim, the dates the conduct occurred, and the names and addresses of all physicians and hospitals having contact with the claimant, and all witnesses. The Director shall immediately notify the Health Care Provider of the filing of the claim and furnish him a copy thereof.

(2) A statement signed by the claimant, on a form provided by the Director, for each Health Care Provider involved (whether a party or not), authorizing the Panel to obtain access to all medical and hospital records and information pertaining to the claim and, for purposes of its consideration of the matter only, which includes distribution of such records to the Health Care Providers named in the claim before the Panel or their attorneys, waiving any privilege as to the contents of those records. Nothing in that statement may in any way be construed as waiving that privilege for any other purpose or in any other context, in or out of court.

(3) A claimant may amend the application as a matter of course within 20 days of the receipt of the application by the Panel, but thereafter only upon approval of the Director, or the Chairman of the Panel, if one is selected. The Director or, in the event of the selection of a Panel chairman, such chairman may, upon his own initiative or upon the written request of the Health Care Provider, request the application be amended to provide additional details of the claim. Such an amendment, and any other amendments to the application, must be delivered to the Director within twenty (20) days of receipt of a written request or authorization by the Director or Chairman, along with sufficient copies for service by the Panel on all other parties. In the event an amendment to the

claim is filed less than thirty (30) days prior to hearing, upon request of the other party, the hearing will be automatically continued to a date not less than thirty (30) days after the original hearing date. Any continuances of the hearing in excess of thirty (30) days after the original hearing date shall be granted only upon a showing of good cause.

RULE 7. Answer to Application.

(a) Within twenty (20) days after receipt of the claim, the Health Care Provider shall answer the application for review, by delivery of the answer in writing and signed by the Health Care Provider or his or her attorney, by certified mail, to the office of the Director, with sufficient copies for service by the Panel on all other parties. For good cause shown, the Director may extend the answer time.

The answer shall be deemed an answer to any amended application, unless within twenty (20) days after the receipt of the amended application, the Health Care Provider delivers in the same manner as required above, an amended answer.

(b) The Health Care Provider shall, on a form provided by the Director, authorize the Panel to inspect all medical and hospital records and information pertaining to the application and, for the purposes of such inspection only, which includes distribution of such records to the claimant or his or her attorney, waiving any privilege as to the contents of those records. Nothing in the statement waives that privilege for any other purpose.

(c) Upon receipt of an answer or an amended answer to an application, the Director shall serve a true copy of the same upon the claimant and all other health care providers in the same manner as provided for service of the application in Rule 8(a).

RULE 8. Transmittal of Documents.

(a) Upon receipt of an application for review or an amendment thereto, the Director shall serve a true copy of the same upon the Health Care Provider whose conduct is claimed by the application to have constituted the basis for a malpractice claim. Service shall be effected by mailing, certified, a copy of the claim to the Health Care Provider, postage prepaid, return receipt requested.

the facts constituting the alleged professional malpractice which he is prepared to prove. The Health Care Provider against whom the claim is brought may be present, and he or his counsel may make an introductory statement of his case.

(b) Claimant shall proceed first with his case, followed by the Health Care Provider. Both parties may call witnesses to testify, who shall be subject to cross-examination and who shall be sworn. Medical texts, journals and other documentary evidence relied upon by either party may be offered and admitted, if relevent, and if submitted timely under Rule 14. Written statements of fact by treating Health Care Providers or claimants may be reviewed.

(c) The hearing will be confidential and informal, and the Panel shall not make, pay for or retain any transcript; with the consent of the chairman of the Panel and all parties to the claim, the parties may provide for the making, payment and retention of a transcript. The Montana Rules of Evidence shall not apply to hearings before the Panel; however, irrelevant, immaterial or unduly repetitious evidence may be excluded by the chairman.

(d) All members of the Panel shall have the right to examine the parties and witnesses, subject to the control of the chairman.

(e) At the conclusion of the hearing, the Panel may take the claim under advisement or may request that additional facts, records, witnesses or other information be obtained and presented to it at a supplemental hearing, which shall be set for a date and time certain, not longer than thirty (30) days from the date of the original hearing, unless the party bringing the matter for review consents in writing to a longer period.

(f) Any supplemental hearing shall be held in the same manner as the original hearing, and the parties and their attorneys may be present.

(g) No panel member may be called to testify in any proceeding concerning the deliberations, discussions, decisions and internal proceedings of the Panel.

RULE 16. Panel Deliberations and Decisions.

(a) The deliberations of the Panel are confidential. Upon consideration of all the relevant material, the Panel shall decide:

RULE 13. Pre-hearing Telephone Conference. At least five (5) days prior to the hearing date set, the following parties shall confer, by telephone conference call or personally, with the chairman of the Panel: claimant and/or his attorney, the Health Care Provider and/or his attorney, and the Director of the Panel. During the pre-hearing conference call, the parties shall consider the following:

(1) Simplification and identification of issues;

(2) Obtaining of admissions to or stipulations of facts not remaining in dispute and of the authenticity of documents;

(3) Limitation of the number of expert witnesses to be called and scheduling of their appearances;

(4) Estimation of length of hearing and, if applicable, consideration of any transcription request;

(5) Any other matters that might aid in expeditious consideration and determination of the claim.

