MINUTES

MONTANA HOUSE OF REPRESENTATIVES
52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By **Rep. Angela Russell, Chair**, on February 20, 1991, at 3:20 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 620

Presentation and Opening Statement by Sponsor:

REP. CAROLYN SQUIRES, House District 58, Missoula, stated that this bill requires respiratory therapists to become licensed and regulated by the State of Montana. The purpose of the bill is to protect the public from respiratory care practitioners (RCPs) who are not qualified to provide confident care in the health care profession and to ensure a minimum level of training for practice of this allied health care profession. Montana has more than 300 RCPs presently working in hospitals, other health care facilities, and in home health care agencies. RCPs are called upon to notify increasingly sophisticated medical services. They are allowed to administer medications and perform in basic

procedures such as arterial cultures and invasion. These procedures require the increasing level of skill and training. There is no requirement that respiratory care can practice under qualified medical direction. There is no continuing education requirement in place for RCPs. We need this licensure bill to ensure these things. The hospital association may tell you that licensing RCPs will increase hospital costs of employed RCPs, but our research shows no evidence of this. The market dictates what people are paid, not the fact that they are licensed. You may wonder why individual hospitals are home health care agencies themselves and assure competency of those who work for them as RCPs. The problem is that not all hospitals have standard programs to ensure a high level of care and not all practitioners work in hospitals, many work for home health care agencies and there is no way of ensuring their competency.

Proponents' Testimony:

Mike Riggens, Montana Society for Respiratory Care, submitted written testimony. **EXHIBIT 1**

Walter Fairfax, M.D., Montana Society for Respiratory Care, stated that he supports the effort to recent professionals of the allied health care workers, particularly people involved in taking care of critically ill persons, as well as chronically ill persons in in-patient and out-patient settings. This bill would allow professional organizations and professional practice that is developed to ensure the quality of care that we expect. We expect increasing things from them in the future and only through this sort of effort will this provide for the people of Montana.

Earl Thomas, Director American Lung Association of Montana, submitted written testimony. **EXHIBIT 2**

Mary McCue, Montana Society for Respiratory Care, submitted written testimony. **EXHIBIT 3, 4 & 5**

Rich Lundy, Montana Society for Respiratory Care, stated that he is the author of this bill on respiratory therapists.

Opponents' Testimony:

Jim Ahrens, President, Montana Hospital Association, stated that the bill is well drafted and is a matter of philosophy from the Hospital Associations view. MHA has a longstanding position against licensure of new categories. There are currently 300 respiratory therapist practicing in hospitals and they are practicing safely. Hospitals also have a congressional process and are subject to a board and decisions that are passed on down. The professionalism is there already and the people that are here today demonstrate that, the question is whether or not licensure enhances professionalism.

Questions From Committee Members:

REP. JOHNSON asked if the respiratory therapist could be put under the public board if it was established. **Mr. Riggens** stated that yes it would, but it would also depend on the make up of that board and what involvement we would have with that.

REP. JOHNSON asked if there are only 300 people in the state and you are going to charge $50 dues, that is only $1,500 and there are more than three meetings a year. **Mr. Riggens** stated that the fiscal note shows that there is a surplus each year as part of the center of the application process.

REP. TUNBY asked what the grandfather clause in the bill said. **Ms. McCue** stated that the grandfather clause says they have to have worked for a year. There are people who have been working who have not taken the exams and don't have the one or two programs. We did not want to exclude all of them.

REP. WHALEN asked if this legislation went through the Sunrise Committee and what was the position of the Sunrise Committee. **Ms. McCue** stated that it went through the Sunrise Committee and they recommended that they be licensed.

Closing by Sponsor:

REP. SQUIRES stated that the proponents have done a great job in completing the draft for this licensure bill. In response to the question about the board, no we do not want to go on that board. We consider ourselves scientific, therefore we would like to stay independent. In response to the fiscal note the funds were calculated and there is a certain amount of dollars in reserve and there is the appropriate amount that funds the board adequately and they would have the FTEs.

EXECUTIVE ACTION ON HB 620

Motion: **REP. SQUIRES MOVED HB 620 DO PASS.**

Discussion:

REP. MESSMORE stated that she support HB 620.

REP. DOWELL stated that he supports HB 620.

Vote: Motion carried 19-1 with REP. KASTEN voting no.

HEARING ON HB 627

Presentation and Opening Statement by Sponsor:

REP. JIM ELLIOTT, House District 51, Trout Creek, stated that this bill deals with the funding program for senior citizen ombudsman (SCO). The SCO is a federal mandate that the federal government gives us without also giving us any money to carry it out. The state must have the program in order to get money to

the older Americans Act. A SCO investigates and resolves the complaints of residents of long-term care facilities. They are hired through the local agencies and are paid by those local agencies with what is known as information and referral money. The amount of pay that they get, whether they get paid for meals or their miles, is contingent on the amount of money the local agencies can spare. Basically, the bill mandates the state to pay for the program, or reimburse some of the expenses of the program.

Proponents' Testimony:

Doug Blakley, State Ombudsman Program, submitted written testimony. **EXHIBIT 6**

Lola McDougle, State Ombudsman Program, Area 6, stated that money is their problem. The way the Ombudsman Program works is that there will be a problem in a nursing home and then the Ombudsman will get a call. The Ombudsman has to call their area director and ask if they can go. The area director has to come up with the money to pay for the mileage and food, but there are times when they couldn't call their area director and they receive a call saying they must go. They have to make the decision of whether they should go and that they might get paid.

Mac McDougle, Volunteer Ombudsman, stated that everyone will eventually become involved with a nursing home whether it be a relative living there or themselves. The Ombudsman primary job is to ensure their human rights, dignity, and their involvement they must go before the greivence committee without feeling discriminated against. Many people feel that they are left out of society and that they are put into nursing homes and that they are forgotten.

Duane Lutke, Director, Western Montana Area VI Agency on Aging, submitted written testimony. **EXHIBIT 7**

Lenore Taliaferro, self, submitted written testimony. **EXHIBIT 8**

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

REP. ELLIOTT stated that everyone has had relatives in nursing homes and one day many of us will be in them ourselves. It is important to have trained people to help us and help our parents. We know that the amount of money in this bill is negotiable and the fiscal note provides a good reference point for the amount needed. Please pass this bill to the floor of the House and if we pass it out there then the Appropriations will look at it.

EXECUTIVE ACTION ON HB 627

Motion: **REP. KASTEN MOVED HB 627 DO PASS.** Motion carried unanimously.

HEARING ON HB 604

Presentation and Opening Statement by Sponsor:

REP. JAN BROWN, House District 46, Helena, stated that this bill will allow adults to obtain information regarding out-of-wedlock births. The normal certified copy of a birth certificate has been made for both parents, which is referred to as a "long form". When a birth certificate is filed for an out-of-wedlock birth the fathers name usually isn't on it. When a certified copy of such a certificate is issued it doesn't have to make either parent sign and this is called a "short form". Under present law, if you were born out-of-wedlock and you want to obtain a long form of your own birth certificate, you have to get a court order to do it first and that is extensive and takes up the time of the court. The Department of Health and Environmental Sciences (DHES) wanted this bill because they wanted to make it easier for the people who are born out-of-wedlock to obtain the long form copy of their own birth certificate.

Proponents' Testimony:

Sam Sperry, Department of Health, submitted written testimony. **EXHIBIT 9**

Opponents' Testimony: None

Questions From Committee Members:

REP. S. RICE asked what would happen to a child that lives with one parent and that parent remarries and then the child is adopted by the new parent, would that child be able to get the long form without a signature. **Mr. Sperry** stated that the a substitute birth certificate is incurred by the DHES. The original birth certificate would reflect the out-of-wedlock birth as sealed. Those are only available under a court order. The substitute certificate would then not present a problem.

REP. J. RICE asked what the purpose of the bill was. **Mr. Sperry** stated that the existing statute has provided direction for DHES under the conditions for which we can disclose an out-of-wedlock birth. The written statute includes many provisions. One of those provisions are that we can disclose an out of wedlock birth only upon the order of the court.

REP. J. RICE asked if the committee adopt a new subsection (a), is there a reason for subsection (b) to exist. **Mr. Sperry** stated that subsection (b) is there to deal with the event of an adopted person requesting the opening of a sealed file.

Closing by Sponsor:

REP. BROWN closed on HB 604.

EXECUTIVE ACTION ON HB 604

Motion: **REP. BROWN MOVED HB 604 DO PASS.**

Motion: **REP. WHALEN** moved to amend HB 604.

And, that such amendments read:
1. Page 1, line 18.
Strike: "or to whom information pertains"

Discussion:

REP. GALVIN asked if it could be given to the birth mother. **REP. WHALEN** stated that it refers to giving it to people that are 18 years of age or older or that have not been adopted. We are not talking about a child we are talking about someone that is older. That person may not want his birth certificate handed out to anybody. It would be a better bill if we include this amendment.

REP. BROWN stated that she agrees with the amendment.

Vote: Motion carried unanimously.

Motion/Vote: **REP. BROWN MOVED HB 604 DO PASS AS AMENDED.** Motion carried 19-1 with REP. KASTEN voting no.

HEARING ON HB 640

Presentation and Opening Statement by Sponsor:

REP. JAN BROWN, House District 46, Helena, stated that under current Montana law, in order to report purposes of fetal death which defined as one that accrues after 20 weeks of gestation. The National Center of Health Statistics states that a gram weight of a dead fetus is included in the definitions. In the new absence, 500 grams is the critical weight considered. The DHES has proposed a misscale that the definition of fetal death be amended so that death that occurred before 20 weeks of gestation that weigh more than 500 grams be included. This would help improve their data collection and statistical reporting in the area of fetal mortality.

Proponents' Testimony:

Sam Sperry, Department of Health and Environmental Sciences, submitted written testimony. **EXHIBIT 10**

Opponents' Testimony:

Scott Crichton, Executive Director of the American Civil

Liberties Union of Montana, submitted written testimony. **EXHIBIT 11 & 12**

Questions From Committee Members:

REP. WHALEN asked if the National Center for Health Statistics has a definition for fetal deaths that we are trying to conform to. **Mr. Sperry** stated that the National Center for Health Statistics makes an attempt once every ten years to define most of the items that are collected through the vital statistics. The existing suggested definition that is in print from the National Center for Health Statistics is more than 20 weeks of gestation.

Closing by Sponsor:

REP. BROWN closed on HB 640.

EXECUTIVE ACTION ON HB 640

Motion/Vote: **REP. BROWN MOVED HB 640 DO PASS.** Motion carried unanimously.

HEARING ON HB 642

Presentation and Opening Statement by Sponsor:

REP. VICKI COCCHIARELLA, House District 59, Missoula, stated that this is a child safety and welfare bill. On page 1, line 19 there is a change from the definition of child. The reason we moved to change that definition of child has to do with matching the federal requirements. Under any state that receives money under the Child Welfare Program needs to have this definition of child to receive that kind of funding. On page 2, line 4 it states who needs to be licensed in the state as far as an educational facility included in this change, if you are taking care of children under the age of 3 then we are legitimately considered a daycare rather than a education facility. The last change is on page 3, line 19 we are defining related by marriage. In part on page 2, line 1 a term that is being used that is in the statute now that has not been defined before.

Proponents' Testimony:

Boyce Fowler, Program Officer, Department of Family Services, stated that there are three components of change. The first change effects the age of children attending daycare. Since the last Montana Child Care Act was passed, there have been two further credible pieces of legislation passed, one was the Welfare Reform Act of 1988, which included the jobs program and the requirement of the state providing daycare for that program and the second most recently is the Child Care Development Block Grant of 1990, which passed a few months ago. This will require the state to provide child care too. In those federal bills, the

age is referred to as providing care to children under the age of 13. Currently, our state law reads under the age of 12. The second item is in regards to services of children who are 3 years and older. Infants and toddlers usually aren't considered as being in an educational facility and it is of concern that they regard to the care of the safety of infants and toddlers and that they be located in a facility which is in control in regards to the safety requirements. The third item is in regards to the change in our family structure and what is considered "blood" and "marriage" relationships. We have adopted the regulations of a specified relative and identified what "blood" and "marriage" relationship would be.

Cheryl Burpee, submitted written testimony. **EXHIBIT 13 & 14**

Michael Burpee, self, stated that his wife's testimony is a problem that has effected their family emotionally and financially. The cost of treatment of this problem is $51 per hour and most people cannot afford this treatment. If they could afford these types of costs, then his wife wouldn't have to work and she could have stayed home with the children. They wouldn't have had to take their children to daycare and this situation would not have even happened.

Kate Cholewa, Montana Womens Lobby (MWL), stated that to eliminate the type of educational facilities that may be excluded from licensure and registration, MWL believes are providing greater protection for our children. With this bill, we have at least children up to 2 years old required to be in a licensed daycare. The licensing encourages standards of safety and we encourage you to support this provision. MWL believe it to be a good one for our children.

Catherine Campbell, Montana Alliance for Better Child care, stated that this is the fifth legislative session that she has appeared to ask that this issue be addressed. All children under the age of 5, whether they are in daycare or in preschool, be protected under basic safety and health regulations. The protection of the child under the age of 3 is important. She submitted testimony. **EXHIBIT 15**

Opponents' Testimony: None

Questions From Committee Members:

REP. KASTEN asked does this also mean that preschool will be in the study for educational purposes. **REP. COCCHIARELLA** stated that a child who is younger than 3 years old is not in that study for educational purposes and yet if they are in a situation like that then they need to be a licensed daycare.

REP. KASTEN stated that often situations in small towns you enroll one of your children in preschool and you have a younger child you would like the two to be kept together, would be

included under this bill. **REP. COCCHIARELLA** said no, all that preschool would have to do is be licensed as a daycare to take of that child.

REP. J. RICE asked if we are narrowing the options of a daycare facilities both in terms of defining the educational facility under subsection (b), page 2 in terms of defining the relative exception, is there a problem with people claiming that they are relatives and taking care of children that we need to narrow that relative definition. **REP. COCCHIARELLA** stated that the problem right now is that we have no definition and we referred to page 2, line 1 related to by blood or marriage. This is providing an original definition like this language.

REP. J. RICE asked if there was a specific problem where people are claiming to be relatives or are we just putting some definition in the law. **REP. COCCHIARELLA** said that is correct.

Closing by Sponsor:

REP. COCCHIARELLA stated that this bill doesn't go far enough in taking care of our children. If there are amendments to be proposed that children 5 years and under would be better cared for in our state. We are asking for children who can't usually speak or express themselves. Children under the age of 3 aren't very verbal and don't have a way to say what happened to them and can't even express their fear. Its only fair that we as citizens take care of the children in these situations. Low income people need this bill to be passed. Quite often those people are trying to get off welfare and they each have children in a licensed facility to receive the benefit of that care under the programs they are working under.

EXECUTIVE ACTION ON HB 642

Motion: **REP. CROMLEY MOVED HB 642 DO PASS.**

Discussion:

REP. TUNBY stated that this bill looks like it is really great. What is the reason why it didn't pass in previous sessions. **REP. STICKNEY** stated that because of the facts that many organizations want to provide child care, do not want to be licensed because that requires they do certain things or not do certain things. The definition of child care facility and preschool is not a simple thing but is an important thing. She supports this bill, we need to be very careful in stating what a licensed daycare does and what a preschool does.

