

MINUTES

MONTANA HOUSE OF REPRESENTATIVES 52nd LEGISLATURE - REGULAR SESSION

COMMITTEE ON HUMAN SERVICES & AGING

Call to Order: By Rep. Angela Russell, Chair, on February 22, 1991, at 3:00 p.m.

ROLL CALL

Members Present:

Angela Russell, Chair (D)
Tim Whalen, Vice-Chairman (D)
Arlene Becker (D)
William Boharski (R)
Jan Brown (D)
Brent Cromley (D)
Tim Dowell (D)
Patrick Galvin (D)
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)

Members Excused: Stella Jean Hansen

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 831

Presentation and Opening Statement by Sponsor:

REP. JAN BROWN, House District 46, Helena, stated that this bill was requested by the Department of Institutions (DOI). This bill merely allows DOI to adopt the standards governing the approval of chemical dependency treatment programs.

Proponents' Testimony:

Darryl Bruno, Department of Institutions, submitted written testimony. EXHIBIT 1

Mona Jameson, self, stated that Title 53, Chapter 24 actually

requires a county to develop a chemical dependency plan. In that plan, the county is suppose to focus on the need for approved programs. The county may determine that if there are no programs, one program is needed, or if there is one existing approved program perhaps there should be two based on public participation at the county level and social service agencies that deal with chemical dependency treatment. Should we have a plan or should we have more than one approved program. The statute, currently, does not clearly allow DOI to adopt rules which address their reliance upon the county plan when determining whether or not programs should be approved. This clarity is significant, without it, it suggests that the county could actually go through this planning process, spend the money, have public hearings, and make the determination of that need may exist for an additional program. Yet, DOI is not clearly authorized in the law to rely on what is in that county plan when someone submits an application for a program.

Mike Rupert, President, Chemical Dependency Program of Montana, Executive Director, Boyd Andrew Chemical Dependency Center, stated that they fully support this bill.

Fred Fischer, Department of Justice, stated that he supports this bill.

Opponents' Testimony: None

Questions From Committee Members:

REP. BOHARSKI asked what is the intent on page 4, subsection 4. Mr. Bruno stated that we want DOI to be able to use the plans in determining the needs of counties for the treatment, rehabilitation, and prevention of chemical dependency.

REP. BECKER asked if the these programs are included in the CON law. Mr. Bruno stated that there are 34 state approved programs in the Montana. There are 12 programs that are in-patient programs providing in-patient services. All in-patient programs must go through the CON process before they can be approved by DOI. The programs on an out-patient basis are normally one or two per area.

Closing by Sponsor: REP. BROWN closed on the bill.

EXECUTIVE ACTION ON HB 831

Motion/Vote: REP. BROWN MOVED HB 831 DO PASS. Motion carried 19-1 with REP. BOHARSKI voting no.

HEARING ON HB 890

Presentation and Opening Statement by Sponsor:

REP. SHEILA RICE, House District 36, Great Falls, stated that she

intends to table this bill because they worked out an agreement with the Department of Family Services.

Proponents' Testimony: None

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: REP. S. RICE closed on the bill.

EXECUTIVE ACTION ON HB 890

Motion/Vote: REP. WHALEN MOVED HB 890 BE TABLED. Motion carried unanimously.

HEARING ON HB 927

Presentation and Opening Statement by Sponsor:

REP. DAN HARRINGTON, House District 68, Butte, stated that the intent of HB 927 is to add a vocational specialist to the medical professions as a team of determining employability to some extent already being done. He submitted amendments. EXHIBIT 2

Proponents' Testimony:

John Ortwein, Montana Catholic Conference, stated that HB 927 addresses the need for those who are attempting to become productive members of society that have not yet overcome firmness in the work place, by extending the timelines to allow individuals to complete training programs in alcohol and drug dependency programs. These individuals will become contributors to society instead of depending upon society.

Harley Warner, Montana Association of Churches (MAC), stated that MAC recommends that social services be added to meet the growing needs of the people of Montana in order to assist them in breaking out of the cycle of poverty. Vocational specialists, as well as other provisions of this bill, will help insure that some of the disadvantaged individuals of Montana have an opportunity to overcome their bare need of employment.

Marcia Schreder, Montanans for Social Justice and Montana Low Income Coalition, stated that they support HB 927. It is vital that the acceptance goes to recipients eligible to receive benefits in the first month and not in the last month. This gives them additional time while they are getting treatment to get their barriers dealt with.

Stanley Colenso, MUC & Butte Community Union, stated that they support HB 927.

Opponents' Testimony:

Norman Waterman, Administrator, Family Assistance Division,
Department of Social and Rehabilitation Services, submitted
written testimony. EXHIBIT

Questions From Committee Members:

REP. SQUIRES asked if the individual is found to have a barrier, such as drug and alcohol abuse in the third month on the four month program and when the problem is diagnosed and that person makes the application to Galen and they are told there is a months waiting list, then the patient is moved into the institution for the 28 day training period, does the clock stop at that particular time because of the inability to function due to his barrier to employment. Mr. Waterman stated that in the third month if a person is found to have an alcohol problem and is willing to participate, then assistance will continue at the time those 30 days later that he entered the institution. General relief would stop.

REP. JOHNSON asked what the definition of "vocational specialist" is. Mr. Waterman stated that the definition is on page 4 of the bill.

Closing by Sponsor:

REP. HARRINGTON stated that a vocational specialist works with the person to try to get them a job. They can recognize this before medical people can. The medical people do not work with these people everyday and do not see the problems that they are faced with.

EXECUTIVE ACTION ON HB 927

Motion: REP. DOWELL MOVED HB 927 DO PASS.

Motion/Vote: REP. BROWN moved to amend HB 927. EXHIBIT 2.
Motion carried unanimously.

Motion/Vote: REP. BROWN MOVED HB 927 DO PASS AS AMENDED. Motion carried 18-2 with REPS. KASTEN and SPRING voting no.

HEARING ON HB 876

Presentation and Opening Statement by Sponsor:

REP. DIANA WYATT, House District 37, Great Falls, stated that the MIAMI project is the Montana Initiative for the Abatement of Mortality in Infants. This bill would sunset without the Governor authorizing continuation. In the extreme successes with this bill and the money allowed by the Legislature, it has been impacting in terms of the economic success of this program and the use of funds. We are also allowing for an increase for the board members.

Proponents' Testimony:

JoAnn Dotson, Program Manager, Montana Perinatal Program, Department of Health and Environmental Sciences, submitted written testimony. EXHIBIT 4 & 5

Don Espelin, President, Board of Healthy Mothers, Healthy Babies, submitted written testimony. EXHIBIT 6

D. Elizabeth Roeth, Chair, Montana Children's Alliance, submitted written testimony. EXHIBIT 7 & 8

Ellen Leahy, Health Officer, Missoula City-County Health Department, submitted written testimony. EXHIBIT 9

Bob Johnson, Montana Public Health Association (MPHA), stated that MPHA has reviewed the MIAMI project concept and in the past legislative sessions has strongly supported this. The MIAMI project has been a success.

Cathy Caniparoli, Montana Nurses Association, Montana Nursing Practitioner State Interest Group, stated that she strongly supports the continuation of the MIAMI project.

Bud Solmonson, Executive Director, Montana Council for Families, stated that they are a state chapter for the national committee on prevention of child abuse and parents anonymous. They are in the business of dealing with child abuse, which is in direct coalition of Healthy Families and Healthy Babies.

John Ortwein, Montana Catholic Conference, submitted written testimony. EXHIBIT 10

Jim Arhens, President, Montana Hospital Association, (MHA), stated that MHA strongly supports this bill.

Gene Huntington, Montana Diabetic Association (MDA), stated that MDA supports this bill.

Judy Garrity, submitted written testimony for Marietta Cross, Chair, Advisory Council for MIAMI project. EXHIBIT 11

Lu Drussen, Lewis and Clark City-County Health Department, submitted written testimony. EXHIBIT 12

Joan Bowsher, Healthy Mothers Healthy Babies, Helena Area Coalition, submitted written testimony. EXHIBIT 13

Paulette Kohman, Executive Director, Montana Council for Maternal and Child Health, submitted written testimony for herself and for the March of Dimes Birth Defects Foundation. EXHIBIT 14 & 15

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: REP. WYATT closed on HB 876.

EXECUTIVE ACTION ON HB 876

Motion: REP. JOHNSON MOVED HB 876 DO PASS.

Discussion:

REP. MESSMORE stated that is in favor of this bill.

Motion: REP. KASTEN moved to amend HB 876.

Strike: "\$135"

Insert: "\$185"

Discussion:

REP. BECKER stated that she opposes the motion. If the committee passes this, it will go to the Appropriations Committee and they will adjust the amount anyway. By increasing the amount of money these people get, improve the outcome.

Vote: Motion failed 13-7 with REPS. JOHNSON, KASTEN, LEE, J. RICE, SPRING, and TUNBY voting aye.

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

HEARING ON HB 835

Presentation and Opening Statement by Sponsor:

REP. DICK KNOX, House District 29, Winifred, stated that this is an act including the definition of health care provider for the purposes of the Uniform Health Care Information Act. The purpose of the bill is to add the pharmacies and durable medical equipment suppliers to the definition of health care provider.

Proponents' Testimony:

Bill Jensen, Blue Cross Blue Shield (BCBS), stated that this bill will add pharmacies to the medical equipment suppliers and to the listed health care providers who are subject to the Health Care Information Act.

Bonnie Tippy, Montana State Pharmaceutical Association, stated that there has been some confusion on the part of pharmacists whether they should disclose information or not disclose information.

Opponents' Testimony: None

Questions From Committee Members:

REP. WHALEN asked if by putting this information under the Montana Health Care Information Act, will it be more difficult to have access. Mr. Jensen stated that at the present time, the pharmacies are unable to release the information to us without the members consent, unless they are designated health care providers. The amendment would add them to the list of health care providers to be covered under the uniform act.

Closing by Sponsor: REP. KNOX closed on HB 835.

EXECUTIVE ACTION ON HB 835

Motion: REP. JOHNSON MOVED HB 835 DO PASS AS AMENDED.

Discussion:

REP. J. RICE stated that pharmacies are now seeking the position that because these standards are in the law, they feel that these standards will release information to prohibition against the release of information, which applies to them in a common law lawsuit situation.

REP. WHALEN stated that is what the pharmacists are saying, but they haven't articulated any basis upon which they make that stand. They don't have any right to release that information.

Motion/Vote: REP. WHALEN MADE A SUBSTITUTE MOTION THAT HB 835 BE TABLED. Motion carried 10-9 with REPS. BOHARSKI, CROMLEY, JOHNSON, KASTEN, LEE, MESSMORE, J. RICE, and TUNBY voting no.

HEARING ON HB 881

Presentation and Opening Statement by Sponsor:

REP. ROYAL JOHNSON, House District 88, Billings, stated that throughout the past 14 months, the emergency medical technicians (EMTs) have been working with the Board of Medical Examiners to clarify the rules of what their scope of practices should be and how they will be handled. This bill attempts to allow the Board of Medical Examiners, under whom these people are licensed, can go ahead and make sure that these people have coverage for the scope of practice. Coverage under the rules that they have made up in conjunction with EMTs.

Proponents' Testimony:

Drew Dawson, Chief, Emergency Medical Services Bureau, Department of Health and Environmental Sciences, submitted written testimony. EXHIBIT 16

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor:

REP. JOHNSON stated that it is more realistic to deal with these conflicts in medical issues by administrative rule than by statutes.

EXECUTIVE ACTION ON HB 881

Motion/Vote: REP. JOHNSON MOVED HB 881 DO PASS AND BE PLACED ON THE CONSENT CALENDAR. Motion carried unanimously.

HEARING ON HB 930

Presentation and Opening Statement by Sponsor:

REP. TIMOTHY WHALEN, House District 93, Billings, stated that this bill incorporates into Montana law the essential elements of the law that was adopted by Congress for establishing the protection and advocacy of mentally ill persons.

Proponents' Testimony:

Mary Gallagher, Staff Attorney, Protection & Advocacy for Mentally Ill Individuals/Board of Visitors, submitted written testimony. EXHIBIT 17

Kelly Moorse, Director, Board of Visitors, stated that since 1975, they have had a patients rights section in the Mental Commitment and Treatment Act. Approximately four years ago this committee incorporated similar legislation when the federal nursing home bill of rights was incorporated into our state law. HB 930 does much the same. Passage of this bill will make Montana law consistent with the federal legislation.

Chris Bakula, Executive Director, Montana Advocacy Program, Inc., submitted written testimony. EXHIBIT 18

John Shontz, Mental Health Association of Montana, stated that in the national headquarters for the Mental Health Association, there is a big bell that is made out of iron that was forged from shackles and chains that held people in mental health institutions all over this country. This bill removes the last vested use of visible shackles that does not infringe professionals choice in terms of delivery of care, but it does allow people who are receiving the care to participate in the management of their treatment programs.

Marty Onishuk, Montana Association of Mentally Ill, she reiterated previous testimony.

Paul Meyer, Western Region Community Mental Health Council, stood in support of HB 930.

Jim Smith, Montana Association of Rehabilitation Facilities,

stated this is a great bill.

Dan Anderson, Administrator, Mental Health Division, Department of Institutions, stood in support of HB 930.

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: REP. WHALEN closed on HB 930.

EXECUTIVE ACTION ON HB 930

Motion: REP. WHALEN MOVED HB 930 DO PASS AND BE PLACED ON THE CONSENT CALENDAR.

Discussion:

REP. KASTEN asked what is the cost for this. REP. WHALEN stated that there won't be any cost. The Board of Visitors is already going to these institutions.

Vote: Motion carried unanimously.

HEARING ON HB 862

Presentation and Opening Statement by Sponsor:

REP. DOROTHY BRADLEY, House District 79, Bozeman, stated that this is necessary when less restrictive services are unavailable or inadequate. Under the current law, the language that is stricken from the bill states that a professional person certifies a mental disorder and then that professional person gets confirmation in the second stage the community mental health person that appropriate services are not available. The problem is that we have 6,000 professional persons that can do that. In this whole process there is no consultation that takes place with Montana State Hospital individuals. It is not a good system. The screening that we would like to take place should be clinically appropriate and there should be more knowledge funneled into the screening process from individuals who are very familiar with the role of the hospital and with exactly what is available to help community based services.

Proponents' Testimony:

Dan Anderson, Administrator, Mental Health Division, Department of Institutions, submitted written testimony. EXHIBIT 19

John Lynn, Director, Community Support Services for Western Montana Region Community Health Center, stated that over the last ten years he has seen community health centers develop programs increasing the capability of serving individuals with a serious mental illness in a community. There is clearly a lack of

coordination of professionals admitting individuals to the state hospital. The result is often expensive and is unnecessary hospitalization. This can add to the disruption and isolation already experienced by individual's crises. HB 862 will not restrict individuals right for treatment, it will ensure treatment in the least restrictive environment and closest to the individuals home. This bill will not close the doors to Warm Springs, but it will ensure that those individuals who pass through the doors are individuals whose needs cannot be met in a community center.

Don Harr, Medical Director, Regency Mental Health Center, stated that he commends this bill. Because of the restrictions that individuals aren't being admitted to the hospital, there are fiscal savings in that.

Paul Meyer, State Council of Mental Health Centers, stated that all five health centers in Montana agree that this bill is a sensible approach to making sense out of the law that exists now.

Marty Onashuk, Montana Alliance for the Mentally Ill, submitted written testimony. EXHIBIT 20

Kelly Moorse, Board of Visitors, stated that the statistics provided by the intake unit of the state hospital showed last fiscal year that 20% of the admissions were identified as inappropriate. This number of unappropriated admissions means that valuable staff time and treatment is taken away from those who are the most ill.

John Shontz, Montana Health Association of Montana, stated that they support HB 862.

John McCrae, Protection Advocacy Program for the Mentally Ill, reiterated previous testimony.

Kristin Bakula, Executive Director, Montana Advocacy Program, Inc., submitted written testimony. EXHIBIT 21

Opponents' Testimony: None

Questions From Committee Members:

REP. MESSMORE asked why do 20% of the population admit themselves and be considered inappropriate coordination. **Mr. Anderson** said some people come to the state hospital for inappropriate reasons, they have other kinds of problems besides serious mental illness. We were written up a couple of years ago in the National Journal about homeless people who seek shelter in winter in the Montana State Hospital. There are people who do have mental health problems who come to the State Hospital who don't really understand what other services are available in the community. They are people that need care, but not that level of care.

