MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on February 4, 1991, at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
Stella Jean Hansen (D)
Royal Johnson (R)
Betty Lou Kasten (R)
Thomas Lee (R)
Charlotte Messmore (R)
Jim Rice (R)
Sheila Rice (D)
Wilbur Spring (R)
Carolyn Squires (D)
Jessica Stickney (D)
Bill Strizich (D)
Rolph Tunby (R)

Staff Present: David Niss, Legislative Council
Jeanne Krumm, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

HEARING ON HB 413

Presentation and Opening Statement by Sponsor:

REP. MARY ELLEN CONNELLY, House District 8, Kalispell, stated that the Denturist Association would explain HB 413.

Proponents' Testimony:

Ron Olson, President, Denturist Association of Montana, submitted written testimony. **EXHIBIT 1**

John Mateskon, Vice President of Denturist Association of Montana, submitted written testimony. **EXHIBIT 2**

Roland D. Pratt, Denturist Association of Montana, submitted written testimony. **EXHIBIT 3**

Opponents' Testimony:

Michele Kiesling, State Board of Dentistry, submitted written testimony. **EXHIBIT 4**

John Smith, Montana Dental Association, submitted written testimony. **EXHIBIT 5**

Bill Zepp, Montana Dental Association, submitted written testimony. **EXHIBIT 6**

Roger Tippy, Montana Dental Association, submitted written testimony and amendments. **EXHIBITS 7 & 8**

Questions From Committee Members: None

Closing by Sponsor:

REP. CONNELLY closed on HB 413.

HEARING ON HB 400

Presentation and Opening Statement by Sponsor:

REP. MARIAN HANSEN, House District 100, Ashland, stated that this bill updates Montana's anti-discrimination language in the mental health statute. This has not been done since the Legislature passed this in the 1960s. This proposed amendment would make the language consistent with actual federal legislation to ensure that comprehensive mental health services are available to all Montana citizens.

Proponents' Testimony:

Frank Lane, Eastern Montana Mental Health Center, stated that this bill defines a community mental health center and defines who must be served. It is wrong for people not to have access to mental health service. He also submitted written testimony. **EXHIBIT 9**

Gordon Morris, Director, Montana Association of Counties, stated that the association does have a resolution 90-2 that speaks to this issue. The intent of this bill is to eliminate inconsistencies with the federal law in regard to mental illness.

Opponents' Testimony:

Dan Anderson, Administrator, Mental Health Division, Department of Institutions (DOI), submitted written testimony. **EXHIBIT 10**

Sally Johnson, Legal Counsel, Department of Institutions, stated

that this bill would create a statute under which every person of every diagnosis or level of human stress or anxiety will be entitled by state law to take mental health treatment. Currently no such mental health services exist in Montana, nor do they exist federally. The DOI received an additional $275,000 in homeless block grant funds, which funds are required and individualized solely for homeless seriously mentally ill persons. The DOI seeks and administers these grants in accordance with the guidelines and rules of federal grant programs and other federal laws and rules under which the Public Health Service act is interpreted.

Kimberley Kradolfer, Department of Institutions, submitted written testimony. **EXHIBIT 11**

Paul Meyer, Executive Director, WMRC Mental Health Center, stated that mental health centers and their clients are citizens of this state and are covered under both federal and state laws for discrimination matters. This bill will present a dilemma in services where they don't have enough dollars to serve everyone they are required to. They won't have the resources to see all of the people in the future.

John Shontz, Mental Health Association of Montana, stated that this bill is to discourage discrimination. He doesn't think that anyone argues that there should be discrimination based on religion, sex, color, creed, race, etc., but the bottom line in delivery of mental health services in Montana is that resources are limited and the Legislature will probably find some position not to kill this bill. As we start moving towards the institutionalization of people and towards pardoning people in the community to keep them there, we are all going to have to make choices of who to serve and who not to serve.

Marty Onishuk, Montana Association for Mental Illness, stated that there isn't enough money to provide services for everybody. We must argue with giving money to certain areas. It is wrong to discriminate. All of us know discrimination should not be happening in any way.

<u>Questions From Committee Members</u>:

REP. MESSMORE asked if the interest was discrimination in Eastern Montana or the interest of tightening up this bill. **Mr. Lane** stated that he was not aware that there is any kind of discrimination. He is aware of available monies for services from the General Fund and Federal Grant monies. These monies have increased over the past two years in Eastern Montana, because of the fact that services and populations have been harbored.

REP. KASTEN asked how do targeted groups in the state affect the delivery of service in Eastern Montana and how much flexibility do you have to cover the problems in Eastern Montana. **Mr. Lane**

stated that since the state has targeted groups, there is a special population they have to increase service to.

REP. KASTEN asked if this bill doesn't pass, is there anything the DOI can do so that services in Eastern Montana could be extended. **Mr. Lane** stated that the funding for community mental health centers in the state, appropriated by the Legislature, has remained fairly flat for ten years.

REP. JOHNSON asked if we currently have programs in the mental health field that are not adequately funded and could suffer the loss of federal monies because of that. **Ms. Johnson** stated that there may be programs that are not adequately funded currently and there are matters that could address that better. If we were targeting, we would be discriminating. It is hard to fund money to meet these specific types of services.

REP. JOHNSON asked if we are trying to extend line 18, would we add sex. **Ms. Johnson** stated that they oppose half of the bill. The way "sex" is deleted is one of the most obvious terms of discrimination in current society.

REP. JOHNSON asked what is the fiscal impact of this bill. **Mr. Anderson** stated they fear the loss of federal funding. This is allocated as about $3.5 million that we can lose from federal funding.

REP. BECKER asked if money is provided from the General Fund that is matched. **Mr. Anderson** stated that the programs which receive federal funding are alcohol and drug abuse program and the homeless people program.

Closing by Sponsor:

REP. HANSON stated that this service is not going to be abused at all. When they talk about prioritizing, that is discrimination in another sense of the word. If we don't do something about these people, that would be criminal itself.

HEARING ON HB 410

Presentation and Opening Statement by Sponsor:

REP. JOHN COBB, House District 42, Augusta stated that this bill is an act to clarify certificate of need requirements. It says that we are not going to worry about a certificate of need for a private physician or dentist unless that service being offered is subject to a certificate of need. He submitted written testimony. **EXHIBIT 12**

Proponents' Testimony: None

Opponents' Testimony:

Jerry Loendorf, Montana Medical Association, stated that this bill contains an unintended result. A certificate of need is a process that the state has to determine if it has a need for particular health care services. The offices of physicians and dentists have always been exempt from that process, and it is a process that would be both long and expensive under the circumstances. In Montana today, we have 18 counties that do not have physicians. 22 counties have physicians and provide services in counties that are having difficulty replacing primary care physicians. Getting physicians to come to this state is difficult. This brings about the position of the certificate of need process. Subsection (c) will undo what the bill intends to clarify, that is to take the offices of physicians and dentists outside of the certificate of need process.

Questions From Committee Members: None

Closing by Sponsor:

REP. COBB stated that the offices of physicians and dentists have nothing to do with the health care facility.

EXECUTIVE ACTION ON HB 410

Motion: **REP. LEE MOVED HB 410 DO PASS.**

Motion: **REP. LEE** moved to amend HB 410.

Page 4,
Insert: (.) after dentist
Strike: the rest of that sentence

Discussion:

REP. KASTEN asked that if physicians could go into a facility that would require a certificate of need and if they would expand an office to include a clinic, would that include a certificate of need. **David Niss** stated that this amendment is probably correct. It looks as though the determination as to whether the service mentioned on page 4 before line 21, is defined with relationship to those requirements in section 1 of the bill.

Vote: Motion carried with **REP. KASTEN** voting no.

Motion: **REP. LEE MOVED HB 410 DO PASS AS AMENDED.**

Discussion:

REP. BOHARSKI stated that the committee should delay action on this bill. REP. LEE WITHDREW HIS MOTIONS. NO ACTION WAS TAKEN ON HB 410.

HEARING ON SB 54

Presentation and Opening Statement by Sponsor:

SEN. DENNIS NATHE, Senate District 10, stated that this bill is in regards to the licensure of occupational therapists (OTs). In 1986 the Legislature licensed the OTs and every two years the Department of Social and Rehabilitation Services (SRS) has to review the payment schedule.

Proponents' Testimony:

Connie L. Grenz, Montana Occupational Therapist Association, submitted written testimony. **EXHIBIT 13**

Michelle Buresh, Occupational Therapy student, Montana Occupational Therapy, submitted written testimony. **EXHIBIT 14**

Dorinda Orrell, Occupation Therapist of Bozeman & Livingston, submitted written testimony. **EXHIBIT 15**

Linda Botten, Montana Occupational Therapist Association & Private Practice Bozeman, submitted written testimony. **EXHIBIT 16**

Lorin Wright, Montana American Physical Therapist Association, stated that there are a number of terms that are confusing. In previous testimony, it was indicated that Medicaid did cover modalities. It needs to be clear that Medicaid terms everything and anybody did in modalities. The wording that was brought forth by the OTs in their bill, including this one, is a step to use physical therapy procedures. This is an agreement they can live with. A task force was set up with the three members of the Montana American Physical Therapist Association for the next few years.

Rich Gajdosik, Physical Therapist, American Physical Therapist Association, stated that there is a lack of formal education with OT programs in preparing OTs to deliver the service. This is not a restriction for OT practice, it is an expansion. Essentially, in light of their educational preparation, there is serious question of whether they are really prepared to do so.

Gail Wheatly, Physical Therapist, submitted written testimony. **EXHIBIT 17 & 18**

Mona Jamison, Montana Chapter American Physical Therapy Association, stated that not everyone is happy with this bill; it was a struggle, but this is what came out. She urged support on this bill.

Mary Borgrud-Krenik, Occupational Therapist, submitted written testimony. **EXHIBIT 19**

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

SEN. NATHE stated that this has been a very toughly negotiated and compromised bill. He urged passing as is.

EXECUTIVE ACTION ON SB 54

Motion/Vote: **REP. CROMLEY MOVED SB 54 BE CONCURRED IN.** Motion carried unanimously.

EXECUTIVE ACTION ON HB 389

Motion: **REP. MESSMORE MOVED HB 389 DO PASS.**

Motion: **REP. J. RICE** moved to amend HB 389.

1. Page 5, line 8.
   Following: the period
   Insert: "Any accommodation that would require an undue hardship or that would endanger the health or safety of any person is not a reasonable accommodation."

2. Page 7, line 16.
   Following: the period
   Insert: "Any accommodation that would require an undue hardship or that would endanger the health or safety of any person is not a reasonable accommodation."