REP. TUNBY asked what the requirements are that are so onerous. **REP. STICKNEY** stated that many of these daycare centers or preschool are run by churches and they refer to being able to include in their care curriculum.

REP. TUNBY asked if the bill takes care of how we protect these children without infringing on the churches rights.

REP. MESSMORE asked what position the church facilities took.
REP. J. RICE stated that the position taken by the churches was wanting to provide education opportunities.

Motion: **REP. DOWELL** moved to amend HB 642.

If limits services to children who are 4 years of age or older.

Discussion:

REP. DOWELL stated that with children under the age of 3, what type of education are we looking at, it will frankly be daycare.

REP. SQUIRES stated that she resists the motion. This is a matter of what is the definition of a daycare and what is a preschool.

REP. DOWELL stated we are talking about 3 year old children. How much education as opposed to daycare are we really talking about.

REP. MESSMORE stated that she also resists the amendment.

REP. STICKNEY stated that it is just a matter of legal definition.

REP. SQUIRES stated that it is a matter of age and terminology based to protect the child in the case study of daycare versus preschool where anything can happen.

Vote: Motion failed 1-19 with REP. DOWELL voting aye.

Discussion:

REP. MESSMORE asked why is preschool not under the definitions.
REP. COCCHIARELLA stated that they don't have to be defined because preschools aren't licensed and that is the problem.

Vote: Motion carried 18-2 with REPS. KASTEN and SPRING voting no.

HEARING ON HB 700

Presentation and Opening Statement by Sponsor:

REP. THOMAS NELSON, House District 95, Billings, stated that this bill is an act to allow the Department of Health & Environmental Sciences (DHES) to change the way that they issue health care facility licenses by extending the period of time when some of those facilities from 1 to 3 years. This bill provides the inspections of health care facilities can be less often than

annually.

Proponents' Testimony:

Denzel Davis, Department of Health & Environmental Sciences, submitted written testimony. EXHIBIT 16

Opponents' Testimony: None

Questions From Committee Members:

REP. CROMLEY asked if in the past has there been licenses issued for periods of less than one year. Mr. Davis stated that we can issue licenses for a period of less than 1 year if the facility gave problem under the policy provision licenses.

Closing by Sponsor:

REP. NELSON stated that this bill is at the request of the Governor. This will make the DHES more responsive to the needs of the community and not only in doing so, is able to respond to the needs of the citizen much better than an arbitrary system as we have had.

EXECUTIVE ACTION ON HB 700

Motion: REP. CROMLEY MOVED HB 700 DO PASS.

Discussion:

REP. MESSMORE stated that this is a blessed bill.

REP. S. RICE asked why this is a blessed bill. REP. MESSMORE stated that it helps the facilities be regulated and inspected and all the health care facilities in Montana.

REP. BECKER stated that she will oppose the bill

Vote: Motion carried 13-7 with REPS. BECKER, DOWELL, GALVIN, LEE, SQUIRES, RUSSELL, and WHALEN voting no.

HEARING ON HB 917

Presentation and Opening Statement by Sponsor:

REP. HOWARD TOOLE, House District 60, Southwest Missoula, stated that this bill is at the request of the Department of Health & Environmental Sciences. The bill is somewhat complex because it deals with the AIDS Prevention Act. This is an Act to revise the 1989 Act.

Proponents' Testimony:

Judith Gedrose, Department of Health & Environmental Sciences,

submitted written testimony. **EXHIBIT 17**

F. Woodside Wright, Montana AIDS Advisory Council, submitted written testimony. **EXHIBIT 18**

Vern Erickson, Montana State Firemans Association, stated that by being first responders on many car wrecks or suicides they have no control over the conditions of getting exposure to body fluids. It has been impossible in the past to collect information for any tests to find out if they have been exposed to the HIV virus.

Tom Hopgood, Health Insurance Association of America, stated that they support the bill as drafted. With the provisions that pertain to the insurance company testing recognize that circumstances in which HIV test is performed in the insurance setting are different from the circumstances that have been formed. If someone is concerned about whether they have the HIV virus a person getting tested and the insurance situation is concerned with getting insurance. It is unnecessary for them to receive postcounseling if the result is negative. This bill does provide if the results are available to them and if the result is positive, then it is transmitted to that health care provider and post test counseling will be provided.

Scott Crichton, Director, American Civil Liberties Union, submitted written testimony. **EXHIBIT 19**

Mike Stephen, Montana Nurses Association, stated that the strong point in the provision for the renewal of the definition of health care providers. The pretest and posttest counseling are certainly adequate and the main objective is that this bill does safeguard those that have experienced occupational exposure.

Greg Oliver, Missoula City-County Health Department, stated that they are in support of HB 917.

Ellen Leahy, Missoula City-County Health Department, submitted written testimony. **EXHIBIT 20**

Mary Beth Frideres, Administrator, Lewis and Clark County Health Department, stated that they support the bill and not only the content of this bill, but certainly the process that was followed to come to the consensus on the points that are covered. A lot of thought and care from infected and affected individuals who are concerned about the big picture of protecting the rights of individuals and make it safe to encourage people to come in for testing, as well as address the very complex issues about testing, consent, and confidentiality. Lewis and Clark County Health Department supports this bill because its based on the premise that informed consent must be sought prior to HIV testing and education must be provided.

Jerome Loendorf, Montana Medical Association (MMA), stated that

MMA supports this bill in its entirety. The provisions at the bottom of page 10 deal with testing of a person who is unconscious or otherwise mentally incapacitated and are medical indications of a HIV related medical condition, and the test is advisable in order to determine priority. We are then required to wait for 24 hours before you can begin testing a frequent. We believe this provision is unnecessary.

Opponents' Testimony: None

Questions From Committee Members:

REP. S. RICE asked if this bill will be combined with some of the other bills that have gone to the subcommittee. **REP. RUSSELL** stated that her intention is to put this bill with the other bills that are currently in subcommittee.

REP. CROMLEY asked why the language on page 9, lines 4 through 8, were stricken from the bill. **Ms. Gedrose** stated that the language was changed with the belief that we're opening the possibility for anonymous testing in more places.

REP. BOHARSKI asked why the test would be more difficult to provide to the health care provider than to the individual. **Mr. Hopgood** stated that if you are providing negative test results to the provider, a person would have the test result made available to the individual, positive and negative have to be given to the provider. No, it would not be more difficult to provide the negative test results directly to the applicant in the insurance agency. **Ms. Gedrose** stated that the bill as drafted is a response to concern by health care providers who have received positive results of tests that they did not order.

REP. J. RICE stated that at the earlier hearing on HB 281, the committee heard testimony that a number of health care workers had been exposed to the virus who were not able to obtain the test they felt necessary to the help assess the organization, do you feel that this bill addresses the situation for the health care workers? **Mr. Loendorf** stated that it does not, but it is in conflict with the rest of the situation. HB 281 can either be placed in this bill or the wording changed to be passed with this bill.

REP. BECKER asked how the insurance company works to get an application for life and health insurance, is it a physical or is it a separate test. **Mr. Hopgood** stated that in a normal situation you apply for a policy. The insurance company sends you to a health care provider that takes a battery of tests and then asks questions if whether you smoke and those types of questions. In connection with that, they would draw blood from you and then send it off to be tested in a laboratory.

REP. BECKER asked if the person applying for the insurance pays for the insurance test. **Mr. Hopgood** stated that the insurance

agent pays for this. There are different ways in paying.

REP. STICKNEY asked if the insurance companies feel that they need to have this paragraph in this act. **Mr. Hopgood** said yes.

REP. STICKNEY asked if the EMI people were covered in a separate bill that was passed last session that enabled them to get test results if they were exposed to bodily fluids. **Mr. Erickson** stated that you can require that you get the results. **REP. SQUIRES** stated that the legislature did pass that bill. It said that we could get results, but we couldn't get he answer back.

REP. BECKER asked why 24 hours is included in the bill. **Ms Frideres** stated that this was to give an amount of time to identify someone who can give consent.

Closing by Sponsor:

REP. TOOLE stated that section 6 talks about disclosure without the patients authorization based upon need to know. There is a similar provision on page 12 that allows a local board of health or health department to have access to information including the test results. On the insurance matter when the results are negative the insurer can include that in the application packet, when it is positive, the reason for the statute is that the health care provider can do the post test counseling.

HEARING ON HB 895

Presentation and Opening Statement by Sponsor:

REP. JAN BROWN, House District 46, Helena, opened the hearing on HB 895. The bill has been amended since it was printed and somehow got caught in the crunch. The bill came out of the Legislative Council the way that you have it, but it should have these amendments to it.

Proponents' Testimony:

Ray Hoffman, Department of Health & Environmental Sciences (DHES), submitted HB 895 with amendments. **EXHIBIT 21**

Opponents' Testimony:

Bonnie Tippy, Montana Funeral Home Directors Association (FHDA), stated that the DHES asked if the FHDA would meet with them and discuss the problems with the burial transit permit and death certificates. The original bill was extremely burdensome and the FHDA was very concerned about it. Both groups sat down and started negotiations on the issues. There are still substantial problems with the bill. This legislation is saying that every death where the physician is not actually there when the last breath is drawn is not a medically attended death. No where in the codes, through their research, did they find an answer or any

discretion or definition of what a medically attended death is or what a medically unattended death is. FHDA feels that this bill does say that every death, whether a physician or a coroner is not actually there, is unattended. That means in practice that early in the morning in a nursing home or in a hospice situation and the funeral director personally gets called, they are then responsible for half of the position. No matter what time of day or nigh, the physicians are not always going to be around or easy to find. The next step would be to call the coroner, once you call the coroner, they have to come in. You will wind up with an elderly person that has been terminal for some time and all of a sudden that person has been subject to forced inquest because of this legislation. The current system is quite noticeable. All accidents and suicides become coroners deaths. I believe there should be an interim study of this entire area because there are so many people effected. While it seems that it simplifies things, it really makes things more complicated. FHDA hasn't been able talk with DHES to work this out.

Questions From Committee Members:

REP. CROMLEY asked if 99% of the deaths happened when the coroners were called. **Mr. Hoffman** stated that there are two individuals in the State of Montana that can determine whether a person is demised or not. Those are the physicians and chemists or the coroners.

REP. CROMLEY asked if the doctor is there to determine if the person is dead, but they weren't there when the person died does the coroner have to be called. **Mr. Hoffman** said that is correct.

REP. SQUIRES asked what is the jurisdiction on hospice people. **Mr. Hoffman** stated that hospice was specifically brought up by the FHDA. In a hospice situation there is going to be people dying, and the arrangement for the demise might have already been made. That would be the authorization that a physician could preauthorize the funeral director to remove those remains in that situation.

REP. BECKER asked if the coroners in Montana are considered medical persons. **REP. MESSMORE** stated that coroners in Great Falls are not medical persons and the majority of coroners in Montana are not medical people. **REP. SPRING** stated that when his wife died, there was no coroner or medical doctor, but there was a minister. He rises in opposition to this legislation.

REP. JOHNSON asked that in the deliberations with the people involved, has there been anything done that indicates that they would have had some input to this bill. **Mr. Hoffman** said no, within the last 30 days we have had to contact with the FHDA. Within the last 3 weeks we have had contact with a couple of coroners in the state.

REP. S. RICE asked how long the unworkable law has been on the

books. **Mr. Hoffman** stated that some of these laws have been in the books since 1947. Some of them have been since 1967.

REP. SQUIRES asked if a coroner works from 8:00 a.m. to 5:00 p.m. and there is an automobile accident at 7:00 p.m. what do we do with this person, do they lay there until they can be released at 8:00 a.m. the next morning to the mortuary. Do you want these family members to go through not knowing where that family member has been. **Mr. Hoffman** stated that the status of the current registrar is that you must get the burial permit to move the body, and that may not be available. The coroner or physician should be available. That is the responsibility of a coroner or a physician.

REP. MESSMORE stated that physicians are not in attendance for the majority of deaths even in a hospital. Bodies are removed from hospital units to the morgue or funeral homes and a physician or coroner are not in attendance. The best thing that could happen to this legislation would be to meet between and now and the next legislature, whether an interim study has to be proposed, and come back and report.

REP. BOHARSKI asked if this bill wouldn't work through rules. **Mr. Tippy** stated that rulemaking doesn't go so far as you can change the basic premise of the bill that you take the authority of burial transit permit basically from registrars to physicians and coroners and you take a lot of authority away from other authorized medical personnel, we cannot change that part of the statute.

REP. BOHARSKI asked why the changes were added to this bill. **Mr. Hoffman** stated that the changes were put in after meeting with the FHDA. The changes were made after the Director of DHES, FHDA, Ms. Tippy and myself met. The majority of the changes are grammatical.

REP. TUNBY asked who would threaten a lawsuit if the law isn't enforced. **Mr. Hoffman** stated an example would be a funeral home director who would not meet the burial transmittal that is competitive job.

Closing by Sponsor:

REP. BROWN closed on HB 895.

HEARING ON HB 681

Presentation and Opening Statement by Sponsor:

REP. JIM RICE, House District 43, Helena, stated that this is an act to revise the laws in regard to residential treatment facilities. A residential treatment facility can be defined as a mental health facility with multiple medical, clinical, vocational, educational, and recreational services in a group

living environment providing 24 hour supervised care. It is a necessary component for the care of the emotionally and psychiatrically disturbed children. There is a wide variety of services that are offered to troubled children ranging from in-patient services all the way to foster care. Residential treatment facilities are in the middle and they guide these children from a less restricted environment and prepare them for an even less restrictive environment as they continue in their care. This bill redrafts some of the definitions. It specifically removes the 30 bed size limit. It removes the provision that the provider must be a nonprofit entity and removes the requirement that a provider must be nonhospital based. This bill also addresses the certificate of need application for these kinds of facilities. He offered amendments to HB 681. **EXHIBIT 22**

Proponents' Testimony:

Jack Casey, Administrator Shodair Children Hospital, stated that Shodair provides in-patient psychiatric services to children under the age of 15 with a bed capacity of 22. Shodair has been in the business of providing health care services to children and families in Montana for over 90 years. Throughout the 95 years providing those services, Shodair has always responded to the needs of the families and children of Montana. For residential treatment that is not available and is not going to send a child to another type of facility, and back to their home or origination for a variety of reason whether it be abuse or sexual abuse, the hospital is put into a position to retain a child until a bed comes up in a residential facility. Medicaid at the present time is designed to not pay for its terms as administrative days or for waiting for placement days. This has resulted in acute care and hospitals providing care without compensation. In FY 91, Shodair has provided over $550,000 worth of free care. We cannot continue to provide that kind of care. With the passage of HB 681 it will enable Shodair to provide the necessary beds for children that we discharge from Shodair and be placed into a residential setting immediately at a lower cost and less restrictive environment. It will also provide services to the children in our immediate areas and for the state to provide services at a residential level.