REP. RUSSELL asked if the 20% inappropriate admissions is changing. Ms. Moorse stated that the hospital feels that with the use of the voluntary screening committee that we can continue to reduce that. Two pilot programs have been established within the state to help address those that are in the community.

Closing by Sponsor: REP. BRADLEY closed on HB 862.

EXECUTIVE ACTION ON HB 862

Motion: REP. LEE MOVED HB 862 DO PASS.

Discussion:

REP. WHALEN stated that this bill gives DOI more rulemaking authority. Mr. Anderson stated that there is currently a screening process for voluntary persons at the state hospital, however, the screening process is a two stage process which begins with any professional person in the state. A professional person includes every doctor in the state and those people that are certified by DOI.

Vote: Motion carried 12-8 with REPS. RUSSELL, WHALEN, BECKER, DOWELL, GALVIN, S. RICE, SQUIRES, and STRIZICH voting no.

HEARING ON HB 909

Presentation and Opening Statement by Sponsor:

REP. DAVE BROWN, House District 72, Butte, stated that we are dealing with people who have a disease, illness, and sickness that needs to be treated. We need to establish a base criteria for chemical dependency counseling. This bill sets up a study in the Department of Institutions where it will be handled. The rules will eventually be coming to DOI. This will ask DOI to come back next legislative session and say these are the minimum rules we ought to have in the state and here is the recommendation after the statute next time in that regard.

Proponents' Testimony:

Darryl Bruno, Department of Institutions (DOI), submitted written testimony and amendments. EXHIBITS 22 & 23

Norma Jean Boles, Department of Institutions (DOI), stated that she develops the standards of supervised evaluations education. The minimum requirements are essential to the professionalism of the chemical dependency treatment field. The CDC system has evolved since 1980 and has grown as a profession. We have continuously attempted to upgrade this system by rule revision, however rule revision has a limit. The chemical dependency treatment program is statewide and can easily implement post statutes without negative impact to the grandfather clause. Given the current requirements, many persons desire this

credential. The testing procedure is confidently on that the successful completion of all three exams. Inappropriate applicants are not being certified as they cannot pass the exams, however, they are impacting work loads. Since July 1, 1989, 250 individuals have registered for certification. The Alcohol and Drug Abuse Division feels this bill will enhance quality of chemical dependency treatment services in Montana.

Frank Fisher, Prevention Coordinator, Department of Justice, Chemical Dependency Counselor, stated that he is in support of the minimum standards that are suggested in this legislation.

Mike Males, Chemical Dependency Programs of Montana, submitted written testimony. EXHIBIT 24

Larry Akey, Gaming Industry Association of Montana, stated that for some of the population, recreational gaming becomes more than entertainment. As an industry, we recognize that we have more of a responsibility for dealing with that. The Gaming Advisory Council spent a significant amount of time on the issue of problem gambling.

Ann Bellwood, Rocky Mountain Treatment Center, stated that they are accredited by JCHO for substance abuse and psychiatric disorder addictions such as gambling and eating disorders. They support this bill. Many of their patients that are chemically dependant are also gambling addictive.

Opponents' Testimony: None

Questions From Committee Members:

REP. RUSSELL asked how many certified chemical dependency counselors are there in Montana. Ms. Bellwood said we have 587.

Closing by Sponsor:

REP. BROWN closed on HB 909.

EXECUTIVE ACTION ON HB 909

Motion: REP. LEE MOVED HB 909 DO PASS.

Motion/Vote: REP. CROMLEY moved to amend HB 909. Motion carried unanimously.

Page 1, line 25.
Following: "has"
Insert: ": (i)"

Page 2, line 3.
Strike: "(b) has"
Insert: "(ii)"

Page 2, line 7.
Strike: "(c)"
Insert: "(b)"

Vote: REP. LEE MOVED HB 909 DO PASS AS AMENDED. Motion carried 19-1 with REP. TUNBY voting no.

HEARING ON HB 948

Presentation and Opening Statement by Sponsor:

REP. ROYAL JOHNSON, House District 88, Billings, stated that this bill is an optional opportunity to establish a community coordinating mechanism for all responders to the needs of juveniles.

Proponents' Testimony:

Steve Nelson, Montana Board of Crime Control, stated that the confidentiality law are being intervened on the actual part of government. This particular law provides a tool that communities can use to provide the communication among agencies in order to serve use in order to communicate so that the youths can properly be served.

Harold Hancer, self, stated that this bill represents state of the art in where we need to be in dealing with the best interest of children who have problems and who come from dysfunctional families.

Ann Gilkey, Department of Family Services (DFS), stated that DFS supports HB 948. She submitted written amendments. EXHIBIT 25

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: REP. JOHNSON closed on HB 948.

EXECUTIVE ACTION ON HB 948

Motion: REP. CROMLEY MOVED HB 948 DO PASS.

Motion/Vote: REP. CROMLEY moved to amend HB 948. Refer to Committee Report. Motion carried unanimously.

Motion/Vote: REP. CROMLEY MOVED HB 948 DO PASS AS AMENDED AND BE PLACED ON THE CONSENT CALENDAR. Motion carried unanimously.

HEARING ON HJR 40

Presentation and Opening Statement by Sponsor:

REP. TIMOTHY WHALEN, House District 93, Billings, stated that

when Medicare is cut, it hurts the senior citizens who are having to take money out of their savings in order to pay for things to live. We need to send a message to Congress saying enough is enough.

Proponents' Testimony: None

Opponents' Testimony: None

Questions From Committee Members: None

Closing by Sponsor: REP. WHALEN closed on HJR 40.

EXECUTIVE ACTION ON HJR 40

Motion: REP. WHALEN MOVED HJR DO PASS AND BE PLACED ON THE CONSENT CALENDAR. Motion carried unanimously.

EXECUTIVE ACTION ON HB 761

Motion: REP. BECKER MOVED HB 761 DO PASS.

Motion: REP. BECKER moved to amend HB 761.

Title, line 4.
Strike: "REQUIRING"
Insert: "AUTHORIZING"

Title, line 6.
Following: "OFFENSE;"
Insert: "PROVIDING FOR COUNSELING OF THE CONVICTED
PERSON AND THE VICTIM;"

Title, line 6.
Strike: "IS ENTITLED TO"
Insert: "MUST"

Page 1, line 14.
Strike: "must"
Insert: "may"

Page 1, line 15.
Strike: "serological"

Page 1.
Following: line 21
Insert: "(3) If the results of the test authorized by
this section indicate that the convicted person
suffers from a sexually transmitted disease, the
county attorney of the county in which the person
was convicted shall arrange for posttest
counseling of the convicted person and of any
victim of the convicted person.
(4) The provisions of the AIDS Prevention Act do

not apply to [sections 1 through 3]."

Page 1, line 25.

Strike: "may"

Insert: "shall"

Page 2, lines 2 through 19

Following: line 1

Strike: lines 2 through 19

Insert: "(a) the health care provider who conducted the test, who shall release the test results to the convicted person and to any victim of the convicted person;
(b) the health officer to whom the department has required the reporting of communicable diseases under 50-1-2-2; and
(c) the defense counsel for the convicted person."

Page 2, line 22.

Strike: "or local board of health"

Page 3, lines 1 through 3.

Strike: "for" on line 1 through "or" on line 3

Page 3, line 3.

Following: "treatment"

Insert: "or prosecution or defense of the convicted person"

Page 3, line 6.

Strike: "authorized"

Insert: "required"

Vote: Motion carried unanimously.

Motion/Vote: REP. STICKNEY MOVED HB 761 DO PASS AS AMENDED.

Motion carried unanimously.

EXECUTIVE ACTION ON HB 780

Motion/Vote: REP. STICKNEY MOVED HB 780 BE TABLED. Motion carried unanimously.

EXECUTIVE ACTION ON HB 917

Motion: REP. STICKNEY MOVED HB 917 DO PASS.

Motion/Vote: REP. BECKER moved to amend HB 917. EXHIBIT 27.

Motion carried unanimously.

Motion/Vote: REP. J. RICE moved to amend HB 917. EXHIBIT 28.

Motion carried unanimously.

Motion/Vote: REP. J. RICE MOVED HB 917 DO PASS AS AMENDED.
Motion passed unanimously.

EXECUTIVE ACTION ON HB 281

Motion/Vote: REP. MOVED HB 281 BE TABLED. Motion carried unanimously.

EXECUTIVE ACTION ON HB 895

Motion: REP. BROWN MOVED HB 895 DO PASS.

Motion/Vote: REP. BROWN moved to amend HB 895. EXHIBIT 29.
Motion carried unanimously.

Motion/Vote: REP. BROWN MOVED HB 895 DO PASS AS AMENDED. Motion carried 19-1 with REP. CROMLEY voting no.

EXECUTIVE ACTION ON HB 681

Motion: REP. J. RICE MOVED HB 681 DO PASS.

Motion/Vote: REP. J. RICE moved to amend HB 681. EXHIBIT 30.
Motion carried unanimously.

Motion/Vote: REP. J. RICE MOVED HB 681 DO PASS AS AMENDED.
Motion carried 18-2 with REPS. BOHARSKI and KASTEN voting no.

EXECUTIVE ACTION ON HB 246

Motion/Vote: REP. BOHARSKI MOVED TO RECONSIDER ACTION ON HB 246 AND TAKE FROM THE TABLE. Motion carried 18-2 with REPS. DOWELL and GALVIN voting no.

Motion/Vote: REP. BOHARSKI moved to amend HB 246. Motion carried unanimously.

Motion/Vote: REP. BOHARSKI MOVED HB 246 BE TABLED. Motion carried unanimously.

ADJOURNMENT

Adjournment: 9:30 p.m.


ANGELA RUSSELL, Chair


Jeanne Krumm, Secretary

AR/jck

HOUSE OF REPRESENTATIVES
HUMAN SERVICES AND AGING COMMITTEE

ROLL CALL

DATE 2-22-91

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

CS05HUMSER.MAN

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 831 (first reading copy -- white) do
pass .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 927 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

and, that such amendments read:

1. Page 4, line 25.

Following: "means"

Strike: "a certified"

Insert: "an"

2. Page 5, line 1.

Following: "other"

Strike: "similar professional who is"

Insert: "experienced personnel who are"

3. Page 6, line 19.

Following: "department"

Insert: "or a vocational specialist as authorized by the
department"

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 876 (first reading copy -- white) do
pass .

Signed: _____
Angela Russell, Chairman

9 4-
2 13-4
10P

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 881 (first reading copy -- white) do
pass and be placed on consent calendar .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 930 (first reading copy -- white) do
pass and be placed on consent calendar .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Bill 862 (first reading copy -- white) do
pass .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 909 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Page 1, line 25.
Following: "has"
Insert: ": (i) "

2. Page 2, line 3.
Strike: "(b) has"
Insert: "(ii) "

3. Page 2, line 7.
Strike: "(c) "
Insert: "(b) "

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 2

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 946 (first reading copy -- white) do pass as amended and be placed on the consent calendar.

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 8.

Following: "CHILDREN"

Insert: ", AND YOUTH IN NEED OF SUPERVISION"

2. Page 1, line 14.

Strike: "contract"

Insert: "written agreement"

3. Page 1, line 19.

Following: "the"

Insert: "county"

4. Page 1, line 20.

Strike: "and"

5. Page 1, line 21.

Strike: "."

Insert: "; and"

6. Page 1.

Following: lin 21

Insert: "(g) the superintendents of public school districts."

7. Page 1, line 22.

Strike: "contract"

Insert: "written agreement"

February 23, 1901
Page 2 of 2

8. Page 1, line 24.
Strike: "contract"
Insert: "written agreement"

9. Page 2, line 13.
Strike: "contract"
Insert: "written agreement"

10. Page 2, line 14.
Strike: "contract"
Insert: "written agreement"

11. Page 2, lines 15 and 16.
Strike: "in" on line 15 through "maximum" on line 16

12. Page 2, line 16.
Strike: "of all types"

13. Page 2, line 20.
Following: "children"
Insert: ", and youth in need of supervision"

14. Page 2, line 24.
Strike: "contract"
Insert: "written agreement"

9/4
- 17-7
107

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 1

Mr. Speaker: We, the committee on Human Services and Aging
report that House Joint Resolution 40 (first reading copy --
white) do pass and be placed on consent calendar .

Signed: _____
Angela Russell, Chairman

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 2

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 761 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 4.
Strike: "REQUIRING"
Insert: "AUTHORIZING"

2. Title, line 6.
Following: "OFFENSE;"
Insert: "PROVIDING FOR COUNSELING OF THE CONVICTED PERSON AND THE VICTIM;"

3. Title, line 6.
Strike: "IS ENTITLED TO"
Insert: "MUST"

4. Page 1, line 14.
Strike: "must"
Insert: "may"

5. Page 1, line 15.
Strike: "serological"

6. Page 1.
Following: line 21
Insert: "(3) If the results of the test authorized by this section indicate that the convicted person suffers from a sexually transmitted disease, the county attorney of the county in which the person was convicted shall arrange for

posttest counseling of the convicted person and of any victim of the convicted person.

(4) The provisions of the AIDS Prevention Act do not apply to [sections 1 through 3]."

7. Page 1, line 25.

Strike: "may"

Insert: "shall"

8. Page 2, lines 2 through 19.

Following: line 1

Strike: lines 2 through 19

Insert: "(a) the health care provider who conducted the test, who shall release the test results to the convicted person and to any victim of the convicted person;

(b) the health officer to whom the department has required the reporting of communicable diseases under 50-1-202; and

(c) the defense counsel for the convicted person."

9. Page 2, line 22.

Strike: "or local board of health"

10. Page 3, lines 1 through 3.

Strike: "for" on line 1 through "or" on line 3

11. Page 3, line 3.

Following: "treatment"

Insert: "or prosecution or defense of the convicted person"

12. Page 3, line 6.

Strike: "authorized"

Insert: "required"

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 2

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 917 (first reading copy -- white) do pass as amended.

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 24.

Following: "REQUIRED;"

Insert: "PROVIDING FOR HIV TESTING OF PATIENTS POTENTIALLY
INFECTING HEALTH CARE FACILITY PERSONNEL OR EMERGENCY
RESPONDERS;"

2. Page 3, line 17.

Following: "transmission"

Insert: "in accordance with modes of transmission recognized by
the center for disease control of the United States public
health service"

3. Page 9, line 8.

Following: "~~department~~"

Insert: "at one of the counseling-testing sites established by
the department, or "

4. Page 10, lines 24 and 25.

Strike: "24 hours"

Insert: "a reasonable time"

5. Page 11.

Following: line 3

Insert: "(10)(a) If an agent or employee of a health care
facility, a health care provider with privileges at the
health care facility, or a first responder has been
voluntarily or involuntarily exposed to a patient in a
manner that may allow infection by HIV by a mode of
transmission recognized by the center for disease control of

the United States public health service, the physician of the patient shall, upon request of the exposed person, notify the patient of the exposure and seek written informed consent in accordance with guidelines of the center for disease control for an HIV-related test of the patient. If written informed consent cannot be obtained, the health care facility, in accordance with the infectious disease exposure guidelines of the health care facility, may, without the consent of the patient, conduct the test on previously drawn blood or previously collected bodily fluids to determine if the patient is in fact infected. A health care facility is not required to perform a test authorized in this subsection. If a test is conducted pursuant to this subsection, the health care facility shall inform the patient of the results and provide the patient with post-test counseling. The patient may not be charged for a test performed pursuant to this subsection. The results of a test performed pursuant to this subsection may not be made part of the patient's record and are subject to 50-16-1009(1).

(b) For the purposes of this subsection, written informed consent means an agreement in writing that is freely executed by the subject of an HIV-related test, by the subject's legal guardian, or if there is no legal guardian and the subject is incapacitated, by the subject's next-of-kin, significant other, or a person designated by the subject in hospital records to act on the subject's behalf.

Renumber: subsequent subsection

6. Page 16, line 20.

Strike: "person"

Insert: "contact as defined in 50-16-103"

7. Page 16, line 22.

Strike: "patient"

Insert: "contact"

8. Page 16.

Following: line 23

Insert: "NEW SECTION. Section 1. {standard} Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

Renumber: subsequent section

HOUSE STANDING COMMITTEE REPORT

February 23, 1991

Page 1 of 3

Mr. Speaker: We, the committee on Human Services and Aging report that House Bill 895 (first reading copy -- white) do pass as amended .