Discussion:

REP. STICKNEY asked where the amendments came from. **REP. J. RICE** stated this amendment was mentioned by Ann McIntyre. This is the language that is in the Federal Act, which would make the state law consistent.

Vote: Motion carried unanimously.

Motion/Vote: **REP. MESSMORE MOVED HB 389 DO PASS AS AMENDED.** Motion carried unanimously.

EXECUTIVE ACTION ON HB 260

Motion: **REP. STICKNEY MOVED HB 260 DO PASS.**

Motion: **REP. S. RICE** moved to amend HB 260. **EXHIBIT 20**

Discussion:

REP. BECKER asked what does 40-8-103, MCA cover. **David Niss** stated that placement for adoption means the transfer of physical

custody of a child with all parental rights having been terminated and the child is otherwise legally free for adoption.

REP. MESSMORE stated that there seems to be a compromise between the insurance companies and service providers.

REP. WHALEN asked what the effect of the amendment would be regarding a thirty day provision before coverage would apply. **David Niss** stated that it is only to apply to newborns, otherwise a one year waiting period would apply if the insurance were to be applied to a child other than a newborn.

Motion: REP. DOWELL MADE A SUBSTITUTE MOTION THAT THE AMENDMENTS TO HB 260 DO NOT PASS.

Discussion:

REP. DOWELL said these amendments were the entire opposition to the bill.

REP. RUSSELL stated that if the committee adopts the amendments it will change the bill significantly from what the sponsor has asked of the committee.

REP. LEE stated that amendment number 5 cleared up the gray areas of actually who had custody and who was in fact responsible. This wasn't legally effective, until the actual transfer of custody.

REP. S. RICE stated that this bill should be put into a subcommittee.

REP. STICKNEY, REP. S. RICE, and REP. DOWELL WITHDREW THEIR MOTIONS. NO ACTION WAS TAKEN ON HB 260. A SUBCOMMITTEE WAS APPOINTED. REPS. HANSEN, GALVIN, and MESSMORE WERE APPOINTED.

ADJOURNMENT

Adjournment: 5:50 p.m.

ANGELA RUSSELL, Chair

Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 2-4-91

NAME	PRESENT	ABSENT	EXCUSED
REP. ANGELA RUSSELL, CHAIR	✓		
REP. TIM WHALEN, VICE-CHAIR	✓		
REP. ARLENE BECKER	✓		
REP. WILLIAM BOHARSKI	✓		
REP. JAN BROWN	✓		
REP. BRENT CROMLEY	✓		
REP. TIM DOWELL	✓		
REP. PATRICK GALVIN	✓		
REP. STELLA JEAN HANSEN	✓		
REP. ROYAL JOHNSON	✓		
REP. BETTY LOU KASTEN	✓		
REP. THOMAS LEE	✓		
REP. CHARLOTTE MESSMORE	✓		
REP. JIM RICE	✓		
REP. SHEILA RICE	✓		
REP. WILBUR SPRING	✓		
REP. CAROLYN SQUIRES	✓		
REP. JESSICA STICKNEY	✓		
REP. BILL STRIZICH	✓		
REP. ROLPH TUNBY	✓		

CS05HUMSER.MAN

HOUSE STANDING COMMITTEE REPORT

February 5, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that Senate Bill 54 (third reading copy -- blue) be concurred in .

Signed: _____

Angela Russell, Chairman

Carried by: Rep. Messmore

8:10 am
2/5/91

HOUSE STANDING COMMITTEE REPORT

February 5, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 389 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:
1. Page 5, line 8.
Following: the period
Insert: "Any accommodation that would require an undue hardship or that would endanger the health or safety of any person is not a reasonable accommodation."

2. Page 7, line 16.
Following: the period
Insert: "Any accommodation that would require an undue hardship or that would endanger the health or safety of any person is not a reasonable accommodation."

EXHIBIT 1
DATE 2-4-91
HB 413

HB 413

Testimony - Ron Olson

Human Services and Aging Committee

February 4, 1991

Madam Chairperson and members of the committee for the record my name is Ron Olson, I am the President of the Denturist Association of Montana, also a director of the National Association of Denturist and am in private practice in Billings.

To day I am here to ask your support for HB 413 .

HB 413 would change the internship that is now required from 2 years to 1 year. We feel that after 2 years of academic study, requiring an additional 2 years is more of a determent than a help and will lessen the possibility of an internship being used as a cheap labor device.

HB 413 will change the manner in which Continuing Education is approved for our relicensure requirement. In the past when the Board of Dentistry would not approve any out of state CE courses we were forced to bring in outside clinicians at a very high cost to our members. We learn not only by participating in the courses but by association with other denturists. We have had members who have traveled to meetings outside of Montana that have been sponsored by national and international denturist organizations and they are the only attendees that have not received Continuing Education credits for these classes. We feel this is wrong and should be corrected.

We have also ask that the word "surgically" be inserted on line 6, page 5 so that it corresponds with section 4 (2) on page 6. Also we want to make it clear that we can treat patients with loose and flabby tissue. The use of tissue conditioner over a period of time can measurably increase wear ability and comfort to the patients. If surgery is required, the patient is referred to a oral surgeon.

And last we ask the addition of subsection (d) on page 5 which gives the patient the "freedom of choice" in the decision of having a partial denture constructed. All patients are asked to see a dentist to check their existing teeth before we construct a partial. <u>But, we cannot make them go to the dentist.</u> Some claim that they have just been to a dentist and that the additional expense in the form of travel, time of of work, exam fees, etc means that they can not afford a partial. We feel that by allowing them sign a waiver is a better choice than not getting a partial made.

I would like to thank the committee for its time and ask that you support HB 413.

HB 413

EXHIBIT 2
DATE 2-4-91
HB 413

Testimony - John Mateskon

Human Services and Aging

February 4, 1991

Madam Chairperson and members of the committee for the record my name is John Mateskon, I am Vice President, Denturist Association of Montana and I am in private practice in Bozeman.

I am here today to ask for your support for HB 413.

Some dentist have concerns that by inserting the word "surgically" will allow denturists to do TMJ evaluation and treatment. Approximately one third of patients getting new dentures are wearing dentures 25 years or older. Most have worn out the dentures to the point of experincing some TMJ problems. Anybody who fits dentures, be it dentist or denturist, has to evaluate the TMJ joint to properly fit the dentures.

To make a new set dentures for a patient with disregard to a TMJ problem would definitely be negligent on the part of the provider.

Thank you for your time and I ask for your support for HB 413.

EXHIBIT 5
DATE 2-4-91
HB 413

HB 413

Testimony - Roland D Pratt

House Human Services and Aging Committee

February 4, 1991

Madam Chairperson and members of the committee for the record my name is Roland D Pratt and I am the Lobbyist for the Denturist Association of Montana.

I would like to address a few of the points contained in HB 413.

First, I feel we have agreement that a 1 year internship when added to the prior education is adequate for the preparation of the individual denturist.

Secondly, I would like to point out that Denturist are the only licensees that the Board of Dentistry supervises that have a Continuing Education requirement for relicensure. And another point I would like to make is that it is also the only board that I am aware of that does not recognize the CE approval of other organization that offer courses that are pertinent to the profession that they are governing. At the present time the only courses approved are those that are conducted within the state and are available only to Montana licensees. Needless to say this cost is very high when you have to bring speakers and equipment to Montana. We do not think this is fair nor cost effective.

Thirdly ,I would like to comment on line 6,page 5, if you read it without the word surgically" inserted it states that a denturist can not diagnose or treat anything, which is not the original intent of the law. This wording allows for the treatment and manipulation of gum tissue and allows treatment by alignment of the bridges. It also reinforces the wording in subsection (2) page 6 that states surgery cannot be used.

Last, is the wavier subsection which has already been covered. I would only add that this section is needed to protect the denturist and the patient.

Thank you and I would ask for your support for HB 413.

4

DATE 2-4-91

HB 413

DEPARTMENT OF COMMERCE

PUBLIC SAFETY DIVISION

STAN STEPHENS, GOVERNOR

111 N. JACKSON

STATE OF MONTANA

HELENA, MONTANA 59620-0407

BOARD OF DENTISTRY

February 4, 1991

To: House Human Services and Aging Committee

From: Montana Board of Dentistry

RE: HOUSE BILL 413

My name is Michele Kiesling. I am the Dental Hygiene member of the State Board of Dentistry, and I am here today on behalf of the Board to ask you to oppose HB 413 in its present form.

I will address each section of the Bill and the Board of Dentistry's stance on each section.

SECTION 1. 37-29-303(2)(b)(i)
The Board of Dentistry is in agreement with this change.

SECTION 2. 37-29-306(1)
The Board of Dentistry opposes this change as written. We feel that the term "recognized denturist organization" is unclear, and would suggest the following wording: Approval of acceptable hours of continuing education may be made by the board upon recommendation of the Montana Denturitry Association.

SECTION 3. 37-29-402(3)
The Board of Dentistry opposes insertion of the term "surgically". As defined in 37-29-102, "the practice of denturitry means:

(a) the making, fitting, constructing, altering, reproducing, or repairing of a denture and furnishing or supplying of a denture directly to a person or advising the use of a denture; or

(b) the taking or making or the giving of advice, assistance, or facilities respecting the taking or making of any impression, bite, cast, or design preparatory to or for the purpose of making, constructing, fitting, furnishing, supplying, altering, repairing, or reproducing a denture."

The practice of denturitry does not include the diagnosis or

treatment surgically or otherwise of any abnormalities. A denturist is restricted to the fabrication of dentures.

SECTION 4. 37-29-403(1)(d)

The Board of Dentistry opposes inserting subsection (d). The teeth that serve as anchors for a partial denture must be healthy. A denturist has neither the diagnostic tools nor the educational background to determine when such teeth are diseased or at risk. Placing a partial denture on compromised teeth does the patient a grave disservice and may contribute to the loss of additional teeth. Also, in order to stabilize the partial denture clasps, most anchor teeth must be modified by removing some of the tooth structure. This irreversible procedure can, by law, only be done by a licensed dentist. This proposed change is not in the best dental health interest of the public.

In conclusion, I ask that you please consider the aforementioned concerns when you are making your decisions about House Bill No. 413.

EXHIBIT 5
DATE 2-4-91
HB 413

February 4, 1991

FROM: John E. Smith D.M.D.

To: Members of the House Human Services and Aging Committee.

Subj: Opposition to amendments in Section 3 and Section 4 of House Bill #413.

1. If the word "surgically" is inserted in section 3 of the bill, then denturists could render non-surgical treatment of various abnormalities. Since "abnormalities" are not defined these could include non-surgical treatment of various oral-facial conditions including; tooth decay, periodontal (gum) disease, TMJ dysfunction, fungal infections, toothaches, and crooked teeth. The respective treatment for these abnormalities might include fillings, cleaning and scaling teeth, prescribing medications, root canal therapy, and braces.