Glen McFarlane, Yellowstone Treatment Center (YTC), Montana Residential Child Care Association, stated that YTC was the one residential treatment center that was approved under HB 304 for the original pilots under the examination period of the Medicaid funding for residential treatment. YTC does support HB 681. The children in the State of Montana have benefitted from that service. Prior to the time of making medication in the Medicaid funding, there was real concern and it would have come to the point in the fiscal year when YTC would no longer have been able to treat Montana children based on the grade that was approved through the budgeting process for residential treatment. The use of Medicaid dollars and the ability to leverage the state General

Fund dollars 3 to 1 has allowed the State of Montana to proceed with simple treatment services at YTC that probably would not have been available. The number of children who are being treated in the YTC is increasing on the basis because of that program. There are benefits to the children of Montana. There are benefits to the families of the community. YTC feels that leveraging the states General Fund dollars allows for the Government of those additional services on a rapid basis.

Robert Olson, Montana Hospital Association, submitted written testimony. **EXHIBIT 23**

Opponents' Testimony:

Russ Cater, Chief Legal Council for Department of Social and Rehabilitative Services (SRS), stated that DSRS opposes this bill. SRS are concerned about how much money is being spent by higher level of psychiatric care and that DHES is spending enough money for the other services. This bill is a step in the right direction. Our only opposition is the fact that the certificate of need approach needs to be reemphasized and that the grandfathering position, which is currently in this bill should be deleted. SRS believes the certificate of need approach is really what is important in this bill to ensure that facilities are not being built in this state that are not needed. We are concerned that too much money could be spent in this higher level of care. The certificate of need process needs to address this issue. The Medicaid program has a utilization review program that can look and screen the children in these facilities to see if they should be there. Utilization, in view of an approach, is not sufficient. The approach that is taken by the certificate of need will actually address, not the individuals that are in the facility that need to be there, but they will also address alternative services that could be provided. The certificate of need addresses where these facilities should be located in Montana.

Tom Olson, Director, Department of Family Services (DFS), submitted written testimony for **Julia E. Robinson, Director of DFS. EXHIBIT 24**

Questions From Committee Members:

REP. MESSMORE asked if this bill is included in the budget. **Mr. Olson** said yes, it is in the budget.

REP. MESSMORE asked what is the standard of supervision in subsection 1. **Mr. Casey** stated that the registered nurses supervise.

REP. SQUIRES asked if you reached the 52 bed capacity then will our kids have to go out of state again. **Mr. Olson** stated that until such time that we can develop such programs, perhaps what we are trying to do is develop a care system. Residential

treatment is a level of care that is subject to whether or not a child can have more residential treatment than they benefit from a very good foster environment with a community based services involved.

REP. SQUIRES asked would it not be more cost effective to do it on a community basis versus the in therapy psychiatric care facility. **Mr. Olson** stated that it is more cost effective. There are a number of children that require extensive in patient types of services.

REP. S. RICE asked how many children are in out of state facilities. **Mr. Olson** stated that currently there are 63 children in these facilities.

REP. RUSSELL asked if there is a policy where one child is in state and one child out of state. **Mr. Olson** said no. That is a destructive policy for children. If we have to place them there then we will, but we are placing children on our waiting list.

REP. BOHARSKI asked if all children that go through these facilities go through the DFS. **Mr. Olson** stated no, Medicaid placement can be made by anyone and requested that treatment be received.

REP. BOHARSKI asked if there was a better way to restrict services through a screening process. **Mr. Olson** stated that he firmly believes that a screening process is required. We apparently do have the utilization review process in place for these children for medical necessity.

Closing by Sponsor:

REP. J. RICE closed on HB 681.

EXECUTIVE ACTION ON HB 681

Motion/Vote: **REP. J. RICE MOVED HB 681 DO PASS.**

Motion: **REP. J. RICE** moved to amend HB 681.

Discussion:

REP. J. RICE stated that this would allow these facilities to set a residential treatment facilities without the necessity of going through a certificate of need process until October 1, 1991. In Shodair's case they would be up and running and would avoid the COM process.

REP. J. RICE WITHDREW HIS MOTIONS. THERE WAS NO ACTION TAKEN ON HB 681 THAT DAY.

HEARING ON HB 785

Presentation and Opening Statement by Sponsor:

REP. CHARLOTTE MESSMORE, House District 38, Great Falls, stated that this bill was at the request of the Department of Health & Environmental Sciences (DHES). This bill provides the current Health Maintenance Organization Act (HMO) to eliminate the requirement of certification from the DHES before a certificate of authorization is issued to an HMO in Montana, and further to eliminate other requirements made to the DHES.

Proponents' Testimony:

Dale Taliaferro, Administrator, Health Service Division, Department of Health and Environmental Sciences, stated that the Montana HMO was passed in 1987 and following this Act, DHES investigated what we would have to do to carry out our part. We are charged with the regulation of quality care, accessibility, and keeping utilization for HMO. $110,000 was given to the DHES for authority for 1988, but part of it was to come from fees charged to HMOs. There are two way to fund this. One is to directly fund regulation and the other is to do it with fees. If you are a large state with a lot of HMO's it doesn't make much difference which way, either one works. In sparsely populated states, it is almost impossible to do this by fees. An HMO has the same regulation for their service providers as anyone else. The real issue isn't exactly quality, its accessibility. Accessibility is dependant on whether the HMO has enough contract providers to give people the services or provisions to get the services elsewhere. It really is financially accessibility. Our approach would be to hide the funds and look for a contractor who had the physicians, nurses and expertise reviewing the data the standards for what is expected in primary care.

Tanya Ask, Blue Cross Blue Shield (BCBS), stated that there is an HMO operating in the State of Montana. The reason for supporting this is because this will enable that additional certificate of authority to be issued for that particular HMO. Right now the HMO is operating as a line of business along with other lines of businesses. It is not separate corporate entity like BCBS. The difference between the HMO BCBS operates and the HMO Mr. Taliaferro was referring is that BCBS is a primary care model, but all of the providers who are alone or are contacted with us in that HMO are also independent practitioners. In a staff model HMO, which is one of the main reasons that we have a regulation like this, is you have either the insurer/employee provider or you have the provider running the insurance mechanism. The reason the quality of care is so important in those instances is with that direct financial interest there may be the possibility that because there is such a financial interest, all of the appropriate care may not be provided.

Opponents' Testimony:

Dave Barnhill, Deputy of Insurance Commissioner, Insurance

Department, stated that they are opposed to this bill. DHES now employees over 300 people and have 7 attorneys. They have had four years to put this in place. As the result of these rules not being in place, we do not have a single certified HMO in Montana. The Insurance Department placed their rules into place the same year that the law was enacted. There is a need for joint jurisdiction over HMOs. There is an incentive to cut costs.

Questions From Committee Members: None

Closing by Sponsor:

REP. MESSMORE closed on HB 785.

EXECUTIVE ACTION ON HB 785

Motion/Vote: REP. MESSMORE MOVED HB 785 DO PASS. Motion carried. EXHIBIT 25

EXECUTIVE ACTION ON HB 355

Motion/Vote: REP. WHALEN MOVED TO TAKE HB 355 OFF TABLE. Motion carried. EXHIBIT 26

Motion: REP. WHALEN MOVED HB 355 DO PASS.

Motion: REP. WHALEN moved to amend HB 355. EXHIBIT 27

Discussion:

REP. J. RICE stated that there were many groups who testified against this bill.

Motion/Vote: REP. BOHARSKI MADE A SUBSTITUTE MOTION THAT HB 355 BE TABLED. Motion failed. EXHIBIT 28

Vote: Motion carried. EXHIBIT 29

Motion: REP. WHALEN MOVED HB 355 DO PASS AS AMENDED.

Discussion:

REP. WHALEN stated that the insurance companies tell you that this will cost more money, but they won't tell you how much more money. There is no requirement that they tell the insurance company how much they pay in claims or anything else. The insurance groups make the claims about the effect of legislation if it isn't passed, and usually the legislative body makes acts on those statements. He will not take credible claims unless someone is willing to back the claims with some information. This doesn't cover group policy so he doesn't understand why the labor groups opposed this. This has the potential of reducing health care cost in the future. He thinks the insurance

companies would want this mandated so that it can reduce the health care costs in the future.

REP. BECKER stated that this is already a mandated coverage. We are not talking about adding a mandate, because it is already mandated. We are talking about increasing the amount of coverage available.

REP. BOHARSKI stated that this is the same thing as adding a mandate. We are adding new money through an already mandated benefit.

Vote: Motion carried. **EXHIBIT 30**

Vote: Motion carried. **EXHIBIT 29**

ADJOURNMENT

Adjournment: 9:45 p.m.

Angela Russell
ANGELA RUSSELL, Chair

Jeanne C. Krumm
Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES

HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL **DATE** 2-20-91

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

11:00
2-21-91
JDB

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 620 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

HB
2-21-91
JDB

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 627 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

3:55
-21-91
HB

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 604 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:
1. Page 1, line 18.
Strike: "or to whom the information pertains"

11:00
2-21-91
HDR

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 640 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

11:00
2-21-91
TDA

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 642 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

11:0
2-21-
5 DB

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 700 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 681 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 11.
Following: "50-5-101,"
Insert: "50-5-301,"
Following: "50-5-317,"
Insert: "50-6-101,"

2. Page 19, lines 1 and 2.
Strike: "long-term treatment services for mental illness in a"

3. Page 19, line 2.
Strike: "setting"
Insert: "psychiatric care"

4. Page 19.
Following: line 3
Insert: "(32) Residential psychiatric care means active psychiatric treatment in a residential treatment facility, to psychiatrically impaired individuals with persistent patterns of emotional, psychological or behavioral dysfunction of such severity as to require 24 hour supervised care to adequately treat or remediate their condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time."
Renumber: subsequent subsection

5. Page 19.
Following: line 7
Insert: "Section 2. Section 50-5-301, MCA, is amended to read:
"50-5-301. (Temporary) When certificate of need is required -- definitions. (1) Unless a person has submitted an application for and is the holder of a certificate of need granted by the department, he may not initiate any of the following:
(a) the incurring of an obligation by or on behalf of a health care facility for any capital expenditure, other than to acquire an existing health care facility or to replace major medical equipment with equipment performing substantially the same function and in the same manner, that exceeds the expenditure thresholds established in subsection (4). The costs of any studies, surveys, designs, plans, working drawings, specifications, and other activities (including staff effort, consulting, and other services) essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made must be included in determining if the expenditure exceeds the expenditure thresholds.
(b) a change in the bed capacity of a health care facility through an increase in the number of beds or a relocation of beds from one health care facility or site to another, unless:
(i) the number of beds involved is 10 or less or 10% or less of the licensed beds (if fractional, rounded down to the nearest whole number), whichever figure is smaller, in any 2-year period;
(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, residential treatment facility, 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 providing for transients, students, or persons not requiring institutional health care; or juvenile and adult correctional facilities operating under the authority of the department of institutions.

(c) "Obligation for capital expenditure" does not include the authorization of bond sales or the offering or sale of bonds

pursuant to the state long-range building program under Title 17, chapter 5, part 4, and Title 18, chapter 2, part 1.

(d) "Personal care facility" means an entity which provides services and care which do not require nursing skills to more than four persons who are not related to the owner or administrator by blood or marriage and who need some assistance in performing the activities of everyday living. The term does not include those entities excluded from the definition of "long-term care facility" in subsection (3)(b).

(4) Expenditure thresholds for certificate of need review are established as follows:

(a) For acquisition of equipment and the construction of any building necessary to house the equipment, the expenditure threshold is $750,000.

(b) For construction of health care facilities, the expenditure threshold is $1,500,000. (Repealed effective July 1, 1991--sec. 2, 3, Ch. 377, L. 1989.)"

Renumber: subsequent sections

6. Page 20.
Following: line 25
Insert: "Section 5. Section 53-6-101, MCA, is amended to read:

"53-6-101. Montana medicaid program -- authorization of services. (1) There is a Montana medicaid program established for the purpose of providing necessary medical services to eligible persons who have need for medical assistance. The Montana medicaid program is a joint federal-state program administered under this chapter and in accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended. The department of social and rehabilitation services shall administer the Montana medicaid program.

(2) Medical assistance provided by the Montana medicaid program includes the following services:

(a) inpatient hospital services;

(b) outpatient hospital services;

(c) other laboratory and x-ray services;

(d) skilled nursing services in long-term care facilities;

(e) physicians' services;

(f) nurse specialist services;

(g) early and periodic screening, diagnosis, and treatment services for persons under 21 years of age;

(h) services provided by physician assistants-certified within the scope of their practice and that are otherwise directly reimbursed as allowed under department rule to an existing provider;

(i) health services provided under a physician's orders by

a public health department; and

(j) hospice care as defined in 42 U.S.C. 1396d(o).

(3) Medical assistance provided by the Montana medicaid program may, as provided by department rule, also include the following services:

(a) medical care or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law;

(b) home health care services;

(c) private-duty nursing services;

(d) dental services;

(e) physical therapy services;

(f) mental health center services administered and funded under a state mental health program authorized under Title 53, chapter 21, part 2;

(g) clinical social worker services;

(h) prescribed drugs, dentures, and prosthetic devices;

(i) prescribed eyeglasses;

(j) other diagnostic, screening, preventive, rehabilitative, chiropractic, and osteopathic services;

(k) inpatient psychiatric hospital services for persons under 21 years of age;

(l) services of professional counselors licensed under Title 37, chapter 23, if funds are specifically appropriated for the inclusion of these services in the Montana medicaid program;

(m) ambulatory prenatal care for pregnant women during a presumptive eligibility period, as provided in 42 U.S.C. 1396a(a)(47) and 42 U.S.C. 1396r-1;

(n) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396(d)(h), in a residential treatment facility as defined in 50-5-101, that is licensed in accordance with 50-5-201;

~~(n)~~(o) any additional medical service or aid allowable under or provided by the federal Social Security Act.

(4) The department may implement, as provided for in Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended, a program under medicaid for payment of medicare premiums, deductibles, and coinsurance for persons not otherwise eligible for medicaid.

(5) The department may set rates for medical and other services provided to recipients of medicaid and may enter into contracts for delivery of services to individual recipients or groups of recipients.

(6) The services provided under this part may be only those that are medically necessary and that are the most efficient and cost effective.

(7) The amount, scope, and duration of services provided under this part must be determined by the department in

accordance with Title XIX of the federal Social Security Act (42 U.S.C. 1396, et seq.), as may be amended.

(8) Services, procedures, and items of an experimental or cosmetic nature may not be provided.

(9) If available funds are not sufficient to provide medical assistance for all eligible persons, the department may set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the medical services made available under the Montana medicaid program.

(10) Community-based medicaid services, as provided for in part 4 of this chapter, must be provided in accordance with the provisions of this chapter and the rules adopted thereunder. (Subsection (2)(j) terminates June 30, 1991--sec. 4, Ch. 633, L. 1989; Subsection (3)(m) terminates June 30, 1991--sec. 15, Ch. 649, L. 1989.)"