Signed: _____
Angela Russell, Chairman

And, that such amendments read:

1. Title, line 9.

Strike: "50-13-402,"

2. Page 1, line 12.

Following: "of"

Insert: "a dead"

3. Page 1, line 13.

Following: "A"

Insert: "dead"

4. Page 1, line 15.

Strike: "by the board of morticians, provided for in 2-15-1853,"

Insert: "under 37-19-302, or his agent,"

5. Page 1, line 17.

Following: "written"

Insert: "or oral"

Following: "authorization of"

Strike: "the"

Insert: "a"

6. Page 1, lines 17 through 19.

Strike: "in" on line 17 through "attended" on line 19

Insert: ", coronor, or mortician licensed under title 37"

7. Page 1, line 19.

Strike: "written"

8. Page 1, lines 20 through 23.

Following: "department"

Strike: remainder of lines 20 through "released" on line 23

9. Page 1, line 24.

Strike: "written"

10. Page 2, line 1.

Strike: "within the state only"

11. Page 2, line 2.

Following: "mailed"

Insert: "or delivered"

Strike: "24"

Insert: "72"

12. Page 2, line 3.

Following: "registrar"

Strike: "of"

Insert: "in"

13. Page 2, line 4.

Strike: "in which"

Insert: "where"

14. Page 2, line 5.

Following: "Death"

Insert: "or fetal death"

15. Page 2, line 7.

Following: "data"

Insert: "on the deceased, or on the parents in the case of a fetal death,"

16. Page 2, line 9.

Strike: "the registration part of"

Following: "death"

Insert: "or fetal death"

17. Page 2, lines 9 through 16.

Following: "certificate."

Strike: remainder of lines 9 through "death" on line 16

18. Page 2, line 18.

Strike: "the state copy of"

19. Page 2, lines 22 and 23.

Strike: "20 days of the date of death"

Insert: "the time frame prescribed by the department"

20. Page 2, line 23.

Strike: "state"

Following: "death"
Insert: "or fetal death"

21. Page 2, line 24.
Strike: "for"
Insert: "in"

22. Page 2, line 25.
Strike: "in which"
Insert: "where"

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

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

25. Page 3, line 10.
Strike: "or"

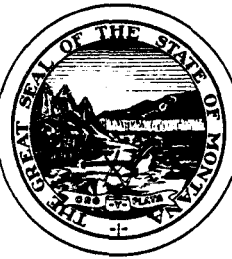
26. Page 3, lines 11 and 12.
following: "for burial or cremation"
Insert: "; or"

27. Page 3.
Following: line 12
Insert: "(d) anatomical donation"

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

29. Page 4, line 8.
Strike: "50-15-402,"

DEPARTMENT OF INSTITUTIONS

EXHIBIT 1DATE 2-22-91HB 831

STAN STEPHENS, GOVERNOR

1839 11TH AVENUE

STATE OF MONTANA

(406) 444-3930

HELENA, MONTANA 59620-1301

TESTIMONY FOR HB 831

The present statute is limiting as 53-24-208(1) states "The standards may concern only the health standards to be met and standards of treatment to be afforded patients." The Alcohol and Drug Abuse Division proposes the following: The standards shall be adopted by rule and may concern the health standards to be met and standards for the approval of treatment programs for patients.

This allows standards addressing administration\ organizational management, personnel/certification/staff development and client treatment addressing five components. These are necessary to the optimal functioning of a chemical dependency treatment program. Examples include personnel standards which address qualifications and certification of staff and administrative standards encompassing goals and objectives with required effectiveness indicators.

National accreditation organizations providing on site program inspections in hospitals and rehabilitation centers across Montana i.e. the Joint Commission on Accreditation of Hospitals (JCAH) and the Commission on Accreditation of Rehabilitation Facilities (CARF), conduct comprehensive reviews focusing on all areas of operation listed. Our responsibility at the state level is essentially no less than theirs.

Our current standards encompass all these but unfortunately, the Alcohol and Drug Abuse Division has had to utilize legal counsel with every rule revision to obtain rules crucial to effective programming.

Additionally, this bill expands current statute 53-24-211 (4) MCA: which states: The department may adopt rules regarding the submission, submission dates, updates, approval, and disapproval of plans." The following statement will be added " and the use of plans by the department in determining the needs of the county for the treatment, rehabilitation, and prevention of chemical dependency."

Montana law 53-24-204(1)(h) states: "The department shall encourage planning for the greatest utilization of funds by discouraging duplication of services, encouraging efficiency of services through existing programs, and encouraging rural counties to form multicounty districts or contract with urban programs.

This expansion is necessary as the department has been challenged on its ability to utilize the relevance of the county plan in need determinations and therefore comply with Montana law.

County plan guidelines issued by the Department require counties to perform the following tasks:

- . Document collaboration with human service agencies, law enforcement, education, prevention organizations, etc.
- . Describe service area and the county's planning process.
- . Needs assessment of the county by providing the following information: population, arrests, hospitalizations, DUI's, minor in possession arrests, admissions to treatment, and an estimation of number in need of treatment.
- . Treatment and rehabilitation services available and what county sees as a need for services. Also identifying their critical populations.
- . Prevention\education and early intervention services available and what needs the county identifies in this area, again identifying critical populations.

Given the comprehensive process, the department wishes to incorporate this information into the need determination procedure.

This bill has no fiscal impact. Realistically, the bill will save the department money. Historically, the department has been required to pay legal fees to establish our rule making authority.

Amendments to House Bill No. 927
First Reading Copy

Requested by Representative Dan Harrington
For the House Human Services and Aging Committee

Prepared by Tom Gomez
February 22, 1991

1. Page 4, line 25.
Following: "means"
Strike: "a certified"
Insert: "an"

2. Page 5, line 1.
Following: "other"
Strike: "similar professional who is"
Insert: "experienced personnel who are"

3. Page 6, line 19.
Following: "department"
Insert: "or a vocational specialist"

DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES HB 927STAN STEPHENS
GOVERNORJULIA E. ROBINSON
DIRECTOR

STATE OF MONTANA

P.O. BOX 4210
HELENA, MONTANA 59604-4210
(406) 444-5622
FAX (406) 444-1970**TESTIMONY OF THE DEPARTMENT OF
SOCIAL AND REHABILITATION SERVICES
BEFORE THE HOUSE HUMAN SERVICES COMMITTEE
(Re: HB 927 - Revise Laws Relating
to General Relief)**

For the record, my name is Norman Waterman and I am the Administrator of the Family Assistance Division of the Department of Social and Rehabilitation Services.

I would like to take this opportunity to express the Department's opposition to House Bill 927.

The Department believes that the present statutes are adequate to meet the needs of the General Relief Assistance population in the twelve state-assumed counties and have met the expectations of the 51st Montana Legislature.

The General Relief Assistance program has been successful in reducing the caseload and program costs and we believe in this program. These reductions are due, in part, to time-limited benefits for employable individuals. The time limitations, as well as program design, were proposed by the Joint Interim Subcommittee on Welfare which was appointed by the 50th Montana Legislature. Subsequent approval by the 51st Legislature gave SRS the authority to implement the program.

Employable persons having serious barriers to employment have six months of benefits available to them while they continue in the Project Work Program to overcome their barriers. The program is working. Each person, at some point, must assume responsibility for his own future. We aid in their efforts to learn to read, to gain a GED, to gain work experience and to overcome drug or alcohol problems. There is no reason to believe that receiving general relief assistance for a longer period of time or placing them in additional or repetitive community programs will be any more productive for these individuals.

The present GRA/PWP system has proven to be successful in providing for those in need, while preserving the legislative intent of not having an entitlement program for employable persons.

Testimony
HB 927
Page -2-


If these individuals utilize the various program components as presently available, they are given an opportunity to overcome their barriers within the present six month limitation.

The General Relief Assistance program already provides employability assessments both initially and on an on-going basis to detect barriers and provides activities to overcome barriers to employment. The Project Work Program has been successful in assisting individuals in obtaining employment.

I think the record established by our present program proves that change is unnecessary at this time.

If you have any questions, I will be happy to answer them now. I will also be available for questions during the remainder of this hearing.

Submitted by:



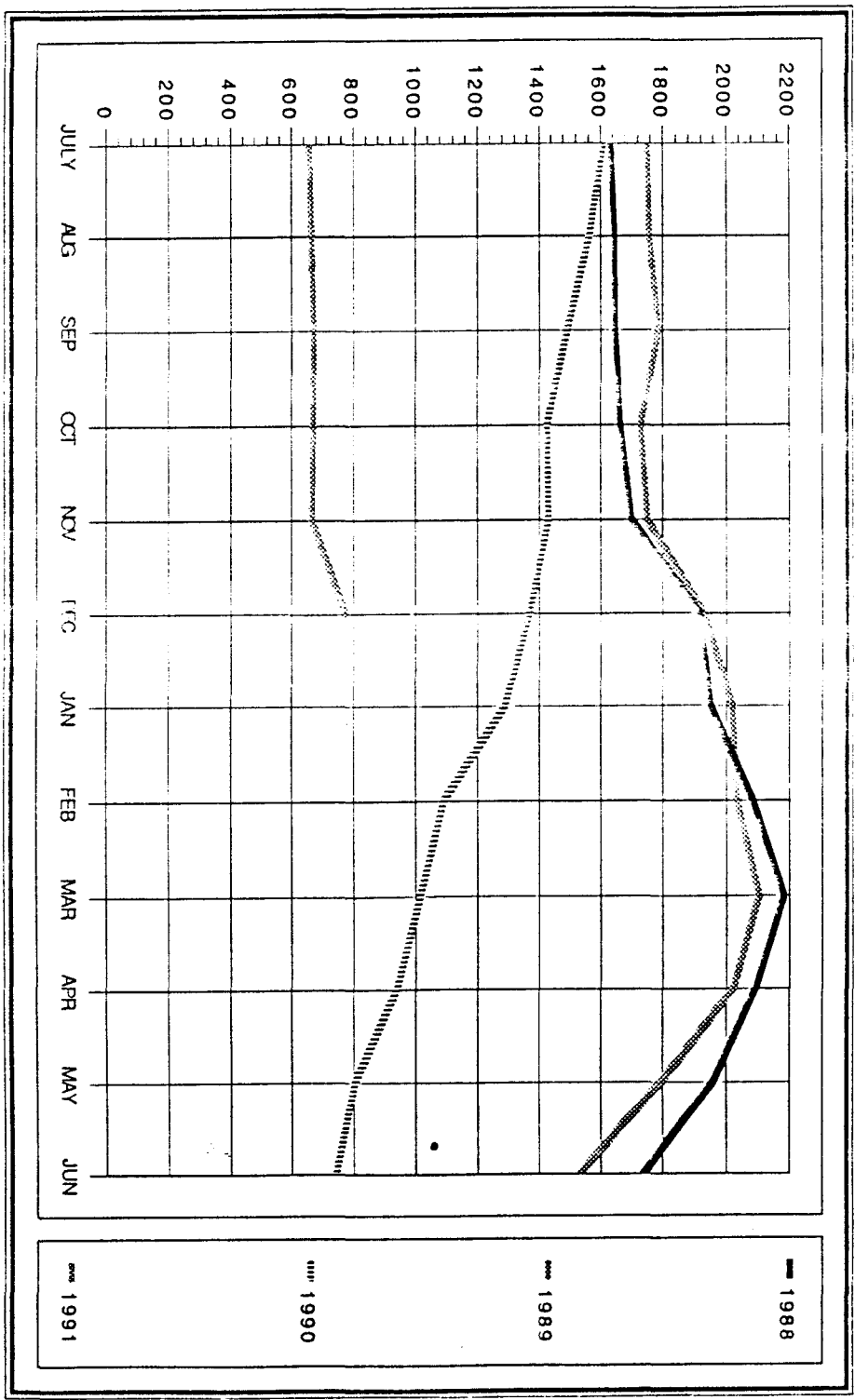
Julia E. Robinson, Director
Department of Social and
Rehabilitation Services

EXHIBIT 2
 DATE 2-22-91
 HB 927

Comparison of General Relief Caseload
 Fiscal Years 88-89-90-91

REPORT OF: 21-Jan-91

FISCAL YEAR	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	TOTAL	AVG/MONTH
1988	1,632	1,645	1,646	1,663	1,699	1,915	1,949	2,083	2,182	2,092	1,958	1,738	22,202	1,850
1989	1,749	1,756	1,784	1,728	1,749	1,925	2,019	2,032	2,103	2,021	1,794	1,532	22,193	1,849
1990	1,608	1,562	1,490	1,426	1,430	1,366	1,287	1,089	1,013	937	801	741	14,750	1,229
1991	656	663	669	668	664	773							4,093	585

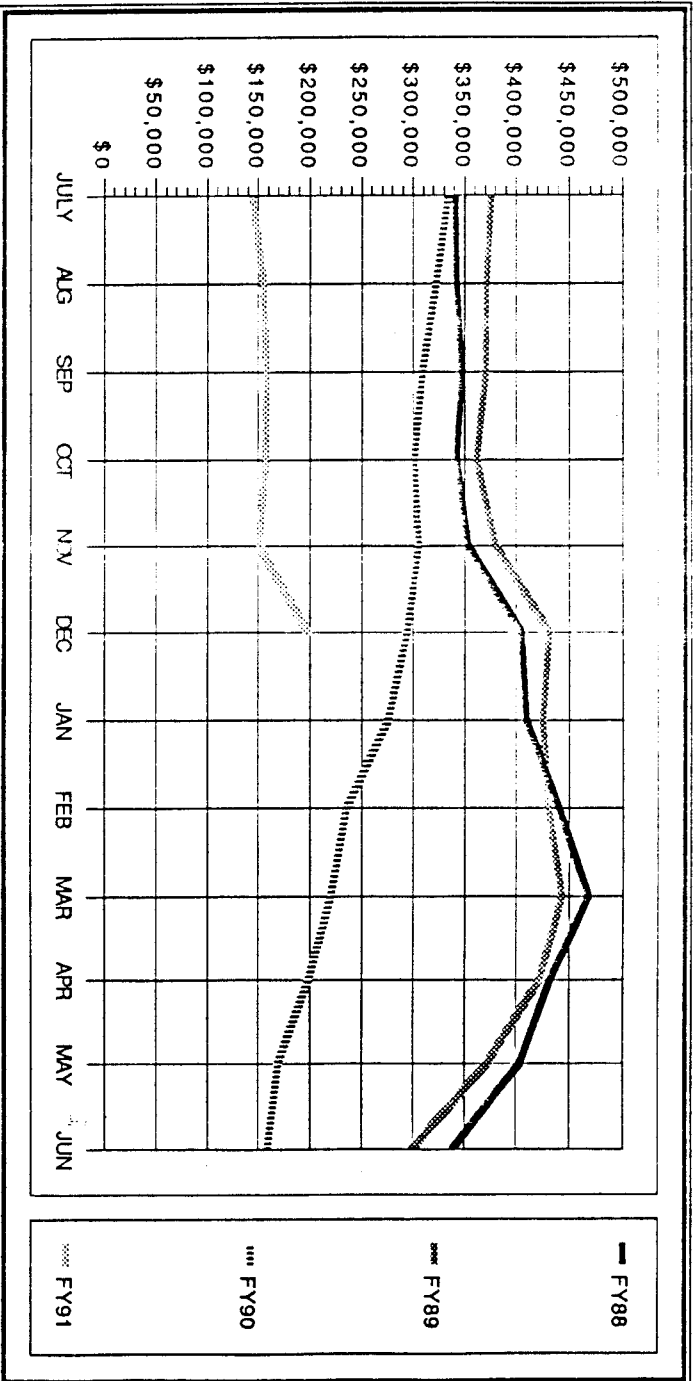


Comparison of General Relief Expenditures
Fiscal Years 88-89-90-91

REPORT OF: 21-Jan-91

	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN
FY88	\$340,345	\$341,785	\$346,488	\$341,641	\$353,201	\$404,465	\$409,411	\$440,140	\$467,879	\$431,866	\$403,540	\$337,804
FY89	\$375,571	\$370,474	\$370,038	\$361,557	\$379,189	\$430,906	\$424,655	\$430,350	\$442,772	\$421,784	\$372,064	\$298,883
FY90	\$333,451	\$321,885	\$308,481	\$300,556	\$305,001	\$293,625	\$275,312	\$234,899	\$219,794	\$198,334	\$168,800	\$158,676
FY91	\$144,074	\$155,020	\$157,484	\$157,149	\$150,252	\$197,789						

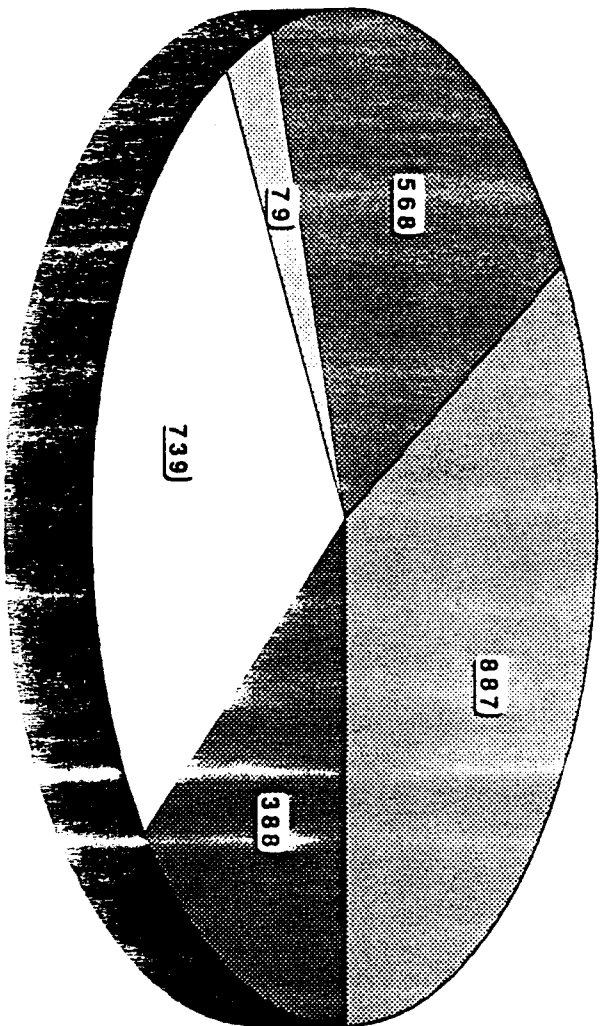
TOTAL
\$4,618,565
\$4,678,243
\$3,118,814
\$961,768



3
16-22-91
126

3
2-22-91
126

Project Work Program
Terminated from General Assistance
January, 1990 to November, 1990



Other (33.3%)

Employed (21.3%)

Employed/Sanctioned (3.0%)

Sanctioned (27.8%)

Time Limited Benefits (14.6%)

Representative Russell and members of the committee, I am Jo Ann Dotson, program manager of the Montana Perinatal Program within the Department of Health and Environmental Sciences. We have administered the MIAMI project since its inception in 1989.