2. The effective treatment of any abnormality requires a correct diagnosis. For many abnormalities only a differential diagnosis can be arrived at and treatment involves continual assessment to eliminate possibilities and reach a final diagnosis. For example, a patient might come to a dentist with the complaint of a tooth that is very sensitive to cold. After ruling out the possibility of a cavity the dentist is left with several other potential diagnoses including; root sensitivity from exposed root structure, a cracked tooth, irritation of the tooth from heavy chewing. or the nerve of the tooth is dying and a root canal may be needed. Treatment follows a path from the most conservative to the least conservative until the problem is resolved. TMJ dysfunction is perhaps the best dental example of an area in which diagnosis and treatment are interdependent.

The point here is that treatment of abnormalities is often intertwined with diagnosis and if non-surgical treatment of abnormalities by denturists is allowed, inappropriate treatment may be rendered. Irreversible harm to patients may occur.

3. With regards to section 4, it is considered dental malpractice to construct a partial denture over teeth having untreated, undiagnosed periodontal disease, decay, or abscesses. The reason patients need to see a dentist before partial denture construction is so that these problems can be cared for. This protects not only the patient, but it also protects the denturist from a malpractice suit. I don't believe a waiver will protect a denturist from malpractice.

EXHIBIT 4
DATE 2-4-91
HB 413

Montana Dental Association
P.O. Box 281 • Helena, MT 59624 • (406) 443-2061

Constituent: AMERICAN DENTAL ASSOCIATION

February 4, 1991

To: Members of the House Human Services and Aging Committee

From: Bill Zepp, Montana Dental Association

Re: House Bill 413

The Montana Dental Association, with a current membership of 463 or 82% of the practicing dentists in the state of Montana, is supportive of portions of House Bill 413, but share the concerns expressed on behalf of the Montana Board of Dentistry.

Specifically, the MDA supports the revision of 2 years of internship to 1 year. The denturist community has the best understanding of the appropriate and necessary term of internship.

The MDA agrees with the Board of Dentistry that approval of acceptable continuing education hours, should be recommended by the appropriate denturist organization and approved by the Board of Dentistry. The hours of continuing education are required for renewal of license by the Board of Dentistry; the Board of Dentistry must retain final control regarding the approval of these hours. Mandatory continuing education requirements have been developed by the Board for both dentists and dental hygienists and should be implemented in the near future. The Montana Dental Association understands and has agreed to this same procedure for approval of continuing education hours for dentists. That is, recommendation for approval will be given by recognized dental associations, institutions and organizations and final approval by the Board of Dentistry.

However, the MDA strongly opposes both remaining proposed changes to the denturity practice act. The suggested language would allow the non-surgical treatment of abnormalities. A dentist has presented testimony indicating his concerns and opposition to this change. It is indeed significant that members of the dental community would not propose to provide non-surgical treatment of all abnormalities themselves -- and these individuals have the required education and training to provide diagnosis of these conditions.

Lastly, the requirement for referral of a partial denture patient by a denturist to a dentist insures that all necessary preparatory services, including prophylaxis and xray examination are provided, to the patient. Section 37-9-403, as presently written, protects both the patient and the denturist. Since the denturist cannot, by law or training, provide certain services necessary in preparing and fitting a partial denture, any waiver of these essential services constitutes a disservice to patient and provider alike.

EXHIBIT 7
DATE 2-4-91
HB 413

DEPARTMENT OF COMMERCE

PUBLIC SAFETY DIVISION

STAN STEPHENS, GOVERNOR

111 N. JACKSON

STATE OF MONTANA

HELENA, MONTANA 59620-0407

BOARD OF DENTISTRY

February 1, 1991

To: Roger Tippy, Attorney at Law

From: Lisa F. Casman, Administrative Assistant

RE: BOARD APPROVED DENTURIST CONTINUING EDUCATION PROGRAMS

Per your request, please be advised that since 1987 the Montana Board of Dentistry has approved a variety of denturist continuing education courses. Listed below are some, not all, denturist continuing education courses previously approved by the Montana Board of Dentistry.

Trubyte EPF
Dentsply International
York, PA
Course: Complete Denture Technique

Denturist Association of Quebec
425 de Maisonneuve Blvd, Suite 1210
Montreal, Quebec, Canada
Course: Prosthetic Appliance

Denturist Association of Montana
Great Falls, MT
Course: Oral Pathology
Course: Complete and Partial Dentures
Course: Legal Review and Stress Management
Course: Ivoclar Hormonically Balanced Efficiency System

Academy of General Dentistry
211 East Chicago Avenue
Chicago, ILL 60611
Course: Interpore

Montgomery County Community College
340 Dekalb Pike
Blue Bell, PA
Course: Radiology Review

page 2
Tippy
CE Programs
Denturist

Maryland State Dental Association
6470 Dobbin Road
Columbia, MD 21045
Course: Dental Implants - Auxiliary

Loma Linda University
School of Dentistry
Loma Linda, CA
Course: Intraosseous Implants

Should you have any questions, please feel free to contact me.

cc/file

EXHIBIT 8
DATE 2-4-91
HB 413

House Bill 413

1. Title, page 1, line 6
   following: "REQUIREMENTS"
   strike: "PROHIBITING A DENTURIST FROM TREATING ANY ABNORMALITY BY SURGERY; REQUIRING A PATIENT WHO REFUSES TO SEE A DENTIST TO SIGN A WAIVER BEFORE A DENTURIST MAY PROVIDE A PARTIAL DENTURE."

2. Title, page 1, line 10
   following: "37-29-306,"
   strike: "37-29-402, AND 37-29-403,"

3. Section 2, page 4, line 9
   following: "board"
   strike: "or"
   insert: "and may also be made by a board-"

4. Section 2, page 4, line 10
   following: "organization"
   strike: ", or both"

5. Section 3, page 5, line 1
   strike: sections 3 and 4 in their entirety

EXHIBIT 9
DATE 2-4-91
SB 400

WITNESS STATEMENT

NAME FRANK LADE BILL NO. HB400

ADDRESS 1819 Main Miles City

WHOM DO YOU REPRESENT? Eastern Mont. Mental Health Center

SUPPORT ✓ OPPOSE _____ AMEND _____

COMMENTS:

Briefly covers the federal legislation

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.

Form CS-34A
Rev. 1985

EXHIBIT 10
DATE 2-4-91
HB 400

TESTIMONY ON HB 400
by DAN ANDERSON
FEBRUARY 4, 1991

TO: House Human Services Committee

Madame Chairperson, members of the committee, my name is Dan Anderson. I am Administrator of the Mental Health Division of the Department of Institutions.

I believe that HB 400, if enacted, will cause serious harm to the community mental health program in Montana. Sally Johnson, an attorney for the Department, will tell you specifically how this bill would jeopardize federal funding. What I would like to discuss are the values, philosophy and planning process of the Mental Health System.

This bill really goes to the whole purpose of having a state community mental health program. I don't believe that it is the intent of the legislature that community mental health services be an entitlement program -- that is, a state subsidized service available to any and all people who request it.

Instead, I believe the intent is to help provide community mental health services to those citizens of Montana who are not able -- because they are children, because they are poor, because they are disabled -- to get these services on their own.

As soon as we start talking about targeting state funded services for groups of people who would otherwise be unable to obtain these services, we are, perhaps "discriminating".

On what basis does the Department of Institutions "target" services and therefore, perhaps "discriminate" ? First, we seek guidance from statutes:

State law (53-21-185, MCA) says that "the Department and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement".

The federal law governing the Alcohol, Drug Abuse and Mental Health Block Grant says:

(3) "The State agrees to make grants to community mental health centers in the State for the provision of comprehensive mental health services --

> (A) principally to individuals residing in a defined geographic area (hereinafter in this section referred to as a "mental health service area"), <u>with special attention to individuals who are chronically mentally ill</u>,

(B) within the limits of its capacity, to any individual residing or employed in its mental health service area regardless of ability to pay for such services, current or past health condition, or any other factor, and

(C) which are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care."

The federal law governing the other federal funding source received by the Department -- the "Mental Health Service for the Homeless" Block Grant says:

"The Secretary may not make payments unless the State involved agrees that the payments will be expended solely for ... the purpose of providing services ... to individuals who are suffering from serious mental illness or are suffering from serious mental illness and from substance abuse..."

These laws target and emphasize the seriously or chronically mentally ill apparently because the Montana legislature and the U.S. Congress believe the State has particular responsibility for providing services to this group of people. If HB 400 passes, will the Department be able to continue assuring services for this group of clients? Will the Department be able to accept federal money which is tied to service for this group of people?

Beyond statutory responsibilities, the Department uses a planning process, required by State law and an advisory council required by federal law to help us set priorities. Our advisory council consists of mental health center employees, consumers of mental health services, family members of consumers, and state agency representatives. With the help of the council, the Department sets priorities for services and determines how our resources can best meet the needs of people with mental illnesses.

An additional method we have of defining priorities for state funded services is our contract development process. We have opened up that process to include not only Department and community mental health center input but also proposals for contract and funding changes from advocates, consumers, and other interested persons. As of the January 1, 1991 deadline, we have received no proposals from any person or organization, including the community mental health centers, that the Department should discontinue targeting certain client groups. The only comment on this contract issue was an endorsement by the Montana Alliance for the Mentally Ill of our emphasis on services for the seriously mentally ill.

In summary, the targeting of client groups least able to obtain service on their own is supported by state law, federal law, and the state mental health planning process.

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Passage of this bill would jeopardize federal funding we currently receive and potential additional federal Medicaid funds under the targeted case management option.

If this bill passes, the Department will probably have to seek other providers in order to assure that services for priority groups are maintained. This could destroy the regional mental health center system and create hardships for clients dependent on those agencies for mental health services.

I urge members of this committee to vote against HB 400.

Thank you.

EXHIBIT 11
DATE 2-4-91
HB 400

TESTIMONY OF
KIMBERLY A. KRADOLFER
ASSISTANT ATTORNEY GENERAL
ON HB 400

HOUSE HUMAN SERVICES COMMITTEE
FEBRUARY 4, 1991

I am an assistant attorney general in the Agency Legal Services Bureau. I am one of the attorneys representing the State of Montana in the pending class action lawsuit against Montana State Hospital at Warm Springs, Ihler, et al. v. State of Montana. The Department of Institutions has asked me to testify in opposition to this bill based upon my experience in that case in researching, briefing, and arguing issues pertaining to community mental health care and my knowledge of the relevant court order in that case.