Renumber: subsequent sections

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 785 (first reading copy -- white) do pass .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 21, 1991

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 355 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, lines 7 through 11.
Strike: "PROVIDING" on line 7 through "PROFESSIONAL" on line 11
Insert: "PROHIBITING AN INSURER FROM REFUSING TO PAY FOR BENEFITS MANDATED BY LAW"

2. Page 2, lines 20 and 21.
Strike: "$8,000 for an adult and $10,000 for a minor"
Insert: "$7,000"

3. Page 2, lines 22 and 23.
Strike: "$16,000 for an adult and $20,000 for a minor"
Insert: "$14,000"

4. Page 4, lines 1 and 2.
Strike: "$8,000 for an adult and $10,000 for a minor"
Insert: "$7,000"

5. Page 4, lines 3 and 4.
Strike: "$16,000 for an adult and $20,000 for a minor"
Insert: "$14,000"

6. Page 4, lines 5 through 14.
Following: line 4
Strike: subsection (2) in its entirety
Renumber: subsequent subsection

7. Page 4, lines 15 through 19.
Following: "(3)"
Strike: the remainder of line 15 and all of lines 16 through 19
Insert: "An insurer, health service corporation, or an employees' health and welfare fund that provides accident and health insurance benefits to residents of the state under group health insurance or group health plans may not refuse to pay for, and thus effectively limit, a type of care or treatment when benefits are mandated under this part."

EXHIBIT 1
DATE 2-20-91
HB 620

Legislative Audit Committee

State of Montana

Report to the Legislature

December 1990

Sunrise Report -- 1991 Biennium

Summary of Sunrise Proposals for the Licensure of:

- Respiratory Care Practitioners
- Naturopathic Physicians
- Midwives
- Auctioneers
- Property Managers

Direct comments/inquiries to:
Office of the Legislative Auditor
Room 135, State Capitol
Helena, Montana 59620

90SP-45

[redacted]
4510-13th Avenue S W
Fargo North Dakota 58121-4510
701 / 282-1100

2-20-91
620

January 30, 1985

Mr. Gary Brown
Respiratory Therapy
St. Luke's Hospitals
Fargo, North Dakota 58122

RESPIRATORY THERAPY SERVICES

Respiratory therapy services in the state of North Dakota have been observed in the audit process and also in the individual group studies of cost per hospital day.

It is apparent by these studies that respiratory therapy in some areas has been used excessively with possibly little professional expertise to monitor or deliver these services. Without the proper education and/or background, the services cannot be supervised properly, nor would symptomology of the patient be conferred correctly to the physician. Without this expertise, services as a rule are not discontinued timely or changed according to the condition of the patient.

It has become apparent from audits completed that the cost and usage of respiratory services is a greater section of the total bill when the services are delivered by the uneducated individual.

Actual statistics for a past year for a particular bed-sized hospital were $7.04 per day for educated providers and $22.76 for the uneducated provider. Another bed-sized hospital statistic was $12.50 for the educated provider while $20.87 for the uneducated provider.

It appears the proper training and education are vital for the proper delivery of respiratory services while keeping the safety and well-being of the patient in mind as well as the total dollar spent for this service.

Marlene Moderow, R.N.

MARLENE MODEROW, R.N.
Medical Review Field Auditor

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Endotracheal Intubation	Emergency or elective placement of endotracheal tube into the trachea or respiratory tract in order to provide an airway and/or ventilate a patient, includes infants, children, adults.	Cardiac or respiratory arrest. Any other event whereby patients can no longer breathe on their own or require possible assisted ventilation. Routinely done for long operative procedures.	1. Improper placement of tube resulting in asphyxiation, hypoxia (lack of oxygen to brain and other vital organs), carbon dioxide narcosis. 2. Damage and/or paralysis of vocal cords. 3. Rupture and hemorrhage to esophagus and/or trachea. 4. Atelectasis--collapsed lung. 5. Pneumothorax (lung collapse). 6. Dental fractures. 7. Aspiration of blood, stomach contents. 8. Infection.
Suctioning	A procedure necessary for removal of secretions from endotracheal, tracheostomy tubes or the respiratory tract directly to maintain a patent, functioning airway.	Patients that have endotracheal / tracheostomy tubes in place. Patients unable to cough to remove secretions. Newborns or infants with pulmonary distress.	1. Sudden death syndrome secondary vagal stimulation. 2. Cardiac arrest or standstill. 3. Cardiac arrythmias. 4. Hypoxia--oxygen lack to brain, vital organs. 5. Bleeding/hemorrhage, damage to trachea. 6. Infection.

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Arterial Blood Gas Sampling	A procedure whereby a therapist inserts a needle into an artery (radial, brachial or femoral) to obtain arterial blood for analysis. Determines the need for oxygen therapy and amounts of oxygen and carbon dioxide in blood. Determines metabolic status (A/B).	To determine cardio-respiratory status of patients: Including patients with-- Shortness of breath Mechanically ventilated patients Kidney failure Trauma victims Diabetic crisis Cardiac/respiratory arrest--pre-arrest state Drug overdose Post-operative patients	1. Damage or destruction of artery resulting ultimately in amputation of affected limb. 2. Hematoma/hemorrhage. 3. Damage/paralysis of nerve adjacent to sampling site. 4. Infection. 5. Intense pain due to poor technique. 6. Air embolus.
C.P.R. - Cardio-Pulmonary Resuscitation	A life saving procedure requiring immediate and appropriate assessment and response to a patient with cardiac or respiratory arrest. Includes providing airway and artificial ventilation along with external cardiac compressions.	Cardiac or respiratory arrest. Newborn-premature infants requiring resuscitation measures at birth. Airway obstruction-choaking victims.	1. Improper technique can result in death. 2. Fractured ribs, sternum 3. Liver lacerations. 4. Gastric distention (air in stomach) with resultant aspiration/pneumonitis. 5. Fractured necks in infants/children. 6. Pneumothorax--burst/collapsed lung in infants/children.

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Oxygen Therapy	Oxygen is a drug administered by a mask, nasal cannula, tent (infants/children) or positive-pressure demand valves.	Hypoxemia -- low oxygen content in the blood. Examples of patients requiring oxygen are: Chronic lung patients Emphysema Pneumonia Asthma Bronchitis Cystic Fibrosis Cardiac patients *There are approximately 8,000 patients in New Jersey AT HOME on oxygen.	1. Oxygen toxicity--results in damage to lung tissue. 2. Blindness in infants. 3. Can eliminate the drive to breathe in some patients (COPD) 4. Infection.
Postural Drainage Chest Percussion	A mode of therapy requiring proper positioning of patient for safe/effective drainage of lung segments.	Any disease state requiring removal of mucous secretions from lungs. Cystic Fibrosis Pneumonia Bronchitis Asthma Emphysema	1. Can increase intracranial pressure--patient must be properly monitored--especially infants--may cause intracranial bleeding 2. Spread of infection to another lung segment. 3. Aspiration. 4. Pneumothorax.

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PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Aerosol Therapy	A mode of therapy to dispense medication directly to respiratory tract. Given by mask or hand-held device. Can be given with compressed air or oxygen to infants, children, adults. Drugs used include: Sympathomimetic agents (bronchodilators) Antibiotics Antifungal agents Mucolytics	Patients with shortness of breath (SOB) due to: Asthma Emphysema Chronic Lung Disease Cystic Fibrosis Tuberculosis Pneumonia Bronchitis Retained Secretions (mucous) Inhalation burns (heat, smoke) Chemical inhalation	1. Irregular heart rates/ rhythms. Tachycardias/ arrhythmias leading to cardiac arrest. 2. Effects blood pressure. 3. Can effect central nervous system causing tremors, agitation, insomnia. 4. Nausea. 5. Overhydration--fluid overload with resultant heart failure from excessive use of ultrasonic therapy. 6. Allergic reactions to medications. 7. Infection from improperly dispersed medication. 8. Inherent problems from overuse of oxygen (see Oxygen Therapy). 9. Can aggravate asthmatic attack if improperly administered.
IPPB Therapy	A mode of therapy to disperse medication directly to respiratory tract. Similar to aerosol therapy, but IPPB (Intermittent Positive Pressure Breathing) is administered under pressure to the lungs. Can be used with compressed air or oxygen to children, adults. Drugs include: Sympathomimetic agents Antibiotics	Patients with S.O.B. See Aerosol Therapy (above)	Same hazards as aerosol therapy and: 1. Pneumothorax-- air which does not belong in chest cavity requiring emergency insertion of chest tube to prevent cardio-respiratory arrest. 2. Decreases cardiac output. Can result in arrest. 3. Oxygen complications.

PROCEDURE	DESCRIPTION OF THERAPY	INDICATIONS FOR THERAPY	HAZARDS/COMPLICATIONS
Mechanical Ventilation --- Respirators	A life support device-machine to which the patient is directly attached via endotrachéal/ tracheostomy tube for the purpose of providing ventilation (breathing) for the patient.	Any condition affecting the ability of the person to breathe thereby maintaining proper oxygen, carbon dioxide levels, adequate metabolic status to maintain life. Respiratory/Cardiac Failure Trauma/Shock Post Operative complications Anethestic Overdose Drug Overdose Ethanol poisoning (alcohol overdose) Foreign Body Obstruction Premature Infants	Due to the fact that once a patient is placed on a life support system/ventilator, the ultimate hazard secondary to mechanical failure, poor monitoring of patient is, death, permanent brain or vital organ destruction. Some of the major medical emergencies that arise are: Deceased cardiac output Deceased blood pressure Deceased urinary output Barotrauma-pneumothorax Collapsed lung Oxygen toxicty Severe metabolic inbalances Severe electrolyte imbalances Infection Tracheal hemorrhage

AMERICAN LUNG ASSOCIATION OF MONTANA

Christmas Seal Bldg. — 825 Helena Ave.
Helena, MT 59601 — Ph. 442-6556

EARL W. THOMAS
EXECUTIVE DIRECTOR

EXHIBIT 2
DATE 2-20-91
HB 620

TO: HUMAN SERVICES COMMITTE
CHAIRMAN: ANGELA RUSSELL

ROOM ~~211~~ 312-2 Wednesday February 20, 1991

FROM: EARL THOMAS, EXECUTIVE DIRECTOR

SUBJECT: HB620 - SPONSOR CAROLYN SQUIRES
"LICENSURE FOR RESPIRATORY CARE. ESTABLISHING A RESPIRATORY CARE BOARD:

THE AMERICAN LUNG ASSOCIATION OF MONTANA SUPPORTS HB 620 BECAUSE WE BELIEVE IT WILL PROTECT THE PUBLIC FROM UNQUALIFIED RESPIRATORY CARE.

THE FIELD OF RESPIRATORY CARE IS A VERY DEMANDING ONE. ONE ONLY NEED LOOK AT THE COURSE OF STUDY AT EITHER OF MONTANA'S TWO RESPIRATORY THERAPY SCHOOLS TO RECOGNIZE WHAT A RIGOROUS AND SOPHISTICATED FIELD THIS IS.

RESPIRATORY CARE IS AN EXPANDING FIELD BECAUSE RESPIRATORY ILLNESS IS ONE OF THE FASTEST RISING DISEASES IN THE UNITED STATES AND MONTANA CONSISTENTLY RANKS IN THE TOP FIVE.

A NATIONAL HEALTH INTERVIEW SURVEY DONE IN 1987 SHOWED THAT PERSONS SUFFERING FROM CHRONIC BRONCHITIES, EMPHYSEMA AND ASTHMA INCREASED 75.9% FROM 1970 to 1987. THE ATTACHED YELLOW SHEET PROVIDES FURTHER SUPPORT ON HOW LUNG DISEASE DEATHS ARE INCREASING.

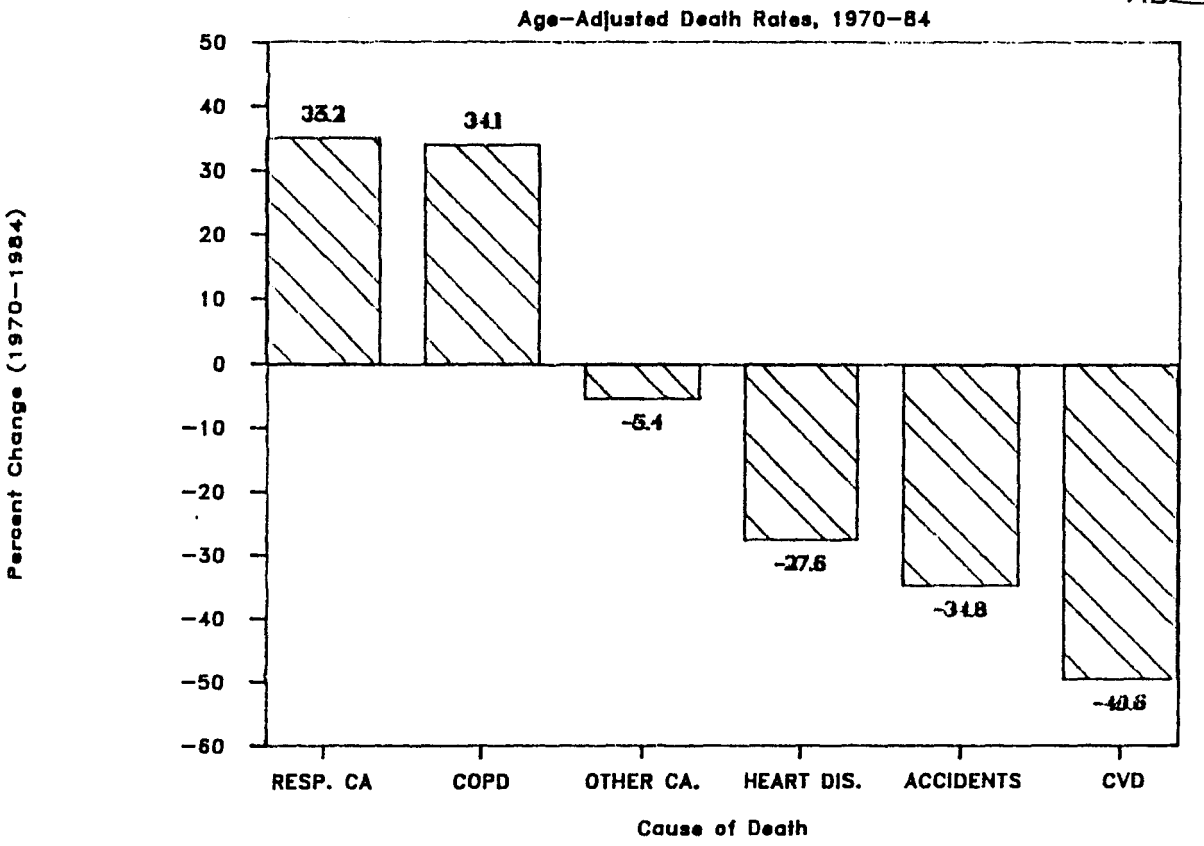
SINCE LUNG ILLNESSES ARE 75 TO 85% PREVENTABLE. WE ARE NOW PAYING THE PRICE FOR THE 43% OF THE POPULATION WHO SMOKED IN THE 1960'S. WE ARE PROUD TO STATE THAT MONTANA CURRENTLY HAS ONE OF THE LOWEST SMOKING RATES IN THE COUNTRY WITH LESS THAN 20%. HOWEVER IT WILL BE MANY YEARS BEFORE WE SEE THE BENEFITS OF THIS.