The MIAMI project is a four pronged approach designed to address poor pregnancy outcomes and high infant mortality rates.

- Low Birth Weight Prevention - with 7 community-based projects in the state.
- Infant Mortality Review - which is the intense study of why babies die before their first birthday.
- Public Education (Baby Your Baby campaign) - which makes the public aware of the importance of early and continuous prenatal care.
- Medicaid Changes - which have helped to increase women's access to prenatal care.

HB 876 provides the Department with the authority to continue the MIAMI project. It also enhances the project by adding components to address needs which have been identified during the past year and one-half. For example:

- A Native American member on the Advisory Council will help focus ways to better access and serve Indian women;
- Expanding infant mortality review to include morbidity (or illness) of low birth weight babies will give a clearer picture of their health care problems and needs;
- Increasing and expanding Medicaid will provide services for many presently uninsured pregnant women and will assist in their access to medical prenatal care.


The MIAMI project has been extremely successful. Low birth weight births have decreased in several sites, with some counties now lower than the state percentage of 5.5. These and other accomplishments of the project are described in the MIAMI report.

Despite that success, Montana continues to have poor pregnancy outcomes and high infant mortality rates, especially among our Native American population.

MIAMI has shown that it can effectively address problems such as limited numbers of health care providers, socio-economic constraints to care, and substance use/abuse among pregnant women. The structure of the Advisory Council and the carefully constructed interplay of the parts of the project will be lost if the MIAMI project is not continued.

Thank you. I'd be happy to provide additional information or answer questions you may have. (Telephone number 444-4233)

2/22/91

 Jo Ann Dotson RN, MSN

Montana's Initiative for the Abatement of Mortality in Infants

MIAMI

EXECUTIVE SUMMARY

Accomplishments and Recommendations

INFANT MORTALITY: A GROWING CONCERN

The death of an infant is a profound human tragedy. Each year, some 40,000 American infants die before their first birthday. The rate of infant death is a major standard, accepted throughout the world, for measuring a society's overall health status and a nation's health and well being.

As a society, we have made great gains in ensuring the survival of our infants and improving the quality of their lives. However, among industrialized nations, the U.S. has one of the highest rates of infant mortality (9.9 deaths per 1,000 live births in 1988), ranking 19th behind such countries as Singapore, Hong Kong and Spain.

The high U.S. mortality rate is brought about largely by low birth weight babies (LBW) being born too soon or too small (from prematurity or from not growing adequately during pregnancy), and by increases in infant death rates during the first year of life (postneonatal mortality). During this period babies are most vulnerable to damaging effects of poverty and inadequate health care.

THE "MIAMI" CONCEPT

Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) was developed to address issues critical to the well being of pregnant women, women anticipating pregnancy, and children. Despite our "low risk" (primarily Caucasian) population, in 1987 Montana ranked 29th in the nation in infant mortality, down from our 20th rank in 1986. The major reason Montana babies die before their first birthday is low birth weight. The most effective tool to decrease the incidence of low birth weight is early, comprehensive and continuous prenatal care.

CONTENTS

- Infant Mortality: A Growing Concern
- The "MIAMI" Concept
- MIAMI Advisory Council
- Low Birth Weight Prevention
- Infant Mortality Review
- Public Education (Baby Your Baby)
- Medicaid Changes for Pregnant Women
- Recommendations

In Montana, a low birth weight baby is born every 12 hours and every 3 days one baby under one year of age dies.

Care for pregnant women is at most a 10 month commitment. SHORT TERM COMMITMENT REAPS LONG TERM BENEFITS.

For further information and copies of the complete report, contact the Montana Perinatal Program (MPP), Family/MCH Bureau, Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. Phone (406) 444-4740.

The MIAMI concept faces those issues identified nationally, and encompasses the best of what has been learned in Montana and recommended nationally. Goals of the MIAMI project are:

- assuring that mothers and children, regardless of income or availability of health services, receive access to quality maternal and child health services;
- reducing infant mortality and the number of low birth weight babies; and
- preventing the incidence of children born with chronic illnesses, birth defects, or severe disabilities as a result of inadequate prenatal care.

A seven-member MIAMI Advisory Council was appointed by Governor Stephens to advise the Montana Department of Health and Environmental Sciences (MDHES) on "matters pertaining to the MIAMI project and to make recommendations regarding maternal and child health services." Members of the Council include:

Marietta Cross, R.N., Missoula, Chairperson, representing a non-profit child health organization (Healthy Mothers, Healthy Babies);

Jeffrey Hinz, M.D., Great Falls, pediatrician, representing the medical profession;

Cherry Loney, Great Falls, Health Officer, Cascade City-County Health Department, representing local health departments.

Lil Anderson, Billings, Associate Director, Yellowstone City-County Health Department, representing a local service provider;

Nancy Colton, Bozeman, parent, representing a parent support group;

J. Dale Taliaferro, Helena, Administrator, Health Services Division, representing MDHES; and

Nancy Ellery, Helena, Administrator, Medicaid Services Division, representing the Montana Department of Social and Rehabilitation Services (MDSRS).

Four components make up the MIAMI Project. They are:

- Low Birth Weight Prevention
- Infant Mortality Review
- Medicaid Changes for Pregnant Women
- Public Education ("Baby Your Baby")

Descriptions of each component and accomplishments to date appear on the following pages.

The MIAMI project builds on the concept that the whole is greater than the sum of the parts.

MIAMI ADVISORY COUNCIL

Marietta Cross, R.N., Chairperson, Missoula

Jeffrey P. Hinz, M.D., Great Falls

Cherry Loney, R.N., Great Falls

Lil Anderson, R.N., Billings

Nancy Colton, Bozeman

J. Dale Taliaferro, Helena

Nancy Ellery, Helena

MIAMI PROJECT/MPP STAFF

Maxine Ferguson, Bureau Chief, Family/MCH, MDHES

Jo Ann Dotson, Nurse Coordinator, MPP

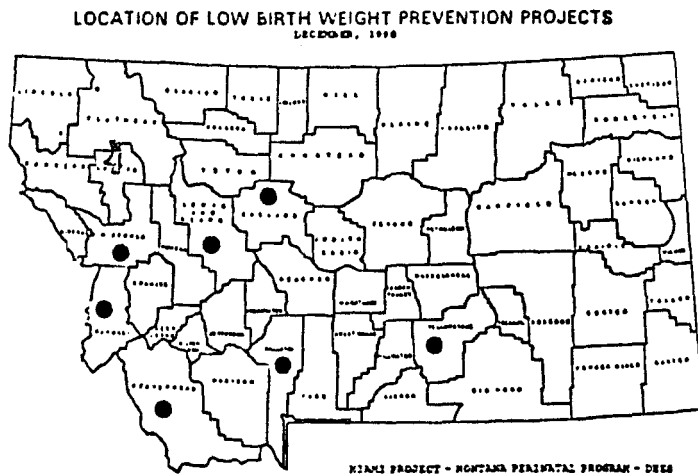
Cindy Little, Admin. Assistant, MPP

Sidney C. Pratt, M.D., Medical Advisor

LOW BIRTH WEIGHT PREVENTION

Low birth weight prevention services utilize a care coordination approach based on screening eligible pregnant women for medical and/or psychosocial risk of preterm labor or low birth weight; assisting these women to access prenatal care, preferably during the first trimester of pregnancy; education about signs and symptoms of preterm labor; education and assessment of the use of alcohol, tobacco and other drugs; assessment of nutritional status and risk; referral to WIC, other agencies and programs for services, treatment, and other assistance. A program model identifying these components has been developed and is utilized by local projects.

Low birth weight prevention projects are located in public health departments or hospitals in seven counties where approximately 50% of Montana's births occur. Nearly 1,350 women received services from the projects during the past year. Locations of these services are shown on the map.



A total of \$152,150 for the 7 projects was administered by the Montana Perinatal Program during FY '90. This does not include funding provided by local health departments and hospitals in support of these projects.

Sources of state-administered funds included Federal Maternal/Child Health and Preventive Health Block Grants and State General Fund dollars. Costs per client are shown in the table below.

Table 1
Funds Contracted for LBW Prevention Projects
and Costs Per Client Served

Data Sources: Project Application/Contracts	
Total Funding to Projects	\$152,250.00
Number of Women Served	1,341.00
Cost/Client	\$ 113.46

In Montana, a low birth weight baby costs a minimum of \$610 per day and may be hospitalized 7 to 20 days. A very low birth weight survivor (one who eventually goes home) averages \$31,000 to \$71,000 in hospital costs alone. Very low birth weight infants are more likely to have problems requiring lifetime care. Lifetime costs for a VLBW infant average \$415,588.

DEFINITIONS:

Low Birth Weight (LBW) - 2500 grams (5 lb., 8 oz.) or less;

Very Low Birth Weight (VLBW) - 1500 grams (3.3 lbs.) or less.

Many factors interact to produce a low birth weight baby. These include environment, culture, politics, economics and health systems as well as social class factors, health behaviors, access to prenatal care, stress, age, race, marital status, education, maternal complications and preterm labor.

Low birth weight prevention projects are impacting Montana babies. Only 4.92% of births to project clients were low birth weight, compared to a pre-project rate of 9.2%.

\$113.46 of state-administered funds can save approximately \$32,558 in acute care costs when used to prevent one "high cost" baby.

Several sites were able to determine the rate of low birth weight among client populations prior to beginning a low birth weight prevention project. Based on current LBW rates, the number of LBW babies prevented were calculated for four sites. Potential savings by these prevention efforts are shown in the table below.

Table 2

Cost Savings of Four Projects Through LBW Prevention

Project	Projected LBW Babies *	Actual LBW Babies	Number of LBW Babies Prevented	Acute Care Savings*
A	9	5	4	\$130,232
B	2	1	1	32,558
C	22	9	13	423,254
D	19	12	7	227,908
TOTAL POTENTIAL SAVINGS				\$813,950

- * Number of LBW babies which would have occurred to FY'90 LBWPP clients if calculated at preproject rates
- Based on figure from Montana SRS "High Cost Babies" study, 1988.

"Studies have documented that indigent women have better outcomes as a result of prenatal care in organized, publicly supported settings such as health departments and community health centers. . . ."



**PREVENT
PREMATURITY**

Call right away if

- you have any fluid from your vagina
 - you have any blood from your vagina
 - you have a sudden increase in vaginal discharge
- If you are having any of these warning signs —

- menstrual-like cramps
- low, dull backache
- pelvic pressure
- abdominal cramps
- vaginal discharge changes

Lie down and check for contractions. If you have five or more contractions in one hour, or if the warning signs do not go away in one hour, CALL:

1. Your physician or C.N.M.
2. Your local hospital or O.B. unit

The Wall Street Journal [June 24, 1988] concluded that for each week of prematurity prevented, a company may save as much as \$10,000 in insurance costs. In an article titled "What Price Prematurity?", Rachel Schwartz calculated costs saved by the upward shifting of infants into the next higher birth weight category. Postponing delivery through monitoring and early detection of two 800 gram infants (approximately 1 lb., 12 oz. each) even for one week may result in savings of up to \$33,700. These figures underscore the importance of educating pregnant women about the signs and symptoms of preterm labor.

The care coordination approach's success is demonstrated in one project's quarterly report, which states:

"Kate" went into preterm labor at 25 weeks due to premature rupture of the membranes. She was hospitalized for a total of ten days and was sent home on oral [medication] and strict bed rest for the duration of pregnancy. . . . The community health nurse provided support and education throughout "Kate"'s difficult pregnancy. . . . "Kate" delivered a healthy baby boy at 39 weeks . . ."

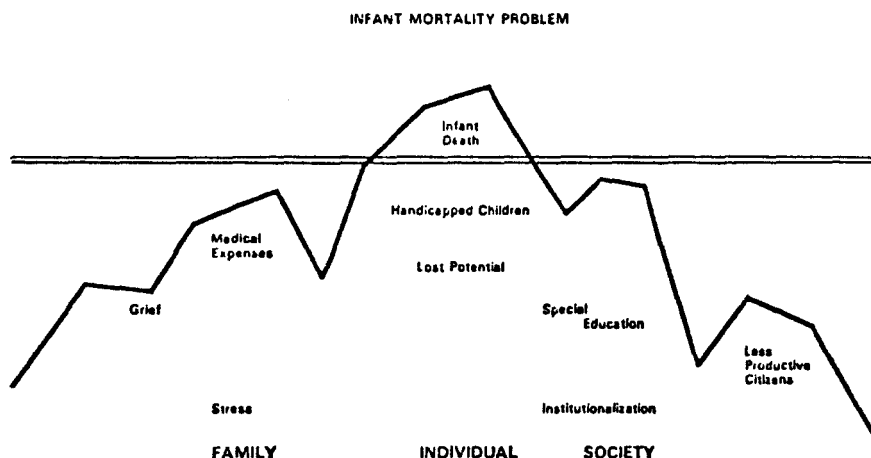
Successful as the care coordination model for low birth weight prevention has been, it does not tell the entire story. Community changes are evident in each area where a low birth weight prevention project has been in existence for two or more years. Community coalitions composed of persons from many agencies and organizations concerned with improved care for mother and children are working together. Referrals to the projects have increased, both in number of women referred and source of referrals. Creative approaches to educating clients about preterm labor have been developed. One example is a wallet size card which lists the signs of preterm labor.

A wallet card listing signs of preterm labor has proved successful in educating pregnant women.

INFANT MORTALITY REVIEW

Infant mortality has a major impact on the lives of all Montanans. The tragedy of death, while devastating to the family and friends, is actually only the tip of the iceberg. As depicted in a model developed by South Carolina (Figure 1), its impact on society is actually only the most visible effect, with family stress, medical costs, special education needs, and lost potential affecting the society in many other ways. The problem requires careful study, so that not only the actual deaths may be reduced, but also the other consequences may be decreased.

Figure 1



Infant death is like the tip of an iceberg. It is easy to see and its cost is measured in lives lost. Handicaps occurring in the perinatal period are less obvious but just as costly to individuals, families and society.

QUALITY PRENATAL, DELIVERY AND NEWBORN CARE CAN REDUCE INFANT DEATH AND DISABILITY ASSOCIATED WITH PREGNANCY AND EARLY CHILDHOOD.