HB 400 is a bill with the stated purpose of prohibiting discrimination in the availability of public mental health services on the basis of age, diagnosis, or physical or mental impairment. The bill will have two very significant and apparently unintended results, however. First, the bill will create a right to community-based treatment for the seriously mentally ill which will result in a mandate for deinstitutionalization. Second, the bill will create an entitlement to mental health care for any and all sufferers of any mental and emotional disorders in the State of Montana: i.e., a socialized system for comprehensive mental health care for all residents of the State of Montana. The bill will create additional "protected classes" that may not be denied care on the basis of their age, diagnosis, or physical or mental impairment. This will preclude the Department from being able to

target those persons most in need of care. It will also create a right to care for those who at this time do not have a right to mental health care in the community: the most serious mentally ill who are dangerous to themselves and others and those who may not even meet the definition of mentally ill (the "worried well")

The State provides community health services at this time, as this committee knows, by contracting with mental health corporations to provide services for those groups which are most in need of the services. That discretion was reviewed in 43 Ops. Atty' Gen'l No. 64, issued July 11, 1990. There, the Attorney General opinion recognized that the Department has a statutory duty to develop a comprehensive plan for the development of public mental health services in the state and that it is not inappropriate for the Department to contract for services designed to provide services for those individuals the Department feels are in the greatest need of those services.

Section 53-21-206, MCA, now reads that services "are available without discrimination on the basis of race, color, creed, religion, or ability to pay." The changes to the statute will **require** that services be provided to everyone without discrimination on the basis of race, color, creed, religion, age, diagnosis, physical or mental impairment, or ability to pay. That change will create an entitlement which will require the Department to provide services to anyone in need of mental health services. It will effectively create a mandate for a comprehensive community

mental health services for anyone arguably suffering from anything that could be classified as a mental illness.

I. Background

Neither the Montana nor the federal constitution require that a state provide any substantive services whatsoever to their citizens. In the leading United States Supreme Court decision on the rights of the mentally handicapped or mentally ill, Youngberg v. Romeo, 457 U.S. 307 (1982), the court recognized that principle. There, the Court held that once the State decides to provide services, **it must meet constitutional standards in doing so.** (That case involved a decision on what level of treatment needed to be provided to a developmentally disabled patient at Pennhurst, a Pennsylvania facility, and it involved issues of patient liberty and safety). The court recognized, however, that even where the State assumes a duty to provide certain services, it "has considerable discretion in determining the nature and scope of its responsibilities" and that the State need not "choose between attacking every aspect of a problem or not attacking the problem at all." 457 U.S. 317. If, as proposed, a state chooses to create protected classes--all entitled to the same treatment--the state will be precluded from discriminating on the basis of the classes which have been created. Such discrimination would be a violation of the equal protection clause.

II. Community Placement: Deinstitutionalization of the Seriously Mentally Ill

In the Ihler case, the contention was made that Montana and federal law created an entitlement to treatment in the community setting because that was the least restrictive environment. The district court rejected that contention and held, as have virtually all other states and most other federal courts, that there was no such entitlement.

I would like to apprise this committee of cases in California and in Arizona in which courts addressed the argument that, based upon language in state statute, there is an entitlement to community-based care. This committee should carefully consider the decisions in those cases. One court held that the state statute created such an entitlement. The other state court held that state statute did not create an entitlement.

A. Arizona

Arnold v. Department of Health Services, 775 P.2d 521 (Ariz. 1977) (en banc). Here, the Arizona Supreme Court examined statutory language pertaining to community mental health services. The court noted that deinstitutionalization of patients into the community had accelerated during the 1960's and 1970's, but that the creation of a comprehensive, community-based system of care was never fully developed. The court there recognized that the main elements to such a system should include a full continuum of care: medications, case management, day treatment, crisis stabilization, work adjustment, socialization, recreation, outreach, and mobile outreach services. Additionally, the residual phase of treatment must include social skills training, case management, outreach, and other modalities. The case was a class action brought by 4500 chronically mentally ill patients who lived in both hospital and outpatient settings.

Arizona's community program responsibility was much like Montana's. It established the Department of Health Services

> as the lead agency in integrating, coordinating, and ensuring adequate mental health care. Cf. § 53-21-202, MCA. The Arizona court held that Arizona's statutes required DHS officials to establish a statewide residential treatment program for the CMI and to administer a unified mental health care system involving Arizona State Hospital (ASH) and community programs. That duty is similar to Department of Institution's responsibility to provide services in the community, where possible, and in Montana State Hospital at Warm Springs. The Arizona State Hospital, as MSH, had the responsibility to prepare coordinated treatment plans and to provide outpatient mental health services for discharged patients.
>
> The Arizona trial court and the Arizona Supreme Court both held that the Department of Health Services **must provide a full continuum of mental health care to all** class members (chronically mentally ill) **who could reasonably benefit**, including, but not limited to: inpatient care, case management, residential services, day treatment, outreach, medications, outpatient counseling, socialization, recreation, work adjustment, and transportation. DHS was required to provide a community residential treatment system that coordinates with all available treatment services and resources for the chronically mentally ill in the community. The court rejected the failure of the legislature to appropriate sufficient funds as a basis for providing care primarily in the state hospital.

Here, Department of Institutions has the duty to coordinate mental health care, using both MSH and community programs to most effectively meet mental health care needs. The Department has the duty to provide care for the seriously mentally ill in the community **when possible.** See § 53-2-101, MCA. However, the Department has the discretion to follow legislative appropriation mandates to provide services at Montana State Hospital for the seriously mentally ill where it is not possible to meet their needs in the community setting. HB 400 will, however, require the Department to meet those needs in the community. It will not be possible to discriminate against those individuals on the basis of

the seriousness of their illness and require placement in the state hospital. HB 400 will require comprehensive community treatment for everyone from the questionably ill to the most serious mentally ill.

B. California

> Mental Health Association v. Deukmejian, 233 Cal. Rptr. 130 (Cal. App. 1986). The California court, by contrast, rejected the notion that California's statutes created a right to mental health treatment for gravely disabled persons in community treatment programs. There, the legislature's funding of the community mental health system did not provide for sufficient community care opportunities for the gravely disabled. There was no statute that entitled all patients to be treated in the community, regardless of the seriousness of their illness. It was therefore appropriate to care for the gravely disabled in hospital settings. The decision allowed California to discriminate on the basis of the seriousness of the illness.

HB 400, however, as noted above, will prevent discrimination on the basis of the seriousness of illness. It will therefore create an entitlement to community-based care which will mandate deinstitutionalization.

III. The "Worried-Well"

A concern which has been raised in deposition testimony in the Ihler case is that even under the present system--where the Department has the ability to target community care funds to those most in need of the care--that too much of the funding has been going to those who really do not need it. That group of patients with adjustment disorders have been referred to as the "worried well." Many mental health professionals do not feel that those

individuals fall within the clinical definition of "mentally ill." There has been criticism that some community mental health centers (CMHCs) have diverted state funding toward those persons.

The plaintiffs in Ihler have relied upon a rating of state mental health programs in analyzing the adequacy of care in Montana. The study they rely upon is entitled: Care of the Seriously Mentally Ill: A Rating of State Programs, by E. Fuller Torrey (1990) (A Joint Publication of Public Citizen Health Research Group and the National Alliance for the Mentally Ill), pp. 170-72 (attached hereto as Exhibit A). The 1990 study rates Montana as being tied for 47th in providing care. The study severely criticizes regional centers for seeing as many as four times the number of patients with "adjustment disorders or no mental disorders for every patient with a diagnosis of schizophrenia." Id. at 171.

The assessment is of course colored by the fact that the survey is evaluating the care Montana provides to seriously mentally ill individuals. However, it does make a point that often times those who are not seriously mentally ill are already using resources which the Department, in meeting its statutory mandate to provide adequate transitional care to those released from Montana State Hospital, § 53-21-185, MCA, may need to retarget to aftercare programs for released patients.

HB 400 would require the Department to provide any mental health care from which a person could arguably benefit to everyone.

The Department would not be able to target the groups that could most benefit from the treatment. The Department would not even be able to withhold treatment from persons who are not mentally ill. HB 400 requires that the treatment be provided to all without regard for diagnosis or mental or physical impairment. Certainly anyone who fit a classification in the Diagnostic and Statistical Manual (Third Edition - Revised) (DSM III - R) would be entitled to care: the "disorders" included in that standard diagnostic tool range from paranoid schizophrenia to addiction to alcohol, drugs, nicotine, or caffeine. However, even such minimal screening would not be permissible under the bill.

Under HB 400, anyone would be entitled to mental health care in the community at the state's expense: counseling to assist transition through a divorce or loss of a loved one or loss of a job; academic problems; codependency counseling for substance abuse; counseling for those with interpersonal problems with coworkers or romantic partners; treatment for drug and alcohol abuse, nicotine addiction, or caffeine addiction; weight-loss counseling.

IV. Conclusion

HB 400 is a bill which will place heavy burdens upon the State of Montana and upon the general fund. Current Montana law gives the Department of Institutions and this Legislature the discretion to appropriate those funds which are available for mental health

care to the groups which are most in need of the services. HB 400 will remove that discretion.

HB 400 will also reverse the current state of the law, which holds that there is no entitlement to community-based mental health services. It will create an entitlement to comprehensive community mental health treatment for everyone. The entitlement will require the State to provide community care to the most serious mentally ill and to those who do not even suffer from mental illness, but who feel that they would benefit from some counseling. Where such an entitlement is created, the Legislature cannot rely upon its decisions in fixing appropriation amounts at a level it feels are reasonable in light of current state fiscal health. If funding is challenged as inadequate to meet all needs, a court will legitimately be able to order the State to provide adequate funding to meet the full needs of all those entitled by the statute to mental health care.

I urge this committee to reject HB 400 and to unanimously recommend it "Do Not Pass." Thank you.

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Care of the SERIOUSLY MENTALLY ILL

A RATING OF STATE PROGRAMS

Third Edition: 1990

E. Fuller Torrey, M.D.
Karen Erdman
Sidney M. Wolfe, M.D.
and
Laurie M. Flynn

A Joint Publication of
Public Citizen Health Research Group
and ***National Alliance for the Mentally Ill***

Exhibit A to
Krados Dep. testimony

services are virtually nonexistent, with the exception of one joint day program in Region 10, although other regions have plans to improve; the juvenile justice has just as few services and no plans. Aside from the new Medicaid funding for case management and day programs, the only promising sign is the establishment of a State-Level Case Review Team earlier this year; like case management, however, such a team will have little impact without services to allocate.