RESPIRATORY CARE PRACTIONIERS ARE NOT ONLY IN HOSPITALS AND CLINICS BUT ALSO IN THE PATIENTS HOMES PROVIDING CARE AND EDUCATION.

PLEASE GIVE HB 620 A DO PASS RECOMMENATION TO INSURE THE CONTINUED HIGH QUALITY OF RESPIRATORY CARE

EXHIBIT 2
DATE 2-20-91
HB 620

PERCENT CHANGE: LEADING CAUSES OF DEATH



Source: NCHS Monthly Vital Statistics Report
Final Mortality Statistics, 1970-84.

COPD: COPD and Allied Conditions (includes Asthma)
CVD: Cerebrovascular Disease
CA: Cancer

ICD Revision in Use:
1970-1978: Eighth Revision COPD = 490-493, 519.3
1979-1984: Ninth Revision COPD = 490-496

EXHIBIT 3
DATE 2-20-91
HB 620

Some Facts About House Bill 620
Sponsored by Rep. Carolyn Squires
Licensure of Respiratory Care Practitioners

--- Will respiratory care practitioners be given an exclusive license to practice respiratory care?

No, this bill allows other health care providers who are allowed under their own scope of practice to perform respiratory care to continue to do so.

--- How many states currently license respiratory care practitioners?

31 states have some form of licensure and regulation.

--- Do present statutes guarantee quality respiratory care? Why is licensure necessary?

Due to the legal liability of personnel departments that prevents them from providing detailed information regarding a job applicant, it is difficult for hospitals and other employers to know if a prospective respiratory care practitioner employee is competent. This allows those few incompetent practitioners to move from job to job without detection. Licensure and regulation provide a means to ensure quality respiratory care. There also presently are no mandatory continuing education requirements to ensure continuing quality respiratory care.

The Joint Commission on the Accreditation of Hospitals (JCAH) requirements that accredit hospitals has not dealt with the problem of incompetent practitioners and does not mandate continuing education.

--- Will licensure raise the cost of employing respiratory care practitioners?

No. Regarding salaries, the market dictates what respiratory care practitioners are paid, not the fact the group licensed. As to insurance reimbursement issues, Medicare, Medicaid, and private insurance policies already provide for reimbursement of respiratory care services, for both inpatient and outpatient services. This bill does not add a new group to the list of health care providers seeking reimbursement for their services.

EXHIBIT 4
DATE 2-20-91
HB 620

I. Introduction

A. My name is Nancy Whitmer, I am a former Special Education teacher and the mother of 6 boys, one 19 who is currently on a PLV 100 ventilator.

B. I am here as a concerned citizen as well as a concerned parent to advocate for the Respiratory Therapists and their proposal, seeking licensure for those therapists in their profession.

1) It was anxiety provoking for me when I was informed that the(250) Respiratory Therapists in Montana are the only allied healthcare professionals involved in life-saving and life sustaining procedures which are not licensed. I had always assumed they were.

a) It did explain, though, the many instances which we have had unpleasant experiences with Respiratory Care Therapists and those who worked among them.

b) Obviously, with no Board to establish minimum standards or levels of competency: [1] there are no controls to prevent the public from the unqualified practice of respiratory care or [2] from the unprofessional conduct of persons even though they are qualified.

The general public in many instances, is no better off than a lottery player ... when referred, you hope to get a currently educated, competent Respiratory Therapist ... many times a respiratory crisis occurs before the layman realizes he as a problem.

c) As a teacher, my profession demands that those in it return to school at regular intervals to stay current and updated in their respective fields. It demands, that if they are returning after a lengthy absence they need to take even more credits and be re-certified or they may not re-enter the classroom.

1) Kids in the classroom would not be at risk in a life/death situation with an out-dated, under skilled teacher ... but the Respiratory Therapist who operates in that same manner exposes his clients to life threatening risks ... skills of the profession require continuous updating as modern technology advances.

2) Even the hairdresser who cuts my hair is required by state law to have a license, so is the manicurist. They undergo periodic, unannounced inspections from the state to ensure public health and safety.

These above mentioned professions have the "tools" through STATE BOARDS, EXAMS, requirements for continuing education etc. to police their own professions, THE RESPIRATORY THERAPISTS DO NOT.

DATE 2-20-91
HB 620

II. In my own personal experiences with my son's respiratory care, we have encountered at least 20 different Respiratory Therapists in the last 13 years.

A) Jon was diagnosed as having Duchinne Muscular Dystrophy at age 6 in 1977. He was given a life expectancy of the age of 12 - at that time.

1) Today, at 19. He is a freshman at Eastern Montana College, having graduated with honors from Billings Senior High School 1989.

2) He is alive only because of the technological advances in the field of Respiratory Management. In 1977 respiratory care for Jon was merely a lung exercise, breathing in and out with a book on his chest. In 1980 he had a positive pressure machine which would automatically inflate his lungs (as would a balloon).

These were simple procedures - even his younger brothers could help with them.

3) In 1987 Jon went into respiratory failure. Since then we have used:

1) Aerosol breathing treatments - medication prescribed and inhaled directly into lungs.

2) Diaphramatic rocking bed (expl.)

3) Iron lung (no one familiar at time - too young)

4) Porta lung - with negative pressure ventilators

5) PLV 100 with nose piece - a positive pressure ventilator.

a) This machine represents the ultimate in high technology and the advances being made in the respiratory field. Ours is the only one in Billings. There currently is only 1 Respiratory Therapist who has any working knowledge of the operation.

As you can see, in a 10 year period ... the gradual increase in our respiratory needs were met by modern technology, (sometimes modern therapists, reaching back in time to adapt to our needs). In the 10 year span we also saw the skills of the various Respiratory Therapists attending to Jon challenged to grow along with our needs. The skills needed in 1977 differed vastly from those needed in 1987 to 1990. Without continuing education for Therapists their performance will be sub-standard, and so will the care delivered to the patient.

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B. Children like Jon, and those having other respiratory diseases (Cystic Fibrosis, Myesthenia Gravis, etc.), and adults with emphysema and heart ailments all live longer, more productive lives thanks to the diagnostic tools, and modern advances implemented in the Respiratory field.

1) They will not give us maximum benefit, or any at all, if the Respiratory Therapists are not acquainted with them or if they have not kept abreast with the changes in their field. We can be assured this thru licensure, Board, ongoing education requirements, and setting minimum standards.

2) Many skills are involved today; evaluation, testing. Machines used for some of this look like the "dash board" of a spaceship.

Blood gas studies are used to determine the oxygen levels in the blood, this is accomplished by withdrawing blood from a main artery in the patient's body (similar to those in dye studies done by Medical Doctors).

The Respiratory Therapists today are part of a profession that requires them to do more than roll an O^2 tank into a patient's room or administer aerosol treatment to a child with asthma or croup.

C. It is the Respiratory Therapist, in our experience, who tests and evaluates patients so that a respiratory program can then be prescribed by a doctor.

1) It is the Respiratory Therapist who draws the arterial blood gases to obtain blood samples (these tell us the levels of O^2 and CO^2 in the blood). This has been literally a life and death situation in Jon's case, levels too high can result in coma and death.

2) It is the Respiratory Therapist who trains the families in home care of the patient and makes house calls to "trouble shoot" any problems and to help with a solution.

D. The Respiratory Therapist is, in essence, the eyes and ears for the Pulmonary Doctor (reporting to him the findings).

1) The Respiratory Therapist's expertise in the field, his observational skills, evaluation procedures, knowledge and experience <u>CAN MAKE A DIFFERENCE</u>, <u>CAN SAVE A LIFE</u>.

a) Sloppy and unprofessional conduct, whether it be due to ignorance or not, is negligence and <u>can cost a life</u>.

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b) We have had experiences with both;

1) In one instance when Jon was in the hospital for respiratory failure, 2 liters of O^2 was prescribed for him (a routine prescription since the O^2 level in his blood was low). For Jon, with Muscular Dystrophy, that was too much, he went into a CO^2 induced coma. It was an alert Respiratory Therapist who observed this and recognized that extra O^2 was being "piped" in but the CO^2 (left over, deadly air) was not being exhaled. Immediately the O^2 was reduced to 1/4 liter. Jon was almost immediately more alert.

a) Families of patients are not trained to evaluate the unexpected or assess out of the ordinary medical problems. I was not, at that time. Today I have learned to be a more informed parent. Many parents do not have the access that I have had thru medical travels to Seattle and Dallas. We assume that the person with the white coat and name tag is qualified in his or her profession. Licensure of Respiratory Therapists in Montana would serve to assure families, patients and co-workers that some set standards are being met.

b) I do not pretend to have the expertise to evaluate a professional unless it's blatant, open, or obvious.

1) This occurred when Jon was in the Iron Lung. After the unpleasant occurrence with too much oxygen, it was charted that he should have NO O^2 when in the Lung.

One Respiratory Therapist, who held a position higher than the average R.T. and who also held himself in quite high esteem, came into Jon's room one night and began to hook up the O^2. I objected saying the doctor had ordered it ceased at night when in the Lung. He was insistent that he was proper in administering it, I was insistent also - would not allow it - I <u>strongly</u> informed him that he should call the doctor. So he did call the doctor and was told it was ON THE CHART - NO O^2 ... <u>HE HAD NEGLECTED TO READ IT</u>.

DATE 2-20
HB 620

a) This incidence was unnecessary and unprofessional. His personality had caused problems before - not just among patients. He was a definite irritant to some of his peers.

b) He may have been experienced and qualified, but he was not professional. We were relieved to see, upon a return visit to the hospital, that he no longer worked there (we had nothing to do with this). The relief was short lived however, when at a later date, I admitted my mother to the other hospital in Billings - I saw him in the hall outside of the Respiratory Unit. I was informed upon inquiry after this that the person had never received formal schooling and was not credentialed.

It is people such as this individual (in the Respiratory field) whether they lack the skills and expertise needed for the practice of high technology Respiratory Care, or maybe they have the skills and credentials, but their conduct is not suited to that of a professional and who may put patients at risk.

Today, there is no "tool" to weed them out, no "Big Brother" so to speak, for fellow Respiratory Therapists to have as a "lever". A State Board and licensure would help accomplish this.

IN MY OPINION, WHICH IS DRAWN FROM 13 YEARS EXPERIENCE WITH RESPIRATORY THERAPY, THERE SHOULD BE NO QUESTION AS TO <u>WHETHER OR NOT</u> THE RESPIRATORY THERAPISTS <u>SHOULD</u> BE LICENSED, BUT <u>HOW SOON</u> IT CAN BE <u>ACCOMPLISHED</u>.

Thank you for your time.

THE RESPIRATORY CENTER

EXHIBIT 5
DATE 2-20-91
HB 620

RONALD E. BURNAM, M.D., F.C.C.P.
FREDERICK W. KAHN, M.D., F.C.C.P.
THOMAS P. THIGPEN, M.D., F.C.C.P.

February 8, 1991

Montana State Legislature
State Capitol
Helena, MT 59624

To Whom It May Concern:

I am writing you in regards to the proposed respiratory care legislature act that is before the current session of the legislature.

I am a practicing physician in Billings and a respiratory specialist. I would like to go on record as being a firm supporter of this type of legislative act.

Respiratory care has expanded rapidly over the past several years with very sophistocated modalities now available both as inpatient and outpatient possibilities. Because of the sophistication of these services that need to be provided I think that it is adamant that there be some mechanism to oversee the training and supervision of the individuals who provide these various services. It seems to me that the way that this bill is proposed it is obvious that a great deal of thought has been put into this and that the public can be assured that people who are providing services are in fact qualified.

Once again, I think this is a good thing to have and I would very much ecourage your support.

Sincerely,

Thomas P. Thigpen, M.D.

TPT/bjs

Yellowstone Medical Building
1145 North 29th Street
Suite 300, Billings, MT 59101

THE RESPIRATORY CENTER

EXH.BIT 5
DAT 2-20-91
HB 620

RONALD E. BURNAM, M.D., F.C.C.P.
FREDERICK W. KAHN, M.D., F.C.C.P.
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Sincerely,

Thomas P. Thigpen

Thomas P. Thigpen, M.D.

TPT/bjs

Yellowstone Medical Building
1145 North 29th Street
Suite 300 Billings, MT 59101

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2-20-91
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EXHIBIT 6
DATE 2-20-91
HB 627

(406) 444-3111

CAPITOL STATION
HELENA, MONTANA 59604

February 8, 1991

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ou that I am in full support of the need for licensure for
n the state of Montana. It is quite clear that respiratory
iders need some type of program to demonstrate a minimum
he area of respiratory therapy. We are doing more and
tal and outpatient setting including analysis of blood
plex and often critically ill patients with ventilatory
en treatments, pulmonary function testing and the like,
andate that a minimum level of competency be ascertained
ion in that setting. It is hard for me to believe that
dy gotten behind this program and virtually mandated the
of activities of respiratory care providers given the
of issues relating to quality of care in the hospital

ive is that we clearly do need to set minimum standards
ams, demonstrated competency, work experiences, and ongoing
to fully ensure that our therapists are trained and deliv-
y of care possible. Certainly in this current medical
an that is suspect. Therefore, I give you my strongest
ill do everything in my power to formulate policies and
piratory care providers to become a reality in the state

Yellowstone Medical Building
1145 North 29th Street
Suite 300, Billings, MT 59101

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EXHIBIT 9
DATE 2-20-91
HB 604

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

STAN STEPHENS, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

FAX # (406) 444-2606

HELENA, MONTANA 59620

TESTIMONY PRESENTED BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

February 18, 1991

HB 604 - PERMITTING DISCLOSURE OF OUT-OF-WEDLOCK BIRTH TO ADULTS

This bill proposes amendment of 50-15-206 M.C.A. Existing statute defines the conditions whereby disclosure of an out-of-wedlock birth is permissable.

In order to comply with this statute, the Department has utilized the concept of a "short form" certified copy of a birth certificate. A "short form" contains the same information as a normal certified copy except the names of both parents are omitted. The Department has determined that to issue a "long form" copy of an out-of-wedlock birth certificate on which the father's name would be missing would constitute illegal disclosure.

Currently an adult born out-of-wedlock can usually obtain a normal copy of his/her birth certificate by presenting to the Department a court order which orders us to issue the "long form." The process of obtaining such an order is expensive for the individual and probably increases the workload of the courts. The only alternative to this procedure is to deny an individual adult access to their own personal records.