(Figure adapted from South Carolina DHIC/MCH 1983)

WHY ARE MONTANA'S BABIES DYING?

INFANT MORTALITY REVIEW:

A process for examining factors which contribute to infant death through a systematic evaluation of individual cases in order to identify potential opportunities to maternal and infant health.

--William Sappenfield M.D.

DEFINITIONS:

Infant = child aged 1 year and under

Neonate = child aged 28 days and under

Postneonatal = period of time from age 29 days to 1 year

Fetal death = The birth of a fetus after 20 weeks gestation which shows no evidence of life after complete birth.

(Montana Vital Statistics definitions)

Fetal and infant mortality is more than a medical problem; socio-economic impacts cannot be ignored. According to a 1986 Innovations report, government has begun to enter the arena of health care delivery to infants and pregnant women, "because there are . . . people who are in great need of perinatal and maternal care that is unavailable due to cost, ignorance, or lack of accessibility." The report further states that "the mere presence of medical services does not necessarily mean that they are available and will be used by all people. Indeed, the primary obstacles for indigent patients are cost and lack of accessibility."

- What are the obstacles resulting in Montana's high mortality rates?
- How much do we really know about pregnant women's perceptions of health care, and reasons for their health care practices?
- But most importantly, **WHY ARE MONTANA'S BABIES DYING?**

"A child doesn't have to be in a wheelchair to have a birth defect. Limiting a child's full potential, even by a small amount, is going to have an effect on society."

*Lawton Chiles, Chairman
 National Commission to Prevent
 Infant Mortality*

These questions are the impetus for Montana's ongoing work on infant mortality. Montana's infant mortality rate of 11.3 in 1989 is our highest since 1980, and represents a 31 % increase from the 1988 rate of 8.6. (See Table 3) While this figure may be only a "blip" on a statistical screen, it does serve as a reminder to all concerned with the welfare of our children that infant deaths in our state are still a major problem.

Montana's 1989 infant mortality rate among Native Americans is over double the rate of infant mortality in the Caucasian population.

Table 3

Montana Statistics

Year	Live Births	Infant Deaths	Infant mortality rate (Deaths per 1000 births)
1989	11667	132	11.3
1988	11682	100	8.6
1987	12239	121	9.9
1986	12728	122	9.6
1985	13497	139	10.3
1984	14141	125	8.8
1983	14054	126	9
1982	14538	147	10.1
1981	14309	153	10.7
1980	14208	176	12.4

Montana's Native American infant mortality rate of 25.2 in 1989 is extremely high, rivaling the rates reported in minority populations in large urban settings in other states. The initial response to dismiss these figures as a result of low numbers or other reasons unique to Montana must be suppressed; North Dakota, a bordering state with many similar characteristics including weather, access, and population, had the best ranking in infant mortality among the 50 states in 1986, compared to Montana's dismal 20th ranking.

The MIAMI legislation (MCA 50-19-301 to 323) mandated the MDHES to conduct an Infant Mortality Review (IMR). Prior to the mandate, the MDHES contracted with Drs. Fred Reed and William McBroom of the University of Montana Center for Population Research to conduct research on the infant mortality issue. Their data set includes over 84,000 birth certificates for the time period from 1980 through 1985 and the linked birth-death certificates for that same time period. Their research made it very clear that further evaluation was needed, and data sources beyond the birth and death certificates were also needed.

In July of 1990, the MDHES began infant mortality review which reflects Dr. Sappenfield's definition requiring individual case review. Three counties, selected because of their size, interest, and ability to fund data collectors, have been participating on a voluntary basis in data gathering during a 6 month pilot study (July 1990 through December 1990). Although urban Native American babies are included in the current study, expansion plans need to include Indian infant mortality in all settings.

MEDICAID CHANGES FOR PREGNANT WOMEN

In 1984, 17 percent of women of reproductive age lacked insurance to pay for prenatal care and another 9 percent had only Medicaid coverage. . . As of 1985, the United States had made virtually no progress in meeting the goals set in 1980 by the Surgeon General for (1) reducing the percentage of babies born with low birth weight to no more than 5 % of live births and (2) ensuring that 90% of pregnant women obtain care within the first 3 months of pregnancy. *A substantial Medicaid effort, linked with other programs, can help to erase this country's poor performance among industrialized nations in terms of infant mortality. The effort can also help to reduce the disgracefully high infant mortality rates currently found among minorities.*

Under the auspices of the Governor's Human Services Sub-Cabinet, a subcommittee on Maternal Child Health was appointed. Their first report, KIDS COUNT, included MCH issues and initiatives, along with recommendations. Expanding medicaid eligibility for pregnant women and increasing access to providers through fee improvements are among the issues included:

- Increasing the eligibility income level to 133% of the federal poverty level (FPL) was implemented on April 1, 1990.
- Implementation of "presumptive eligibility" is targeted for January 1, 1991.
- "Continuous eligibility" is also targeted for implementation on January 1, 1991.
- Statewide, eligibility staff have been educated about the importance of early prenatal care and are expediting Medicaid applications for pregnant women.
- Outstationing eligibility staff has been determined unfeasible at this time.
- Increasing the eligibility income level to 185% of the federal poverty level will require state legislation.
- Reimbursement for delivery services has been increased to \$756-\$806, approximately 42% of usual and customary charges.

DEFINITIONS:

Presumptive eligibility - allows qualified providers to certify Medicaid eligibility for pregnant women while a formal application is being processed.

Continuous eligibility - allows Medicaid eligibility to continue in cases where the pregnant woman would no longer be eligible for financial assistance based on a change in income.

In 1988, Montana Medicaid spent \$4.2 million (51% of the total delivery budget) on only 4% of the births. A majority of the births were low birth weight which could have been prevented with early, regular prenatal care.

Medicaid pays an average of \$19.48 for each prenatal visit. Compare that cost to neonatal intensive care costs of \$610 - \$2000+ per day!

PUBLIC EDUCATION -- "BABY YOUR BABY"

One of the answers to improved infant health and survival is the development of a multi-media awareness and public education campaign that will communicate with expectant mothers. The "Baby Your Baby" (BYB) campaign is designed to educate and motivate expectant mothers (and those who care about them, i.e., relatives, friends, parents) to enroll in a medical support program in the first trimester of pregnancy.

"Baby Your Baby" is directed primarily to high risk women. Specific target groups include teenagers, alcohol and/or drug addicted or affected women, and low socio-economic groups, including the homeless.

Many public and private organizations are supporting the BYB campaign through funding or other support. Major funders have contributed \$7500 or more to the campaign effort. Sponsors also provide funding for the campaign. Endorsing organizations support the concept and approaches of the campaign, and recognize the importance of educating the public about the needs of pregnant women.

Elements of the statewide campaign include, but are not limited to television and radio public service advertising, print advertising, billboards, posters, video documentaries, television news series and insert segments, newspaper tabloids, incentives and referrals. A toll free information line (1-800-421 MOMS) has been established so women can register for the program. Airing of the television and radio spots will begin in January 1991.

Public/Private Partnership

The BABY YOUR BABY campaign is a public/private partnership. The cost of the campaign is being underwritten by sponsors from both the public and private sectors.

Securing funding and developing contracts for service have occupied a major portion of the past year. A contract has been developed between MDHES and Healthy Mothers, Healthy Babies for conducting the education campaign, in response to a Request for Qualifications issued by MDHES. Other contracts and agreements permit Medicaid match of state general funds and all private sector donated funds. HMHB purchased program rights from the Utah Department of Health and KUTV in Salt Lake City, established KTGF in Great Falls as the program originator and network anchor in Montana, and has retained a technical advisor, a public relations firm and a production company.

Brochures about health services, child care, pregnancy care and social service programs make up an information packet which will be mailed to women who register in the BABY YOUR BABY program. Incentives designed to attract expectant mothers into the program have been field tested. The registration also serves as a referral and tracking system.

Community forums held in 17 Montana cities in November and December of 1990 informed health care, social services and other community professionals about the program, and even more important, assisted communities in developing local activities and referral services for the BYB campaign.

Careful evaluation of the project will be done so that the findings can be utilized by MDHES, MDSRS, HMHB and others.

BYB Major Funders

- Blue Cross and Blue Shield of Montana
- Healthy Mothers, Healthy Babies -- The Montana Coalition
- St. Peter's Community Hospital, Helena
- State of Montana
 - Department of Family Services
 - Department of Health and Environmental Sciences
 - Family/MCH Bureau
 - Perinatal Program
 - WIC Program
 - Immunization Program
 - Department of Social and Rehabilitation Services
 - Child Support Enforcement Bureau
 - Medicaid Division
 - Developmental Disabilities Division

BYB Sponsors

- Children's Trust Fund
- Dr. Leonard Kaufman
- Kiwanis of Helena
- March of Dimes, Montana Big Sky Chapter
- Montana Medical Genetics Program at Shodair Hospital
- Montana Area Health Education Center
- The Doctors' Company

BYB Endorsing Organizations

- Local health departments
- Local HMHB coalitions
- Montana Academy of Family Physicians
- Montana Academy of Pediatrics
- Montana Children's Alliance
- Montana Hospital Association
- Montana Council for Maternal Child Health
- Montana Medical Association
- Montana Medical Auxiliary
- Montana Nurses' Association
- Montana Section - American College of Obstetricians and Gynecologists
- Montana Section of Nurses Association of the American College of Obstetricians and Gynecologists
- Montana State Governor's Office

Date of report release: 12/90

RECOMMENDATIONS OF THE MIAMI ADVISORY COUNCIL

1. Extend the sunset on MIAMI legislation to June 30, 1993.
2. Create a state center for health statistics, which will facilitate the retrieval of information needed to guide health provision and planning.
3. Develop a rural health planning commission, which will provide support and consultation to rural health practitioners, as well as guide state planning for rural health provision.
4. Encourage policy changes which will improve health care of infants and pregnant women through tort reform.
5. Support the Montana Medical Genetics program.
6. Support the public vaccine program so that no child will be denied vaccine and potentially pass preventable illnesses on to women and/or their fetuses.
7. Facilitate the creation of a central registry and tracking system for infants who have a high risk of experiencing developmental delay.

LOW BIRTH WEIGHT PREVENTION

8. Accommodate increased client loads by additional funding to the existing seven (7) low birth weight prevention projects.
9. Contingent on adequate funding of existing projects, fund an additional nine (9) low birth weight prevention project sites.
10. Facilitate the role of mid-level health care providers in Montana.
11. Collaborate with Indian Health Services, tribal health and urban Indian centers to improve coordination of services to Native Americans.
12. Facilitate home visits for all high risk and/or first time mothers.
13. Increase referrals of Low Birth Weight Prevention Project clients to local family planning clinics and other applicable services.

INFANT MORTALITY REVIEW

14. Expand infant mortality review to additional sites, including more locations where Native American populations may be accessed.
15. Fund expansion of the review process to include low birth weight births, to allow examination of causes of infant morbidity.

MEDICAID CHANGES FOR PREGNANT WOMEN

16. Expand Medicaid eligibility coverage for pregnant women and children up to age six to 185 percent of the federal poverty level.
17. Increase reimbursement for prenatal and delivery services to 90% of actual fee.
18. Implement a targeted case management system for high risk pregnant women.
19. Maintain presumptive and continuous eligibility as a Medicaid priority.
20. Support low cost health insurance packages which include maternity and well-child services.

PUBLIC EDUCATION

21. Promote public education of perinatal issues through the media, especially in the form of the Baby Your Baby campaign.

TESTIMONY

HB 876

2/22/91

HOUSE COMMITTEE ON HUMAN SERVICES
REPRESENTATIVE RUSSELL, CHAIRPERSON

Support MIAMI

Madam chair and members of the Committee.

I am Don Espelin, a pediatrician here in Helena and president of the board of Healthy Mothers, Healthy Babies. Healthy Mothers, Healthy Babies is a statewide, non-profit corporation made up of volunteers whose mission in life is improving maternal and child health.

To that end we feel the infant mortality rate in Montana is excessive and getting worse. In 1989 we lost 131 babies before their first birthday. Fully one half of these could have been prevented.

To put this in proper perspective, at the height of the polio epidemic Montana lost only 20 people of all ages per year. HB 876 would continue and beef up the MIAMI project.

It is critical for the well being of our most vulnerable citizens, our babies, that MIAMI continue and be strengthened.

I urge you to give this bill a DO PASS, and further I would ask you to become an advocate for our babies.


DONALD E. ESPELIN, M. D.

President of the Board
Healthy Mothers, Healthy Babies

EXHIBIT 7
DATE 2-22-91
HB 876

MIAMI BILL HB 876

TESTIMONY BY

D. ELIZABETH ROETH
CHAIR
MONTANA CHILDREN'S ALLIANCE

HB 876 MIAMI

SPONSOR REPRESENTATIVE DIANA WYATT

REQUEST: ESSENTIAL ELEMENTS OF MIAMI

- 1) Remove sunset
- 2) Advisory Council
 - a) Appoint members
 - b) Add Native American member(s)
 - Tribal Health
 - Indian Health Service
 - Consumer
- 3) Infant Mortality Review
 - a) Advance present sites from pilot to in place function
 - b) Add 3 new sites each year of biennium to total of 9
 - c) Expand review process to include morbidity of low birth weight births
- 4) Low Birth Weight Projects
 - a) Fully fund existing projects
 - b) Expand to 16 sites as identified by Dept. of Health
- 5) Medicaid Changes
 - a) Continue presumptive and continuous eligibility -mandate not as option
 - b) Increase eligibility to 185% of poverty
 - c) Implement targeted case management for high risk women in collaboration with SRS
- 6) Public Education (Baby Your Baby)

12/90

HEALTHY MOTHERS, HEALTHY BABIES
 MONTANA COALITION

BABY YOUR BABY CAMPAIGN

** Major Funders

State of Montana

Department of Health and Environmental Sciences			
Perinatal Program	\$15,000	Match	Total
		\$15,000	\$30,000
Wic Program	3,000	Fed	3,000
Immunization Program	2,300	Fed	2,300
Department of Social and Rehabilitation Services			
Child Support Enforcement	\$ 4,999	Fed	4,999
Medicaid	10,000	Fed	10,000
Developmental Disabilities Division	10,000	Fed	10,000
Department of Family Services	5,000	Fed	5,000
Blue Cross Blue Shield	15,000	15,000	30,000
St. Peter's Hospital-Helena	10,000	10,000	20,000
Total	\$ 75,299	\$ 40,000	\$115,299

EXPENSE 7
DATE 2-22-91
RS 876

** Sponsors

	Donation/Grant	Match	Total
Children's Trust Fund	\$ 2,500	\$ 2,500	\$ 5,000
Dr. Leonard Kaufman	1,000	\$ 1,000	2,000
Kiwanis of Helena	2,000	2,000	4,000
March of Dimes, Montana Big Sky Chapter	1,500	1,500	3,000
Medical Genetics Program at Shodair Children's Hospital	2,500	2,500	5,000
Montana Area Health Education Center	4,000		4,000
Doctors' Company	4,000	4,000	8,000
Montana Power Company	2,500	2,500	5,000
	<hr/>		
	\$ 20,000	\$ 16,000	\$36,000
Summary			
Grants/donations/State and Fed funds	\$ 95,299	\$ 56,000	\$151,299

Supporting Organizations:

State of Montana
Governor's Office
Department of Health & Environmental
Sciences:
Perinatal Program
WIC Program
Immunization Program
Social and Rehabilitation Services
Child Support Enforcement
Medicaid
Department of Family Services
Blue Cross & Blue Shield of Montana
Children's Trust Fund
Healthy Mothers, Healthy Babies
Kiwanis of Helena
Local Health Departments
March of Dimes, Montana Big Sky Chapter
Medical Auxiliary
Medical Genetics Program at
Shodair Children's Hospital
Montana Academy of Family Physicians
Montana Academy of Pediatrics
Montana Hospital Association
Montana Medical Association
Montana Nurses' Association
Montana Section - ACOG
Montana Section - NAACOG
The Doctors' Company

Major Funding Provided By:

State of Montana
Blue Cross & Blue Shield of Montana
Healthy Mothers, Healthy Babies,
The Montana Coalition

Community Forums Funded By:

Montana Health Education Center (AHEC)

For More Information:

Healthy Mothers Healthy Babies
Box 876
Helena, MT 59624
(406) 449-8611



EXHIBIT 8

DATE 2-22-91

NO 876

Caring and Sharing

An Introduction for
Community Care Providers
To

BABY YOUR BABY

A Community Service
Campaign for
Mothers-To-Be
and for Those Who
Care About Them.