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Mississippi is trying to improve. The governor has been fairly supportive, although not a vocal advocate for people with mental illness; a few legislators have also been helpful. Leadership in the state department of mental health department is fairly competent, with a few excellent officials leading the way in system improvements. Still, CMHC officials resistant to change and cooperation remain firmly entrenched in their positions of power, which will make further progress difficult. And as always, the bottom line for any hope of progress is going to be money: Mississippi spends less per capita than all but three states to serve people with mental illness, with its spending amounting to about half the national average. Even poor states have some ability to fund new programs and must decide which needs to prioritize. Mentally ill Mississippians have waited long enough.

47. Montana (tie)

Hospitals	1
Outpatient/community support	1
Vocational rehabilitation	1
Housing	0
Children	1
Total points	4

Per capita income (1987):	$12,347
Per capita income rank:	41
Per capita mental health spending (1987):	$35.63
Per capita spending rank:	28

Direction: ○ Going nowhere

In February 1990, Montana's Department of Institutions issued a paper entitled "A Vision of a Comprehensive Treatment and Support System for Adults With Severe and Disabling Mental Illness." Like most such documents, it is an enlightened plan which, if put into effect, would substantially improve services for Montana's mentally ill residents. Whether this "vision" will be any more than that, however, remains to be seen, for the state appears to be going nowhere fast.

Hospitals

Public inpatient services for mentally ill Montanans center on the State Hospital in Warm Springs. Situated 20 miles north of Butte, this isolated hospital, which currently has 288 patients, lies in a mountain-fringed valley in a town that consists of the hospital and a single gas station. The hospital is not accredited, and the nursing care unit, which appears to deliver good services, is the only part that is HCFA certified. Although physically pleasant, other units have a variety of problems, including a shortage of psychiatrists despite the fact that the job pays $95,000 and offers free housing. Allegations of patient abuse in the 100-bed forensic unit led to a class action suit by a coalition of advocates that is currently being litigated. Similar allegations have been made elsewhere in the hospital, including against one staff member who has been linked to several cases of patient sexual abuse but who continues to be employed; corrective personnel actions come very slowly in rural communities where everybody knows everybody. The state is currently discussing the possibility of closing the hospital altogether, although where the patients would go is a mystery.

A major problem is that patients can be sent directly to the hospital by any physician in the state without being prescreened by one of the five regional CMHCs; such patients often arrive with grossly inadequate clinical information. Although in theory admission could be refused, in reality there is no alternative once they have arrived in town, except to send them to the gas station which is not considered to be a reasonable alternative treatment plan even in Montana. Another serious problem in Montana is the detention of mentally ill individuals in county jails, especially in Kalispell and Helena, while awaiting transportation to Warm Springs. That this should continue to take place in the state's capitol city despite speeches in the legislature that such practices are inhumane is a sad commentary.

The paucity of psychiatric beds in local hospitals is also remarkable in a state in which the state hospital may be hundreds of miles away from the person needing hospitalization. The Deaconess hospitals in Great Falls and Billings are helpful. On the other hand, the private Glacier View Psychiatric Hospital in Kalispell obtained permission to build from the state after promising to make some beds available to public patients, but, once constructed, reneged on the offer; that the state tolerates such corporate misbehavior is inexplicable.

Exhibit A to Kvado Fee testim

HB 400

Outpatient and Community Support

The state's five regional CMHCs vary widely in providing outpatient services. The Region II CMHC in Great Falls is highly regarded. Region I CMHC in Miles City, on the other hand, is among the worst CMHCs in the nation; it sees four patients with adjustment disorder or no mental disorder for every patient with a diagnosis of schizophrenia. Great Falls' New Directions Center is a noteworthy clubhouse that even has a special program for mentally ill adults who are parents. Riverhouse in Missoula is also said to be a good clubhouse. Case management services are improving, although the state has not yet implemented the Medicaid special option for targeted case management services.

Vocational Rehabilitation

Vocational rehabilitation services in Montana have made little progress. Despite increased training, most vocational rehabilitation counselors seem skeptical of developing job opportunities for mentally ill individuals. Individuals who could be rehabilitated languish instead in boring day programs. The major exception to this has been Region II, where programs such as New Directions in Great Falls have made a commendable effort. The lower end of the spectrum is Region I, where vocational rehabilitation is not even part of the vocabulary of the professionals who are in charge. It is easy to blame everything on the rural character of the state, but there are job opportunities in rural areas as well.

Housing

If it were not for Wyoming's equally complete lack of interest in providing housing for people with mental illness, Montana would be the clear winner of this year's Apathy in Housing award. After examining the state of the art in housing for people with mental illness, and the innovations occurring in states such as Ohio and Rhode Island, one is hard pressed to believe that Montana's housing for people with mental illness consists of about 100 group home beds and a few dozen beds in shared supported apartments. Period. That's all. The group homes, some of which offer extremely poor living conditions, nonetheless have waiting lists since they are virtually the only option available. They are supposed to be transitional but are used as long-term housing because their residents have nowhere to go when they leave. Boarding homes — the usual fall-back housing nationwide for people with mental illness who have nowhere else to live — are almost nonexistent, and those that do exist are in terrible condition.

As for independent living and supported housing, the state does not appear to have heard of them. It's no wonder that the state hospital is forced to discharge patients to the rescue mission. Montana provides no rent subsidies to mental health consumers and has made no efforts to obtain HUD funding, to start a housing development corporation, to assist consumers in obtaining Section 8 rent subsidies, or to collaborate with the state housing authority. With such a lack of options, one wonders where on earth Montana's several thousand mentally ill residents are living. Wherever it is, it is clear that the state does not care.

Children

Montana's services to seriously emotionally disturbed (SED) children exemplify more clearly than those in any other state what happens when the state's mental health agency offers no leadership in meeting the needs of SED kids. Instead of creating a system of services for emotionally disturbed children, the mental health agency has essentially left it to other child-serving agencies to provide what these kids need, offering only outpatient counseling and a few supplemental services itself.

For example, Montana has 40 state-funded inpatient beds for emotionally disturbed children — but they are available only to children judged delinquent by the courts. Not one state-funded bed is available to a child without a court order. The state has two residential treatment centers and four group homes for children and adolescents, but these are not funded by the mental health system and serve a mixed population of children in need — abused, neglected, developmentally disabled, and so forth, rather than just emotionally disturbed. Home-based services are funded by the Department of Family Services, and therefore are available only to abused and neglected children, never to SED children who have not been abused or neglected. In this kind of a non-system, SED children are consistently deprived of the specialized attention and services they need.

The list of problems goes on and on. Case management, one service in which the state mental health department should take a leadership role, does not exist. Crisis services are wholly inadequate. There are no day treatment programs for children below age 12. About 50 children are receiving residential treatment out of state for lack of services within Montana's borders. The criminal justice system is grossly inadequate in its treatment of SED youth; one recent tragedy involved a 14-year-old emotionally disturbed boy who died, allegedly as a result of police beatings and inadequate treatment, shortly after a brief confinement in Flathead County jail. There are a few signs of hope: Montana recently received its first CASSP grant and is beginning a pilot project to put mental health staff in the schools, and the education system is said to be improving in its identification of SED children. But Montana is starting from so little that most of its SED kids may be adults by the time the state pieces together its scraps of service into a system it can be proud of.

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One of the biggest assets in Montana's system is the useful role that family and consumer groups are playing. There is also leadership potential in the Department of

Exhibit A to Kvaalen testimo

Institutions, and there are some helpful individuals in the legislature (such as Rep. Tim Whalen and Sen. Chet Blaylock) and on the Board of Visitors (Kelly Morse). Montana's fiscal condition is relatively good, so the only constraint in translating its "vision" into reality is its collective will.

9. Idaho (tie)

Hospitals	1
Outpatient/community support	1
Vocational rehabilitation	0
Housing	0
Children	1
Total points	3

Per capita income (1987):	$11,868
Per capita income rank:	46
Per capita mental health spending (1987):	$16.74
Per capita spending rank:	51
Direction:	▲ Improving slowly

In September 1962, at a state conference on mental illness, Governor Robert E. Smylie assured Idahoans: "We are making progress ... Our mentally ill citizens are at last being afforded the opportunity for happy and useful futures ... [We are making] a world that will brighten their hearts and minds for a brighter tomorrow." Twenty-eight years of tomorrows later, the mentally ill residents of Idaho are still waiting, and waiting, and waiting. The state has distinguished itself by (1) being the stingiest state, spending only $16.74 per capita on public services for people with mental illness as of 1987 (New York state, by contrast, spent $140.08 per capita); (2) being the only state in which individuals with mental illness are *routinely* taken to county jails for their initial evaluations; and (3) having the worst housing in the nation for people with mental illness. Although there are recent indications of improvement, the overall situation in 1990 for the state's mentally ill residents is, in one word, disgraceful.

Hospitals

Public psychiatric inpatient care is provided primarily by State Hospital South (140 beds) in Blackfoot and State Hospital North (30 beds) in Orofino. The former, which opened in 1886 as the Idaho Insane Asylum, moved into a new building in 1989 and is quite acceptable as state mental hospitals go. It has partial HCFA certification and probably could achieve JCAHO accreditation if it invested the additional funds that would be necessary. State Hospital North, on the other hand, is often without any psychiatrist at all and ranks as one of the worst state hospitals in the nation. Very few general hospitals in Idaho will accept psychiatric patients unless they have insurance.

The most extraordinary aspect of public psychiatric care in Idaho is the route of hospital admission. It is standard practice throughout Idaho to take mentally ill individuals needing hospitalization *first to jail* where the person is fingerprinted, put in a cell, and held until seen by a "designated examiner" within 24 hours. Following the examination a search for a bed commences, a search which may take another two or three days in rural areas. Idaho shares with some counties in Montana this outrageous practice of jailing mentally ill individuals who have been charged with nothing other than being sick; the practice was stopped in most states 150 years ago.

Outpatient and Community Support

This issue leads directly to the heart of the problem — the seven community mental health centers. Since the state owns and operates them, there is no reason why they should not provide priority services to individuals with serious mental illnesses, and they claim to do so. Reality, however, is often something else; for example, the state's federally required P.L. 99-660 plan shows the Region V CMHC as having 12 percent of its caseload diagnosed with schizophrenia but 25 percent diagnosed with "adjustment disorder" or "no mental disorder." There are virtually no crisis beds nor services for patients dually diagnosed with substance abuse. Mentally ill homeless people are routinely offered "bus therapy," especially in northern Idaho where they are given one-way tickets to Spokane. Case management was finally implemented in 1989. A new focus on clubhouses is also a hopeful sign (Club Inc. in Idaho Falls is nice); it should be remembered, however, that Idaho had seven Fairweather Lodges a few years ago but allowed them to wither away.