Presented by:

Sam Sperry
Chief, Vital Records and Statistics Bureau
Department of Health and Environmental Sciences

EXHIBIT 10
2-20-91
640

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

STAN STEPHENS, GOVERNOR

COGSWELL BUILDING

STATE OF MONTANA

FAX # (406) 444-2606

HELENA, MONTANA 59620

TESTIMONY PRESENTED BEFORE THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

February 20, 1991

HB 640 - AMENDING DEFINITION OF FETAL DEATH

This bill proposes a change in the definition of Fetal Death found at 50-15-101 (5) M.C.A. Existing definition establishes a fetal death on the basis of gestational age of the fetus. This change would supplement the existing definition with the weight of the fetus. The effect of this change would be to identify fetal deaths in Montana that have heretofore been unreported.

Improvement in Montana's perinatal and postneonatal mortality rates requires that medical practitioners and public health professionals be provided with increasingly more detailed information on the many facets of pregnancy, prenatal care and birth. Medical science is now focusing on 500 grams as a critical fetal weight or live birth weight. Changing this definition will allow reporting of medical information crucial to our understanding of fetal loss - information not presently available to society. This change will also provide hospitals with improved capability in deciding whether a fetal death is reportable.

The Department feels that this change in definition is essential to improving data collection and statistical reporting in the area of fetal mortality.

Presented by:

Sam Sperry
Chief, Vital Records and Statistics Bureau
Department of Health and Environmental Sciences

2-20-91
HB 640

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

WILLIAM L. WEBSTER, *et al.*,
Appellants,

v.

REPRODUCTIVE HEALTH SERVICES, *et al.*,
Appellees.

On Appeal from the United States Court of Appeals for the Eighth Circuit

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AMICI CURIAE BRIEF OF 167 DISTINGUISHED SCIENTISTS AND PHYSICIANS, INCLUDING 11 NOBEL LAUREATES, IN SUPPORT OF APPELLEES †

JAY KELLY WRIGHT *
DAVID T. COHEN
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Attorneys for Amici Curiae

* *Counsel of Record*

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WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

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2-20-91
640

EXHIBIT 11
DATE 2-20-91
HB 640

ACLU OF MONTANA
AMERICAN CIVIL LIBERTIES UNION

P. O. BOX 3012 • BILLINGS, MONTANA 59103 • (406) 248-1086

February 20, 1991

State Office
335 Stapleton Building
Billings, Montana 59101

BOB ROWE
President

SCOTT CRICHTON
Executive Director

JEFFREY T. RENZ
Litigation Director

Madam Chair, Members of the Committee:

For the record, my name is Scott Crichton, Executive Director of the American Civil Liberties Union of Montana, a dues paying membership based organization of more than 800 families concerned about maintaining protections guaranteed us by the Constitution and the Bill of Rights.

I am here today to oppose HB 640 because the bill makes no sense. I try to understand why this bill is proposed at all and am at a loss to explain the need for this legislation.

While I am no medical expert, I have reviewed the Amicus brief of 167 distinguished scientists and physicians, including nobel laureates, in support of the appellants in the well known Webster v. Reproductive Health Services case. It is a lengthy document and I have a copy to submit to the committee with this testimony for those who would like to review it in depth.

What concerns me is the suggestion we have heard in other bills dealing with fetal viability. It is the notion that there has been enormous movement in the point of viability since the 1973 Roe v. Wade ruling. This brief documents that such arguments are flatly contrary to scientific evidence. "Although advances in technology have improved the chances of survival for premature birth within the range of 24 to 28 weeks, the outer limit of viability at 24 weeks has not been significantly changed." (see page 8 of the brief). See also P. 10-11.

It is my understanding from this brief and in speaking with others knowledgeable in the field, that it is a biological impossibility that a 500 gram fetus could be delivered prior to 20 weeks of gestation.

Perhaps there is a justifiable position from the Department of Health and Environmental Sciences that will persuade a majority of this committee to put a DO PASS recommendation on this bill. I am concerned, however, that somehow this bill could be used to argue that scientific observations concerning the outer limit of viability recognized in Roe v. Wade are no longer accurate. That would misrepresent scientific fact and would merely represent value judgements interested in undermining the foundations of reproductive rights in our society.

I urge a DO NOT PASS on HB 640. Thank you.

"Eternal vigilance is the price of liberty"

EXHIBIT 13
DATE 2-20-91
HB 642

In January of 1986, both my husband and I were working full-time. We did some checking and found a licensed daycare in Helena. This facility provided the amount of daycare we needed and was affordable. I was told I could bring the children anytime, day or night, including weekends. We began bringing our children on a regular basis of three to four days per week for the next four or five months. At that time Adam was 7 years old, Jonathan 4 years old, and Chrystal 3 years old. The owner of the daycare would take Adam to school. Jonathan and Chrystal would stay the whole day from aproximately 0630 to 1500.

During the first few weeks of going to this daycare, the children would complain about having to go there. We assumed this to normal. They continually complained throughout the next few months. We asked them why they did not like it. Their response was never specific, just that they did not like it. In the Spring of 1986 we began looking for another daycare.

During the next few years, Jonathan and Chrystal attended the Foot-Kindshey Daycare and Preschool when they were not attending Headstart. Both facilities stated that Chrystal was doing okay, but Jonathan was extremely quiet. He would talk only if he absolutely had to. Also he had difficulty playing with

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other children. Though Chrystal was doing well at the schools, she started having nightmares. At first she would only cry and then go back to sleep. Gradually, they became more frequent and intense. Through study, I found that these nightmares were not nightmares at all, but considered night terrors. She would sweat profusely, and with her eyes wide open she would cry and scream. Many times while crying she would say " I'm sorry, I'm sorry, I love you, I love you, I love you, I'm sorry....." Along with this reply she would sometimes describe a place or an activity. During one night terror she asked, " Why did you put me in this room and take my clothes off and pour cold water on me?" Another time, while having a night terror, she pointed at something. She continued to scream and cry for aproximately 15 minutes. She never would say what she was pointing at.

The night terrors usually lasted 5 to 15 minutes. It would take aproximately 15 minutes to calm her down to where she could sleep. The next day she would not remember any of what went on the night before.

Toward the end of 1989 one or two night terrors per week was a common occurrance. They became more severe.

Jonathan continued to have problems in school. He could not

function successfully in the first grade. He had few friends if any. The teachers repeatedly stated that he very seldom talked.

In January of 1990, our family sought help at the Mental Health Services in Helena. Both younger children recieved most of the care which lasted from January through June of1990. During this time it was determined that both children received abuse of some sort; physical, psychological, and/or sexual

Since June of 1990, Chrystal has had no night terrors. She does experience general aches and pains which her therapist stated would happen. This is another way of expressing the trauma she went through. Jonathan is doing much better in school and is verbally expressing himself.

EXHIBIT 14
DATE 2-20-91
HB 642

MENTAL HEALTH SERVICES, INC.

STUART KLEIN, MA
EXECUTIVE DIRECTOR

OFFICES

REGIONAL HEADQUARTERS ADMINISTRATION
512 Logan
Helena Montana 59601
(406) 442-0310
FAX# (406) 443-7011

ANACONDA
(Rm. 211 First Security Bank Bldg.)
P.O. Box 978
Anaconda, Montana 59711-0978
(406) 563-3413

BOZEMAN
514 W. Lamme
Bozeman, MT 59715
(406) 586-4090

BUTTE
2500 Continental Drive
Butte, Montana 59701
(406) 723-5489
FAX# (406) 782-4020

Gilder House
2460 Kossuth
(406) 723-7104

Silver House
8 S. Montana Street
(406) 723-4033

DILLON
25 S. Reeder
Dillon, Montana 59725
(406) 683-2200

HELENA
512 Logan
Helena, Montana 59601
(406) 442-0640

Center for Sexual Wellness
512 Logan
(406) 442-0649

Montana House
422 N. Last Chance Gulch
(406)443-0794

Transitional House
[illegible] Missoula Avenue
(406) 443-4922

Southwest Adolescent Treatment Center
32 South Ewing
(406) 442-9902

LIVINGSTON
P.O. Box [illegible]
12a South Second
Livingston, Montana 59047
(406) 222-3332

Mountain House
12a S. Second
(406) 222-3336

February 21, 1991

DATES OF SERVICE:

2/28/90	1-hour (Medicaid)
3/01/90	1-hour (Medicaid)
3/15/90	1-hour (Medicaid)
4/11/90	1-hour (Medicaid)
7/10/90	1-hour (Medicaid)

Charges were reimbursed by Medicaid at the following rates:

2/28/90 - 6/30/90 $12.76 per/unit of service
7/01/90 - current $11.44 per/unit of service

Each child received three individual sessions through the EAP.

DFS—99(A)
(Rev. 11/89)
Page 1 of 2

EXH. 15
DATE 2-20-91
HB 642

State of Montana
Department of Family Services
INFANT DAY CARE CHECKLIST

Name:_____

Address:_____

Phone No.:_____

REGISTRATION

CERTIFICATE NUMBER

	RULE #	AREA OF EVALUATION AND OR INSPECTION	PROVIDER Check Here			DEPARTMENT Check Here		
			YES	NO	NA	YES	NO	NA
1	11.14.501(1a)	Pre-admission physical within 2 weeks/special needs						
2	11.14.501(1b)	Health examinations verification						
3	11.14.502(1)	Sufficient supply clean, dry diapers						
4	11.14.502(2)	Soiled diapers laundered/disposed properly						
5	11.14.502(3)	Diaper changing surfaces cleaned						
6	11.14.502(4)	Soft, absorbent disposable/laundered towels						
7	11.14.502(5)	Safety pins out of reach/infant not left unattended						
8	11.14.502(6)	Toilet articles identifed/separated/sanitary						
9	11.14.502(7)	Separate wash basin						
10	11.14.502(8)	Toilet training						
11	11.14.503	Wet/soiled clothing changed promptly						
12	11.14.506(1)	Individualized diet/feeding schedules						
13	11.14.506(2)	Formula/breast milk procedure followed						
14	11.14.506(3)	Bottle feeding procedure followed						
15	11.14.506(4)	Sufficient/appropriate food storage						
16	11.14.506(5)	Bottles filled on premises refrigerated/discarded properly						
17	11.14.506(6)	Sanitized bottles and nipples						
18	11.14.507	Bathing procedures followed						
19	11.14.508(1)	Adequate, individualized sleep opportunities						
20	11.14.508(2)	Infant provided with adequate crib, cot, mat						
21	11.14.508(3)	Crib/mattresses meet or exceed requirements						
22	11.14.508(4)	Adequate clear space for cribs, cots or mats						
23	11.14.508(5)	Individual clean, washable blanket						
24	11.14.508(6)	All cries of infants are investigated						
25	11.14.511(1a)	Vehicle equipped with car beds/seats that meet Fed. standards						
26	11.14.511(1b)	Car beds anchored to floor/infants strapped in						
27	11.14.511(1c)	Car seats anchored to floor/infants strapped in						
28	11.14.511(1d)	Adequate transportation staff/no child unattended						
29	11.14.512(1)	All infants have freedom of movement						
30	11.14.512(2)	No more than one hour in crib, playpen, etc.						
31	11.14.512(3)	Individual, personal contact/attention once/hour						
32	11.14.512(4)	Provision to safely explore/stimulation & quiet/outside activities						

DATE 2-20-91

	RULE #	AREA OF EVALUATION AND OR INSPECTION HB 642	PROVIDER ~~Check~~ Here			DEPARTMENT Check Here		
			YES	NO	NA	YES	NO	NA
33	11.14.512(5)	Individual sleeping/waking periods						
34	11.14.513(1)	Infants protected from drafts/exposure						
35	11.14.513(2)	Outdoor area fenced/hazard free/easily supervised						
36	11.14.513(3)	Adequate protection against insects						
37	11.14.513(4)	Provision for both sunny/shady areas						
38	11.14.515(1)	Feeding tables or high chairs for every 4 children						
39	11.14.515(2)	Adequate playpens, jump chairs, adult rockers						
40	11.14.516	Meets adult/infant staffing 1 adult 4 children						
41	11.14.519(1)	Diet/schedule posted						
42	11.14.519(2)	Individual storage space provided						
43	11.14.519(3)	Staff clothing covered						
44	11.14.519(4)	Separate play area						

COMMENTS: _____

REPORT COMPLETED BY: _____ **DATE OF INSPECTION:** _____

I have received a copy of this Family Day Care Visitation Checklist and concur ☐ do not concur ☐ with the findings and/or ratings.

_____

Provider Signature

EXHIBIT 16
DATE 2-20-91
HB 700

HB 700

Chairman Russel, and Representatives I am Denzel Davis, Chief of the Licensing, Certification and Construction Bureau. I come before this committee to support the passage of HB 700.

Background Information:

50-5-204 was amended by the legislature in 1983. "(4) The department may inspect a licensed health care facility whenever it considers it necessary and shall inspect each licensed facility at least once within the 3 years following the date of its last inspection."

50-5-204 was again amended by HB 204 in 1985. "(2) If the department determines that the facility meets minimum standards and the proposed existing staff is qualified, the department shall issue a licence for 1 year." HB 204 corrected the 1983 statute and brought the State into compliance with Federal requirements.

HB 700 addresses new changes in the Federal requirements brought about by the Omnibus Budget Reconciliation Act of 1987 (OBRA). The addition of new Federal enforcement regulations for Medicare and Medicaid providers will allow for new provider agreements for periods up to 15 months. Current agreements are given for a 12 month period. The term of the agreement will be based on the facilities compliance record as recorded by current and past surveys.

The Health Care Financing Administration (HCFA) has over the past three years reduced the inspection frequency by prescribed percentages for non-long term care providers, to bi-annual inspections.

Section 1 line 21 and 22 changes the existing statute to read "Licenses <u>may be issued for a period of 1 to 3 years.</u>"

Section 2, sub-section (1) delete's the language <u>annually thereafter</u> and adds language to correspond the new issuance period of section 1
(1) At least 30 days prior to opening a facility and <u>after that no later than the expiration date of the license.</u>

Section 3, sub-section (1) is amended to reflect the actual procedure used when an inspection is conducted for a new provider.

(2) Addresses unannounced inspections for renewal inspections deleted from item (1)

(3) Language is added to this sub-section that corresponds with the amended licensure period of Section 1, sub-section (2).

HB 700 has many positive values. It address the changes in federal regulations. HB 700 allows the Licensing and Certification Bureau to shift its available resources from historical annual inspections to focused inspections of health care facilities that have and continue to indicate non-compliance with State and Federal conditions of participation. To shift survey operations that address the increased number of complaints received by the Bureau.

HB 700 addresses the need to acknowledge health care providers who historically provide quality care and compliance with regulations, by issuing extended licenses and Medicare/Medicaid agreements.

HB 700 address the issue of joint State and Federal survey and certification operations. This bill will allow the State to issue licenses for periods that correspond with Medicare and Medicaid agreement periods.

HB 700 does not in any way reduce but enhance the Bureau's ability to assure that quality care is being provided to residents and patients receiving services.

I would urge the committee to vote passage of this bill.

EXHIBIT 17
DATE 2-20-91
HB 917

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES
AIDS Prevention Act Amendment
House Bill 917 Testimony--2/20/91

Representative Russell and members of the Committee, I am Judith Gedrose, Chief of the Preventive Health Services Bureau of the Montana Department of Health & Environmental Sciences and wish to provide testimony in support of House Bill 917.