EXHIBIT 9
DATE 2-22-91
HB 876



CITY-COUNTY HEALTH DEPARTMENT

February 22, 1991

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

Dear Representative Russell,

I am writing in SUPPORT of HB 876, an act to revise and continue the MIAMI project.

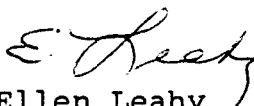
The continuation of our department's low birthweight prevention project depends on the passage of HB 876. These efforts are such a high priority in public health that we in Missoula appropriate our scarce local revenue to fund half of our program. We would not be able to continue, however, without the state appropriation contained in HB 876.

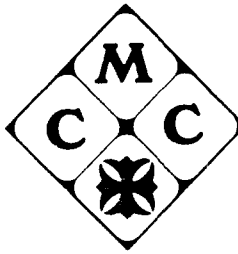
Low birthweight prevention programs work. In the five years since Missoula's program began, local access to early prenatal care has increased steadily. At the program's outset in 1985 only one physician participated. Today, the program and its clients enjoy the support of 15 participating physicians. We began with an annual client caseload of 80 clients five years ago and today serve upwards of 250 annually. There is more work to be done, however, as we estimate that another 200 clients per year in the Missoula area alone are eligible but unserved.

The truest test of this program's worth is demonstrated by the fact that, since 1985, Missoula's rate of low birthweight babies has decreased from nine per thousand births to five - thereby saving many thousands of dollars in neonatal intensive care and rehabilitative care costs that would have been paid with public dollars. I, frankly, do not know how local health departments could continue to address this public health need in the absence of the MIAMI project efforts and funding.

I urge your support of HB 876.

Sincerely,


Ellen Leahy
Health Officer



Montana Catholic Conference

EXHIBIT 10
DATE 2-22-91
HB 876

**HB 876
FEBRUARY 22, 1991**

MADAM CHAIRMAN RUSSELL AND MEMBERS OF THE COMMITTEE

I am John Ortwein, representing the Montana Catholic Conference.

The Montana Catholic Conference supports HB 876.

Our concern for life--the life of the child and the life of the mother dictates our interest in this legislation.

Earlier this week I contacted the Catholic Health Association in Washington D.C. concerning this legislation. They indicated to me that a great deal of suffering is caused by inadequate prenatal care. They told me that studies have indicated that instances of mental retardation and a variety of long-term difficulties can often be prevented by adequate prenatal care.

Again, we support HB 876.

Chairman Russell, members of the committee:

My name is Marietta Cross. I am a registered nurse employed in Missoula. My background is maternal child nursing and newborn intensive care. I also serve as Chair of the Advisory Council for MIAMI.

I strongly urge your support of HB 876.

Since the creation of MIAMI in 1989, the reduction of low birthweight babies in the population served has been almost 50%. To translate this into dollar savings alone to the citizens of Montana, would conservatively amount to millions.

Low birthweight is the major factor in infant death in Montana. A low birthweight baby is born in this state every twelve hours. The single most effective way to prevent low birthweight is early, regular and comprehensive prenatal care. The existing Low Birthweight Prevention Projects of MIAMI are a most important part of the Project. They enable the access into care of an increasing number of women who otherwise would receive little or no care. The need for more Low Birthweight Prevention Projects is real. These Projects, as well as the other facets of MIAMI, provide the important groundwork for preventive health care for pregnant women and children. Care for pregnant women is a short term commitment that reaps long term benefits.

MIAMI is a quantum leap for Montana in attaining an intelligent maternal child health program. Because of its existence we can work to change the demographic, socioeconomic and behavioral factors that put pregnant women at risk for poor outcomes. We can no longer depend upon expensive, high tech, neonatal medicine to significantly lower our infant mortality rate. We need to continue to improve the availability and access to preventive care for pregnant women and children in Montana. This is what MIAMI is doing. We know that it works.

I concur with other members of the advisory council in strongly urging the continuation and expansion of MIAMI.

Thank you for your attention.

Marietta Cross, RN

Testimony before the House Committee on Human Services and Aging
February 22, 1991



LEWIS AND CLARK

CITY-COUNTY HEALTH DEPARTMENT

EXHIBIT 1
DATE 2-22-91
HB 876

City-County Building
316 North Park
Box 1723
Helena, Montana 59624
Telephone 406/443-1010

FACT SHEET

What is low birthweight (LBW)?

- * Low birthweight means a baby born under 5 lbs, 8 ozs.

What is infant mortality?

- * The death of an infant under the age of one year.

Why is LBW a problem?

- * The lifetime costs of caring for a LBW baby can exceed \$400,000 (MIAMI Executive Summary).
- * 20% of LBW infants are re-hospitalized more than once during their first year of life.

How does low birthweight impact infant mortality?

- * 2/3 of neonatal deaths (infant under 28 days) occur among low birthweight infants.
- * Low birthweight infants are 5 times more likely to die in their first year of life than normal birthweight infants.

How big a problem is LBW and infant mortality in Montana?

- * Initial hospital costs alone average \$31,000 to \$71,000 (MIAMI Executive Summary).
- * 1989--the infant mortality rate among Native Americans was double that of the caucasian population
- * a LBW baby is born every 12 hours in Montana.
- * In 1978 Montana ranked 8th (1st is the best ranking) in the nation in low birthweight, that then dropped to 20th in 1986 and 29th in 1987 ("Children 1990").
- * 1988--Montana Medicaid spent 4.2 million dollars (51% of the delivery budget) on 4% of the births.

What causes low birthweight?

- * No one knows for sure. There is not one definitive "cause".
- * Some factors that increase the risk of a low birthweight infant are: mother's age (under 17 or over 34), smoking, substance abuse, poverty, poor nutrition, exposure to DES (a drug that was used to prevent miscarriage).
- * Medical factors contributing to low birthweight: multiple gestation, cervical surgery, hypertension, placental problems, spontaneous early rupture of membranes.
- * These risk factors are not mutually exclusive nor are these lists exhaustive.

Is LBW preventable?

- * In many cases, the answer is yes. Some of the risk factors can be eliminated such as smoking. Other factors, such as twins, can not be controlled or prevented.
- * The most effective LBW prevention is early and regular prenatal care.

How much do the LBW projects cost?

- * Total State funding: \$152,250 in 1990. This cost does not reflect the total costs of the projects. Most projects have supplemental funding.

How much money do the LBW projects save?

- * \$113.46 of state-administered funds can save approximately \$32,558 in acute care costs when used to prevent one "high cost" baby (MIAMI Executive Summary).
- * Healthy Pregnancy Services (Lewis and Clark County LBW prevention project) spent \$324 per client in FY 90. That includes state and local monies.

* Case Study:

21 year old married woman with a history of preterm labor who stayed in the hospital two (2) months prior to her last delivery. Despite preventive bedrest, she went into preterm labor at 27 weeks. Healthy Pregnancy Services provided support with regular home visits, education, and phone calls. With help and cost information from Healthy Pregnancy Services the insurance company reversed their decision and agreed to pay 100% of in-home services. This allowed her to stay home on bedrest at considerable cost savings. The client delivered at 38 weeks, a 5 lbs, 11 oz. infant. Potential cost savings: \$38,316. This estimate is based on the minimum daily hospital charge of \$610 and accounts for \$1200 less than the entire cost of Healthy Pregnancy Services in FY 90.

HEALTHY MOTHERS/HEALTHY BABIES HELENA AREA COALITION

My name is Joan Bowsher of the Lewis and Clark County Women, Infants and Children (WIC) Program and I am here representing the Healthy Mothers/Healthy Babies - Helena Area Coalition. We are a local chapter of the statewide Healthy Mothers/Healthy Babies coalition. This chart lists our current membership. As you can see, we are a broad based community group of volunteer individuals and organizations with a membership of approximately 50. Although we do not agree on every issue, we put our differences aside to work towards our common goal, to reduce infant mortality and low birthweight.

Our coalition chose to support this bill as our legislative priority. We urge you to support it as well without amendments.



Montana Council for Maternal and Child Health

The Voice of the Next Generation
in Montana's State Capitol

EXHIBIT 14
DATE 2-22-91
HB 876

2030 11th Ave., Suite 10

Helena, MT 59601

(406) 443-1674

TESTIMONY FOR THE HOUSE HUMAN SERVICES AND AGING COMMITTEE

Re: HB 876, MIAMI Reauthorization

Date: February 22, 1991

The Montana Council for Maternal and Child Health, a non-profit public policy research, education, and advocacy organization, supports HB 876, repealing the June 30, 1991 sunset of the Montana Initiative for Abatement of Mortality in Infants.

This bill continues, and improves on, the excellent work started by the DHES Perinatal Program under the initial MIAMI project.

Other testimony today establishes the achievements of this vital project: the establishment of public health nursing programs for pregnant women, improvements in Medicaid coverage for prenatal care; increased early access to prenatal care for program clients despite a decline in the numbers of obstetrical providers; the first stages of infant mortality review to explore the tragedy of Montana's increasing infant mortality rates, and the establishment of the "Baby Your Baby" public education program which will soon be reaching women in every major media market in the state.

What I would like to emphasize is the cost-effectiveness of the MIAMI project. The Montana Council for Maternal and Child Health has recently completed a literature review of cost-effectiveness studies of various methods to reduce infant mortality. What we found confirmed what we intuitively believed, that for a fetus at risk of premature birth, the mother's womb does a better job, at much less expense, than a glass incubator and a lot of fancy wires and tubes.

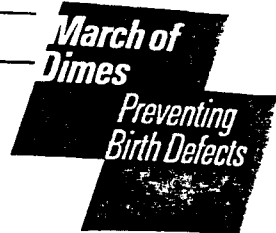
One study in particular brings home the message I want to leave with you today.¹ The University of New Hampshire and the New Hampshire Department of Health and Human Services studied the relationship between adequacy of prenatal care and birthweight in New Hampshire, and the total costs of low birthweight for the state. To make a long story very short, the study concluded that it would cost less than half as much to provide free prenatal care for every pregnant woman in the state who needs it, regardless of income or other eligibility factors, than to pay the costs of hospitalizing their low-birthweight infants.

Thank you for your attention.

Paulette Kohman
Executive Director

¹. Gorsky & Colby, *The Cost Effectiveness of Prenatal Care in Reducing Low Birth Weight in New Hampshire*, HSR: Health Services Research 24:5, p. 583 (December 1989)

EXHIBIT 15
DATE 2-22-91
HB 876



MARCH OF DIMES BIRTH DEFECTS FOUNDATION

STATEMENT IN SUPPORT OF "MIAMI" PROJECT

The March of Dimes Birth Defects Foundation supports an appropriation of state funds to implement the Montana Initiative for the Abatement of Mortality in Infants Project, also known as the MIAMI Project. The MIAMI Project will provide comprehensive clinics, at 16 sites across the state, for pregnant women at high risk for delivering low-birthweight babies.

For 50 years, the March of Dimes has pioneered efforts to ensure the health of America's children and babies. As part of our mission to prevent birth defects, we work to reduce the incidence of low birthweight and infant mortality. The appropriation of \$1.28 million in state funds for the MIAMI Project will increase the availability of comprehensive prenatal care for high-risk women and help reduce the rate of infant mortality in Montana.

The Importance of Prenatal Care

Studies have shown that early and regular prenatal care for women is vital. Prenatal care helps ensure healthier mothers and babies and is the primary means of preventing low birthweight, the leading cause of infant deaths in America. Each year, 250,000 babies in the United States are born weighing less than 5.5 pounds. These babies are at high risk of becoming sick or disabled, or of dying during their first year of life.

Infant mortality and low birthweight can be significantly decreased if women receive early and regular prenatal care. In a 1985

additional sites for a total of 16 sites across the state.

This expansion of targeted, comprehensive maternity care would have a positive effect on the health of Montana's citizens, lowering the rate of infant mortality and the costs to the state resulting from unhealthy births.

Our Recommendation

The March of Dimes considers high-risk maternity care services to be among the highest priorities for Montana's resources. We urge the legislature to appropriate the funds necessary to implement this project. This will provide an opportunity to reduce state health care cost and is an investment in a healthy start in life for Montana's citizens.

HOUSE BILL 881

Madam Chair, members of the committee. I am Drew Dawson, Chief of the Emergency Medical Services Bureau in the Department of Health and Environmental Sciences.

The Emergency Medical Services Bureau is responsible for the planning and implementation of a state-wide emergency medical services program. Our responsibilities include the day-to-day administration of the EMT training and certification program. This is done on behalf of, and in cooperation with, the Montana Board of Medical Examiners.

The current EMT certification law was passed in 1975 just as emergency medical services were evolving throughout the nation. In 1975, there were only two national standard EMT training programs-Basic and Advanced-both of which were reflected in the legislation.

As emergency medical services has progressed, additional national curricula and certification levels have evolved including EMT-Basic, EMT-Defibrillation, EMT-Intermediate and EMT-Paramedic. Montana has adopted these levels of training and certification. Under previous legal advice, administrative rules classified EMT-Defibrillation, EMT-Intermediate and EMT-Paramedic as subcategories of EMT-Advanced. I have attached a summary of each of the training programs and the numbers of personnel currently certified in Montana. These persons are working on emergency medical services, both volunteer and paid, within your communities.

Several factors have precipitated the need for this legislation:

1. Current legal counsel has advised us that there should be more clear-cut statutory authority for the Board of Medical Examiners to establish various categories of emergency medical technicians and the acts they may perform.
2. The national standard EMT curricula are currently undergoing major revisions by the U.S. Department of Transportation. To remain consistent with national standards and with current advancements in emergency medicine, the Board of Medical Examiners needs the flexibility to establish various categories of EMTs and to determine the specific procedures EMTs may perform at each level.
3. As advancements are made in emergency medical services, some existing procedures often become obsolete. New techniques and medications become more appropriate. It is essential that the Board of Medical Examiners, in concert with the medical and EMS community, be able to rapidly respond to these changing needs. It is more realistic to deal with these complex medical issues by administrative rule rather than by statute. This involves considerable input from established medical and emergency medical organizations in Montana.

This legislation accomplishes three major purposes:

16
2-22-91
881

EMT TRAINING IN MONTANA

EMT-BASIC - 1145 current certified

The emergency medical technician - basic training program, approximately 110 hours in length, is intended to prepare a person to respond to, treat and transport the patient to a medical facility. The program includes ten (10) hours of required hospital observation time to allow the student to see, touch and perform assessment skills on actual sick people while under the direct observation of other medical personnel.

The EMT-Basic may perform the skills identified in the national curriculum including initial assessment of the patient, rendering basic life support care, immobilizing and transporting the patient, operation of the ambulance and other skills necessary for ambulance personnel.

EMT-DEFIBRILLATION - 470

EMT-D requires 16 hours of training beyond EMT-Basic, a written and practical certification examination and medical control. A medical director is responsible for the training.

In addition to skills allowed the EMT-Basic, the EMT-Defibrillation may, when functioning in a licensed EMT-D service, defibrillate patients in ventricular fibrillation.

EMT-INTERMEDIATE - 50

The EMT-I is a level of certification beyond the EMT-Basic. It requires an additional 116* hours of training, commitment from a medical facility for conducting clinical training, a written and practical certification examination and medical control. A medical director is responsible for the training. The emergency medical service is required to license at the EMT-I level in order to provide care at the EMT-I level.

In addition to the skills allowed the EMT-Basic, the EMT-I, when functioning according to protocol in a licensed EMT-I service, may:

- defibrillate patients in ventricular fibrillation
- perform endotracheal intubation
- start IV lines and administer specific IV fluids

* MINIMUM recommended number of hours to complete.

EMT-PARAMEDIC - 25

The EMT-P level is a level of certification beyond the EMT-Basic. It requires an additional 600* hours of training, commitment from a medical facility for conducting clinical training, a written and practical certification examination and required medical control. A medical director is responsible for the training.

16
2-22-91
881

In addition to the skills allowed the EMT-Intermediate, the EMT-P, when functioning according to protocol in a licensed advanced life support service, may:

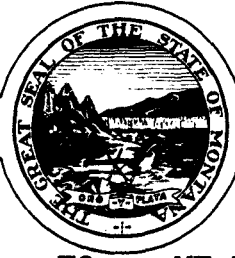
- administer a variety of medications authorized by their medical director, their protocols and the Board of Medical Examiners. Many of these are cardiac medications.

- perform a variety of other advanced life support techniques identified in the national standard paramedic curriculum

* **MINIMUM** recommended number of hours to complete.