Vocational Rehabilitation

Vocational rehabilitation for people with mental illness in Idaho is like the mythical yeti — rumored to be out there somewhere, but nobody has actually seen it. Supported employment Programs were not implemented until late 1989. A few consumer-run operations, such as a thrift store and greenhouse, are a very modest start. Sightings of actual vocational opportunities for people with mental illness should be reported immediately to the state Division of Vocational Rehabilitation.

Housing

Idaho is about a decade behind most other states in providing housing for people with mental illnesses. Until

Exhibit A to Kradolfer Test

VOLUME NO. 43 OPINION NO. 64

INSTITUTIONS, DEPARTMENT OF - State-controlled funding for regional mental health centers;
MENTAL HEALTH - Duty to inform detainee subject to involuntary commitment petition of rights;
MENTAL HEALTH - State-controlled funding for regional mental health centers;
PEACE OFFICERS - Duty to inform detainee subject to involuntary commitment petition of rights;
MONTANA CODE ANNOTATED - Sections 53-21-106, 53-21-114, 53-21-115, 53-21-129, 53-21-202 to 53-21-204, 53-21-206;
ADMINISTRATIVE RULES OF MONTANA - Sections 20.14.501 to 20.14.512
OPINIONS OF THE ATTORNEY GENERAL - 43 Op. Att'y Gen. No. 5 (1989).

HELD: 1. The Department of Institutions may allocate state general fund appropriations to purchase services for certain priority populations from regional mental health centers.

2. Pursuant to section 53-21-114, MCA, the mental health professional examining a person under a petition for involuntary commitment must determine whether the person has been informed of his rights and, if not, inform him of them.

July 11, 1990

Lee R. Kerr
Treasure County Attorney
P.O. Box 72
Hysham MT 59038

Dear Mr. Kerr:

You have requested my opinion on the following questions:

1. May the Department of Institutions allocate state general fund appropriations for mental health centers to certain priority populations based on age, diagnosis, and severity of disorder considering section 53-21-206, MCA, which provides that mental health services are available without discrimination on the basis of race, color, creed, religion or ability to pay and shall comply with Title VI of the Civil Rights Act of 1964?

2. Pursuant to section 53-21-114, MCA, must the mental health professional examining a person under a petition for involuntary commitment inform that person of his rights?

The Department of Institutions has broad responsibility for the administration of the state mental health program and mental health centers. The duties of the Department require it to:

> (2) initiate preventive mental health activities of the statewide mental health programs, including but not limited to the implementation of mental health care and treatment, prevention, and research as can best be accomplished by community-centered services. Such means shall be utilized to initiate and operate these services in cooperation with local agencies as established under this part[;]
>
> (3) make scientific and medical research investigations relative to the incidence, cause, prevention, treatment, and care of the mentally ill;
>
> ....
>
> (5) prepare and maintain a comprehensive plan for the development of public mental health services in the state. The public mental health services shall include but not be limited to community comprehensive mental health centers, mental health clinics, traveling service units, and consultative and educational services[;]
>
> (6) provide by regulations for the examination of persons who apply for examination or who are admitted either as inpatients or outpatients to the Montana state hospital or other public mental health facilities;
>
> (7) receive from agencies of the United States and other state agencies, persons or groups of persons, associations, firms, or corporations grants of money, receipts from fees, gifts, supplies, materials, and contributions for the development of mental health services within the state[.]

§ 53-21-202, MCA. The State is divided into mental health regions and each region is authorized to incorporate as a nonprofit community mental health center. § 53-21-204, MCA. The Department and each center are authorized by sections 53-21-203 and 53-21-204(2), MCA, to enter into contracts in order to carry out the Department's plan for prevention, diagnosis and treatment of mental illness.

Information gathered from the Department of Institutions indicates there are five regional mental health centers in the state. Funds disbursed by the Department to the centers include state general

fund appropriations and federal grants. After targeting some of these funds for certain essential services, the Department utilizes a formula for dividing the majority of the funds among the regional centers. The formula is based on an estimate of the number of seriously mentally ill adults, the number of emotionally disturbed children identified by public schools, the number of service units provided to children and adolescents, and the number of admissions to Montana State Hospital. Each center "bills" the Department for services rendered and is reimbursed by the Department for the services provided to patients. The Department provides approximately 42 percent of the funding for the centers. The remainder of the centers' funding is provided by patient fees (17 percent), Medicaid, Medicare and state medical benefits (25 percent), other agencies (5 percent), counties (7 percent), and other miscellaneous sources (4 percent). The Department contracts with the centers for services it will purchase and the centers use the remainder of their funds as they see fit.

Your first question is whether this allocation of funds controlled by the Department constitutes discrimination in violation of section 53-21-206, MCA. That section and the federal law it cites require that the services of the Department and the centers be available without discrimination on the basis of race, color, creed, religion or ability to pay. Based upon the documents which you submitted with your opinion request and which describe the Department's formula for allocating funds, it appears that the Department's procedures for allocating funds to the centers do not relate in any way to a patient's race, color, creed, religion or ability to pay. The procedures do not, in fact, determine a person's eligibility for mental health services. The Department, which has the statutory duty to develop a comprehensive plan for the development of public mental health services in the state, merely contracts to "spend" state-controlled funds in a manner calculated to promote services for those individuals the Department has determined are in greatest need of those services. The centers may utilize resources obtained from other sources as they choose, and no showing has been made that any class of persons is being denied services. I therefore conclude, based upon the information submitted to me, that the Department's use of funds it controls is not a violation of section 53-21-206, MCA.

Your second question concerns application of section 53-21-114, MCA, which states in part:

> (1) Whenever a person is involuntarily detained or is examined pursuant to 53-21-121 through 53-21-126, the person shall at the time of detention or examination be informed of his constitutional rights and his rights under this part. Within 3 days of such detention or examination, he must also be informed in writing by the county attorney of such rights.

You suggest that mental health professionals should not be required to so inform a person, and suggest that the statute be interpreted

to require peace officers to inform the detainee of his rights when involuntarily detained and remove the burden from the mental health professional. The statute is silent regarding who must inform. However, the statutes contemplate much more training, knowledge and involvement concerning the mental health statutes and the commitment process by the mental health professional than by a peace officer. In In the Matter of the Mental Health of E.P., 47 St. Rptr. 297, ___ P.2d ___ (1990), the Court admonished the Mental Health Center, the county attorney, and the Department of Family Services for failure to comply with the statutory due process rights of the patient. The peripheral involvement of the peace officer who took E.P. into custody and promptly delivered E.P. to the center ended when she was delivered to the professional person. 47 St. Rptr. at 301. See also In re M.C., 43 St. Rptr. 508, 512, 716 P.2d 203, 206-07 (1986) (section 53-21-129, MCA, concerning emergency detentions, merely permits a peace officer to take a person into custody for an evaluation; it does not give the officer authority to decide whether the person should be placed in emergency detention. The professional person makes that determination). 43 Op. Att'y Gen. No. 5 (1989).

In order to be certified as a "professional person" under the mental health laws, the mental health professional must demonstrate proficiency and knowledge of the mental health laws. § 53-21-106, MCA; §§ 20.14.501 to 20.14.512, ARM. Section 53-21-115, MCA, of the mental health laws sets forth the procedural rights of a person detained or examined pursuant to a petition for involuntary commitment. Thus, a certified professional person has access to and knowledge of a detainee's rights and the law requiring notice of those rights. I therefore conclude that the professional person must determine whether a person has been informed of his rights and if he has not been so informed, to inform the person of them.

THEREFORE, IT IS MY OPINION:

1. The Department of Institutions may allocate state general fund appropriations to purchase services for certain priority populations from regional mental health centers.

2. Pursuant to section 53-21-114, MCA, the mental health professional examining a person under a petition for involuntary commitment must determine whether the person has been informed of his rights and, if not, inform him of them.

Sincerely,

Marc Racicot

MARC RACICOT
Attorney General

MR/KS/bf

(19) "Health care facility" or "facility" means any institution, building, or agency or portion thereof, private or public, excluding federal facilities, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. The term does not include offices of private physicians or dentists. The term includes but is not limited to ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, hospitals, infirmaries, kidney treatment centers, long-term care facilities, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, residential treatment facilities, and adult day-care centers.

(20) "Health maintenance organization" means a public or private organization which provides or arranges for health care services to enrollees on a prepaid or other financial basis, either directly through provider employees or through contractual or other arrangements with a provider or group of providers.

(21) "Home health agency" means a public agency or private organization or subdivision thereof which is engaged in providing home health services to individuals in the places where they live. Home health services must include the services of a licensed registered nurse and at least one other therapeutic service and may include additional support services.

(22) "Hospice" means a coordinated program of home and inpatient health care that provides or coordinates palliative and supportive care to meet the needs of a terminally ill patient and his family arising out of physical, psychological, spiritual, social, and economic stresses experienced during the final stages of illness and dying and that includes formal bereavement programs as an essential component.

(23) "Hospital" means a facility providing, by or under the supervision of licensed physicians, services for medical diagnosis, treatment, rehabilitation, and care of injured, disabled, or sick persons. Services provided may or may not include obstetrical care, emergency care, or any other service as allowed by state licensing authority. A hospital has an organized medical staff which is on call and available within 20 minutes, 24 hours per day, 7 days per week, and provides 24-hour nursing care by licensed registered nurses. This term includes hospitals specializing in providing health services for psychiatric, mentally retarded, and tubercular patients.

(24) "Infirmary" means a facility located in a university, college, government institution, or industry for the treatment of the sick or injured, with the following subdefinitions:

(a) an "infirmary—A" provides outpatient and inpatient care;

(b) an "infirmary—B" provides outpatient care only.

(25) "Joint commission on accreditation of hospitals" means the organization nationally recognized by that name with headquarters in Chicago, Illinois, that surveys health care facilities upon their requests and grants accreditation status to any health care facility that it finds meets its standards and requirements.

(26) "Kidney treatment center" means a facility which specializes in treatment of kidney diseases, including freestanding hemodialysis units.

(27) (a) "Long-term care facility" means a facility or part thereof which provides skilled nursing care, intermediate nursing care, or intermediate

(ii) a letter of intent is submitted to the department; and

(iii) the department determines the proposal will not significantly increase the cost of care provided or exceed the bed need projected in the state health plan;

(c) the addition of a health service that is offered by or on behalf of a health care facility which was not offered by or on behalf of the facility within the 12-month period before the month in which the service would be offered and which will result in additional annual operating and amortization expenses of $150,000 or more;

(d) the acquisition by any person of major medical equipment, provided such acquisition would have required a certificate of need pursuant to subsection (1)(a) or (1)(c) if it had been made by or on behalf of a health care facility;

(e) the incurring of an obligation for a capital expenditure by any person or persons to acquire 50% or more of an existing health care facility unless:

(i) the person submits the letter of intent required by 50-5-302(2); and

(ii) the department finds that the acquisition will not significantly increase the cost of care provided or increase bed capacity;

(f) the construction, development, or other establishment of a health care facility which is being replaced or which did not previously exist, by any person, including another type of health care facility;

(g) the expansion of the geographical service area of a home health agency;

(h) the use of hospital beds to provide services to patients or residents needing only skilled nursing care, intermediate nursing care, or intermediate developmental disability care, as those levels of care are defined in 50-5-101; or

(i) the provision by a hospital of services for ambulatory surgical care, home health care, long-term care, inpatient mental health care, inpatient chemical dependency treatment, inpatient rehabilitation, or personal care.