RULE 14. Exhibits and Documentary Evidence. No later than thirty (30) days prior to the hearing date set for the claim, all parties shall furnish each other a copy and the Director seven (7) copies of all records and other documents and exhibits other than medical records obtained by the Panel, properly idenfitied, upon which they intend to rely at the time of the hearing; provided, however, if a party proves that competent evidence was not available within such thirty (30) day period, the party producing such evidence shall be required to notify the Director, the other party, and all panel members of such evidence as soon as it becomes available to him and serve copies thereof upon all such persons. The chairman shall have the discretionary authority to admit such later acquired evidence upon such terms and conditions as he deems just and equitable in the premises.

RULE 15. Hearing Procedures.

(a) At the time set for hearing, the claimant submitting the case for review shall be present, personally, unless that presence is: (1) waived by all health care providers; or (2) excused by the Panel Chairman or the Director upon a timely request stating the reasons therefore. The claimant or his counsel shall make a brief introduction of his case, including a resume of

(b) Additionally, upon receipt of the application for review, the Director shall:

(1) Mail all parties a copy of these Rules of Procedure;

(2) Mail a copy of the application to the directors of the Health Care Provider's professional society or association and the State Bar. If no state professional society or Association exists with respect to such Health Care Provider, or if the Health Care Provider does not belong to such a society or association, the Director shall transmit the application to the Health Care Provider's state licensing board.

(c) Upon receipt of the selected panelists pursuant to Rule 9, the Director shall transmit by mail to all parties a list of all Panel members selected, including a short professional biographical sketch of each panelist.

(d) At least ten (10) days prior to the hearing date set for a claim, the Director shall furnish to each panel member copies of all claims, briefs, medical records and other documents pertaining to the claim; except when the chairman, or Director if a chairman has not been selected, of the Panel determines that it is impractical to reproduce or mail a medical record or other document, in which case such records or documents shall be made available to Panel members at the hearing and at the Panel office prior to the hearing, and each Panel member shall be notified of the decision of the chairman or Director and the availability of the materials.

RULE 9. Selection of Panel Members.

(a) Except as herein provided, there shall be three (3) panel members from the Health Care Provider's profession and three (3) panel members from the State Bar in review of each case. The attorneys shall select one of their members as chairman of the Panel as soon as possible but in no event less than ten (10) days prior to the time set for the hearing.

(b) Those eligible to sit on the Panel are Health Care Providers licensed pursuant to Montana law residing in Montana and members of the State Bar of Montana residing in Montana.

(c) The Health Care Provider's professional association or society and the State Bar shall select twelve (12) panel members within four-

teen (14) days from the date of transmittal of the application for review to said societies. If no such society or association exists or if the Health Care Provider does not belong to such a society or association, the Health Care Provider's state licensing board shall within the same time period as required above select twelve (12) persons from the Health Care Provider's profession and, where applicable, persons specializing in the same field or discipline as the Health Care Provider.

(d) Whenever there are multiple Health Care Providers the claim against each Health Care Provider may be reviewed by a separate Panel, or at the discretion of the Panel initially appointed or by stipulation of the parties, a single Panel may review all the claims against all parties.

(e) Whenever the theory of **respondeat superior** or some other derivative theory of recovery is employed, two (2) of the panel members shall be chosen from the Health Care Providers profession and one (1) panel member shall be chosen from the profession of the Health Care Provider named as employer, master, or principal.

(f) Upon selection of panel members, those selected shall be communciated to the Director, along with a short professional biographical sketch of each person selected and their business telephone numbers and addresses.

RULE 10. Disqualification of Panel Members.

(a) Any panel member shall disqualify himself from consideration of any case in which, by virtue of his circumstances, he feels his presence on the panel would be inappropriate, considering the purpose of the Panel.

(b) The Director may excuse a proposed panelist from serving on the Panel.

(c) Whenever a party makes and files an affidavit that a panel member selected by these Rules cannot, according to the belief of the party making an affidavit, sit in review of the application nor review with impartiality, that panel member may proceed no further. A party may not disqualify by affidavit more than three panel members in any single malpractice claim, and any such affidavit to be effective must be filed within fifteen (15) days of the transmittal by mail to the parties by the Director of the name or names of the panel member selected in these rules who is sought to be disqualified. Nothing in these rules shall additionally be construed so as to defeat a party's right to such disqualification.

(d) To replace any panel member disqualified or excused under these rules, a replacement panel member shall be selected, pursuant to Rule 9 of these rules, within five (5) days of receipt by the professional association, state licensing board, or the State Bar of notification by the Director of the panel member disqualified or excused. Notification of replacement panel members shall be made by the Director pursuant to Rule 8 (c).

RULE 11. Medical Consultation. A claimant request for Director cooperation in retaining a consultant must be made within four weeks of filing of the application. The Director shall cooperate fully with the claimant in retaining a physician qualified in the field of medicine involved, who will consult for purposes of the panel hearing with the claimant upon payment of a reasonable fee by the claimant, which said fee shall be calculated on an hourly rate and, upon claimant's request, reviewed by the Panel. In the event the Panel determines the consulting fee charged the claimant is unreasonably high, they shall, upon vote of majority, reduce the same to a reasonable fee.

RULE 12. Time and Place of Hearing.

(a) After the application has been received, a date, time and place for the hearing shall be fixed by the Director, and prompt notice thereof shall be given by the Director to the parties involved and the members of the Panel.

(b) In no instance may the date set be more than one hundred twenty (120) days after the transmittal by the Director of the Health Care Provider of the application for review, unless the Panel, by majority vote, finds good cause exists for extending the period. Such vote may be taken by letter or telephone.

(c) Panel hearings may be held in any county the Panel considers necessary or advisable. The county commissioners or other governing authority shall provide, upon request of the Director, suitable facilities for any such hearing.