OFFICE OF THE GOVERNOR
MENTAL DISABILITIES BOARD OF VISITORS
LEGAL SERVICES PROGRAM

EXHIBIT 17
DATE 2-22-91
HB 930



STAN STEPHENS, GOVERNOR

P.O. BOX 177

STATE OF MONTANA

(406) 693-7035

WARM SPRINGS, MONTANA 59756

TO: MT HOUSE HUMAN SERVICES COMMITTEE
FROM: MARY GALLAGHER-STAFF ATTORNEY *mg*
PROTECTION & ADVOCACY FOR MENTALLY ILL INDIVIDUALS/BOARD OF VISITORS
DATE: FEBRUARY 22, 1991
RE: HEARING ON HOUSE BILL 930

MADAME CHAIR AND MEMBERS OF THE COMMITTEE:

I am here today in support of House Bill 930 at the invitation of Representative Whalen. In 1986 the United States Congress established the Protection and Advocacy Act for Mentally Ill Individuals Act (PAMII) because of the problems it saw regarding the treatment and rights of persons with mental illness—particularly in institutions and other mental health facilities throughout the country.

Currently, the Montana PAMII program has the authority under the federal act to do everything listed in the New Section of this bill to address those treatment needs. However, passage of this bill would help to inform facilities that they are subject to cooperation with the program's federal mandate. It would provide notice in Montana law to facilities on what is required of them and provide guidance on confidentiality issues when an advocate visits their facility. To date, most facilities have been cooperative with these provisions but many had little, if any, knowledge of the existence of the federal mandates until they were contacted by the PAMII program. This bill would assist with notice to facilities and enable the program to meet its' mandate.

Secondly, this bill seeks to incorporate provisions from the federal Restatement of The Bill of Rights For Mental Patients which is also part of the PAMII Act. The Restatement spells out the federal guidelines of basic rights for what any patient at a mental health facility should be able to expect on how they should be treated and what they should expect in terms of limitations on rights and liberties. Most of these provisions already exist in our mental health code. This bill adds those basic provisions from the federal Restatement which are not are not currently in the code or which are not as specifically stated in the code.

The Restatement addresses very basic, but important, rights for persons with a serious mental illness who are in facilities—people who have not always able to speak up for themselves, and who, until recently, have had very little voice within the system that provides them with treatment. I urge the committee to pass this bill to affirm these basic rights and to ensure that the advocacy system can address the federal mandate without hindrance.

Thank you.

WHAT DOES HB 930 ADD TO, OR CLARIFY, IN MONTANA'S MENTAL HEALTH CODE?

SECTION 1. The New Section clarifies what the PAMII system is designed to do, which is to investigate incidents of abuse and neglect of mentally ill individuals and seek remedies to assure their rights are respected within the mental health system. It states generally what the PAMII system shall have access to within mental health facilities.(Section 1;pg 1&2)

SECTION 2. This section address the circumstances wherein a provider of services may be called upon to be a guardian of one of its' clients. It is essentially a cautionary measure for a situation which could potentially be an exploitive situation, monetarily or otherwise. (see Sec.2; 53-21-141(2).)

SECTION 3. This section addresses the right to appropriate treatment under conditions which limit the restrictions placed on a person to only restrictions which are necessary and consistent with the individual's treatment needs and any judicial order.It adds the federal language on private conversations while a person is a patient.(Sec.3;pg 5; 53-21-142(2) and (3).);

Section 3 also provides for notification of a person in a mental health facility that a grievance procedure is available to address grievances about the facility. It requires the person be informed that he/she may exercise this procedure without retaliation and have access to an available advocate to address those concerns. (Sec.3; 53-21-142(14),(15),(16).)

A final sub-section of Sec.3 addresses the notion that the Restatement of Rights does not negate the professional persons' decisions regarding evaluation, treatment and discharge providing that professional judgment is utilized.(Sec.3; 53-21-142(17)).

SECTION 4.This section addresses a patient's consent to the taking of his or her photograph. (Sec.4, 53-21-144);

SECTION 5. This section addresses the notion that physical restraints may not be used for punishment, for convenience of staff or as a treatment substitute (Sec.5, 53-21-146);

SECTION 6. This section is further clarification on the use of experimental treatments (Sec.6, 53-21-147);

SECTION 7. This section addresses a patient's right to participate in their treatment planning in an informed way with reasonable explanations about the course of treatment and with their understanding and approval within the perimeters of applicable law; (Sec.7, 53-21-162)

SECTION 8. This section addresses the necessity to keep records confidential after discharge of the patient;(Sec.8, 53-21-166)

SECTION 9. This section addresses the rights of patients to receive appropriate discharge referrals when they leave a mental health facility.(Sec.9, 53-21-181)

17
2-22-91
930

TO: MT HOUSE HUMAN SERVICES COMMITTEE
FROM: MARY GALLAGHER
STAFF ATTORNEY
PROTECTION & ADVOCACY FOR MENTALLY ILL INDIVIDUALS/BOARD OF VISITORS
DATE: FEBRUARY 22, 1991

RE: HEARING ON HOUSE BILL 930 specifically on SECTION 7 -
regarding Informed Consent requirement for
treatment plans

Yesterday the Department expressed some concern about Section 7, 53-21-162(6)(c): regarding a patients right not to receive treatment established pursuant to the treatment plan in the absence of the patients informed consent to treatment. Two exceptions are listed: one for emergencies and the other for the applicable law for persons committed to a facility by the court. The concern expressed was for patients who refused to give informed consent to a treatment plan and for patients who were not able to give informed consent because of their mental(or physical) status.

These issues are addressed in several places in current Montana law. The first concern can be addressed by referring to the current code section 53-21-136 on provisions a facility may follow if a person committed to a facility fails to comply with a treatment plan. That section states:

COMPLIANCE WITH TREATMENT PLAN. If the respondent fails to comply or clearly refuses to comply with all or part of the treatment plan, the professional person appointed under 53-21-122 shall make all reasonable efforts to solicit the respondent's compliance. Such efforts must be documented and reported to the court with a recommendation to the court as to whether the respondent should:

- (1) have his case dismissed; or
- (2) be given a supplemental hearing.

Section 53-21-136, Mont.Code Ann.

The second concern can be addressed by referring to the Montana guardianship statutes in Title 72, MCA on how to deal with patients who are not able to give informed consent. Nothing in this bill would preclude a mental health facility from establishing policies to deal with those patients who are not able to give informed consent or who refuse treatment. Most facilities already have those policies in place. In fact, **HB 930 represents the generally accepted professional standards currently practiced in this state and elsewhere.** Therefore, any attempt to amend the bill on these issues is unnecessary and warranted.

EXHIBIT 18
DATE 2-22-91
HB 930 & 862

MONTANA ADVOCACY PROGRAM, Inc.

1410 Eighth Avenue
Helena, Montana 59601

(406)444-3889
1-800-245-4743

February 22, 1991

Representative Russell, Chair
Human Services and Aging Committee
Capitol Station
Helena, Montana 59620

RE: H.B. 862
H.B. 930

Dear Angela:

I have missed seeing you since your other commitments necessitated you vacating your seat on the State Planning Council! As you know the mission of the Montana Advocacy Program (MAP) is to protect and advocate for the rights of Montanans with disabilities while enhancing dignity and self-respect. I am submitting this written testimony today in support of two House Bills your committee will be hearing this afternoon.

The first, H.B. 862, revises the requirements for screening voluntary admissions to the Montana State Hospital. The meat of the revision is that "Before admission may be approved, the admitting professional making the referral shall consult with the designated admitting professional at the state hospital," and agreement is reached that services cannot be provided in the community and the admission is appropriate. While MAP will always advocate for community-based services over any institutional placement, we believe this revision is an improvement over the existing and builds in an additional safeguard for the individual. As such, we endorse this revision.

The second, H.B. 930, is "An Act incorporating the federal provisions regarding protection and advocacy for the mentally ill described in 42 U.S.C. 10801 et. seq. into Montana law...and amending" certain sections of existing 53-21-141. Passage of this bill will make Montana law consistent with the federal legislation referenced. MAP strongly endorses H.B. 930.

EXHIBIT 18
DATE 2-22-91
HB 930

Thank you for taking these comments into consideration. Please do not hesitate to contact me if I can provide you with additional information.

Sincerely,



Kristin Bakula
Executive Director

kb
c: File

TESTIMONY ON HB 862
BY DAN ANDERSON
HOUSE HUMAN SERVICES AND AGING
COMMITTEE

FEBRUARY 22, 1991

MADAM CHAIR, MEMBERS OF THE
COMMITTEE. MY NAME IS DAN
ANDERSON. I AM THE
ADMINISTRATOR OF THE MENTAL
HEALTH DIVISION OF THE
DEPARTMENT OF INSTITUTIONS.

THE DEPARTMENT OF INSTITUTIONS
ESTABLISHED A MENTAL HEALTH
LAW TASK FORCE IN 1990 TO REVIEW
MENTAL HEALTH STATUTES AND
MAKE RECOMMENDATIONS FOR
CHANGE. THAT TASK FORCE
CONSISTED OF MENTAL HEALTH
PROFESSIONALS, ADVOCATES,
CONSUMERS, PHYSICIANS,

ATTORNEYS AND FAMILY
MEMBERS OF CONSUMERS. THIS BILL
WAS DRAFTED BY, AND
UNANIMOUSLY RECOMMENDED BY THE
TASK FORCE. IN ADDITION, THE
MONTANA STATE MENTAL HEALTH
PLANNING AND ADVISORY COUNCIL
HAS UNANIMOUSLY ENDORSED HB 862.

THIS LEGISLATION IS PART OF THE
DEPARTMENT OF INSTITUTIONS'
EFFORTS TO ESTABLISH A GENUINE
SYSTEM OF MENTAL HEALTH
SERVICES IN MONTANA. A GOAL OF
THAT SYSTEM IS TO ASSESS
PATIENT NEEDS AT THE LOCAL

LEVEL AND PROVIDE SERVICES THAT
ARE APPROPRIATE FOR THAT
PATIENT IN THE LEAST RESTRICTIVE
ALTERNATIVE WHICH IS POSSIBLE.
THE DEPARTMENT BELIEVES THAT
ENTRY INTO THE PUBLIC MENTAL
HEALTH SYSTEM SHOULD OCCUR AT
A LOCAL LEVEL AND A DECISION
SHOULD BE MADE THERE WHETHER
OR NOT THE PERSON NEEDS THE
MORE INTENSIVE SERVICES
AVAILABLE AT THE MONTANA STATE
HOSPITAL. A PATIENT'S FIRST
CONTACT WITH THE PUBLIC MENTAL
HEALTH SYSTEM SHOULD NOT BE AT
MONTANA STATE HOSPITAL.

THIS LEGISLATION SEEKS TO
STREAMLINE AND STRENGTHEN THE
SCREENING PROCESS WHICH IS
ALREADY IN PLACE FOR VOLUNTARY
ADMISSIONS TO THE MONTANA
STATE HOSPITAL. THE DEPARTMENT
PROPOSES TO SET UP A NETWORK
OF MENTAL HEALTH PROFESSIONALS
WHO WILL HAVE THE AUTHORITY TO
APPROVE ADMISSION TO THE STATE
HOSPITAL.

MORE IMPORTANTLY, THESE
PROFESSIONALS WILL HAVE THE
KNOWLEDGE AND SKILLS NECESSARY
TO FIND LESS RESTRICTIVE

COMMUNITY BASED SERVICES WHEN
THOSE SERVICES WOULD BE
ADEQUATE TO MEET THE PATIENT'S
NEEDS.

THE PROCESS IS DESIGNED TO BE
SIMILAR TO THE ADMITTING
PROCESS OF OTHER HOSPITALS
WHERE THERE IS A LIMITED NUMBER
OF PEOPLE WHO HAVE ADMITTING
PRIVILEGES TO THE HOSPITAL. WE
BELIEVE THAT BY HAVING A
LIMITED NUMBER OF PEOPLE WHO
CAN MAKE REFERRALS TO THE
STATE HOSPITAL, WE WILL BE ABLE
TO PROVIDE TRAINING FOR THOSE

INDIVIDUALS AND ASSURE THAT
THOSE INDIVIDUALS ARE
PROFESSIONALS WHO ARE SKILLED
AT ASSESSING PATIENT NEEDS AND
ALSO SKILLED AT OBTAINING
WHENEVER POSSIBLE, APPROPRIATE,
NON-INSTITUTIONAL SERVICES ON
BEHALF OF THE PATIENT.

AN IMPORTANT FEATURE OF THIS
LEGISLATION IS THAT MONTANA
STATE HOSPITAL STAFF WILL HAVE
A HAND IN MAKING THE DECISION
REGARDING VOLUNTARY ADMISSIONS.
THIS PROVIDES FOR A CONTINUAL
DIALOGUE BETWEEN COMMUNITY-

BASED MENTAL HEALTH
PROFESSIONALS AND THE STAFF OF
THE STATE HOSPITAL REGARDING
THE APPROPRIATENESS OF
ADMISSIONS.

IT IS IMPORTANT TO EMPHASIZE
THAT THE GOAL OF HB 862 IS NOT
A DECREASE IN ADMISSIONS TO
MONTANA STATE HOSPITAL,
ALTHOUGH THAT MAY RESULT. THE
TRUE GOAL IS TO PROVIDE THE
APPROPRIATE LEVEL OF SERVICES
TO PEOPLE WITH MENTAL ILLNESS.
STATE LAW REQUIRES THAT THE
APPROPRIATE LEVEL OF SERVICE BE

IN THE LEAST RESTRICTIVE SETTING
POSSIBLE.

THE DEPARTMENT VIEWS THIS
LEGISLATION NOT AS A CURE-ALL
FOR ASSURING APPROPRIATE
ADMISSIONS TO THE STATE
HOSPITAL, BUT, WE THINK HB 862
WILL PROVIDE THE FRAMEWORK FOR
A CONTINUUM OF CARE AND
TREATMENT WHICH CAN BE MORE
RESPONSIVE TO PATIENT NEEDS.

I WANT TO EMPHASIZE THAT THIS
BILL HAS THE WIDE APPROVAL AND
ENDORSEMENT OF THE MENTAL

HEALTH COMMUNITY IN MONTANA AS
ONE STEP THAT WE ARE TAKING IN
ATTEMPTING TO CREATE A GENUINE
SYSTEM OF PUBLIC MENTAL HEALTH
SERVICES FOR THE CITIZENS OF
MONTANA WHO HAVE A MENTAL
ILLNESS.

THANK YOU.

Feb.22, 1991



MonAMI

Montana Alliance for the Mentally Ill

To House Human Services Committee

SUPPORTING HB 862 TO SCREEN ADMISSIONS TO THE STATE HOSPITAL

Chair Russell and Members of the Committee

I'm Marty Onishuk, representing MonAMI, an organization of consumers with mental illnesses and their families. We now have eight chapters in Montana and are part of the National Alliance of the Mentally Ill with a membership of over 100,000.

Because we believe treatment should be provided in the least restrictive environment as near to home as possible, we support screening of patients for admission to the state hospital at Warm Springs. If patients show up at the door and need shelter, they can now be referred to the pilot program in Butte which is geared to helping people resolve their problems in the community. We recognize a "safety-net" is necessary for consumers outside of the system. But community-based programs with good case-managers in crisis intervention teams, safe houses, short-term hospitalization in the home community, meet the needs of many consumers. This is quicker, cheaper, more humane, and better than admission to the state hospital for a large percentage of people in crisis.

We support this proposal by the Department of Institutions to provide necessary services for our members and their families.

Sincerely,

Martha L. (Marty) Onishuk
5855 Pinewood Lane
Missoula, Mt. 59803
251-2754

2-22-91

Exhibit 21 is a duplicate of Exhibit 18. The original is stored at the Montana Historical Society, 225 North Roberts, Helena, MT 59601. (Phone 406-444-4775)

DEPARTMENT OF INSTITUTIONS

EXHIBIT 22
DATE 2-22-91
HB 909



STAN STEPHENS, GOVERNOR

1539 11TH AVENUE

STATE OF MONTANA

(406) 444-3930

HELENA, MONTANA 59620-1301

TESTIMONY FOR HB 909

HB 909 introduced at the request of Dave Brown mandates minimum entry requirements for certification of chemical dependency counselors, provides for suspension or revocation of certification for violation of professional ethics standards and requires a study of the minimum requirements for certification of persons providing counseling for gambling addictions.

The minimum requirements are essential to the professionalism of the chemical dependency treatment field. The present system has evolved since 1980 and has grown as a profession. It is time to raise the professional standards. The chemical dependency treatment programs statewide can easily implement proposed statutes without negative impact.