In 1989, the legislature passed the AIDS Education and Prevention Act which set consent and counselling standards for those being tested for exposure to the virus causing AIDS. It also had provisions intended to protect others, such as organ recipients. There was concern testing might be decreased by implementation of the act. Testing data indicates this was not the case. There was a 14% increase in the number of HIV tests performed in 1990 over the number done in 1989 at the MDHES Public Health Laboratory.

The proposed revisions to the Act contained in HB917 address problems which have occurred since the 1989 adoption of the statute. They are at least:

1. The existing statute has no provision for testing of a person in a coma or otherwise unable to give consent to testing. The amendments allow next of kin and others to provide appropriate consent.

2. The requirement for a test immediately prior to donation of an organ, semen, etc. in the existing statute conflicts with national standards for donation. The amendments would allow DHES to incorporate, by rule, nationally-accepted standards for handling such donations.

3. The existing statute has caused confusion relative to insurance companies reporting back to persons applying for coverage when the company requires HIV testing. The amendments clarify the role of the insurance company in this area.

4. The existing statute allows release of information under the Uniform Health Care Information Act (Title 50, Chapter 16, Part 5). However, local health departments may have information collected outside the patient-health care provider relationship, making the information collected subject to the more restrictive Government Health Care Information Act and the amendments clarify this.

MDHES supports HB917. The Department drafted the bill after receiving comments over the past 2 years.

cc: Representative Howard Toole

18
DATE 2-20-91
HB 917

BEFORE THE HOUSE COMMITTEE ON HUMAN SERVICES AND AGING

TESTIMONY ON HOUSE BILL 917

Presented by: F. Woodside Wright
Helena, Montana

Thank you for this opportunity to speak on proposed amendments to the AIDS Prevention Act. My Name is F. Woodside Wright. I speak to you as the current Chairman of the AIDS Advisory Council of the Montana Department of Health and Environmental Sciences. This council is the only group that pulls together most of the organizations dealing with AIDS. The Council has a membership that ranges from community based organizations, to the University system, to Out in Montana, Home Health care agencies, the Montana Medical Association, the Montana Nurses Association, The State Bar Association, local health departments and from time to time executive branch agencies. Meetings are held quarterly. One of the main objectives is to provide ongoing discussion between the different groups that deal with AIDS and to address problem areas as they arise.

One example of addressing problems is the review and comment on what is now HB 917. During the last biennium local health departments, people with AIDS, state employees working with AIDS programs, counsellors, physicians, nurses, and others identified problems with the implementation of the AIDS Prevention act. In conjunction with Advisory Council members and others the Health Department put together a proposal for revising the AIDS Prevention Act. The proposal was distributed to Advisory Council members; comments were sought and received; then in early January 1990 the

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HB 917

council met to discuss the proposed legislation. That meeting resulted in some changes to the DHES proposal and a general advisory council consensus of the members present was derived. There are Council members that do not fully support the January meeting results. Consensus is reflected in most of the bill before you. The areas of the bill that do not have Advisory Council consensus are:

1) Section 1, page 3 lines 15-17. This wording was not addressed by the council.

2) Section 2, pages 9-10 lines 24-2 and related material at Section 2, pages 6-7 lines 24-6. The advisory council believes an insurance company should be required to provide the test results and counselling. There is no compelling reason to treat an insurance company differently from others who require HIV tests.

3) Section 2, page 11 lines 1-3. There was no consensus on this provision. The proposal raises major concerns with some members of the council because of the potential for abuse by not only individuals who are contacted by public health officers, but by those health officers themselves. This concern derives from the social stigma, discrimination, emotional and psychological trauma and irrational fears that result from a positive diagnosis of HIV or AIDS or AIDS Related Complex.

4) Section 6 of the bill was not addressed by the Advisory in any detail at all. The Advisory council addressed a physician's responsibility to discuss with a patient's spouse the determination that a patient had was HIV+ or had AIDS. Generally, the council believes the physician should discuss such information with the spouse if the patient does not do so. However, there is no agreement to amend

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DATE 2-20-91
HB 917

the Health Care Information Act, particularly with language as broad as is presented in HB 917. The proposed wording appears to be broader than the revision of the AIDS Prevention Act and as such may raise issues which should be addressed elsewhere.

In Summary, the proposed revisions to the AIDS prevention Act upon which the AIDS Advisory Council has discussed and reached a consensus, are needed and should be adopted. Any concerns with the remaining provisions of the bill are of a type that can be addressed upon consideration in the Senate.

A DO PASS RECOMMENDATION ON HB 917 IS REQUESTED

Submitted this 20th day of February, 1991.

EXHIBIT 19
DATE 2-20-91
HB 917

ACLU OF MONTANA
AMERICAN CIVIL LIBERTIES UNION

P. O. BOX 3012 • BILLINGS, MONTANA 59103 • (406) 248-1086

State Office
335 Stapleton Building
Billings, Montana 59101

BOB ROWE
President

SCOTT CRICHTON
Executive Director

JEFFREY T. RENZ
Litigation Director

February 20, 1991

Madam Chair, Members of the Committee:

For the record, my name is Scott Crichton, Executive Director of the American Civil Liberties Union of Montana, a dues paying membership based organization of more than 800 families concerned about maintaining protections guaranteed us by the Constitution and the Bill of Rights.

This is generally a well crafted bill, that has had significant input from AIDS advisory groups across the state. I am here today to support HB 917 as it is written if it is adequately amended to address several areas of concerns to protecting basic civil liberties.

I'd first like to draw your attention to Section 2, subsection 3 (d) [page 11], where the bill presents new language for the performance of HIV-related testing persuant to 50-18-107 and 108. This refers to sexually transmitted diseases and the powers and duties of health officers. While AIDS is sometimes transmitted by sexual contact, it is not exclusively transmitted in this manner. The AIDS prevention act as it presently stands doesn't allow drawing the blood without informed consent. As this bill is now written, we are to incorporate the provisions of the sexually transmitted disease statutes into the AIDS statutes. We would then be voiding the more protective and stringent provisions of the AIDS Prevention Act. There are probably some very good examples of how this could be misused by michevious and malevolent individuals. The potential violations of privacy rights far outweigh perceived HIV status determination without persons consent. By cross referencing sexually transmitted diseases with AIDS Protections, we are potentially opening up real problems- jail time not being the least of these.

Also of concern in Section 2, subsection 4 [page 3] are proposed changes in language regarding anonymous testing. Anonymous testing is a critical element to an effective testing program and we are concerned that this rewording may signal the beginning of the end for anonymous testing. Counseling test sites established by the department should not be eliminated and we are concerned that this is paving the way for just that. We would recommend keeping the old language here. If it is our intent to get folks in for anonymous testing, we need such testing to be available as widely as possible. We would recommend then that the state commit to state sponsored sites.

"Eternal vigilance is the price of liberty"

Further concerns in Section 2, subsection 7 are also troubling. Why should insurance companies be any different in this regard? Everyone else has to deliver test results in person. What is the compelling reasoning of why insurance companies should be exempted. Someone tested deserves being informed if results are positive or negative.

Section 6, subsection 9 [page 16] also presents some problems from a civil liberties perspective. While there are no doubt some circumstances where this addition makes good sense, it could possibly be misused by corporations also viewed as "persons" from an insurance company or employer's standpoint. It opens door too widely regarding the dissemination of information, giving doctors the ability to override this fundamental patient's right of privacy. Why does this addition also include "any other other individual?"

To close, when we can see a bill that has amendments included that address the concerns we have brought up today, we can recommend a DO PASS on HB917. We hope this committee can make that happen. Thank you.

MISSOULA CITY-COUNTY HEALTH DEPARTMENT

EXHIBIT 20
DATE 2-20-91
HB 917

February 20, 1991

Honorable Representative Angela Russell
Human Services and Aging Committee
Montana House of Representatives
Capitol
Helena, MT 59620

Dear Representative Russell,

I am writing in SUPPORT of HB 917 generally revising the AIDS Prevention Act. I serve on the Montana Department of Health and Environmental Sciences AIDS Advisory Council which, through a lengthy and formal process, endorsed the majority of the proposed revisions.

Our basic purpose in revising the AIDS Prevention Act was to make it more workable in its practical application and clarify the language. We operated from the premise that the original intent of the bill - the provision of informed consent - be preserved. An important substantive change that is addressed in the bill is to allow for testing of an impaired patient, either through proxy consent or by health provider determination, when the test result was deemed necessary for treatment of the patient. A great deal of negotiation and review went into developing the approach to this issue as it is presented to you today in HB 917.

Speaking for myself, I believe a similar pathway could exist for testing an impaired patient who is a source patient in an health care worker exposure situation. But, I do not endorse amendments that would circumvent seeking informed consent when a conscious, competent patient is involved. To allow for such provisions would conflict with guidelines issued by the Centers for Disease Control, the Occupational Safety and Health Administrations, and would directly conflict with the act's original intent.

The bill as presented to you today does have a few other changes that were not reviewed or endorsed by the AIDS Advisory Council. I believe these issues are negotiable and none of them, in my mind, should have sufficient weight to hamper the passage of this bill.

I strongly urge your support of HB 917 and I thank you for your diligence in attempting to sort out the many AIDS issues presented to you this session.

Sincerely,

E Leahy

Ellen Leahy
Health Officer

cc Representative Howard Toole

301 W. ALDER MISSOULA, MT 59802 (406) 721-5700

HOUSE BILL NO. 895

INTRODUCED BY _____

BY REQUEST OF THE DEPARTMENT

OF HEALTH AND ENVIRONMENTAL SCIENCES

A BILL FOR AN ACT ENTITLED: "AN ACT TO GENERALLY REVISE THE LAWS RELATING TO REGISTRATION OF DEATH CERTIFICATES AND THE REMOVAL OF DEAD BODIES; AND REPEALING SECTIONS 50-15-401, ~~50-15-402,~~ 50-15-403, 50-15-404, AND 50-15-405, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1.** **Authorization for removal of a dead body from place of death.** (1) A dead body may be removed from the place of death by a funeral director or mortician licensed ~~by the board of morticians, provided for in 2-15-1853,~~ under 37-19-302 or other persons in charge of disposition of the dead body, only upon the ~~written~~ authorization of the physician in attendance at death or the coroner having jurisdiction when death is not medically attended. The ~~written~~ authorization must be made on a form prescribed by the department ~~and must, at a minimum, contain information regarding the name of the deceased and the name of the person to whom the body was released~~.

(2) The ~~written~~ authorization required in subsection (1) permits removal of a body from the place of death to another location ~~within the state only~~. One copy of the removal authorization must be mailed or delivered, within ~~24~~ 72 hours of the removal of the body, to the local registrar ~~of~~ in the registration area ~~in which~~ where the death occurred.

NEW SECTION. **Section 2.** **Death or fetal death certificate to be filed.** (1) The person in charge of disposition of the dead body shall obtain personal data required by the department from persons best qualified to supply the data and enter it on ~~the registration part of~~ the death or fetal death certificate. ~~The person in charge of disposition shall remove the clerk and recorder copy from the death certificate packet and file it with the clerk and recorder of the county in which the death occurred within 3 days of the date of death. The person shall mail to the local registrar for the registration area in which the death occurred a copy of the registration part of the death certificate within 48 hours of the date of death.~~

(2) The person in charge of disposition of the dead body shall present ~~the state copy of~~ the death certificate to the physician or coroner responsible for the medical certification of the cause of death. The person shall obtain the completed certification of the cause of death from the physician or coroner, and the person shall, within ~~20 days~~ the time prescribed by the department ~~of the date of death~~, file the completed ~~state~~ death or fetal death certificate with the local registrar ~~for~~ in the registration area ~~in which~~ where the death occurred.

~~(3) If it appears that the death resulted from other than natural causes, such as suicide or homicide, the person in charge of disposition of the body and the local registrar shall immediately notify the coroner who shall investigate and certify the cause of death.~~

NEW SECTION. **Section 3.** Notification and confirmation of final disposition. (1) Final disposition of a dead body is by:

(a) burial, entombment, or burial at sea;

(b) cremation; ~~or~~

(c) transportation out of the state~~, for burial or cremation~~; or

(d) anatomical donation.

(2) The person in charge of disposition shall provide information about the location and date of disposition required by the department on a form prescribed by the department. ~~This form must be signed and dated by:~~

~~(a) the person in charge of the location or cemetery where the body is interred;~~

~~(b) the owner or operator of the crematory where the body was cremated; or~~

~~(c) the person outside Montana who takes possession of the body for burial or cremation. One copy of this signed form must be mailed, within 24 hours of final disposition, to the local registrar of the registration area in which the death occurred.~~

~~(3) The person in charge of disposition requiring transportation of a body out of the state for any purposes shall obtain a written permit from the department prior to transporting the body across the state line. A copy of the permit must accompany the body to its out-of-state destination.~~

NEW SECTION. **Section 4.** Repealer. Sections 50-15-401, ~~50-15-402,~~ 50-15-403, 50-15-404, and 50-15-405, MCA, are repealed.

NEW SECTION. **Section 5.** Codification instruction. [Sections 1 through 3] are intended to be codified as an integral part of Title 50, chapter 15, part 4, and the provisions of Title 50, chapter 15, part 4, apply to [sections 1 through 3].