(2) For purposes of subsection (1)(b), a change in bed capacity occurs on the date new or relocated beds are licensed pursuant to part 2 of this chapter and the date a final decision is made to grant a certificate of need for new or relocated beds, unless the certificate of need expires pursuant to 50-5-305.

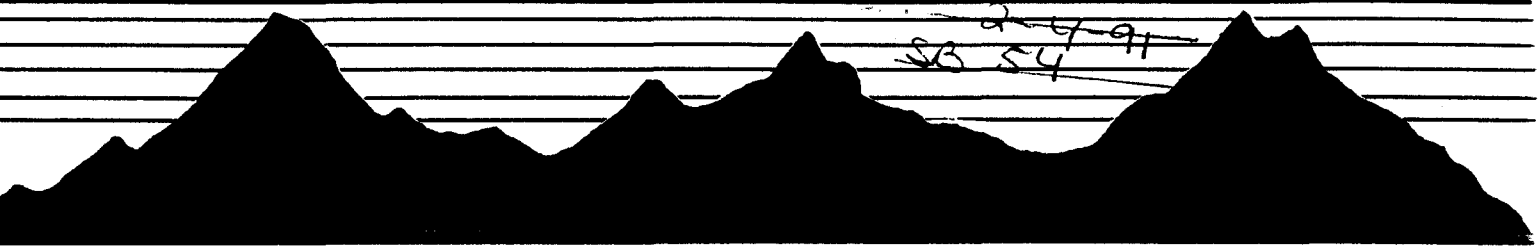
(3) For purposes of this part, the following definitions apply:

(a) "Health care facility" or "facility" means a nonfederal ambulatory surgical facility, home health agency, long-term care facility, medical assistance facility, mental health center with inpatient services, inpatient chemical dependency facility, rehabilitation facility with inpatient services, or personal care facility. The term does not include a hospital, except to the extent that a hospital is subject to certificate of need requirements pursuant to subsection (1)(i).

(b) (i) "Long-term care facility" means an entity which provides skilled nursing care, intermediate nursing care, or intermediate developmental disability care, as defined in 50-5-101, to a total of two or more persons.

(ii) The term does not include adult foster care, licensed under 53-5-303; community homes for the developmentally disabled, licensed under 53-20-305; community homes for persons with severe disabilities, licensed under 53-19-203; boarding or foster homes for children, licensed under 41-3-1142; hotels, motels, boardinghouses, roominghouses, or similar accommodations

12
2-4-91
SB 54



MONTANA OCCUPATIONAL THERAPY ASSOCIATION

I am the president of the Montana Occupational Therapy Association. I request your support for SB 54 as it has been amended and accepted by the Senate.

In 1985 the occupational therapists requested and were granted licensure to protect the consumer from unqualified persons. The legality of that licensure law to allow SRS/Medicaid to reimburse OTs for "modalities" in early 1990 eventually led to an attorney general's review. Although SRS/Medicaid has been reimbursing OTs for the use of modalities for over 25 years; on Jan. 11, 1991, Mark Racicott finalized his interpretation specifically stating: "Occupational Therapists are not permitted by Montana law to employ heat, cold, air, light, water, electricity, or sound as therapeutic agents."

Fortunately the Board of Occupational Therapists and the Dept of Commerce lawyers had already drafted language for legislation to clarify the use of physical agent modalities of occupational therapists. Representatives of the Montana Chapter of the Physical Therapy Association strongly objected to the use of such broad language. Admitting that this was a "turf" battle they made efforts to significantly restrict the practice of occupational therapy. At present occupational therapists have agreed to work within the restrictions of the compromise with its 2 year sunset. The task force of OTs and PTs which began in Oct 1990 and is the groundwork for improved relations and acceptable terminology for 1993 shall be supported.

Occupational therapy students complete a 5 year educational program including internships of 3 months each in physical disabilities, pediatrics and/or psychiatry. The American Medical Association and the American Occupational Therapy Association cooperate to approve standards of quality which meet or exceed the essentials. Essentials include anatomy, kinesiology, physiology, neuroanatomy, and neurophysiology, the etiology, clinical course management, and progression of congenital, developmental, acute, and chronic disease processes and traumatic injuries. With this B.S. degree they are eligible to take the American Occupational Therapy Certification Board Exam. Forty seven jurisdictions regulate OTs based on this exam and only one limits the use of modalities. What is being taught in the schools is a foundation for advancement.

MONTANA OCCUPATIONAL THERAPY ASSOCIATION

Physical Therapists are traditionally known for their use of hot packs, massage and gait training. Occupational therapists are known historically for developing independence in activities of daily living hence the use of the name occupational. We are the experts on the upper extremities. Both professions are over 70 years old and have been progressive in incorporating technological advances to best meet their patients' medical needs. Length of stay in hospitals has decreased due to mandatory regulations and the demand for outpatient and home health services is increasing. As services to meet the demands of the consumers evolve so have therapeutic practices. Insurance reimbursement demands that intervention show a functional outcome; therefore physical therapists have increasingly incorporated some form of ADL-activities of daily living, to follow their treatment and occupational therapists have increasingly incorporated therapeutic agents to facilitate functional outcomes. This was not done haphazardly. Over the years instruction regarding various technological advances have been added to curriculums, internships and continuing education programs. Patients are instructed in home use of ice, heat, wax to relieve pain, increase movement and facilitate function.

I believe that the majority of the OTs and PTs in this state work as a team sharing knowledge and developing treatment plans to best provide for their patients. I know that there are many areas of overlap innately a part of our treatment approaches and that we recognize our individual abilities and limitations with high professional ethics. There are 132 licensed occupational therapists and 330 licensed physical therapists and still great areas of Montana where persons are unable to receive either service within 100 or 200 miles.

I wish to recognize high professional ethics among Occupational Therapists in Montana. Not one consumer complaint has been received by the board in 5 years. The purpose of licensure is not only to protect patients from unprofessional care but also to assure that the care they receive will be the best care available in light of the then current standards. It also imposes upon practitioners the responsibility for assuring that licensure does not impede or prevent the organic growth of the practice in response to advances in science, technology and therapeutic methods. Please note not one claim has been filed against an occupational therapist for injury to a patient with a physical agent modality in the nation, and I remind you that of 47 jurisdictions regulating occupational therapy only one restricts the use of modalities.

Therefore I implore you to support SB#54 to legally clarify the use of therapeutic agents/modalities by occupational therapists. It is in the best interest of the patient to provide the highest quality treatment of which we are capable.

Connie L. Grenz, OTR/L
3/4/91

IT
DATE 2-4-91
SB 54

Michele Buresh
1212 Pinecrest Dr
Bozeman MT 59715

January 31, 1991

My name is Michele Buresh. I am an occupational therapy student completing the last phase of my schooling here in Montana. I am writing to express my concern regarding the SB 54

I will be graduating from the University of Washington OT program in March 1991. Currently I am finishing the clinical experience of schooling. During my physical disability fieldwork at the Montana Deaconess in Great Falls, I was educated in upper extremity shoulder care and the use of treatment modalities such as heat or cold. This experience reinforced my classroom education of modalities and upper extremity shoulder care. The University of Washington requires courses such as Rehab 469– Physical Disability Treatment Modalities and Rehab 444/5 Function of the Locomotor System emphasizes shoulder movement and specifies function. Rehab 442 Advanced Kinesiology and Biomechanics in conjunction with 448 emphasizes use of muscle function and joint motion and offers practical experience of the book knowledge. These classes are jointly attended with physical therapy students.

I attended the University of Washington through the WICHE program and intend on returning to Montana to seek employment in the OT field. Although as an upcoming therapist seeking the optimal job I feel restricted by the SB 54 due to the limitations of shoulder care and modality use. I feel as though to utilize the knowledge I gained through school I may be encouraged to seek employment other than in MT.
If you have any further questions please contact me. Thank you for your time.

Sincerely,
Michele Buresh
Michele Buresh, OTS

EXHIBIT 15
2-4-91
SB 54

February 4, 1991

My name is Dorinda Orrell.

I am here today to support Senate bill 54 clarifying occupational therapists' use of therapeutic agent modalities.

I have received occupational therapy for the rehabilitation of my upper extremity. My occupational therapists successfully applied functional electrical stimulation to facilitation return of movement. My occupational therapists also applied, safely and successfully, biofeedback to assist with relaxation of the muscles of my upper extremity.

I found my occupational therapists to be competent of their knowledge of these modalities and in their safe use. They were always informative of the reasons why. These units were utilized in my occupational therapy program. My doctor has supported my use of occupational therapists for my upper body rehabilitation.

I will continue to need occupational therapy in my life. I will continue to need these therapeutic agents in my recovery of my upper extremity. I wil continue to choose occupational therapists to treat my upper body.

Please support this legislation in clarifying that occupational therapists are qualified to use therapeutic agents in conjunction with occupational therapy procedures.

Thank you.
Dorinda Orrell

Occupational Therapy Associates
of Bozeman, Livingston and Butte
300 N. Willson Suite 2003
Bozeman, MT 59715
Phone (406) 586-3716

EXHIBIT 16
DATE 2-4-91
SB 54

February 4, 1991

Human Services and Aging Committee:

I'm writing to you to support SB 54. This bill is an amendment to clarify occupational therapy's current licensure law. Occupational therapy is one of three rehabilitation professions recognized by the American Medical Association and accredited by the American Occupational Therapy Association. Occupational therapists receive a four year B.S. degree and take a national registration exam.

Occupational therapists have an extensive background in upper extremity neuro-anatomy, physics, kinesiology, physiology, and neurology. Occupational therapists are skilled in treating the shoulder and hand in incorporating functional activities, fine coordination, and activities of daily living. Certain tools and modalities are needed to affectively treat the upper extremity which includes heat, water, cold, and therapeutic devices to prepare the muscles for function. Occupational therapists are qualified to treat and provide modalities to the entire upper extremity.

Thank you for supporting Senate Bill 54. If I can be of further help in answering any specific questions, please do not hesitate in contacting me.