Given the current requirements, many persons desire this credential. The testing process is competency based ie. successful completion of all three exams. Inappropriate applicants are not being certified as they cannot pass the exams, however, they are impacting the workload significantly as we must offer three attempts on each exam. Since July 1, 1989, 250 individuals have registered for chemical dependency certification, the Alcohol and Drug Abuse Division has only certified 88 counselors.

The Alcohol and Drug Abuse Division believes this bill will enhance the quality of chemical dependency treatment services statewide.

Montana law gives the department authority to certify and establish standards for the certification of chemical dependency counselors and instructors providing chemical dependency educational courses. However, the statute does not deal with suspension or revocation of certification, this is a needed addition. In order to be truly effective and responsive to those seeking treatment services the certification system must have the authority to suspend or revoke certification based on violation of the standards for professional ethics.

This bill requires the department to study the minimum requirements for certification of persons providing counseling for gambling addictions and the availability of effective treatment resources in Montana.

22
2-22-91
HB 909

The department concurs it is the most appropriate agency to conduct the study providing the fiscal note is accepted. Research indicates problem and compulsive gamblers can benefit from treatment in the addiction model, however, there are unique differences. The department will study this area and report to the 53rd legislature its findings and recommendations for the certification of gambling addiction counselors.

DEPARTMENT OF INSTITUTIONS

23
DATE 2-22-91
HB 909



STAN STEPHENS, GOVERNOR

1539 11TH AVENUE

STATE OF MONTANA

(406) 444-3930

HELENA, MONTANA 59620-1301

TESTIMONY FOR HB 909

Although, this bill was not drafted at the request of the Department we believe that sections one, two and three, will enhance our certification system for chemical dependency counselors. The Department does not have a position on section four, the gambling study but believes we can complete the study in the time frame, if the fiscal note adhered to in its entirety.

EXHIBIT 24
DATE 2-22-91
HB 909

TO: HOUSE HUMAN SERVICES AND AGING COMMITTEE
FROM: MIKE MALES
RE: TESTIMONY IN SUPPORT OF HB 909
22 February 1990

HB 909 represents the logical evolution of the very important profession of chemical dependency counseling toward increased educational and practical standards. Chemical dependency counselors deal with clients in vulnerable times of their lives, and the public has the right to expect continued upgrading of their expertise. The Department of Institutions has continually strengthened chemical dependency counselor certification standards, and HB 909 is the next step.

HB 909 is an outgrowth of legislation last session in which the state placed increased reliance on chemical dependency counselors to provide newly mandated services to repeat drunken driving offenders. At that time, complaints were registered from a number of diverse quarters about some unqualified personnel in the chemical dependency field, and promises were made to strengthen their training. I am enclosing testimony from a former chemical dependency client illustrating problems in this profession.

HB 909 is a balanced and necessary measure. I suggest three amendments. The first simply clarifies the training requirements and removes ambiguity. The second applies the ethics standards and complaint procedure via the Department of Institutions to existing chemical dependency counselors; I do not see why they should be exempt from these. The last amendment requires existing counselors to meet the certification standards of HB 909 by July 1, 1996, five years from its effective date. This should be plenty of time for them to adapt, particularly since their practice and prior training could be applied.

I commend HB 909 to you and urge the amendments. Thank you.

Mike Males
1104 S. Montana, No. F-12
Bozeman, MT 59715

Amendments to House Bill 948
As Introduced

1. Page 1, line 14
Strike: "contract" and
Insert: "written agreement"
2. Page 1, line 22
Insert: "(g) superintendents of public school districts in the county."
3. Page 1, line 19
Insert: "county" before "superintendent"
4. Page 2, line 14
Strike: "contract" and
Insert: "written agreement"
5. Page 2, line 15
Strike: "in the easiest and quickest manner of a maximum"
6. Page 2 line 16
Strike : "of all types"
7. Page 2 line 20
Insert: "youth in need of supervision" before "and"

EXHIBIT 26
DATE 2-22-91
HB 761

Amendments to House Bill No. 761
First Reading Copy

Requested by Rep. Stickney
For the Committee on Human Services and Aging

Prepared by David S. Niss
February 22, 1991

1. Title, line 7.
Following: "USED;"
Insert: "REQUIRING TREATMENT FOR CONVICTED PERSONS;"
2. Page 1, line 21.
Following: the period
Insert: "The health care provider shall give the convicted person pretest counseling."
3. Page 1, line 25.
Strike: "The"
Insert: "Except as provided in subsection (2), the"
4. Page 2, lines 2 through 19.
Following: line 1
Strike: lines 2 through 19
Insert: "(a) defense counsel for the convicted person;
(b) the health care provider; or
(c) a victim of the convicted person.
(2) The county attorney must release positive test results to the following:
(a) the health care provider who conducted the test, who must release the results to the convicted person; and
(b) the health officer to who the department has required the reporting of communicable diseases under 50-1-202; and
(c) the victim ."
Renumber: subsequent subsections
5. Page 2, line 22.
Strike: "or local board of health"
6. Page 3, lines 1 through 3.
Strike: "for" on line 1 through "or" on line 3
7. Page 3, line 3.
Following: "treatment"

Insert: "or prosecution or defense of the convicted person"

8. Page 3.

Following: line 3

Insert: "(5) The provisions of the aids prevention act do not apply to [sections 1 through 4].

NEW SECTION. **Section 3. Treatment required.** A convicted person on whom positive test results are obtained must be offered appropriate treatment for the sexually transmitted disease indicated by the test. If requested by the convicted person, treatment must be given at no cost to the convicted person by the county in which the convicted person is confined or by the department of institutions if the convicted person is sentenced to confinement in the state prison.

Renumber: subsequent sections

9. Page 3, line 6.

Following: "authorized"

Insert: "or required"

10. Page 4, line 11.

Strike: "3"

Insert: "4"

11. Page 4, line 14.

Strike: "3"

Insert: "4"

12. Page 4, line 16.

Strike: "3"

Insert: "4"

13. Page 4, line 19.

Strike: "3"

Insert: "4"

14. Page 4, line 20.

Strike: "3"

Insert: "4"

EXHIBIT 27
DATE 2-22-91
HB 917

Amendments to House Bill No. 917
First Reading Copy

Requested by Rep. Stickney
For the Committee on Human Services and Aging

Prepared by David S. Niss
February 21, 1991

1. Page 3, line 17.

Following: "transmission"

Insert: "in accordance with modes of transmission recognized by
the center for disease control of the United States public
health service"

2. Page 9, line 8.

Following: "~~department~~"

Insert: "at one of the counseling-testing sites established by
the department, or "

3. Page 10, lines 24 and 25.

Strike: "24 hours"

Insert: "a reasonable time"

4. Page 16, line 20.

Strike: "person"

Insert: "contact as defined in 50-16-103"

5. Page 16, line 22.

Strike: "patient"

Insert: "contact"

Amendments to House Bill No. 917
First Reading Copy

Requested by Rep. Stickney
For the Committee on Human Services and Aging

Prepared by David S. Niss
February 21, 1991

1. Page 11.

Following: line 3

Insert: "(10)(a) If an agent or employee of a health care facility or a health care provider with privileges at the health care facility or if an emergency medical technician or an employee of an ambulance service licensed under title 50, chapter 6 has been voluntarily or involuntarily exposed to a patient in a manner that may allow infection by HIV by a mode of transmission recognized by the center for disease control of the United States public health service, the physician of the person exposed shall, upon request of the person, notify the patient of the exposure and seek written informed consent in accordance with guidelines of the center for disease control for an HIV-related test of the patient. If written informed consent cannot be obtained, the health care facility, in accordance with the infectious disease exposure guidelines of the health care facility, may, without the consent of the patient, conduct the test on previously drawn blood or previously collected bodily fluids to determine if the patient is in fact infected. A health care facility is not required to perform a test authorized in this subsection. If a test is conducted pursuant to this subsection, the health care facility shall inform the patient of the results and provide the patient with post-test counseling. The patient may not be charged for a test performed pursuant to this subsection. The results of a test performed pursuant to this subsection may not be made part of the patient's record and are subject to 50-16-1009(1).

patient

(b) For the purposes of this subsection, written informed consent means an agreement in writing that is freely executed by the subject of an HIV-related test, by the subject's legal guardian, or if there is no legal guardian and the subject is incapacitated, by the subject's next-of-kin, significant other, or a person designated by the subject in hospital records to act on the subject's behalf.

Renumber: subsequent subsection

-End-

Amendments to House Bill No. 895
First Reading Copy

Requested by Rep. Brown
For the Committee on Humand Services and Aging

Prepared by David S. Niss
February 21, 1991

1. Title, line 9.
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.
Strike: "by the board of morticians, provided for in 2-15-1853,"
Insert: "under 37-19-302"
5. Page 1, line 17.
Strike: "written"
Following: "authorization of"
Strike: "the"
Insert: "a"
6. Page 1, lines 17 through 19.
Strike: "in" on line 17 through "attended" on line 19
Insert: ", coronor, or mortician licensed under title 37"
7. Page 1, line 19.
Strike: "written"
8. Page 1, lines 20 through 23.
Following: "department"
Strike: remainder of lines 20 through "released" on line 23
9. Page 1, line 24.
Strike: "written"
10. Page 2, line 1.
Strike: "within the state only"
11. Page 2, line 2.
Following: "mailed"
Insert: "or delivered"
Strike: "24"
Insert: "72"

EXHIBIT 29
DATE 2-22-91
HB 895

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

13. Page 2, line 4.
Strike: "in which"
Insert: "where"

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

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

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

17. Page 2, lines 9 through 16.
Following: "certificate."
Strike: remainder of lines 9 through "death" on line 16

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

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

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

21. Page 2, line 24.
Strike: "for"
Insert: "in"

22. Page 2, line 25.
Strike: "in which"
Insert: "where"

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

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

EXHIBIT 29
DATE 2-22-91
HB 895

25. Page 3, line 10.
Strike: "or"

26. Page 3, lines 11 and 12.
following: "for burial or cremation"
Insert: "; or"

27. Page 3.
Following: line 12
Insert: "(d) anatomical donation"

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

29. Page 4, line 8.
Strike: "50-15-402,"

Amendments to House Bill No. 681
First Reading Copy

Requested by Rep. Jim Rice
For the Committee on Human Services and Aging

Prepared by David S. Niss
February 21, 1991

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 OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 831
 DATE 2-22-91 SPONSOR(S) Rep. Jan Brown

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
DARRYL BRUNO	Dept of Inst	831		X
Mike Roper	C D PRR	831		X

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

HOUSE OF REPRESENTATIVES

1 of 2

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 927
 DATE 2-22-91 SPONSOR(S) Rep. Dan Harrington

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
VORM Waterman	SRS	927	X	X
Perry Robbe	SRS	927	X	
JACK Thompson	SRS	927	X	
HARLEY WARNER	MONTANA ASSOC OF CHURCHES	927		X
John Osterman	mt Catholic Cong	927		X
G/Martin	Montana HRDC	927		X ^{sample}
Wick Lochmell	Great Falls	927		X
Foreman Saunders	But B.C.U.	927		X
Dan Rubick	B.C.U. Butte	927		Y
Tootie Welker	MAPP	927		X
JUDITH CARLSON	HRDC	927		X
Val Meno	Butte Community Union	927		✓
Marcia Schreder	Montana for Social Justice + Montana Low Income Coalition	927	X	X

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

Jim Smith

MR

10

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

2062

Human Services & Aging COMMITTEE BILL NO. 927
DATE 2-22-92 SPONSOR(S) Rep. Don Harrington

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Stanley Colenso	MLIC & Butte Comm. Union	927		X
Frances J. J. J.	Butte Comm. Union	927		X
Patricia Bloom	MLIC			X
Marice H. H.	MLIC			X
Mik O'Sullivan	Carroll College	927		X

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

HOUSE OF REPRESENTATIVES

1 of 2

VISITOR'S REGISTER

Human Services & Aging

COMMITTEE

BILL NO. HB 876DATE 2-22-91SPONSOR(S) Rep. Diana Wyatt

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
John M. Epitz 579 2nd Helena MT 59601	Self			✓
Susan D. Lewis 579 2nd Helena MT 59601	Self			✓
ELLEN LEAHY 301 W. Adams MSN. MT 59802	MISSOULA PUBLIC HEALTH DEPT.			X
Donald E. Espelin MD	Heathly Nations, Heathly Bodies			X
Judy Garrity	Montana Children's (M)			X
Cindy Little	DHES			X
Truman Kohman	Self			
Jane Kohman	Self			
L. Kohman - Spr N.Y.				
To Ann Dotson	DHES - MPP			
Denise Stinac	Self MVA			
Debra Zisendorf	W. Med Assn			✓
Walt Pickett	Self			

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

Justin Carlson

Mt. Clem - NASC

X

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

202

Human Services & Aging

COMMITTEE

BILL NO. HB 876

DATE 2-22-91

SPONSOR(S) Rep. Diana Wyatt

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
BUD SIMONSSON	MONTANA Council for Families	X	
D. Elizabeth Roeth	MT. Children's Alliance	X	
Joan Bowler	HMHB - Helena Area Coalition	X	
JOHN ORTWIG	MT CATHOLIC CONF	X	
Robert R Johnson	Mont. Pub. Health Assn.	X	
Gene Huntington	Montana Dietetic Assoc.	X	
Paulette Kohman	MT Council for Maternal & Child Health	X	
Cathy Campascoli	MNA, MNPSIG	X	
Thom Smethell	MNA	X	
Teresa K. Henry	MNA	X	
Sharon Mezger	MNA	X	
Lud Olesson	Lewis & Clark City Co Health	X	
Marty Orushuk	MT. League of W Veterans	X	
Debbie Brumgardner	Democratic Women's caucus	X	

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 835
 DATE 2-22-91 SPONSOR(S) Rep. Knox

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
<i>Dyle Riche</i>	<i>D/C 8/5</i>	<i>835</i>		✓
<i>Bill Jensen</i>	<i>Blue Camp Blue Hill</i>	<i>835</i>		✓

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 881
 DATE 2-22-91 SPONSOR(S) Rep. Rayal Johnson

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Drew Dawson	DHES, EMS Bureau			✓

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 930
 DATE 2-22-91 SPONSOR(S) Rep. Tim Whalen

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Mary Gallagher	Board of Visitors/PAMI	930		X
John Lynn	Mental Health	930		X
Marty Onishuk	Mon AMI	1		X
Kerry Moore	Board of Visitors	930		X
Dan Anderson	MT Dept Institutions	930		X
PAUL MEYER	Western Region Community Mental Health Center	930		X
John Shute	Mental Health Assn.	930		X

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 862
 DATE 2-22-91 SPONSOR(S) Rep. Dorothy Bradley

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
Meresa Reardon	MFT/MFSE	862	X	
P.O. Box 219 Don Harry Billings 59103	Mental Health Center	862		X
John Lynn	Mental Health	862		X
Marty Onishuk	Mon AMI	862		X
PAUL MEYER	STATE COUNCIL OF MENTAL HEALTH CENTERS	862		X
Dan Anderson	MT Dept. of Mental Health	862		X
Kevin Moore	Board of Visitors	862		X
John Shontz	Mental Health Dept	862		X

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 909
 DATE 2-22-91 SPONSOR(S) Rep. Dave Brown

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
DAVE MALES	self	909		X
Mike Ruppert	CDPRM	909		X
DARRELL BRUNO	Dept of Inst.	909		
NORMA JEAN BOLES	Dept of Inst	909		X
Mary McCue	MMHCA	909		X
LARRY AKEY	GAMING INDUSTRY ASSOC	909		X
DAVE BROWN	sponsor - HD#72	909		X
Ann Bellwood	Rocky Mountain Treatment Ctr	909		X
Jan-Nell MacFadden	Mental Health Ass.	867		X

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

HOUSE OF REPRESENTATIVES

VISITOR'S REGISTER

Human Services & Aging COMMITTEE BILL NO. HB 948
 DATE 2-22-91 SPONSOR(S) Rep. Royal Johnson

PLEASE PRINT

PLEASE PRINT

PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	BILL	OPPOSE	SUPPORT
P.O. Box 219 Don Harr Billings 59103	Mental Health Center	948		✓
Steve Nelson	Crime Control	948		✓
Ann Gilkey	DFS	948		X
Harold Hansen	Self -	948		✓

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

VISITOR'S REGISTER

DATE 2-22-91 SPONSOR(S) Rep. Sheila Rice

PLEASE PRINT

[illegible]

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