-End-

EXHIBIT 2
DATE 2-20-91
HB 895

EXHIBIT 21
DATE 2-20-91
HB 895

SUGGESTED AMENDMENTS TO HOUSE BILL 895 (introduced copy)

1. Title, line 9.
Following: line 8
Strike: "50-15-402,"

2. Page 1, line 12.
Following: "of"
Insert: "a dead"

3. Page 1, line 13.
Following: "A"
Insert: "dead"

4. Page 1, line 15.
Following: line 14
Strike: "by the board of morticians, provided for in 2-15-1853,"
Insert: "under 37-19-302"

5. Page 1, line 17.
Following: "upon the"
Strike: "written"

6. Page 1, line 19.
Following: "The"
Strike: "written"

7. Page 1, lines 20 through 23.
Following: "department"
Strike: remainder of lines 20 through 23 in their entirety

8. Page 1, line 24.
Following: "The"
Strike: "written"

9. Page 2, line 1.
Following: "location"
Strike: "within the state only"

10. Page 2, line 2.
Following: "mailed"
Insert: "or delivered"
Following: "within"
Strike: "24"
Insert: "72"

11. Page 2, line 3.
Following: "registrar"
Strike: "of"
Insert: "in

EXHIBIT 21
DATE 2-20-91
HB 895

12. Page 2, line 4.
Following: "area"
Strike: "in which"
Insert: "where"

13. Page 2, line 5.
Following: "Death"
Insert: "or fetal death"

14. Page 2, line 7.
Following: "data"
Insert: "on the deceased, or on the parents in the case of a fetal death,"

15. Page 2, line 9.
Following: line 8
Strike: "the registration part of"
Following: "death"
Insert: "fetal death"

16. Page 2, lines 9 through 16.
Following: "certificate."
Strike: remainder of lines 9 through 16 in their entirety

17. Page 2, line 18.
Following: "present"
Strike: "the state copy of"

18. Page 2, lines 22 and 23.
Following: "within"
Strike: "20 days of the date of death"
Insert: "the time frame prescribed by the department"

19. Page 2, line 23.
Following: "completed"
Strike: "state"
Following: "state death"
Insert: "or fetal death"

20. Page 2, line 24.
Following: "registrar"
Strike: "for"
Insert: "in"

21. Page 2, line 25.
Following: "area"
Strike: "in which"
Insert: "where"

22. Page 3, line 1 through line 5.
Strike: subsection (3) in its entirety

EXHIBIT 21
DATE 2-20-95
HB 895

23. Page 3, line 9.
Following: "burial"
Insert: "entombment, or burial at sea"

24. Page 3, line 10.
Following: "cremation;"
Strike: "or"

25. Page 3, lines 11 and 12.
Following: "state"
Strike: "for burial or cremation."

26. Page 3, line 12.
Following: "cremation."
Insert: ";or (d) anatomical donation."

27. Page 3, line 16, through page 4, line 6.
Following: "department." on line 16.
Strike: remainder of line 16 through "destination." on page 4, line 6

28. Page 4, line 8.
Following: line 7
Strike: "50-15-402,"

22
DATE 2-20-91
HB 681

HB BILL NO. 681

INTRODUCED BY: Tim Rice

A BILL FOR AN ACT ENTITLED: "AN ACT TO REVISE THE LAWS RELATING TO RESIDENTIAL TREATMENT FACILITIES"; TO REDEFINE "RESIDENTIAL TREATMENT FACILITY"; TO DEFINE "RESIDENTIAL PSYCHIATRIC CARE"; TO ALLOW MEDICAID REIMBURSEMENT FOR INPATIENT PSYCHIATRIC SERVICES FOR PERSONS UNDER 21 YEARS OF AGE IN A RESIDENTIAL TREATMENT FACILITY; AMENDING SECTIONS 50-5-101, 50-5-301 AND 53-6-101, MCA; AND REPEALING SECTIONS 50-5-316 AND 50-5-317; PROVIDING FOR COORDINATION INSTRUCTION; AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

SECTION 1: Section 50-5-101, MCA, is amended to read:

(31) "Residential treatment facility" means a facility of ~~not-less-than-30-beds-that-is-operated-by-a-nonprofit-corporation or-association~~ operated for the primary purpose of providing ~~long-term treatment-services~~ residential psychiatric care ~~for mental-illness~~ to persons under 21 years of age ~~in-a-non-hospital based-residential-setting-to-persons-under-21-years-of-age.~~

(32) "Residential psychiatric care" means active psychiatric treatment provided in a residential treatment facility, to psychiatrically impaired individuals with persistent patterns of emotional, psychological or behavioral dysfunction of such severity to require twenty-four hour supervised care to adequately treat or remediate his condition. Residential psychiatric care must be individualized, and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

~~(32)~~ (33) "State health plan" means the plan prepared by the department to project the need for health care facilities within Montana and approved by the statewide health coordinating council and the governor.

SECTION 2: Section 50-5-301, MCA, is amended to read:

(3) For the 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, residential treatment facility as defined in 50-5-101, 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) (j).

SECTION 2: Section 50-5-316, MCA, is amended to read:

50-5-316. Certificate of need for residential treatment facility. After October 1, 1991, a ~~A~~ person may not operate a residential treatment facility unless he has obtained a certificate of need issued by the department as provided under this part.

SECTION 3: Section 50-5-317, MCA, is hereby repealed.

SECTION 4: Section 53-6-101, MCA, is amended to read:

(3) (n) inpatient psychiatric services for persons under 21 years of age, as provided in 42 U.S.C. 1396d(h), in a residential treatment facility as defined in 50-5-101; and that is licensed in accordance with 50-5-201.

~~(n)~~ (o) any additional medical services or aid allowable under or provided by the federal social security act.

NEW SECTION. Section 5. Coordination instruction. If HB 445 does not pass or is not approved, [Section 2] is void, and the repeal of 50-5-316 in [Section 3] is void.

NEW SECTION. Section 6. Effective Date. [This Act] is effective July 1, 1991.

-End-

MHA MONTANA HOSPITAL ASSOCIATION

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P.O. BOX 5119
HELENA, MT
59604
406) 442-1911
FAX 443-3894

EXHIBIT 23
DATE 2-20-91
HB 681

Testimony of

Montana Hospital Association

House Bill 681

The Montana Hospital Association supports House Bill 681. House Bill 681 removes artificial barriers to the development of residential treatment facilities within the State of Montana.

The development of alternative treatment programs is necessary to allow Montana companies to meet the mental health needs of children.

Hospitals could improve the effectiveness of inpatient hospital services for children through increased use of residential services. Many times a hospital's choices are to keep a child as an inpatient in the hospital, place the child back in a community or transfer the child to a program outside of Montana. These choices are not only reducing the effectiveness of children's services, they are more costly in the long run.

Since 1986 hospitals have been prepared to create residential programs. This effort has been artificially retarded first by limitations on the Medicaid program and then by statutory limitations on the number and type of providers who could be licensed to provide care.

House Bill 681 provides a reasonable opportunity for Montanans to develop programs beyond the single program currently available in Billings. The needs are clearly evident; the Departments of Family Services and SRS both support the creation of alternative treatments to hospital care. Certificate of Need will serve to restrict the size and number of facilities created and their location.

MHA urges your support of House Bill 681.

24
2-20-91
681

DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES

STAN STEPHENS
GOVERNOR

JULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210
(406) 444-5622
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TESTIMONY OF THE DEPARTMENT OF SOCIAL AND REHABILITATION SERVICES BEFORE THE HOUSE HUMAN SERVICES COMMITTEE (Re: HB 681 - Residential Treatment Facilities)

Representative Jim Rice has introduced House Bill #681. The bill revises the law relating to residential treatment facilities. Representative Dorothy Bradley, in conjunction with the departments of Family Services and Social and Rehabilitation Services are contemplating a separate bill to be introduced at the request of the House Appropriations Committee to address residential treatment facilities.

Mr. Tom Olsen, director, of the Department of Family Services, and I recognize the need for additional residential treatment services in Montana. Removal of certain limitations in the current law will work toward addressing that need. These include removal of the requirements to be non-profit, hospital-based, and under 30 beds. In this respect HB 681 is a step in the right direction. Certain controls are necessary, however, to insure that facilities are not built if they are not needed. Otherwise, health care costs in this area will escalate. The need for review and control of program growth through a certificate of need process should be addressed.

Based on information available, it appears that both Shodair Hospital and Rivendell of Billings would be interested and able to meet the requirements of HB 681 almost immediately. It is estimated that an additional 38 total beds could be added by these two facilities. We estimate that this expansion will be approximately $290,000 in general funds for each year of the biennium. Several other facilities may also wish to convert or add residential beds. These include St. Peter's Hospital (Helena), St. Patrick Hospital (Missoula), Rivendell of Butte, and Intermountain Deaconess (Helena).

Submitted by: Julia E. Robinson

Julia E. Robinson, Director
Department of Social and
Rehabilitation Services

EXHIBIT 25
DATE 2-20-91
HB 785

HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE

ROLL CALL VOTE

DATE 2-20-91 **BILL NO.** HB 785 **NUMBER** 1

MOTION: Rep. Messmore's DO Pass.

NAME	AYE	NO
REP. TIM WHALEN, VICE-CHAIRMAN		✓
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		✓
REP. ANGELA RUSSELL, CHAIR	✓	
TOTAL	13	7

EXHIBIT 26
DATE 2-20-91
HB 355

HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE

ROLL CALL VOTE

DATE 2-20-91 **BILL NO.** HB 355 **NUMBER** 1

MOTION: Rep. Whalen's To Bring HB355 off the Table.

NAME	AYE	NO
REP. TIM WHALEN, VICE-CHAIRMAN	✓	
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		✓
REP. ANGELA RUSSELL, CHAIR	✓	
TOTAL	12	8

27
2-20-91
HB 355

Amendments to House Bill No. 355
First Reading Copy

Requested by Rep. Sheila Rice

For the Committee on the Human Services and Aging

Prepared by David S. Niss
February 6, 1991

1. Title, lines 7 and 8.
Strike: "PROVIDING SEPARATE MINIMUM AMOUNTS FOR ADULTS AND MINORS;"

2. Title, line 9.
Strike: "REQUIRING AN"

3. Title, lines 10 and 11.
Strike: all of lines 10 and 11
Insert: "PROHIBITING AN INSURER FROM REFUSING TO PAY FOR BENEFITS MANDATED BY LAW;"

4. Page 2, lines 20 and 21.
Strike: "$8,000 for an adult and $10,000 for a minor"
Insert: "$7,000"

5. Page 2, lines 22 and 23.
Strike: "$16,000 for an adult and $20,000 for a minor"
Insert: "$14,000"

6. Page 4, lines 1 and 2.
Strike: "$8,000 for an adult and $10,000 for a minor"
Insert: "$7,000"

7. Page 4, lines 3 and 4.
Strike: "$16,000 for an adult and $20,000 for a minor"
Insert: "$14,000"

8. Page 4, lines 15 through 19.
Following: "(3)"
Strike: the remainder of line 15 and all of lines 16 through 19
Insert: "An insurer, health service corporation, or an employees' health and welfare fund that provides accident and health insurance benefits to residents of the state under group health insurance or group health plans may not refuse to pay for, and thus effectively limit, a type of care or treatment when benefits are mandated under this part."

EXHIBIT 28
DATE 2-20-91
HB 355

HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE

ROLL CALL VOTE

DATE 2-20-91 **BILL NO.** HB 355 **NUMBER** 3

MOTION: Rep. Boharski's Substitute Motion to Table HB 355.

NAME	AYE	NO
REP. TIM WHALEN, VICE-CHAIRMAN		✓
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	✓	
REP. ANGELA RUSSELL, CHAIR		✓
TOTAL	8	12

EXHIBIT 24
DATE 2-20-91
HB 355

HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE

ROLL CALL VOTE

DATE 2-20-91 **BILL NO.** HB355 **NUMBER** 3

MOTION: Rep. Whalen's amendments

NAME	AYE	NO
REP. TIM WHALEN, VICE-CHAIRMAN	✓	
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	✓	
REP. ANGELA RUSSELL, CHAIR	✓	
TOTAL	16	4

EXHIBIT 30
DATE 2-20-91
HB 355

HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE

ROLL CALL VOTE

DATE 2-20-91 **BILL NO.** HB 355 **NUMBER** 4

MOTION: Rep. Whalen's DO Pass As Amended.

NAME	AYE	NO
REP. TIM WHALEN, VICE-CHAIRMAN	✓	
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		✓
REP. ANGELA RUSSELL, CHAIR	✓	
TOTAL	12	8

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 620

DATE 2-20-91 SPONSOR(S) Rep. Caroline Squires

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
RICH LUNDY 4901 COUNTRY VIEW DR. BILLINGS	MONTANA SOCIETY FOR RESPIRATORY CARE	✓	
Dave Bunkers Billings, MT	MT Society for Respiratory Care	✓	
MIKE ZWICKER BILLINGS, MT	MT Society for Respiratory Care	✓	
WALTER FAIRFAX, MD BILLINGS MT	~~STAFF~~ MSRC	✓	
Thomas Chapman Great Falls	MT Society for Respiratory Care	✓	
Michael Rigali Saeley Lake MT.	MSRC	✓	
Earl Thoman	AMERICAN LUNG ASSN OF MONTANA	✓	
Mary McCue	Mt Soc for RespCare	✓	

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

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 627

DATE 2-20-91 SPONSOR(S) Rep. Jim Elliott

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Lenore F. TALIAFERRO 1026 9th, Helena	Self	✓	
Doug Blakley	St Ombudsman Program	✓	
Dione Lutke	Area Agency Dir's Assn	✓	
Mac McDougle	AREA Ag III	✓	
LoLa McDougle	OMBUDSMAN - Area 6	✓	

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 604

DATE 2-20-91 SPONSOR(S) Rep. J. Brown

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Sam Sperry	Dept. of Health			X

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 640

DATE 2-20-91 SPONSOR(S) Rep. J. Brown

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Sam Sperry	Dept. of Health			x
Scott Crichton	NCLU		✓	

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 642

DATE 2-20-91 SPONSOR(S) Rep. Vicki Cocchiarella

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Boyce Fowler	D. Family Services	642		
Mike Burpee	parents	HB 642		X
Cheryl Burpee	parents	HB 642		X
Kate Cholewa	MT Womens Lobby			X
Kathi Campbell	MABC alliance for Better Child Care	HB 642		X
Ann Gilkey	DFS	642		X

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 700

DATE 2-20-91 SPONSOR(S) Rep. T. Nelson

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Pat Melby	Rimrock Foundation	✓	
Penzel C Davis	DHES.		
Rose Hughes	MT. Health Care Assn	✓	

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB917

DATE 2-20-91 SPONSOR(S) Rep. Howard Took

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Judith Gedrose	MT Dept of Hlth + Environ Sciences	✓	
Tom Hopgood	Hlth Ins Assoc Amer	✓	
[illegible]	Mt. Aids Advisory Council	✓	
Mary Beth Frideres	Lewis and Clark City/County Health Dept.	✓	
Greg Oliver	Missoula City-County Health Dept.	✓	
Patrick Driscoll	American Council of Life Insurance	✓	
[illegible] Fremont-Smith M.D.	Self	✓	
[illegible]	Mt. Med Assn	✓	
Larry Akey	MT Assoc of Life Underwriters		
Judy Williams	Self		
[illegible]	MT Nurses Assoc	✓	
Scott Crichton	ACLU	✓	
Edward L Flies	MT State Council of Professional Fire Fighters	✓	
Vern Erickson	MT State Firemans Association	✓	

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 895

DATE 2-20-91 SPONSOR(S) Rep. U. Brown

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Ray Hoffman	Dept of Health	895		✓

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HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 681

DATE 2-20-91 SPONSOR(S) Rep. Jim Rice

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
GLENN McFARLANE	YELLOWSTONE TREATMENT CTR MT. RESIDENTIAL CHILD CARE ASSOC	X	
~~Sheryl Bumpus~~ ERROR CB	~~parents of~~ preschool age ch. ildren	~~X~~	
~~Mike Bumpus~~ ERROR CB	~~parents~~ preschool age children	~~X~~	
Pat Melby	Yellowstone Treatment Ctr	✓	
Tom Martello	Shodair	✓	
Jack Casey	Shodair	✓	
Robert Olsen	MT Hospital Assoc.	✓	
Russ Cater	SRS		Partial ✓ Opposition
J. Shontz	Mental Health Div of MHA	[redacted]	[redacted]
Ann Gilkey	DFS		X
Tom Hannon	Shodair	X	

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HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 785

DATE 2-20-91 SPONSOR(S) Rep. Char Messmore

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Tanya Ask	BlueCross Blue Shield	HB 785		✓
Dave Barnhill	Insurance dept		✓	
DALE TALIAFERRO	Dept. of Health			✓
LARRY AKEY	MT ASSOC OF LIFE UNDERWRITERS			✓

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