Sincerely,

Linda Botten

Linda Botten, O.T.R./L.

enclosure

EXHIBIT 17
DATE 2-4-91
SB 54

February 4, 1991

My name is Gail Wheatley. I am a physical therapist in Great Falls and am speaking as the physical therapy chair of the joint Occupational Therapy/Physical Therapy Task Force which was established by both associations in September. We were formed to deal with this very issue; a clarification of professions within Montana. We met on two occasions, October and December. We were told in December by the OT association that legislation was likely not forthcoming due to the lateness of the hour. The Task Force further recommended that legislation be delayed until 1993 to work out the very thorny issues which, unfortunately, are in front of you today.

Senate Bill 54 was drafted, sponsored, and introduced without prior knowledge of the joint Task Force. Had we known in advance of this legislation, we would have begun the negotiation process which has been virtually impossible to create under the current circumstances.

There remains disparity yet within both associations as no time was granted to even learn the issues, let alone present them to both memberships. As late as two weeks ago, an OT called me expressing much concern that OT's are not uniformly educated to provide some of the limited treatment delineated in this bill. You will have a copy of her letter.

The Task Force's mission was reauthorized by the PT association at its meeting in January. We are prepared to continue the quest for satisfactory resolution of these issues. This current legislation is neither satisfactory nor satisfying. We have been charged by the Senate to pull this Task Force back together and solve our problems. Our work is cut out for us as we must be productive in these next two years. We are all firmly committed to working together to improve the quality of care given to our patients, and the level of professional excellence from both groups.

What we have under consideration will very likely not be the final answer. But due to that very lateness of the hour and our inability to grapple with it as a Task Force, it is all we can do right now. Resolution will quite likely take two years; further changes cannot be made in these few days. This issue is being hotly debated across the country and entails sweeping changes in education and professional definiton. Expansion of the scope of this bill would take us into areas far more complex and controversial than what we are already struggling with. We are talking, but not yet communicating, and must have the necessary time to step back, meet with each other and our own "constituents", gather information, begin problem solving, and formulate various action plans.

I urge you, as a member of the OT/PT Task Force, to support and retain the Senate version of this bill, and we will, in good faith, work hard to arrive at a compromise we can all support in 1993.

Gail Wheatley PT
761-0471

18
DA 24-91
SB 54

VALLEY HAND REHABILITATION

1135 STRAND AVENUE
MISSOULA, MONTANA 59801
(406) 543-2869

APRIL L. BURKE, OTR/L
HAND THERAPIST
LICENSED OCCUPATIONAL THERAPIST

CATHERINE C. GOODMAN, M.B.A., PT
LICENSED PHYSICAL THERAPIST

PLEASE DELIVER TO SENATOR IMMEDIATELY FOR A 3:00 MEETING

January 23, 1990

Senator Dorothy Eck
State Capitol Building
Helena, MT 59604

Dear Senator Eck,

The Montana Occupational Therapy Association is not speaking for all the Occupational Therapists in Montana. I am a hand therapist in Missoula, employing all of the modalities in question. The Montana Occupational Therapy Association is not presenting my concerns. I am greatly effected by this legislation as it could prohibit me from working.

My concerns:

1. Treatment should be limited to the elbow, forearm, and hand. Shoulder and cervical problems are too closely related and require extra training.

2. The use of modalities is not a basic level activity. Universities are not providing education in modalities in a uniform manner.

3. Education can be acquired through American Society of Hand Therapists and it should be mandatory for a therapist to take the hand certification examination in order to perform modalities. This would ensure quality throughout the profession.

4. Modality use should be determined by what is tested on the hand certification examination.

Please call me at my work number: 543-2869 or home: 549-0213 if you have any questions. Thank you for your consideration.

Sincerely,

April L Burke OTR/L

April L. Burke, OTR/L
Hand Therapist

AB/lm

EXHIBIT 19
DATE 2-4-91
SB 54

ORTHOPEDIC ASSOCIATES, P.S.C.

Suite 100, Yellowstone Medical Building
1145 North 29th Street - Billings, Montana 59101

MARY KRENIK, O.T.R.
(Hand Therapy)

Appointment Telephone (406) 252-8465
Business Telephone (406) 248-7161

FACT SHEET ON OCCUPATIONAL THERAPY

1. How does one become an occupational therapist?

First, you must complete an accredited educational program. Accreditated programs are available in colleges, universities, and vocational technical or community colleges throughout the country. There are no on-the-job training programs in hospitals or other health care facilities.

2. What kinds of educational programs are available?

To become an occupational therapist you must complete either a bachelor degree program, a post-baccalaureate certificate program, or an entry-level master's degree program. All types of programs also include a supervised clinical internship. All programs much meet standards developed by the Occupational Therapy Association, Inc. (A.O.T.A.) Programs are accreditated by the A.O.T.A. and the committee on Allied Health Education and an accreditation of the American Medical Assocation. Some programs are more in demand than others, mostly because of their location.

3. Where do occupational therapists work?

35% of occupational therapists work in hospitals, 17% in public and private schools and 10% in rehabilitation hospitals or centers. Others work in colleges and universities, home health agencies, skilled nursing homes, and private practice. Among occupational therapy assistants, 27% work in hospitals, 20% in skilled nursing homes and immediate care facilities and 14% in public and private schools. Others work in community mental health centers, rehabilitation hospitals, residential care facilities, day-care programs, and community agencies.

4. What health care problems do occupational therapists work with and treat?

Occupational therapy personnel treat patients of all ages who have a variety of health problems, both physical and mental. The most common ailments among patients seen by occupational therapy personnel include: stroke and its related problems, developed mental disabilities, cerebral palsy, mental retardation and other mental health problems.

For more information about Occupational Therapy and a complete list of Occupational therapy programs contact the American Occupational Therapy Association, 1383 Priccard Drive, Boxville, Maryland, 20850. (Phone number- (301) 948-9626)

EXHIBIT 19
DATE 2-4-91
SB 54

ORTHOPEDIC ASSOCIATES, P.S.C.

Suite 100, Yellowstone Medical Building
1145 North 29th Street · Billings, Montana 59101

MARY KRENIK, O.T.R.
(Hand Therapy)

Appointment Telephone (406) 252-8485
Business Telephone (406) 248-7161

February 4, 1991

Human Services and Aging
Montana House of Representatives
Helena, MT 59620

RE: **Senate Bill #54**

Dear Committee Member:

My name is Mary Krenik. I am a nationally registered Occupational Therapist, licensed in the state of Montana and practicing in Billings. I am writing to ask for your support of **Senate Bill #54.**

Your support in this matter will not only positively effect me, but also the hundreds of patients I treat from eastern Montana and Wyoming.

Occupational therapy licensure was introduced in 1984. **Senate Bill #54** is not something new; rather it seeks to remedy some rather unclear language in the original practice act. Occupational therapists have utilized modalities as an innate part of their treatment since the original act was passed and have continued to do so. The National Occupational Therapy Association recognizes that occupational therapists are qualified and competent in the use of these therapeutic agent modalities. This competency may be gained through course work curriculum, continuing education, inservice training or other higher education opportunities.

Thank you for your consideration and support of **Senate Bill #54.** If you would like to discuss this further, please phone me at 252-8485 during the day or 656-3234 in the evening.

Respectfully,

Mary Borgrud Krenik OTR

Mary Borgrud-Krenik, O.T.R.

MBK/cda
Encl.

EXHIBIT 20
DATE 2-4-91
HB 260

Amendments to House Bill No. 260
First Reading Copy

For the Committee on Human Services and Aging

Prepared by David S. Niss
February 4, 1991

1. Title, line 8.
Strike: "AN"
Insert: "A NEWBORN"

2. Page 2, line 2.
Following: "Coverage"
Insert: "for newborn infants as provided in 33-22-301 and 33-22-504"

3. Page 2, lines 5 and 6.
Strike: "in the physical custody of the adoptive parent"
Insert: "placement for adoption as defined in 40-8-10

4. Page 2, line 18.
Following: "Coverage"
Insert: "for newborn infants as provided in 33-30-1001"

5. Page 2, lines 21 and 22.
Strike: "in the physical custody of the adoptive parent"
Insert: "placement for adoption as defined in 40-8-103"

6. Page 3, line 7.
Following: "Coverage"
Insert: "for newborn infants as provided in 33-31-1021"

7. Page 3, line10 and 11.
Strike: "in the physical custody of the adoptive parent"
Insert: "placement for adoption as defined in 40-8-103"

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 413

DATE 2-4-91 SPONSOR(S) Rep. Mary Ellen Connelly

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
FRANK Brisendine 731 STUART HELENA	Denturist Assoc. of MT	X	
Michele Kiesling, RDH. 1610 Florence	State Board of Dentistry		✓
BILL ZEPP Box 281 HELENA	MONTANA DENTAL ASSOCIATION		✓
John Smith D.M.D. 38 So Last Chance Gulch Helena, MT.	Dentistry - M.D.A.		
Roger Tippy	Mnt Dental Assn		✓
Ron Olson	Reg. Denturists Assoc. of MT	✓	
John McKeehan	V.P. " "	✓	
Richard A Pratt	Denturist Assoc. of MT	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

1062

2062

HB 400

ices & Aging COMMITTEE BILL NO. HB 400

91 SPONSOR(S) Rep. Marian Hanson

PRINT PLEASE PRINT PLEASE PRINT

PRINT

ND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Anderson	Dept. Institutions		X
Lynn	Reg IV CMHC		X
radofer	Dept. of Institutions		X
y Onishuk	Mon AMI		X
Kroth	OpenMinds-Msla		X
Morris	MACo	✓	
JOHNSON	Dept. Institutions		X
Shontz	MHAM		X
MEYER	W.M.RC- Mental HEALTH CENTER		X

RT | OPPOSE

T FORMS

PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS
E IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 410

DATE 2-4-91 SPONSOR(S) Rep. John Cobb

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Jerome T Creadon IV	Mt. Med RSSy		✓
Re Charles Cooper	MT Dept of Health & Env Sciences		

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. SB 54

DATE 2-4-91 SPONSOR(S) Sen. Dennis Nathe

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Linda Bothen	Mt OT Association + Private Practice Rep	✓	
Jerome T Loendorf	MD. Med @ SSA	✓	
Connie L. Arens OTR/L	Mt Occupational Th. Assoc	✓	
Greg Duncan - Lobbyist	MT Occupational Th. Assoc.	✓	
Michele Bunce OTS	MT occupational therapy	✓	
Rhonda Orrell	OT of Bozeman + Livingston	✓	
RICH GADOSIK	PT of APTA	✓	
Lorin Wright	Mont. APTA	✓	
Gaby Lusk	PT - APTA	✓	
Gail Whatley	PT	✓	
John Lewis	PT	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.